INFORMING NURSING EDUCATION: THE MEANING AND EXPERIENCE OF

CULTURAL SAFETY AS EXPRESSED BY NURSES

IN THE PACIFIC NORTHWEST

By

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A dissertation submitted in partial fulfillment of
the requirements for the degree of

DOCTOR OF EDUCATION

WASHINGTON STATE UNIVERSITY
Department of Teaching and Learning

May, 2014

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ACKNOWLEDGEMENTS

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Abstract

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May 2014

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The purpose of this dissertation was to explore how selected nurses in the United States (U.S.) Pacific Northwest are adapting and incorporating concepts of Cultural Safety into their clinical and education practices.   The pioneering work of the New Zealand nurses to incorporate the transformative concepts of Cultural Safety into their education programs and nurse practice laws inspires and informs this study. U. S. nurses have not yet implemented a framework that is effective in defining culture broadly and reducing health disparities between the dominant culture and multiple minority cultures. Cultural Safety combined with Critical Race Theory may offer such a useful framework to inform nursing cultural competence in the United States.

Connecting historical, social, political and health issues with meanings and experiences of nurse educators helps to establish a foundation for incorporating reflection and Cultural Safety in contemporary nursing education. A hermeneutic phenomenological study was conducted in order to explore the meaning and practice of Cultural Safety with five nurse educators and practitioners, and to constructively critique U.S. nursing education related to how cultural competence has been taught. Study findings are presented as four themes common to each participant's story. The themes are positionality, embodiment, reflection and the inherent

tension in a Cultural Safety stance. Within positionality are themes of self-identity, power differentials, and critiques of the status quo or meeting a need. Embodiment contains ways of incorporating Cultural Safety into personal life, clinical practice, teaching and scholarship. Reflection is self-identified by participants as a conscious practice, as well as demonstrated in highly articulate narratives. As a critical process, the Cultural Safety stance has an inherent tension that is expressed in the desire for transformation in nursing education and practice which links to positionality and embodiment. There are overlaps and interplays between and among the themes that may be viewed in an encompassing theme of choosing to live one's life in the role of advocate. Challenges of the advocacy role are portrayed in a proposed model for transforming current common U.S. concepts of cultural competence to be more effective in providing care to an increasingly culturally complex society.

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DEDICATION

This dissertation is dedicated to you, the reader, with sincere appreciation for your time and attention. As an educator, a student or a nurse, you influence the lives you touch, and shape the future of your community. I hope you find within these words or between the lines some insight to light your path.

CHAPTER ONE

INTRODUCTION

The writing of this dissertation provides the opportunity to describe and reflect on my journey to becoming a nursing instructor and education researcher, as well as, to examine the need, context, and research methods for exploring how selected nurses in the Pacific Northwest of the United States (U.S.) are adapting and incorporating concepts from New Zealand nursing of Cultural Safety into their clinical and education practices. A qualitative study was conducted in order to explore the meaning and practice of Cultural Safety with five nurse educators and practitioners, and to constructively critique U.S. nursing education related to how cultural competence has been taught. The study findings are presented as four themes common to each participant's story, summarized in one over-arching theme. Implications for U.S. nursing education are offered with a proposed model for transforming current common U.S. concepts of cultural competence by integrating Cultural Safety with Critical Race Theory and Transcultural Nursing in order to be more effective in providing care to an increasingly culturally complex society.

The research inquiry explored how each nurse came to Cultural Safety, how each expresses Cultural Safety in practice and how each finds meaning in this practice. It is hoped that this qualitative study will inform and inspire nurse educators to examine the potential of adapting and teaching Cultural Safety concepts to their students who can potentially reduce health disparities, as well as avoid iatrogenic emotional and physical travesties resulting from cultural blindness and institutional racism as they provide nursing care in the future (Drevdahl, Canales, & Dorcy, 2008; Ford & Airhihenbuwa, 2010; Institute of Medicine (IOM), 1999; Mortensen, 2010; Yurkovich, Hopkins-Lattergrass, & Rieke, 2011).

Definitions

Several definitions are given in this introductory section in order to clarify my use of certain concepts discussed throughout this work. Cultural Safety is a concept that has been evolving as theory and practice in New Zealand nursing since the 1990s (Ramsden, 2003), and is being adopted and adapted in other countries, such as Australia (Johnstone & Kanitsaki, 2007), Canada (Anderson, et al., 2003), Israel (Arieli, Friedman, & Hirschfield, 2012), and the U.S. (Doutrich, Arcus, Dekker, Spuck, & Pollock-Robinson, 2012; Moceri, 2014). A definition of Cultural Safety from the Nursing Council of New Zealand (2011) is:

> The effective nursing practice of a person or family from another culture, and is determined by that person or family. Culture includes, but is not restricted to, age or generation; gender; sexual orientation; occupation and socioeconomic status; ethnic origin or migrant experience; religious or spiritual belief; and disability. The nurse delivering the nursing service will have undertaken a process of reflection on his or her own cultural identity and will recognize the impact that his or her personal culture has on his or her professional practice. Unsafe cultural practice comprises any action which diminishes, demeans or disempowers the cultural identity and well-being of an individual. (p. 7)

The definition of effective in the context of this dissertation is also cited from the Nursing Council of New Zealand (2011), "Having the intended outcome" (p. 20). Thus, the intended outcome of nursing care is the improved health status of the patient or client; and Culturally Safe care has been effective if the client says it has been. In U. S nursing, effective also means having the intended outcome, however the standard for intended outcomes is most often set by the health care system rather than established by clients' individual values. This critical difference

in placement of power in the health care system rather than with the individual patient has not been effective in desired health outcomes for the U.S. a whole (Institute of Medicine, 1999; U.S. Department of Health and Human Services, 2014).

The term cultural competence has been used in the U.S. among helping professions since the 1980s. The seminal work of Cross, et al. (1989) provides the standard for definition of these terms:

> The word **culture** is used because it implies the integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values and institutions of a racial, ethnic, religious or social group. The word **competence** is used because it implies having the capacity to function effectively (National Center for Cultural Competence, 2004).

My work within this dissertation includes examination of what is actually effective in terms of the desired outcomes for the recipients of U.S. nursing care, and to explore how Cultural Safety may be more effective than cultural competence has been. This discussion is undertaken in Chapter Two with more defintions that include Transcultural Nursing and Critical Race Theory.

Definitions are needed related to my research design. For this study, hermeneutic is understood as the interpretation of meaning of text, narrative, and phenomena within a holistic context that includes beliefs, cultural and social influences of both the researcher and the participants (Denzin & Lincoln, 1994). I find it helpful to think of the origin of the the word in the Greek god Hermes, who served as interpretor/messenger to humans of the meanings of communications from the other dieties (Patton, 2002). The ninteenth century German Idealist philosopher, Schleiermacher is credited as a founder of hermeneutics (Bowie, ed., 1998). For the purposes of my research, I trace my understanding through the term Heideggerian hermeneutic

phenomenology to mean the exploration of one's lived experiences to uncover meaning that is inseparable from the experiences (Denzin & Lincoln, 1994). This is further elaborated in Chapter Three.

Content of the Chapters

Chapter One situates the researcher in terms of my background, experiences and reflections that led to a passion for teaching Cultural Safety to nursing students. This is consistent with the hermeneutic methodology and with Cultural Safety practice. I include a description of my original course taught as an on-line elective in the College of Nursing at Washington State University, Cultural Safety and Social Justice in Global Society, with learning theory rationales for its structure and content. The complete course syllabus is found in Appendix A.

Chapter Two offers a review of the historical literature and current research that describes Cultural Safety as practiced and studied in New Zealand, Canada and the U.S. In addition, an overview of reflection on practice, one component of Cultural Safety, is presented as part of the conceptual basis for the research. Overviews of Transcultural Nursing and Critical Race Theory (CRT) are presented, compared and contrasted to Cultural Safety.

Chapter Three describes the research methods and offers a discussion of rigor in critical hermeneutic phenomenology. Chapter Four presents the research findings as four themes common to the five participants expressed in the reflective dialogues conducted with each. The four over-arching themes, as well as multiple subthemes that emerged are evident in the participants' words and in the spaces between the lines. Additional literature reviews were undertaken as themes and meanings were uncovered in the data analysis. This scholarship is incorporated in the discussion of the implications of the findings for U.S. nursing education in

Chapter Five and informs a model proposed to integrate concepts from Critical Race Theory into U.S. nursing education in order to move the traditional U.S. cultural competence model toward a potentially more effective practice including Cultural Safety (Clingerman, 2011; Doutrich, Arcus, Dekker, Spuck, & Pollock-Robinson, 2012; Duke, Connor, & McEldowney, 2009; Ford & Airhihenbuwa, 2010; Greenwood, 2009; Institute of Medicine (IOM), 2003; Joint Commision Standards on Patient Safety, 2010; Kaiser Family Foundation, 2005; Moceri, 2014; NAHO, 2009; Villarruel, 2004; Woods, 2010).

As a nurse educator with 30 years of clinical experience, I undertook this project for several reasons. I have observed myself and other nurses to ignorantly cause distress to clients and patients due to failure to understand and act outside our own cultural biases. Nurse educators through their students have the potential to impact the future health and illness outcomes of whole communities for generations to come. Teaching the evolving concepts of Cultural Safety and including concepts of Critical Race Theory in the U.S. holds promise for educating nurses to be mindful of power differentials that must be shifted to provide patient-centered, family-centered care (Anderson, et al., 2003; Benner, Sutphen, Leonard, & Day, 2009; Bobo, 2004; Calin, 1996; Gibbs, 2005; Jeffs, 2001; Papps & Ramsden, 1996; Tatum, 2009; Taylor, 2009). A culturally safe healthcare system that does not impede those in need of care and that supports communities to prevent ill health is a vision for the future worth exploring (Clingerman, 2011; Doutrich, Arcus, Dekker, Spuck, & Pollock-Robinson, 2012; Duke, Connor, & McEldowney, 2009; Ford & Airhihenbuwa, 2010; Greenwood, 2009; IOM, 2003; Joint Commision Standards on Patient Safety, 2010; Kaiser Family Foundation, 2005; NAHO, 2009; Villarruel, 2004; Woods, 2010).

Who I Am

Laverty (2003) provides this relevant commentary on hermeneutic phenomenology, "In Heidegger's (1927) opinion, all understanding is connected to a given set of fore-structures, including one's historicality, that cannot be eliminated. One, therefore, needs to become as aware as possible and account for these interpretive influences" (p. 9). With this understanding as a guiding influence, I present my own history, reflections and self-interpretations. My process is integral to this research and is evident in the dialogues conducted with the five participants that are presented later in Chapter Four.

I am a nurse and an educator. In a concurrent qualitative study in which I am involved related to preparing nurse educators (Doutrich, et al., 2014), the participants revealed awareness that nurse educators need clinical expertise, as well as expertise in how to teach. The teaching includes how to promote hands-on clinical skills, how to foster deep integrated learning of wide-ranging content, and how to transform novices into ethical, thoughtfully reflective life-long learners and practitioners. This section is a description of how my clinical self and my educator self are evolving together into researcher. This exploration and understanding gained through self-reflection and self-assessment is called for by thought-leaders in education and nursing in order to continue to evolve professionally, as well as to be an effective and authentic educator (American Association of Colleges of Nursing, 2011; Benner, Sutphen, Leonard, & Day, 2009; Benner, 1984; Brookfield, 1995; Campinha-Bacote, 2002; Doutrich, Arcus, Dekker, Spuck, & Pollock-Robinson, 2012; Doutrich, et al., 2014; Duke, Connor, & McEldowney, 2009; Greene, 1991; Rolfe & Gardner, 2006; Schon, 1983) .

An over-arching guide to my research is the concept of Cultural Safety as described and practiced by New Zealand nurses (Doutrich, et al., 2012; Ramsden, 2003; Richardson, 2005). To

know oneself and to be aware of power differentials in relationships are two tenets of Cultural Safety which is formed within the critical social theory paradigm. Because nursing is primarily a female occupation with a long history of gender politics vis-a-vis the male-dominated medical profession, there is a feminist epistemology, also grounded in critical social theory that permeates any research designed to strengthen and bring to light the analytical and self-reflective skills of nursing professionals (Koro-Ljungberg, Yendel-Hoppey, Smith, & Hayes, 2009).

As an educator I would describe myself as being a critical feminist constructivist with roots in behaviorism. Constructivism's core concepts are that learners construct meaning and thus knowledge for themselves out of sensory input; the focus must be on the learner, not on the subject or lesson to be taught; knowledge is the meaning attributed to experience (constructed) by the learner; learning is an active process; learning takes time; assessment becomes part of the learning process. In contrast, behaviorist learning activities involve rote memorization, skills repetition, drill and practice. Constructivist learning activities involve problem solving, group collaboration, exploration, discovery (Schunk, 2012). My model for critical feminist thinking applied to nursing practice and education is found in the writings of Ramsden (2003) that are described in Chapter 2. My goal for this education research was to construct meaning together with the participants as stories, reflections and experiences were shared.

As a registered nurse and certified-nurse midwife for 35 years, I have been exposed to training based in a variety of methods and theories. Earlier childhood experiences naturally also influenced my development. I became a nurse when I was 30, started a free-standing birth center when I was 40, got married when I was 50, became a nurse educator at 56, and now at age 66 aspire to my Doctor of Education in Teacher Leadership. I have been a nurse since 1980, a Certified Nurse-Midwife since 1986 and have participated in approximately 5,000 births. In the

late 1970s, the research on Maternal/Infant Bonding by Klaus and Kennell (1976) and the book, Immaculate Deception, by Suzanne Arms (1975), strongly influenced my decision to become an OB nurse. I wanted to make the world a better place by helping families to have positive birth and bonding experiences. My basic nursing education in the late 1970s had a strong behaviorist foundation with a hint of social cognitive theory (Schunk, 2012). My social context made sense to me only from a feminist perspective. As life experiences unfolded, I incorporated various theories about culture into my world-view and my teaching practice.

In 1986, a group of 30 women in the San Francisco Bay Area got together and divided-up a do-it-yourself manual from what is now called the American Association of Birth Centers (2014) titled, How to Start a Freestanding Birth Center. We formed study groups, researched and lobbied our California government on insurance and health related issues and generally convinced ourselves that our community needed to take charge of our own birthing environment. I trained many women to be labor coaches. Finally, I said that if everyone was serious about supporting the birth center, I would go back to school to be a midwife. We exemplified the finest elements of highly motivated, self-regulated, constructivist feminist activists. I was Director and provided full scope CNM practice with childbirth education and a well-woman's clinic. We had a successful 10-year run with about 350 births, not one emergency transfer. I transferred for risk of need for medical intervention, calmly, resulting in an 11% transfer rate and an 8% C-section rate. We gained national accreditation by the Commission for the Accreditation of Birth Centers (2014) and state licensure by the State of California. My clients taught me about many complementary and alternative healing modalities. I also learned from my patients that I could not "teach" them anything about health that they were not ready or motivated to learn. Trial and error (a behaviorist concept) thus pushed me toward the social cognitive theory

concepts of motivation and readiness. The following is poem I wrote to celebrate these lessons and experiences:

A Child is Born

Hannah wouldn't let her husband in the room the night Eliza Noor was born.

He would step to the doorway, but as soon as his belly preceded him across the threshold,

she came out of her labor trance and yelled,

"Keep him out of here!" (No male third chakras in control of this scene.)

In her written birth plan she had requested silence. No unnecessary words to be

spoken in her presence.

We sat between her legs and honored her wishes, the women who had gathered

to pray and meditate and do the tasks that ease a child in to the world safely,

to welcome the spirit of Eliza Noor to her body.

How is it that a pregnant woman can hold a roomful of people between her legs?

Cynthia came in late into the night or early in the morning.

Cynthia, my red-haired nurse angel whose usual roll was injecting

great glee and enthusiasm into exhausted midnight labors, who is

famous for singing "Buffalo Gal, Won't You Come Out Tonight"

when pushing is taking hours.

Cynthia hadn't read the birth plan, and cheerily burst in the room

mistaking our stillness for flagging energy.

I was so deep in my communion with Hannah's process that I only stared.

Hannah shot open her eyes, returning from her transition zone

"No speaking!" she boomed.

Cynthia got the picture fast and switched to invisible nurse mode.

I love Cynthia's skills.

The next entrants to the room were the Sufi Masters

in an arc over the birth bed. They were taking on their

female valences and singing the way for Eliza Noor.

Hannah asked with a quiet voice, "When will she be born?"

I replied, "Go ahead if you're ready."

No need to examine her:

second baby, show of blood, grunting breaths, Sufi angels singing…

I heard them bless Eliza Noor whose essence is to be the feminine principle

in a too male spiritual practice.

And if I, who doesn't know a Baba from a Sri,

could hear the Sufi master's singing,

I must be blessed by angels too. (1996)

In the process of being a nurse and health educator, I found it necessary to evaluate both my personal intercultural sensitivity and where my patients and students were in their subjective experience of other cultures. Bennett's Development Model of Intercultural Sensitivity has personally been a useful framework for this (Bennett, 2000). His work is grounded in constructivist learning theory. Bennett's six stages have been helpful in understanding my own emotions and experiences in travel and living in other cultures, as well as my professional practice. I think I have moved back and forth through these stages several times over the course of my life. The model helps me to understand that Acceptance, Adaptation and Integration are

part of an on-going process of cultural self-awareness that sometimes may throw me back into Denial, Defense and Minimization (Bennett, 2000).

In 1976, while I was in Africa in a game reserve compound for 3 months, the park worker's wives would tell me, "Just hold the thought and we will understand you". There was some truth in this, as we each felt good will toward the other and wanted to communicate. Now I see this perhaps as minimization of our differences, cultural blindness. Eventually, as I became very ill with fevers and digestive disasters, the women said to me, "You must return to your home. Africa will kill you!" I agreed. We had moved into acceptance of each other and recognized our differences. Bennett (2000) would say that one must move into adaptation from acceptance so that true empathy is experienced. For me, years of reflection on my experiences in Zambia have continued to reveal insights into my own behavior and the people I encountered. I have flip-flopped around in defense and minimization, sometimes idealizing the "simple life" and then feeling "superior" for the perceived accomplishments of my own culture. I hope that the integration of this experience where I lost my health, but gained exposure to a world and culture vastly different from my own, has fed my nursing practice and engendered compassion and understanding.

On April 2, 1997, I met my husband on vacation on the beach in Waikiki. A year later, we were married and moved to Hawaii. Along with swimming and sunning, I worked in an insurance office that sent me to all the islands in the state to train providers and audit medical practices. Here I discovered the challenges of maintaining current immunizations with remote island families who did not believe in germ theory. Missing the great rewards of hands-on patient care, I took a position as a contract registered nurse (RN) in labor and delivery at the Tripler Army Medical Center to brush up my hospital skills. Eventually I transferred to the

Tripler OB/GYN Clinic to provide pre-natal and GYN care as a certified nurse-midwife (CNM). Providing care to active duty women and families was a great privilege. The following story illustrates how my nursing practice has expanded my world view and has provided lessons in communication and learning how to learn.

On Thanksgiving Day, 2001, I dressed for work as a labor and delivery nurse at the Tripler Army Medical Center in Hawaii. As a rule, I blend in, as a nurse is supposed to do, in my scrubs, pulled-back hair and wearing no jewelry. Because it was Thanksgiving Day, I had the impulse to honor the Native Americans whose sharing enabled the settling of this land (and resulted in their own undoing). I put on my beaded Indian corn necklace, purchased in the desert Southwest in a sincere attempt to honor the crafts person who made it and the spirit of new beginnings represented by the corn. I was not unaware of the irony of working at a military center on this day. At report, I was assigned to a "dual active duty couple". I learned that both the patient and her husband were active duty Marines. She was a second-time mom with no complications in her history, in active labor, progressing well. I anticipated a tough, strong woman and an even tougher man, and a smooth delivery.

When I entered the room, the husband was leaning close to his wife, talking softly. The sounds that he made were like a gentle stream in the forest, and the room became a sanctuary as he coached her through her intense contractions. Recognizing that this process was working at this stage of the labor, I did my nursing assessment and stood by. I planned to offer pain meds if the going got tough. Finally, I had to ask, "These are the most beautiful sounds I have ever heard. What language are you speaking?"

"Apache", he replied.

I was profoundly moved, and felt I had been given a gift to hear this private

communication. He went on to explain with great pride that he had met his wife in an Apache immersion school and that their first-born son was fluent in the language as well.

Quickly, I assessed my plan of care. This Apache couple was honoring their traditions by being warriors in their culture and by preserving their precious language. As they were of a strong Indian tradition and were Marines, I did not want to insult them by suggesting the use of pain medication; but on the other hand, I did not want my patient to suffer beyond her desire or ability to cope with the natural, but painful process of birth. Fortunately, the transition phase went quickly in this labor and we were off to the delivery room as nature prevailed.

I felt that what I could do to honor this birth and this couple's culture was to provide as much privacy as possible in a setting that was stark at best. When birth is uncomplicated and unmedicated, and the couple is in tune with their own family process, I try to protect that family circle from unnecessary interference and disruption.   At the end of the day, my little beaded necklace seemed like a silly, ethnocentric gesture. This couple was in control of their own cultural needs. As a nurse, I had the opportunity to help create the kind of dignified and safe environment they deserved.

From this experience I became aware of my own cultural ignorance, bias and stereotype that a Native American is needy, when in this case my patient was not only stronger than I, but happy, creative, and proud. After 20+ years of OB nursing, I did have the skill to know when to just get out of the way. Encounters with every patient increase my knowledge base. The desire to become culturally competent arises from and gives rise to this process. Reflection on practice has been a guiding principle of my professional life and is the Big Picture take home message I embed in all my teaching. This reflection on reflective practice is part of the metacognitive process of constructivist theory (Bennett, 2000; Schunk, 2012).

My husband and I moved from Honolulu to Vancouver, Washington in 2003 in search of weather and seasons that varied markedly during the year, and to rejoin mainland culture. Clark College hired me to develop a Nursing Assistant Certified program, which was approved by the state and has become a successful on-going program offering. The curriculum for that program was by state decree based in behaviorism with a slight nod to cognitive learning theory. Subsequently, I was hired to be a maternity clinical instructor in the Clark College Nursing Program.

The following is a summary of lessons learned as a new nursing clinical instructor teaching students in a hospital setting that I found in a journal I wrote in 2003:

Make friends with the housekeeping staff and let them know that you respect the work they do. They will be great allies and will keep an eye on your students' welfare and let you know if someone is having a problem.

The most important thing I have learned about my teaching in the past year is that each student brings a unique set of skills, expectations, abilities and motivations to this clinical experience. It is important to take time to get to know each student and to honor his/her unique gifts and needs. Planting and nurturing the seeds of tolerance, scholarship and integrity at this stage in their open minds, are the best actions you can take along with recognizing the signs of dehydration and offering bottled water to the overwhelmed student.

This is evidence of the influence of constructivist theory in my thinking and teaching practice at the beginning of my transition from midwifery practice to academia.

Where I Came From

The following paragraphs attempt to explore my childhood, cultural background and values that influenced me early on. My father's grandfather immigrated to a farm in Alabama from Prussia (Swiss-German) in the early 1800s. Father's father later immigrated to a primitive farm in Saskatchewan, Canada where my father grew up doing chores, playing ice- hockey and going to church. The family name is Eichenberger, descending from the Prussian house of VonEichberg. The boys of the family became: ministers, a medical missionary, army officers and a business executive. The girls married and one of them later became an independent career woman who inspired me to trust my urge to explore possibilities in life.

My mother's family traces back to a colonel serving under Washington in the Revolutionary War, and further back to the house of an English king. My mother grew up in Kansas and Missouri, going to church and doing housework generated by her seven younger brothers and a sister. The siblings became: two salespersons and five optometrists. Mother was a homemaker until she became an LPN at age 55, 10 years after my parents divorced.

It took me years to come to understand and then compensate for the high value placed on marriage, male children and the genealogy in both sides of the family. As a strong-willed, unmarried female, I felt distanced from the family for most of my adult life. When I married at age 50, I felt finally accepted as an adult.

Other important values in my youth were attending church, vocalizing beliefs, evangelism to foreign lands, and keeping up certain appearances of righteousness. My present spiritual practice is personal. I have not been able to reconcile the blatant hypocrisy of professed beliefs vs. behind the scenes behaviors I have seen and experienced in some organized groups to which I have belonged. I seem to have internalized the "work hard and keep the house clean"

ethic, for which I am grateful, and have a nostalgic love of Midwestern thunder showers. I wrote

the following poem as an ode to my childhood:

<div align="center">Left of Faith</div>

No need for reincarnation in Kansas.

Last stop.

You stay in Kansas, you know where you are.

Oh maybe there's a yearning for catfish fry

on the Missouri side of the Kaw River,

but that's still Kansas in God's eyes.

Once you've seen the Flint Hills

you know what the earth can do.

Would be no mountains if the prairie wind had its way.

Out West those Sierra peaks keep you wanting lifetimes.

A few of the young ones tempted to dance through the world religions

go to California.

No end to desire meditating on coastal fault lines.

Once you leave Kansas you have to be born again. You stay,

All the overtone chant redemption you ever need

in a cicada night

front porch

fireflies. (1996)

What I Do Now

  Perhaps because I deeply questioned my own cultural values, I was compelled to learn about the various values held by my clients. Labor and delivery can be a powerful motivator forcing one to examine expectations, values and outcomes. It is almost impossible to provide labor support in an out-of-hospital birth center without honoring the individual and cultural values the client brings to the experience. In my teaching practice also I endeavor to be aware of the values and backgrounds my students bring to the learning environment. I agree with constructivists that cognitive development must be considered as the foundation for further learning (Schunk, 2012).

  As I reflect on my own education and on my 30 years of practice as a Registered Nurse and Certified Nurse-Midwife, I recognize that what have endured for me are the abilities to continue to learn new information and new skills and to adapt to changes in the health care system and in our culture. As I contemplate the needs of nurses and society in the next 30 years, I recognize that instilling a healthy constructivist respect for their own abilities to learn and adapt is the greatest value I can offer my students.

  Within recent years, space exploration by several countries on Earth has documented proof of water on the planet Mars (NASA.gov, 2006). Preparations are underway to establish a habitable facility on the moon and in space (Covault, 2013). The people of the world continue to wage war, destroying each other with weapons that were unimaginable to most of us only a few years ago (Britannica, 2014). The human genome has been mapped and made available for entrepreneurial research (National Institutes of Health, 2012). An unprecedented global migration of populations is challenging established cultural identities (Economic and Social

Research Institute, 2012). We do not know what technologies or what diseases will be the subjects of nursing education 30 years from now.

Teaching is an integral part of the nursing role. Teaching nurses is an interdisciplinary process that requires a commitment to maintaining a sound knowledge and skill base, while staying current with theories, trends and advanced technologies (Benner, Sutphen, Leonard, & Day, 2009; Benner, 1984). To respect various talents and ways of learning, one must incorporate theories based on a variety of education philosophies (Carper, 1999). While parts of the nursing curriculum may always be best presented within the context of a behaviorist model, as has been the standard of the past generation of educators, today's values and technologies demand that we meet our students with a constructivist approach. Constructivism is an active process. Learning happens in the mind. Language is essential to learning; learning is social, contextual, takes time, and motivation is essential (Schunk, 2012). All of these elements can be expressed and engaged in face-to face, as well as, on-line education.

As new technologies emerge at a rapid pace, there is some evidence that brain function of young people may be altered by the computer age of learning (Schunk, 2012). Both traditional and contemporary teaching/learning theories need to be applied to distance education, and perhaps the adult learning theories of the future will be revised. In our world of globalization, diversity itself will change in meaning and scope (Benner, Sutphen, Leonard, & Day, 2009; Economic and Social Research Institute, 2012). The transcultural consciousness nursing is striving for currently may be eclipsed by new values and concepts (Doutrich, et al, 2012).

Applying Learning Theory to Online Course Development

In 2007, after completing my Master of Nursing (MN) at Washington State University Vancouver (WSUV) with a focus on nursing education via distance delivery, I was hired to teach

in the WSUV College of Nursing's RN to BSN Program. The students are licensed Registered

Nurses from community colleges who are completing their baccalaureate degrees. A need was

identified from student feedback for an elective course that emphasized content in cultural

competence and social justice issues. I was asked to create such a course for online delivery in

order to maximize access for students in all parts of Washington State.

During my MN studies I became aware of the New Zealand nurses' development of and

practice in Cultural Safety (Ramsden, 2003; Nursing Council of New Zealand, 2011). This way

of being and thinking is grounded in critical theory with a feminist perspective that offers

practitioners a solution to the dominant culture power differentials that have been promulgated

by the U.S. nursing practice of Transcultural Nursing (Leininger, 2002). These theories are

described, compared and contrasted in Chapter Two. My desire and challenge in designing and

delivering my course was and continues to be incorporating evidence-based promising practices

in teaching and learning, in Cultural Safety and cultural competence, and in meeting the students

each semester at their individual developmental levels in regards to cultural self-awareness,

awareness of cultural others, and ability to practice nursing in a culturally competent, safe way.

I endeavored to include the best of the Cultural Safety practices both in content and in course

design.

Using principles from constructivism such as scaffolding of content, multidimensionality

with high levels of individual choice in assignments and content, I employed the guiding

principles of constructivist learning environments mentioned in Schunk (2012). Students are

invited to request content about particular cultural groups or social justice issues that are of

interest to them at the beginning of the term and as the semester progresses. The final weeks of

the semester are most flexible for adding new student specific content. This exemplifies the

concept of posing problems of emerging relevance to the students. The assignments are all centered on discussions of the primary concepts of Cultural Safety and of a cultural competence continuum as described in a textbook we use (Cross, 1988; Srivastava, 2007). Students are encouraged to express their personal opinions while respecting differing opinions of classmates. The homepage of the course in the On-line Learning management system reiterates this expectation:

As the instructor I want to say that in a university setting we encourage expression of opinions and discussion of ideas. It is expected that as Baccalaureate level students you will be able to articulate the theories, evidence and/or bases of your opinions and your professional practice. The ability to self-reflect, to learn about different points of view and to discuss why one takes a particular point of view are among the WSU learning goals for undergraduate education, and are traits expected of a Baccalaureate-prepared professional.

In keeping with these goals, this course brings up many new ideas and controversial subjects. The aim is to learn and grow from the readings and studies in order to be better prepared to work in our rapidly increasingly global society. Participation in this course implies a commitment to the course objectives. I have copied them here from the syllabus for you to review:

COURSE OBJECTIVES:

1. Analyze health care practices in the care of vulnerable and diverse populations based on current research evidence.

2. Analyze health care practices in the care of elderly, culturally and linguistically diverse, and economically challenged clients and their families based on standards of care

from professional organizations (e.g. ANA, AACN) and relevant literature.

3. Integrate cultural, linguistic, and age-related competencies in the analysis of individual, family and group healing and health promotion needs.

4. Use effective teaching-learning principles to assist colleagues to increase the quality of their health care to individuals, families and global society to reflect the values of Cultural Safety, social justice, inclusion and advocacy. (Dekker, 2014)

As students begin their bi-weekly postings, the areas for development are identified depending on the self-awareness and acceptance levels that are expressed. The range can be from naiveté, "I don't have a culture, I am just normal" to safe and competent, "I always choose to care for the non-English speaking patients, so I can learn from them, as well as make sure they get what they need." The variety of topics to explore meets each of these levels of need. Several assignments ask for students to demonstrate in writing that they understand the basic tenets of Cultural Safety, and that they be able to teach their colleagues in practice some component of Cultural Safety in the context of a social justice issue of their choosing. These constructions require constant attention and revision of content details and resources by faculty, but have served the course objectives well in delivery (Schunk, 2012).

I designed the weekly assignment sheets using a circle to represent the web-based exploration the students are to do before reflecting and posting. As the course progresses the "cycles of learning" form a model of interconnecting circles that continually reinforce the lessons from the beginning to the end. The short term memory is stimulated by the novelty of the circle and long term memory is re-enforced by the repetition of the imagery. An overall course representation of all the circles shows students the overall course map as a visual model, rather than a linear progression. This is based on the cognitive learning process and is intended to

provide students with a clear expectation of course outcomes (Schunk, 2012).

Appendix A contains the Cultural Safety and Social Justice in Global Society course syllabus and several weekly assignments. This course integrates Cultural Safety and Critical Race Theory with Transcultural Nursing content. The teaching methods and stance of the instructor strive to be grounded in Cultural Safety. Content and assignment options are offered that allow students to pursue their own areas of interest and to express themselves in a variety of modes. For example, there are three options for the final assignment. One is to teach colleagues about causes and potential interventions for a health disparity issue using an effective on-line visual format and evidence table of research articles. Another option to do a modified duoethnography invites an exploratory dialogue between two participants who look at artifacts from their pasts and reinterpret their meaning in the light of a focus of inquiry. Duoethnography is grounded in social justice and transformative education (Sawyer & Norris, 2012). The product is a visual presentation of images with descriptions of student discussions identifying their cultural backgrounds. Seaton (in Ironside, 2005) mentioned that on-line education is a good example of interdisciplinary triangulation (or crystallization) among nursing, education, and information and communication technology. This duoethnography assignment is an example of applying an interpretive methodology to pedagogical practice. This assignment is effective to encourage reflection on self as a foundation to reflection on practice. Cultural Safety and Critical Race theories identify cultural self-awareness as essential to being able to embrace others. A third option for the course final assignment that students may choose is based on Greenwood (2009) and invites students to explore a place that is of significance to them. They research the ownership and use of the land back to the Native inhabitants who may have been displaced by colonization. This place-based learning is also founded in social justice and critical

theories.

Summary

Chapter One has introduced this dissertation and the researcher. My personal and professional narratives of who I am and what I do have mirrored two of the three levels of inquiry with which I engaged the research participants in dialogue: 1) what drew you to Cultural Safety? And, 2) describe how you practice Cultural Safety. The third inquiry, what does it mean to you to practice cultural safety? is described from my perspective in the Chapter Five discussion of future implications of the research for U.S. nursing education and practice. The following Chapter Two discusses theoretical concepts related to this research, historical background and identification of need for this inquiry.

CHAPTER TWO

PARADIGMS, FRAMEWORKS, THEORIES, CONCEPTS AND BELIEFS

Introduction

Chapter Two reviews scholarly writings from nursing and education that describe the concepts of Cultural Safety as it has developed in New Zealand, a comparison of Cultural Safety to Transcultural Nursing, critical reflection and reflection on practice, and elements of Critical Race Theory as it relates to Cultural Safety and to critical reflection in nursing education in the United States. Historical perspectives, social theories, pedagogies, and current research are described that support approaches to enabling nursing students to be critically reflective regarding culturally informed practice. This historical and theoretical literature review provides scholarly background for this research to augment the personal background offered in Chapter One. Gaps in published literature about U.S. nursing applications of Cultural Safety demonstrate the need for this study as no articles have been published to date informing nursing education on the meanings and experiences of cultural safety as expressed by nurses in the Pacific Northwest of the U.S.

Cultural Safety

Cultural Safety first commanded my attention in 2004 when a classmate introduced the concept from a research article in a Master of Nursing course discussion. Cultural Safety sounded right to me; the term itself provided an alternative point of view to Transcultural Nursing or cultural competence, which were the concepts in the tool kit I had up to that point. This dissertation is an attempt to further understand how Cultural Safety can inform my own teaching and U.S. nursing education.

Since exposure to the introductory article (Papps & Ramsden, 1996) multiple searches through nursing and education databases, as well as, various New Zealand university websites

have provided for review of dissertations, research and discussions that describe Cultural Safety

and begin to evaluate how it is taught, as well as its impact on New Zealand nursing. A

definition of Cultural Safety from the Nursing Council of New Zealand (2011) is,

> The effective nursing practice of a person or family from another culture, and is
> determined by that person or family. Culture includes, but is not restricted to, age or
> generation; gender; sexual orientation; occupation and socioeconomic status; ethnic
> origin or migrant experience; religious or spiritual belief; and disability. The nurse
> delivering the nursing service will have undertaken a process of reflection on his or her
> own cultural identity and will recognize the impact that his or her personal culture has on
> his or her professional practice. Unsafe cultural practice comprises any action which
> diminishes, demeans or disempowers the cultural identity and well-being of an
> individual. (p. 7)

An Australian nurse researcher has defined Cultural Safety as:

> … an environment that is safe for people: where there is no assault, challenge or denial of
> their identity, of who they are and what they need. It is about shared respect, shared
> meaning, shared knowledge and experience, of learning, living and working together with
> dignity and truly listening (Williams, 1999, p. 213).

> The professor from that 2004 course became equally drawn to Cultural Safety and

traveled to New Zealand to interview nurses about their experiences of the teaching and the

process involved in its development. She invited me among others to collaborate in the

interpretation and write up of her data with a published article resulting. Five themes were

uncovered in this hermeneutic study of 12 nurses, "…(a) 'Reflection is key,' (b) 'Know who you

are and where you come from,' (c) 'Learn to walk alongside,' (d) 'Getting it right,' and (e)

'Change over time' the evolving nature of Cultural Safety." (Doutrich, Arcus, Dekker, Spuck & Pollack-Robinson, 2012, p. 144). These themes are validated and expanded upon in the published discussions and research of New Zealand , Australian, Canadian and United States nurse scholars (Anderson, et al., 2003; Gibbs, 2005; Jeffs, 2001; Mkandawire-Valhmu & Doering, 2012; Mortensen, 2010; Nursing Council of New Zealand, 2011; Nicoll & Higgins, 2004; ReimerKirkham, Baumbusch, Schultz, & Anderson, 2007; Richardson, 2004; Richardson & Carryer, 2005; Woods, 2010). By 2008, I had created an elective course for Washington State University that is on-going, titled Cultural Safety and Social Justice in Global Society (Dekker, 2014).

The architect of Cultural Safety in New Zealand was Irihapeti Ramsden (2003), who, in the 1980s and 90s, used her knowledge and position in both the Maori and pakeha (Maori word for New Zealanders of European descent) worlds to create the Cultural Safety transformative model of nursing and nursing education that was identified as unique in international scholarship (Ramsden, 2003). Ramsden stated that she was influenced by Freire's *Pedagogy of the Oppressed* (1970); her dissertation also cites bell hooks, *Teaching to Transgress* (1994), amongst a number of other theorists, indigenous and non-indigenous, including Trinh T Minh-ha (1995), Henri Giroux (1992) and Fritjof Capra (1989) who were all concerned with understanding and addressing various forms of political marginalization, power relationships and oppression consistent with critical social theory frameworks. Ramsden died in 2004 after battling cancer, but her pioneering work in developing the Cultural Safety theory and education model lives on in the New Zealand Nurse Practice Act as a required element of nursing education and practice (Nursing Council of New Zealand, 2011).

Subsequent nurse scholars in New Zealand, Australia, Canada and now in the United States have studied, critiqued, adapted, and applied Cultural Safety to their respective countries (Anderson, et al., 2003; Doutrich, et al.,, 2012; Duke, Connor, & McEldowney, 2009; Group, 2006; Mkandawire-Valhmu & Doering, 2012; ReimerKirkham, Baumbusch, Schultz, & Anderson, 2007). Even though Cultural Safety grew from Maori nursing needs and insights, there is a universal quality that resonates with nurses in other countries who are looking for answers to the question, how do I meet the needs of patients, clients and students who have values, language, needs and expectations vastly different from my own? (Anderson, et al., 2003; Arieli, Friedman, & Hirschfield, 2012; Mkandawire-Valhmu & Doering, 2012; ReimerKirkham, Baumbusch, Schultz, & Anderson, 2007). One particularly relevent dissertation from a New Zealand nurse working in Australia was a critical discourse analysis focused on Cultural Safety and Transcultural Nursing, that asked 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?" (Seaton, 2010, p. vii). The scholar's conclusion, supported by current publications, was that Canadian nurses seem to be moving forward by incorporating First Nations' priorities into their practice model (Anderson, et al., 2003; Mortensen, 2010), while the U.S. and Great Britain are static, and New Zealand anticipates increased complexities with a multicultural focus. Seaton calls for nurses internationally to re-examine the foundations of their practice models in the light of an increasingly culturally complex global society, and to seek new solutions to nursing education and care of multicultural clients (Seaton, 2010).

Transcultural Nursing

Ramsden credited Leininger with being the first to introduce to nursing education and practice the concept that not all people share the same values and that other cultures exist besides

White America (Ramsden, 2003). Leininger was the U.S. developer of the Transcultural

Nursing movement that includes her theories of culture care, the Sunrise Model, the

Transcultural Nursing Society and certification as a specifically prepared Certified Transcultural

Nurse (Transcultural Nursing Society, 2014). Beginning her practice in the 1940s and '50s,

Leininger stated that in those years there were no nursing theories. Post World War II nurses in

the mainstream were supporting the medical model that was implementing treatments and

pharmaceuticals developed in response to the needs of soldiers and veterans. A few nurses, such

as Leininger observed that intangibles such as caring and beliefs about one's health played a role

in recovery and healing (Leininger, 1995). Nurse scholars educated at Columbia Teacher's

College in the late 1940s and '50s began to develop theories and publish in scholarly journals

according to traditional standards of peer review. Very influential national theorists who shaped

U.S. education were part of Teachers College from the 1920s to'60s, such as John Dewey

(1916), Edward Thorndike (Schunk, 2012), and Maxine Greene (1991) (who continues her

emeritus status), so the climate was rich with models for generating theory and forming national

thought and policy (Meleis, 2012). Leininger proudly set herself apart from the "Eastern" nurses

by her graduate education in anthropology in the Midwest and the Pacific Northwest (Leininger,

1995).

Leininger vs. Ramsden

Even though Leininger valued caring as a nursing characteristic and she recognized that

individuals from different cultures might have different interpretations of caring, she placed a

higher value on an anthropolgy-based scientific method of nurse-patient interaction that forms

her culture care theory and her complex Sunrise Model. Leininger responded in 1997 to a Maori

nurse scholar's article published in a New Zealand journal (Coup, 1996) that was critical of

Transcultural Nursing and her culture care theory. Leininger's comments may be interpreted as ethnocentric as she stated the New Zealand nurses,

> …seem excessively focused on cultural safety, power, social inequalities, demeaning practices, and need to study and focus on holistic cultural care dimensions….cultural safety is one aspect and is embedded in social structure factors, ethnohistory, world view, caring modes, and many other areas as found in the Theory of Culture Care. This is why the Culture Care Theory remains the most powerful theory and approach to health care and why nurses in New Zealand need the theory along with transcultural nursing education (Leininger, 1997, p. 22) .

This fierce defense of the rightness and universality of her theory was a trait of Leininger up to her death in 2012. Students of Transcultural Nursing are encouraged to embrace it wholeheartedly after rigourous study. Any disparities between one's experience and the application of the theory are explained by one not adequately embracing or understanding the theory (Leininger, 1995). Leininger allowed that Cultural Safety could be a component of culture care, but was not a sufficient model upon which to base one's practice, completely ignoring that Cultural Safety grew from the actual experience of the Maori nurses in response to discussion of Transcultural Nursing (Leininger, 1997; Ramsden, 2003).

In her dissertation which includes many of her writings over 20 years, Ramsden describes the origin and the naming of the concept Cultural Safety in this pivotal scene. In a nursing class on professionalism and cultural competency, a first-year Maori nursing student spoke up and said, "…You people talk about legal safety, ethical safety, safety in clinical practice and a safe knowledge base, but what about Cultural Safety?" (Ramsden, 2003, p. 1). Ramsden also provided a clear comparison of her perceptions of Cultural Safety and Leininger's theory copied

here as Figure 1 from a downloaded copy of her doctoral work. Leininger might take exception

to this comparison, but the differences described here are congruent with my personal

understanding and experience of how Transcultural Nursing is taught in the U.S.

CULTURAL SAFETY NURSING	TRANSCULTURAL
Emic, indigenous cultural reality	Etic, outsider cultural perspective
Concerned with the transfer of power and establishment of trust.	Seeks to maintain power
Developed from experience of colonization	Ethno nursing developed from cultural anthropology
Cultural knowledge belongs to the culture	Cultural knowledge can be acquired and managed by the nurse
Culturally safe care	Culturally congruent care
Provides care regardful of individual differences. Sees patient as individual who may share information about difference if trust can be established.	Provides care regardless of individual differences. Sees patient primarily as group member.
Negotiated and Equal Partnership Model	Patient and nurse are co-participants
Interactions are bicultural	Nurses are multicultural
'Culture' is applied in its broadest sense	'Culture' refers to ethnicity
A requirement for nursing and midwifery registration in New Zealand	Certificate of competence in the United States

Figure 1: Key features of Cultural Safety and Transcultural Nursing (Ramsden, 2003, p. 119).

By 2009, Duke, Connor, and McEldowney, New Zealand nurse scholars, offered an

approach to integrating cultural safety with cultural competence (Duke, Connor, & McEldowney,

2009) using the novice to expert model (Benner, Tanner, & Chesla, 1996). This work suggested

that cultural safety naturally fit with the developing skills of nurses as they matured in practice.

By linking cultural safety to the Benner (1996) model, the New Zealand nurses created a connection, rather than a comparison to U.S. concepts of competence.

Cultural Safety vs Liberal Ethnocentrism

One of the most revolutionary elements of Ramsden's work is her bringing to light the need for rejection of the historical foundation of modern nursing in the form of altruism and liberal do-gooding. Many graduating nurses in the U.S. and other countries recite an oath upon graduation, often in a candlelight ceremony, in which they vow to care for all people *regardless of race, religion, creed, ethnicity, gender, sexual orientation, or any aspect of identity.* Ramsden pointed out that today's nurses cannot function from this White ethnocentric stance, but rather need to be *regardful* of their clients' cultures (Ramsden, 2003). The key word, "regardless" is a culturally blind perspective that results in ignoring the individual needs of clients by treating everyone in the same way from the provider's personal perspctive (Srivastava, 2007). Being "regardful" of clients results in health care that is culturally safe when the client says it is (Doutrich, et al., 2012; Ramsden, 2003).

This is the essence of the difference that Cultural Safety brings to nursing education in the United states that has yet to be brought to mainstream attention. In her data collection among New Zealand nurses, Doutrich asked, where do we (in the U.S.) start to implement Cultural Safety? One response was, "Begin with your own broken treaties" (anon, personal communication, 2007). This is a strong message of Cultural Safety, that all nurses need to be mindful of the cultures, beliefs and values of those upon whose land we reside and who may have been have uprooted.

Critical Race Theory

In the United States, Critical Race Theory is one response to looking to our own broken treaties as it has developed from the experiential perspectives of Black Scholars. The equivalent concept of broken treaties in relation to American Blacks include the atrocities of colonial slavery, on-going segregation after the Emancipation Proclamation, and the school integration and voter registration struggles that are still evident in current school desegregation trends (Reardon, Grewal, Kalogrides, & Greenberg, 2012). Additional recent examples of broken trust are seen in certain state laws that restrict targeted voter registration (Magidson & Samuels, 2013) and current health disparities that result from social inequities (Collins, David, Handler, Wall, & Andes, 2004). The potential for Critical Race Theory to inform U.S. health care practice is beginning to be explored and recommended by U.S. practitioners in the psychology and public health arenas (Ford & Airhihenbuwa, 2010; Graham, Brown-Jeffy, Aronson, & Stephens, 2011; Salter & Adams, 2013; Thomas, Quinn, Butler, Fryer, & Garza, 2011). In U.S. nursing, specifically, a search for "Critical Race Theory", and "health", and "nursing" resulted in one article only, titled, "Race and microagression in nursing knowledge development" (Hall & Fields, 2012). The search result of one article implies the need to examine the presence of racial microagression in nursing knowledge development by the apparent lack of attention to Critical Race Theory.

The potential for Critical Race Theory to inform nursing practice in the U.S. is suggested by a comparison to Cultural Safety. Both sets of concepts were informed by critical theories in their development (Bobo, 2004; Kincheloe & McLaren, 2003; Ramsden, 2003; Taylor, Gillborn, & Ladson-Billings, 2009). Table 1 Presents my comparison of Critical Race Theory to Cultural Safety.

Table 1.

Cultural Safety	Critical Race Theory
• Reflection is key to self-knowledge and safe practice	• Personal narrative as social action and personal healing tool
• Know your own story	• Identify and own one's power position to create equity in relationships
• Walk along side in supportive partnership, rather than above clients or students	• Survivors of historical trauma must be heard
• Desire to not continue structural violence of the past	• Teachers must confront their own racial bias
• Cultural Safety is evolving as society evolves	• Dominant culture will not change without discomfort

(Ramsden, 2003; Taylor, Gillborn, & Ladson-Billings, 2009

Education and legal scholars arising from Latino cultures, multiple Asian cultures, and cross-culturally from women have published on critical theories from their unique perspectives (Taylor, Gillborn, & Ladson-Billings, 2009). Nursing and other health sciences began researching race in the 1970s, but primarily as embedded in cultural studies. Each year in the 21st Century has brought increased clarity and focus on racism, not as an element of culture, but as social injustice and a cause of health disparities that must be addressed in the light of public health (Porter & Barbee, 2004). The 2004 issue #22 of the Annual Review of Nursing Research is devoted to "Eliminating health disparities among racial and ethnic minorities in the United States" (Villarruel, 2004, p.i). In addition, the concept of race, as it relates to health is being reexamined and redefined by the mapping of the human genome and genomics research (Beery & Workman, 2012). Ford and Airhihenbuwa (2010) introduced, "…Public Health Critical Race praxis (PHCR). PHCR aids the study of contemprary racial phenomena, illuminates disciplinary conventions that may inadvertently reinforce social hierarchies and offers tools for racial equity approaches to knowledge production." (p. 1390). The authors of PHCR describe health researchers who apply Critical Race Theory to their work as "healthcrits," who identify their

personal racial awareness in relationship to every project undertaken. Like the writers on Cultural Safety, those who are writing on Critical Race Theory emphasize that the stance is not rigid or proscribed, but rather fluid as societal evolution occurs. Avoidance of becoming a rigid orthodoxy is an inherent principle of praxis grounded in critical social theories (Kincheloe & McLaren, 2003).

A Discussion of Safety

       Cultural conflict.

A potential semantic and contextual disconnect exists between Critical Race Theory and Cultural Safety in the use of the term "safety." One dynamic and effective element of Critical Race Theory is the need to jar liberal members of the dominant majority out of comfort with good intentions into effective action and advocacy for social justice and institutional transformation. From this perspective, the word, safety, is not a desirable end, but rather a road block to transformative action (Taylor, Gillborn, & Ladson-Billings, 2009). From the perspective of health care, safety of the patient and client is always of utmost importance and is one of the driving principles of all health care disciplines (QSEN, 2014). In the context of providing health care and positively impacting health disparities, the term Cultural Safety arose as a natural component of other safe health care practices (Ramsden, 2003). The radical and critical element of Cultural Safety is that it challenges the previously ethnocentric dominant culture of health care to recognize bias and to change the power dynamic to give priority to patient/client perspective.

       Culture of safety.

Healthcare in the U.S. has many initiatives to improve patient outcomes and cut costs. Among these is a movement termed culture of safety that grew from a seminal Institute of

Medicine report on hospital deaths due to errors (IOM, 1999). Culture of safety emphasizes interdisciplinary communication skills, and promising practices in preventing medication errors, wrong site surgeries, worker and patient injuries, and an environment of learning rather than blame when errors do occur (Barnsteiner, 2011; ECRI Institute, 2009). The practice of Cultural Safety that is being described and explored in this dissertation has the potential, in my opinion, to inform U.S. healthcare systems and contribute to promoting cultures of safety.

Historical Perspective to Reflection on Practice

In addition to recognizing and shifting power in relationships, Cultural Safety demands self-reflection and reflection on practice. Nursing scholars have made valuable contributions to understanding how to teach and value reflection. Nurse educators are charged with encouraging and teaching reflection on practice as a component of professional nursing behavior. The most recent iteration of the Essentials for Baccalaureate Nursing includes reflection on practice in all nursing competencies (American Association of Colleges of Nursing, 2008). Definitions of professionalism include reflection as essential to growth and the ability to improve upon practice (Benner, et al, 2010; Schon, 1983). Contemporary nursing educators trace the emphasis on reflection in professional practice to Schön's writings. Most nursing and education scholars agree that Schön's work developed from Dewey's (1916) influence on American education (Benner,et al, 2009; Greene, 1991; Kinsella, 2009; Kuiper & Pesut, 2004; Ruth-Sahd, 2003; Schon, 1987; Teekman, 2000; Thorpe, 2004)).

Long before Dewey (1916), reflection on practice was not a new concept to nursing. The meaning of reflection, or "thinking how to nurse", as Florence Nightingale encourages in her historic *Notes on Nursing* (1860, p.10) does seem to be connected to socio-political issues and status of the profession. From the Preface:

The following notes are by no means intended as a rule of thought by which nurses can

teach themselves to nurse, still less as a manual to teach nurses to nurse. They are meant

simply to give hints for thought to women who have personal charge of the health of

others. Every woman, or at least almost every woman, in- England has, at one time or

another of her life, charge of the personal health of somebody, whether child or

invalid,—in other words, every woman is a nurse. Every day sanitary knowledge, or the

knowledge of nursing, or in other words, of how to put the constitution in such a state as

that it will have no disease, or that it can recover from disease, takes a higher place. It is

recognized as the knowledge which every one ought to have—distinct from medical

knowledge, which only a profession can have. If then, every woman must, at some time

or other of her life, become a nurse, *i.e.,* have charge of somebody's health, how

immense and how valuable would be the produce of her united experience if every

woman would think how to nurse. (Nightingale, 1860, pp. 9-10)

Nightingale writes with understated passion, not presuming that nursing would take the place of

(or threaten) a male profession, such as medicine with specialized training and knowledge.

What Nightingale taught was the need for cleanliness in health care settings and in food and

water distribution. She pioneered the use of data collection and statistics to show evidence of

the efficacy of her hygiene measures. There is no doubt that Nightingale changed the way

soldiers and military hospitals were run and ultimately the way that hospitals all over the world

are run today. Her great gift was her ability to use her keen intellect to apply lessons from her

observations, and common sense to improve dire situations, rather than to remain docile and

passive in a traditional female posture expected of her time (Dossey, 2000). As a White woman

raised in an affluent English family, Nightingale exhibited her altruistic cultural norm of

promoting care to all regardless of differences, which Ramsden and Critical Race Theorists identified in more recent times as the ethnocentric stance that denies the culture and personhood of those who are other than mainstream White (Ramsden, 2003; Taylor, 2009).

Eighty years after Nightingale's work, and just as women in the United States had won voting status, a nurse educator wrote in *Studies in Ethics for Nurses*: "Nurses should be trained to think things through to a logical conclusion and to be able to give reasons why they reached the decisions at which they arrived" (Aikens, 1920, p. 17). Aikens (1920) offered no apologies for nurses in their professional role, though that role was still limited to physician's handmaiden. Aikens (1920), who was the head nurse of several urban hospitals during her career, hinted at the patient advocate role of nursing to come that was necessitated by the harm caused from iatrogenic diseases and the unrealistic posture of the medical profession as being infallible.

Today, nearly 100 years after Aikens, nurses and doctors are both men and women. Women take for granted their rights to vote and to choose career paths. The status of nursing as a profession is becoming established, though the need for nursing unions, which are not considered by medicine to be a component of a profession (Cruess, Johnston, & Cruess, 2010) persists due to the for profit structure of the U.S. health care system (Huntington, 2011). Nurse educators are still calling for nurses to think, now in the form of reflecting on practice (Benner, et al, 2009; Calin, 1996; Kuiper & Pesut, 2004; Mantzoukas, 2007; Ruth-Sahd, 2003; Tanner, 2006; Teekman, 2000; Thorpe, 2004). Yet there is little formal agreement among nurse educators about how to elicit or evaluate reflection. Nurse educators report intuitive or tacit understandings of what constitutes deep reflection, yet often are unable to clearly articulate what they expect in responses from students beyond, "I know it when I see it". International nursing and education scholars describe various models for assessing reflection and point out that ethical

evaluation of reflection can be problematic (Koro-Ljungberg, Yendel-Hoppey, Smith, & Hayes, 2009; Mantzoukas, 2007; Schaub-deJong, Schonrock-Adema, Dekker, Verkerk, & Cohen-Schotanus, 2011; Teekman, 2000; Thorpe, 2004). Linking self-reflection and reflection on practice to culturally safe care needs to be made explicit to nursing students. This is accomplished in the course I created and is an effective way to move nursing students out of unconscious comfort with their biases into cultural self-awareness and greater sensitivity to clients (Srivastava, 2007).

21st Century Social Justice Issues

The issues that currently influence many nurse educators to teach students reflection on practice are social justice related to health disparities and the need to cope successfully with social diversity. The practice of Cultural Safety as described by New Zealand nurses (Doutrich, et al, 2011; Ramsden, 2003; Richardson, 2005) includes several concepts related to reflection that address these social issues. To know oneself and to be aware of power differentials in relationships are two tenets of Cultural Safety. While it is unclear how the writings of Dewey(1916) may have influenced the New Zealand nurse educators, Cultural Safety certainly was informed by critical theories (Freire, 1970; hooks, 1994). In the 1960s and '70s in the U.S., during the critical social changes of the civil rights movement and the acknowledgment that nursing was primarily a White woman's profession at the time, the work of Leininger (1995) emerged in the form of Transcultural Nursing. While the New Zealand Cultural Safety architects were participating in critical race discourse and founding their practice in acknowledgment of power differentials and the need for the ally stance in order to alleviate disparities (Coup, 1996; Papps & Ramsden, 1996), Leininger in the U.S. adopted an anthropological perspective to address difference (Leininger, 1997, 2002). As a result, for the past 50 years, White U.S. nurses

have persisted in an us-them dichotomy that has has not resulted in a balanced multicultural nursing workforce and has not resulted in wide-spread alleviation of health disparities or culturally effective interactions with multicultural patients (American Association of Colleges of Nursing (AACN), 2011; Bobo, 2004; Coffman, Shellman, & Bernal, 2004; Campinha-Bacote, 2010; Ford & Airhihenbuwa, 2010; IOM, 2003). Current integration of Cultural Safety with Transcultural Nursing and with reflection on practice holds promise for nursing education to be a catalyst for social change (AACN, 2008; Benner, et al, 2009; Calin, 1996; Campinha-Bacote, 2002; Doutrich, et al, 2012; Duke, Connor, & McEldowney, 2009; Leininger, 2002; Ramsden, 2003; Richardson & Carryer, 2005; Nursing Council of New Zealand, 2011).

Connecting social, political and health issues with the historical meanings to nurse educators of their instruction to students to reflect on practice, helps to establish a foundation for researching the meaning of Cultural Safety in contemporary nursing education. With acknowledgment to Nightingale (1860), Dewey (1916), Ramsden (2003), Greene (1991), and others for their contributions to nursing and education theories, it needs to be iterated that our health care and education systems have evolved to a state of such complexity that new ways of thinking may be required to prepare teachers and health care professionals for effective practice. Reflection on self and on practice are elements of Cultural Safety as practiced in New Zealand (Doutrich, et al., 2012). A starting point for inquiry about Cultural Safety in the U.S. is to explore the reflections of nurse educators and practitioners about their thoughts and practice.

Summary

An over-arching guide to my research is the concept of Cultural Safety as described and practiced by New Zealand nurses (Doutrich, Arcus, Dekker, Spuck, & Pollock-Robinson, 2011;

Ramsden, 2003; Richardson, 2005). To know oneself through reflection and to be aware of

power differentials in relationships are two tenets of Cultural Safety which is informed by

critical theories. Critical theories inform my own teaching to provide transformative

opportunites for students to become thoughtful activists for social justice in their professional

practice (Harry, 1992; Greene, 1991). Integrating transformative self reflection and reflection

on practice is a starting point and a life-long foundation for professional growth (Benner, et al,

2010; Schon, 1983) that promotes Cultural Safety (Doutrich, et al., 2012). My research is driven

by a desire to understand how to better help my students to develop culturally safe practice. As

a nurse educator, I strive to help the nurses I teach to integrate into their care the Cultural Safety

concept of a life-long commitment to reflecting on and learning from their professional practice

in order to grow responsibly and responsively to their communities (Diekelman, 2001; Harry,

1992; Ironside, 2001; Lytle & Cochran-Smith, 1992). Chapter Three describes the research

design and methods used to explore how selected nurse in the Pacific Northwest of the U.S. have

embraced and adapted Cultural Safety in their professional, as well as, personal lives.

CHAPTER 3

RESEARCH DESIGN AND METHODOLOGY

Research Question

The purpose of this research was to explore two questions: 1) what are the meanings and experiences of Cultural Safety as expressed by nurses in the Pacific Northwest of the United States (U.S.), who have adapted the New Zealand concepts?; and, 2) what is the potential for these perceptions to critique and inform U.S. nursing education and practice?

Contexts

Theoretical context.

This chapter describes the methods used in a critical interpretive hermeneutic study to explore the meaning to United States (U.S.) nurses and nurse educators of adopting and adapting concepts of Cultural Safety into practice and curricula. Grounded philosophically in the writings Heidegger (1962), hermeneutic phenomenology seeks to uncover meanings for participants and the researchers of lived experiences. This research is supported by elements of both interpretive and critical social theories. Nurse theorists make distinctions between interpretive and critical social theory paradigms related to nursing research and nursing knowledge development (Meleis, 2012; Newman, 1992; Weaver & Olson, 2006). For example, while the theory of Transcultural Nursing developed within what Meleis (2012) describes as the interpretive paradigm, Cultural Safety theory and practice developed within the critical social theory paradigm (Meleis, 2012). The key differences between these two theories lie within the fundamental differences in their framing paradigms. As nurse educator and researcher, I see value in both paradigms and used elements of both to build upon for this study.

An over-arching guide to my research is the concept of Cultural Safety as described and practiced by New Zealand nurses (Doutrich, Arcus, Dekker, Spuck, & Pollock-Robinson, 2012; Ramsden, 2003; Richardson, 2005; Papps & Ramsden, 1996). To reiterate, knowing oneself and awareness of power differentials in relationships are two tenets of Cultural Safety which is formed within the critical social theory paradigm. Because nursing is primarily a female occupation with a long history of gender politics vis-a-vis the male-dominated medical profession, there is a feminist epistemology, also grounded in critical social theory that permeates any research designed to strengthen and bring to light the analytical and self-reflective skills of nursing professionals (Koro-Ljungberg, Yendel-Hoppey, Smith, & Hayes, 2009). While Weaver and Olsen (2006) describe what scholars have called a limitation of the interpretive paradigm as having a loss of objectivity due to infinite interpretations of meaning and reality, I think that studying the meaning of Cultural Safety in teaching and practice is only meaningful within the context of individual interpretations.

Reflection on practice, an element of Cultural Safety, as researched and elborated by current scholars (Doutrich, et al, 2012) is a concept embedded in critical theory in education. "Emancipatory education is an organized effort to help the learner challenge presuppositions, explore alternative perspectives, transform old ways of understanding, and act on new perspectives" (Mezirow, 1990, p.6). Reflection on practice is discussed, researched and modeled most in literature related to nursing education as a pedagogical tool, as a desired outcome, and as a standard of professional practice to be promoted. Health professions faculty and students need to be made explicitly aware that personal narrative, cultural self-awareness, and identification of values and biases are closely linked to the ability to reflect on professional practice and the ability to provide a safe and authentic healing environment with clients and institutions.

Clingerman (2011) makes a strong case for promoting culturally competent care, which grew out of Transcultural Nursing, within the framework of social justice, thus both the interpretive paradigm and critical social theory play a role in understanding and promoting these issues.

Critical theories inform my own teaching to transform students into thoughtful activists for social justice in their professional practice (Harry, 1992; Greene, 1991). Integrating transformative self reflection and reflection on practice is a starting point and a life-long foundation for professional growth (Benner, et al, 2010; Schon, 1983). My research is driven by a desire to understand within the interpretive paradigm how to better help my students to develop a deep understanding of how to access and practice meaningful self reflection in order to grow by their own reflection on practice (Diekelman, 2001; Harry, 1992; Ironside, 2001; Lytle & Cochran-Smith, 1992). Cultural Safety offers a framework to accomplish this. This research explored what it means to other U.S. nurse educators to teach and practice Cultural Safety; the findings add to knowledge about how this framework may be applied more extensively in U.S. nursing education and practice.

Physical context.

This interpretive hermeneutic study was given exempt status from the Washington State University ethics review process (see Appendix C). The study explored Cultural Safety as described by five nurses who were selected through purposive sampling. The participants were recruited from colleagues and former students who were known to me to be currently teaching Cultural Safety or to be actively engaged in Cultural Safety practice. Informed consent was obtained (see Appendix D) and audiotaped conversations were conducted. The interview format evolved in actuality into dialogues that took place in settings chosen by each participant. Two chose to meet face-to-face at my home, one chose to meet over internet video connection and

two chose to speak over the telephone. Adapting Siedman's (1998) guidelines for interviewing, I engaged with each participant in loosely guided dialogue, condensing Siedman's suggested three one-hour sessions down to one 2-hour session out of courtesy to the participants' schedules. Vandermause and Flemming (2011) discuss the co-creative experience of interviews in this type of interpretive study, that is also consistent with the Cultural Safety stance of "walking along side" (Doutrich, et al., 2012, p148):

> … hermeneutic (interpretive) phenomenology is a scholarly approach that can be used to interpret meaning of everyday lived experiences. Capturing the essential nature of the phenomenon is sought as the researcher and participant co-create the story during the interview. … Thus, meaning can be generated as participants share their experiences, articulate new understandings, and respond to researcher interrogatives that generate interpretation and add to extant knowledge. (Vandermause & Flemming, 2011, p. 375)

Representation.

I asked each participant to choose a name for herself in order to maintain confidentiality. This device is discussed by Vandermause and Flemming (2011) as enhancing the relatablility for readers of the content, as well as connecting participants and researcher to the research in a way that has meaning for each. The reasons given by each for her choice of name were personal and touching.

> Thus, participant pseudonyms can reflect meaningful real-life identities that enliven the research project and represent lived experience. Although the origins of the self-chosen pseudonyms cannot be overtly described in the study findings (to protect identities), they can anchor the participants' investment and enhance the thinking that leads to deeper levels of interpretation (Vandermause & Flemming, 2011, p. 371).

Two exceptions to the pseudonym process occurred. Niki Flemmer chose to use her actual name in this context which honors her story and her very personal engagement with Cultural Safety. The Voyager allowed me to use her reason for name choice that is cited in Chapter Five.

Interviews, Dialogues, and Conversations

Within each dialogue, the first question explored stories of "where you come from" (Doutrich, et al, 2011, p. 148). Knowing your own history is an element of Cultural Safety and is also consistent with the Heideggerian hermeneutic stance that we are beings situated, in context influenced by our pasts (Flood, 2010; Jootum, McGhee, & Marland, 2009; Kinsella, 2006; Mackey, 2005). Included in this historical context was how the participant came to know about and adopt Cultural Safety. The first level of dialogue began with the query, when you think of Cultural Safety, what comes to mind? The second level of inquiry asked what is being taught and practiced that the participant identified as Cultural Safety. This open ended query took the form as Seidman (1998) suggests of eliciting stories about actual teaching experiences, or a typical day. This provided an opportunity to explore the process and content of Cultural Safety teaching through the participants' stories. The third level of inquiry asked the participants to reflect on what it means to them to be teaching and practicing Cultural Safety. This set of three areas of inquiry provided the opportunity for building a dialogic relationship that enabled the researcher and participants to reflect and to share stories and impressions. Most of the reciprocal exchanges were not included in the findings of the study in order to protect confidentiality. For example, Angelita asked me for input on her ideas for a graduate study project related to Cultural Safety. My response to Maraya's story of the homeless mother's adoption plan was profoundly personal. I experienced an emotional reaction to Maraya's insights that surprised me by its intensity, and I was grateful for the opportunity to share thoughts

with Maraya about our lives and our many combined years in maternity nursing.   Niki's interest

in empathy as it relates to her understanding of Cultural Safety led to an on-going exchange that

resulted in our co-authoring a paper with another scholar that has been submitted for publication

(Flemmer, Dekker & Doutrich, submitted).

This process is true to Lopez and Willis' (2004) discussion of this method:

> The hermeneutic phenomenologist, rather than seeking purely descriptive categories of
>
> the real, perceived world in the narratives of the participants, will focus on describing the
>
> meanings of the individuals' being-in-the-world and how these meanings influence the
>
> choices they make… In interpretive phenomenology, it is the interpretation of the
>
> narratives provided by participants in relation to various contexts that is foundational.
>
> (p. 729)

Managing the Process

> **Files.**

The audio taped dialogues were transcribed by the researcher and two graduate students

who were consented to confidentiality. The transcribed words were entered into Ethnograph

Software^{TM} to support systematic analysis. All electronic content was stored in a password

protected computer in the researcher's locked office on the Washington State University (WSU)

Vancovuer campus. Paper copies were stored in a locked file cabinet in the office. De-identified

copies of transcripts were given to three faculty members on the researcher's graduate

committee, who stored the documents in locked offices, then shredded after reading. These files

will all be destroyed after the researcher's dissertation is accepted by the graduate school of

WSU.

Analysis for themes.

An analytic team consisting of the researcher and the two graduate student transcriptionists participated in five sessions over a month to uncover themes. The graduate students were chosen for their own interests and scholarship in Critical Race Theory and Cultural Safety. In addition, transcripts were offered to the researcher's faculty committee who provided input into thematic interpretation. Initally, the transcripts were read and notes were made in the margins. Each of the analysis team noted themes that emerged in their readings. At the first analysis session, common themes were identified. There was agreement among the team members about the consistency of themes expressed among each of the participants. A number of themes were noted under four broader categories after the first readings and then over the subsequent meetings, codes representing the themes were noted in the margins of numbered data sheets.

As I began to enter the codes into Ethnograph with the intention of resorting and re-analyzing for emerging themes and paradigm cases, it became obvious that the dialogues with the participants could each be read as a paradigm case, and as complete narratives that expressed all the themes. The usual process of describing themes and then quoting portions of the participant dialogues as examples seemed an artificial imposition on the eloquence of the participants' actual responses. At this point I recognized that the purpose of this study would be best served by presenting each participant's conversation as a whole narrative in order to maintain the integrity of the responses. The reader has the opportunity to recognize the themes identified by the research team and to experience the context of the reponses for a richer understanding of the meaning and practice of Cultural Safety as expressed by the participants (Shank & Villella, 2004).

At this point in the analytic process, a copy was sent to each participant of her portion of Chapter Four, along with the themes that had been identified, with a request for feedback if the words represented what she intended to say. Two participants chose to slightly edit their responses.

The decision to present the findings as blocks of conversation is supported by DeWitt and Ploeg (2006) and Shank and Villella (2004) and is consistent with their criteria for rigor in conducting and reporting qualtiative research. The critieria used to demonstrate rigor in this study are discussed in the following section.

Evaluation Criteria

Rigor in method.

In the New Zealand framework of Cultural Safety, safe and effective care or teaching has occurred if the patient or student perceives that it has occurred. In a similar way, meaningful themes of the research participants' stories and reflections will have been described if they resonate with the participants, the team of data analysts and future readers. DeWitt and Ploeg (2006) describe resonance in qualitative research as understanding of meaning in the data and the reported text that also is deeply felt and leads to greater understanding of self. Greater understanding of oneself is an element of Cultural Safety that is linked to reflection on practice and on knowing one's own story, how one is situated historically, socially and in the multiple levels of experience that constitute one's culture. The potential of this research to improve nursing practice and education will be demonstrated in the awareness and desire generated in future readers to know themselves and their own stories and how this knowledge may influence their treatment of others. Shank & Villella (2004) described this research potential as illuminative fertility. While this future actualization of the findings may not be formally

recorded (de Witt & Ploeg, 2006), it is suggested that influencing progressive change toward Cultural Safety in nursing education resulting in improved patient care may help to decrease health disparities in cultural groups currently not well served by the dominant culture health care system (Ford & Airhihenbuwa, 2010; Josewski, 2012; ReimerKirkham, et al.,2007; Yurkovich, Hopkins-Lattergrass, & Rieke, 2011).

Adhering to de Witt and Ploeg's (2006) proposed model for evaluating rigor in interpretive phenomenology, concreteness is demonstrated by "usefulness for practice" (p. 224). In Chapter Five, suggestions for nursing education and practiced are summarized from the findings of this study. This interpretive process required reiteration, review and documentation of decision processes to ensure openness as described by de Witt and Ploeg (2006, p. 224). For example, my six years of experience teaching nursing students, presenting to community groups, and participating in prior research about Cultural Safety brought expertise, as well as potential bias to this study. Kinsella (2006) discusses the desirability of the researcher being engaged with the subject. Detailed notes on reflections throughout the process contributed to the openness of the research. Balanced integration, or "congruence between the philosophy, the researcher, and the research topic" (de Witt & Ploeg, 2006, p. 224) was achieved and accounted for in a similar way through reference to current Cultural Safety literature, self-reflection, discussion with a data analysis group of scholars, and collaborative agreement with study participants (de Witt & Ploeg, 2006).

There is coherence between concepts in the Cultural Safety framework, hermeneutic phenomenology, and de Witt and Ploeg's (2006) set of elements to evaluate rigor in interpretive phenomenological research. Reflection on oneself, checking with participants on their perceptions of the researcher's interpretation of their expressed meanings, and relating of the

findings and the process all contribute to rigor, understanding and a spirit of scholarship that invites the reader into the potential transformation of nursing education and practice. This potential transformation is the critical element of this study (Kinsella, 2006; de Witt & Ploeg, 2006; Shank & Villella, 2004).

Rigor in reporting qualitative research.

Rigor is as important in the reporting of findings as it is in conducting qualitative research. Shank and Villella (2004) suggest four critical areas of consideration in the context of reporting qualitative research:

1. Investigative Depth: "Do the researchers uncover anything that was not already known or believed about the area in question—do they discover something that is new?" (p.49).

2. Interpretive Adequacy: the researcher needs to … "provide enough data and context to ensure that interpretations can stand as reasonable to an impartial reader" (p.50).

3. Illuminative Fertility: "The degree of divergence, subtlety, and nuanced insight that we receive is one measure of the *illuminative fertility* of the findings. The other measure is in terms of difference that our findings make in practice" (p.50).

4. Participatory Accountability:

> Almost by nature, qualitative researchers enter into some form of partnership with the participants in their studies. Whether researchers observe, ask questions, or work side-by-side to institute changes, they are on the spot and involved. Researchers must do their best to operate in an ethical manner and to ensure that readers understand their actions, stances, and efforts (p.51).

Partnership is an essential element of Cultural Safety (Doutrich, et al. 2012; Nursing Council of New Zealand, 2011; Ramsden, 2003); thus partnership with participants was my intention in

conducting the research as dialogues rather than as interviews. I am not sure that I was wholey successful in overcoming the traditional interviewer/interviewee power differential that sometimes loomed as a powerful element from the culture of academia between participants and myself. At the start of each session I purposefully talked about my intent for our exchanges to be mutually beneficial for us each to reflect on our understandings, and beneficial for the dissemination of Cultural Safety in future publications. Each of the participants contributed in this partnership her thoughts about what she saw as the potential transformation Cultural Safety could make to U.S. nursing education.

The four values and objectives described by Shank and Villella (2004) reflect my process expressed in this dissertation and guide what Wynn (2009) describes as "…the research process and reporting that need to be present if researchers are to remain ethical and respectful in their interactions with community" (p.52). She describes implementing her "community-graced" (p.i) qualitative research "…that remains ethical can only be accomplished through participatory sharing---through what I am calling a "reciprocal vulnerability", the open sharing of stories, values, motive, biases, histories and personal struggle" (Wynn, 2009, p.52).

Summary

Chapter Three has described the research methods that supported this inquiry. As the process unfolded, the discoveries began to inform the method. Shank and Villella (2004) offer bold counsel for education researchers that I took to heart:

Education is a lively process. The only time that it is not lively is when someone or something is sucking the life out of it. If life has been sucked out during the process as a result of either the research design or the reporting, then corrections to how the study is

being conducted are needed. Correct what has been done, and let your research live.

Everyone will be better for it (Shank & Villella, 2004).

With the sincere hope that everyone will be the better for it, Chapter Four presents the findings of this study in the words of the participants as our conversations unfolded.

CHAPTER 4: Findings

Introduction

Chapter Four presents findings of this study on three levels: 1) a demographic summary of participants and the analysis team, 2) definition of Cultural Safety from participant perspective, and 3) summaries and quotes from the five interviews in the context of themes that emerged from the analysis team's discussion, reflection and systematic review of the transcribed sessions. Four overarching themes were expressed by all five participants within the interviews. These are positionality, embodiment, reflection, and the inherent tension in a Cultural Safety stance. Within positionality are themes of self-identity, power differentials, advocacy and critiques of the status quo or meeting a need. Embodiment contains ways of incorporating Cultural Safety into personal life, clinical practice, teaching and scholarship. Reflection is self-identified by participants as a conscious practice, as well as demonstrated in highly articulate narratives. As a critical process, the Cultural Safety stance has an inherent tension that is expressed in the desire for transformation in nursing education and practice which links to positionality and embodiment. There are overlaps and interplays between and among the themes that are inevitably part of the hermeneutic circle of understanding (Kincheloe & McLaren, 2003).

Demographics

Demographic information about participants is presented in summary form in Table 2. Participants revealed some elements of their demographic identities which are evident in the context of their responses. However, I do not connect demographic data to the reporting and interpretation of responses beyond the general summary. This way of presenting the findings is intended to let the voices of the participants speak primarily as nurses who have embraced Cultural Safety in their practice and teaching. Their specific ages, self-identified ethnicities,

sexual preferences, religions, and family structures are embedded in responses in their own words. In addition, any mention of specific ethnic or tribal groups was edited to general terms in order to attempt to avoid implying any sweeping generalizations or stereotyping of a specific group (Rodenborg & Boisen, 2013). The analysis team consisted of myself and two graduate students. Additional analysis was done with input from my dissertation committee members; thus the whole analysis group is summarized demographically. In recent literature, scholars in multiple disciplines have called for the researchers to examine their own racial identities in order to expand the discussion of racial bias and to give recognition to the role of race in research priorities (Drevdahl, Canales, & Dorcy, 2008; Ford & Airhihenbuwa, 2010; Rodenborg & Boisen, 2013).

Table 2.

Demographic Data of Interview Participants and Content Analysis Group

	Interview Participants n=5	Analysis Group Team: n=3; Committee: n=3
Ages	30-50; mean = 40	30-66; mean = 48
Gender	5 Female	5 F; 1 M
Ethnic Identities (self-identified)	1 Hispanic and Native American 1 Pacific Islander 1 person of color; 2 White	1 Hispanic 2 Black and White 3 White
Areas of Practice	Community Health; Nurse Education; Medical; Obstetrics; Surgery	Community Health; Education; Midwifery; Nurse Education; Obstetrics; Psychiatric Nursing
Education	1 MN, FNP 1 DNP candidate 2 PhD candidates 1 DNP	1 MN 1 DNP candidate 1 EdD candidate 1 EdD; 2 PhD
Years in practice	8 – 25; mean = 13	8 – 34; mean = 22

Questions

Each participant was invited to respond to three levels of inquiry. The general questions were based on Seidman's (1998) guidelines for qualitative research interviewing and on the Heideggerian hermeneutic phenomenology practice of eliciting life stories or lived experiences. These two frameworks complement each other. The general inquiries were intended to elicit background or the context of the participant's experience, the details of experience or practice, and reflections on what the experiences meant personally. The actual questions within the interviews included for background, "When you think of Cultural Safety, what comes to mind?" "When or how did you learn about Cultural Safety?" "What drew you to Cultural Safety?" Details of experience were explored by asking questions such as, "What do you do in a typical day, if you do have a typical day?" "Can you think of an event that involved being culturally safe, or unsafe?" Because meaning was expressed in the telling of the background and the actual practice, the third level of questions became, "You have already spoken about what the practice of Cultural Safety means to you; I wonder if you have any additional thoughts or examples of what it means to you to practice or teach Cultural Safety?" In the actual dialogues with participants the response to each of the questions were sometimes given in preceding or subsequent questions which is an expected experiential part of this type of inquiry (Denzin & Lincoln, 1994). As discussed in Chapter Three, the method of analyzing the transcribed interviews led to the presentation of findings here in a narrative format rather than in thematic pieces. A definition of Cultural Safety is one piece pulled from the narrative, while the remaining findings are presented as individual stories. As several of the participants stated, "We are story tellers."

Definition of Cultural Safety in Maraya's Own Words

In response to the first inquiry, "When you think of Cultural Safety, what comes to mind?" Maraya clearly expressed her familiarity with concepts from New Zealand. She cited a broad definition of culture and a definition from New Zealand practice (Nursing Council of New Zealand, 2011):

> Maraya: I think of patients who are from cultures that might be different than the culture of either the institution or the person giving care to patients. I think of cultures but also think of categories that are of difference, like gender, ethnicity, religion, sexual orientation or even things like socioeconomic status, like refugee status or homelessness or substance abusers. So, I think of it broadly not only in terms of race and culture. So I apply it to every patient I have whether I know what those categories of difference might be or not. I use the New Zealand Nursing Association and their definition of Cultural Safety; you know it's the classic one of the effective nursing, the midwifery practice of somebody who is from a different culture and it is determined by that person. And, it's safe cultural practices of any action which do not demean or that do not disempower the identity or well-being of that person or community.

This definition is entirely consistent with the New Zealand Council on Nursing official definition. Even though the origin of Cultural Safety in New Zealand is from a bi-cultural perspective, current scholars are interpreting culture broadly just as Maraya did. Even though this broad definition of culture is broadening the application of Cultural Safety practice to include all patient interactions (Group, 2006), this does not preclude discussion of Cultural Safety in terms of specific ethnic groups or race relations in general (Rodenborg & Boisen, 2013).

Paradigm Case, Angelita

The purpose of this research is to explore how Cultural Safety is expressed by nurses in the U.S. The New Zealand origins of Cultural Safety had to do with indigenous health policy. The potential for how Cultural Safety may influence health policy and practice with U.S. indigenous peoples is expressed by one of the participants. With this in mind, the conversation with Angelita is presented first as a paradigm example that demonstrates each of the themes within a complex of Native American elements.

Angelita, conversation September 2013.

Angelita: I remember that course on [Cultural Safety] and one being exposed to the term and terminology that came along with that course… what one has been exposed to personally, but it is always nice to be able to put a label and a term on to something so that you can then share it with other people. Those concepts have just been the core of my own nursing practice, and have helped to really organize my own motivations and the things that I would like to help other people implement in their own practice, too.

LD: So when you think of the term Cultural Safety, what comes to mind?

Angelita: Oh, in simple terms, being aware of myself, of what culture means to me, but then also realizing that I am in another cultural space at all times and being aware of what that is, even if it means I don't know much about it, and then asking if appropriate, or when appropriate, asking and finding out those things. And I mean this in the context of nursing whether I am working in a hospital, or currently I am working for a local tribe, and so that took a lot of awareness in regards to a culture shift from where I was working. And so back to the Cultural Safety part, just being aware of myself and of where I am, and being comfortable with myself to recognize that I need to maybe not put another's

culture before mine, but recognizing what is going to work. And so that creating a culturally safe environment for the people I am working with is really what is going to facilitate anything else we are doing together, whether it is something as simple as convincing them to get an immunization, or helping them understand a treatment plan that they are taking with them that they and their provider had just discussed. Did I answer the question?

LD: Yes, absolutely. There're not any right answers or wrong answers, I'm just very interested in hearing about your process and how you came to embrace Cultural Safety?

Angelita: Oh, I think I was, I think in the text I can read the definition of Cultural Safety, when they give an example, but it is very general in terms and I can understand that is helpful because, you know just to kind of apply it anywhere to where you are working or any context, it has to be general, but a lot of times, the things that I read, I have to narrow…maybe not diminish, but I kind of have to apply it to the situation I am in, and maybe some of the meaning is lost, but I make it mean something for myself and for the people I am working with. So I know they talk a lot about, you know, Cultural Safety is being aware of your own set of values and belief systems, but then also being aware of, you know, inequities among groups that you are working with and how that might impact interactions and environmental situations. So, then I also have to recognize that my experience is limited, so I may not even be aware of all the Cultural Safety aspects that there are, but just being open to learning always. And I think that I have been drawn to cultural competence, Cultural Safety courses based on my personality traits, so I don't know that it is something that I read one day and thought, "Oh that sounds really

interesting." But they were already things that I appreciated in myself and others, and so I was just drawn to learn more about that part of nursing.

LD: so you had taken other cultural, emphasis on culture classes?

Angelita: … Even in my ADN program, sometimes the campus offers various free, short, skills training that they advertise on sandwich boards, and I would always drag one of my classmates to go to some kind of leadership or better understanding your peers type of seminars. And so to me there are cultural aspects that you learn about groups of people and I just really like learning about appreciating people in life and how to make people work better together. You can apply that to anything and especially in nursing, I was drawn to nursing and the cultural aspects of nursing because I see every day how important it is to appreciate the person before you go anywhere else with anything you want to do.

LD: I understand that. Let me just say in response to your question about answering the questions is that this study for me is to just really find out how other people have come to Cultural Safety and what it means to them. Because, I know what it means to me and I want to just kind of check what other perspectives there are, and then have that be as a way to introduce other people to Cultural Safety and these concepts, so I chose the people I am interviewing because I know that you have embraced the concepts, so I am just really interested in how you came to it. Can you say a little bit more about how you came to be a nurse, and then, how you see Cultural Safety fitting in to that?

Angelita: Yes, nursing wasn't something I always wanted to do. I often hear that, and sometimes with envy, I think, oh that must be nice to have known what you have always wanted to do. But my background, I grew up, my Mom is of Spanish heritage and my

Dad is Navajo. But I didn't find that out until I was probably about 12, I just grew. My parents worked really hard and they weren't well educated themselves, and not being well-educated I think they saw how that held them back and so I think they wanted their children to be able to go to good schools and so they worked with a local Catholic school so my siblings and I got to go. And it was a predominantly White environment, and I only use that term now, because I didn't know White, Indian, anything like that at a young age. I can honestly say I went through the first 5 grades really unaware of differences in ethnic background. Nobody talked about it. We all went to school together and then I think it was maybe a new person who came into the school. They asked me what I was. And so I think that probably was a defining moment in my life where I thought, "Well what do you mean?" And then they pointed out to me that my hair was darker, and so the first time ever that I noticed, oh I did have tan skin, my hair was darker. But, again, I didn't understand what that meant. I went home and I talked to [my Mom]. I asked her those questions about what had happened at school, and she told me that my Dad was Native American. I was probably about, what age would that be if I was in 5th grade, maybe 10-ish? So then I started feeling things that were just new to me like maybe confusion and anger. I guess I felt like, why wouldn't my Dad, why wouldn't your parent tell you these things. They seemed very important, so I guess that was my first encounter with having an identity crisis, and trying to incorporate this new information. And so that's when I became really interested in American Indians and I approached it I think from this odd perspective where initially I didn't embrace being Navajo as a part of myself, but almost as if I was studying a group of people just because I hadn't been raised with that, so it was all very foreign. I primarily identified myself,

with the White culture; we were raised Catholic. My Mom saw how important that was to us, so we went to the Indian reservation, and this was before Google, so I really admired the hard work that she put into this. She had to use telephone books; you know all the old-fashioned methods. She found his family, because he had left the reservation. I guess having to, not having to, but wanting to learn about a whole new culture and going down to the reservation and all of the new experiences that came with that was very exciting. I think that is one piece that is really important to me especially as I became older and started thinking about what I wanted to do. Going onto the reservation you learn this whole new way of life, this whole new perspective about how people and groups look at things, completely counter to what I had learned the first decade of my life. So having personally experienced such a huge culture shock, I just had a greater appreciation for all the different kind of people that I encountered when I started my nursing career. I went into nursing, gosh, let's see, I'm 33, it really wasn't that long ago, 2006. It's not that exciting of a story. My husband actually has been a paramedic for a long time, and I would ask him questions about his work or his stories, and I came to this point where I got laid off my previous work which was in crime prevention. I worked at police departments. And he maybe got tired of me asking him these questions, he said, "Have you ever thought about going into nursing? You seem so interested" I really hadn't. Like I said, my parents were very pro education, but I think they really weren't sure how to direct us in following a career path. They said you have to do well in school, but otherwise, we were kind of left on our own to find out what we wanted to do. So you know coming from a background like that, you don't come out of childhood thinking, well at least I didn't, thinking that I could be the president of the United States.

… Because on both sides of my family, my Mom's family is poor by American standards, and then the same with my Dad's family, but rich in so many other ways. But in regards to choosing a career path, I was kind of on my own there, so I think that for the first 10 years out of high school, I just wandered around looking for something that paid well, and when my husband brought up nursing I thought, gosh am I smart enough? Can I do that? You know those questions that a lot of people probably ask themselves when they think of something really daunting. So I thought, I'll go to LPN school and see how I do. And it all worked out and I loved it. And I think that it was a really good fit and that was a way for me to help people, which has always been a part of who I am. I volunteered a lot, and that was probably something that my sisters, I was educated by sisters, and you know we always had to do service. Whether it was serving senior lunches, but again it was something I really enjoyed, so nursing just seemed like a natural...

LD: when you say sisters, do mean the nuns at the Catholic school?

Angelita: Yes. And I had nice sisters. That's just been a really huge part of my background is service, and nursing really is a service. And I don't see it necessarily just in a technical aspect, that you are doing nursing skills, but you're helping people find a pathway to be in better healing. In Navajo, they call it walking in beauty, which is much more than just healing a wound, you know it is just finding that peace within yourself. And of course the physical part is a part of that; I think nursing is just so wide open; there is so much more to it than just the physical aspect.

LD: These are wonderful stories. Thank you so much for sharing this. I just wanted to check, so when your mother found your father's family, then contacted them and said

that she wanted to bring you back to meet them? Is that what happened? Then you

became a part of that family?

Angelita: Yes. Yes. …

LD: I can certainly understand how you are describing being drawn to people getting

along and how that can be facilitated. So when you had the opportunity to take the

Cultural Safety class, was it because it was something called Cultural Safety, or was it

because it was the only elective being offered on-line that semester, or do you have

any…all of the above?

Angelita: Well I think in my nursing education, there was always a cultural component.

And I am talking about my LPN, my ADN programs. I don't know if that's required in a

nursing program to have a cultural component, but I found those courses very fascinating.

… all those courses I have really enjoyed and I feel like I have learned the most from,

and I enjoy talking about it with people. I think people enjoy talking about those things

with me, and in the clinical setting, I don't sit there and say, "Well in my cultural class I

learned this…" I think people aren't as receptive to that. I think that for me I've had

more success in saying, oh this person is this ethnic background and they said that this

means a lot to them, maybe they would be open to this idea or this treatment if I present it

this way. And so just really simplifying it and not coming across like you're trying to

teach someone a concept out of a book, I find has helped me more. But it is really

frustrating, because the system itself, there are so many time constraints. Or, maybe

[other providers] didn't take those classes, so really they have no idea what I'm saying to

them, you know, 'what are you talking about'. But you know that's OK, like I said, it's

helped me in my work with patients, and the evidence from me is that I get feedback

from patients that they really appreciate the time… the best compliment I received recently is 'I can tell you really enjoy your work'. So I don't need my manager or supervisor to give me a good evaluation if a positive message comes from the people, I know that I am doing something right. And that's all about appreciating culture.

LD: That kind of brings me to the second level of questions, if you would, just tell me about what you do and how you practice? You have already talked about that you value culture as being critical to everything in nursing, but what is a typical day at your job?

Angelita: Well, I guess, I'm new at my [current] job. I used to work for [a large health care system]. I got involved in end of life care nursing …, and I ended up being a trainer at the hospital. All the hospital staff had to go through the end of life consortium nursing training. I took the culture chapters, just because it was very fascinating to me, and the work that I had done with hospice patients. In end of life I find that culture plays a, pretty much that's all you are doing with nursing care…And so we are all here because, I think we are preparing for, you know, whether we think it is the end, or just a transitional place, and who you are, who's important in your life, and your values systems across the board is what people sit and talk about or ponder about. So, I really enjoy teaching that part of the end of life care training. And I think that hospice care, again, because they focus so much on the person, which incorporates their beliefs, their values- that is such a core piece. I think hospice and culture go hand in hand. So coming out of hospice, I ended that part of my nursing practice in December of 2012, and … knew I wanted to work with Native Americans, but, actually this goes back to when I first realized I was Native American, I see myself as an outsider of my own people, if that makes any sense. So, part of that is my own perception, but also going to the reservation, you know, and

staying there for the summer. Of course, my family, loves me to pieces, but because I am whiter than most Native Americans on the reservation, I experienced some, you know, encounters where I, "belagana" is the term they would use for someone who is an outsider, and so that gives me this sort of awkward position, awkward within myself, where I desire to work with Native Americans, but I am also very tentative, like I don't feel I belong a hundred percent. So … my goal was to work with American Indians, and I wanted to, you know, address health disparities with American Indians, and I [ended my job], and just coincidentally … a position opened up at a local tribe at their clinic. And I kept telling myself, oh that sounds so interesting; I would love to work there. I had looked for positions there in the past 2 years, and had never seen one. So my husband, again, he says, "Well so if that is what you want to do, why don't you just go do that?" And I said, "Well, I'm not ready". And he goes, "Well what are you waiting to be ready for, if this is the group you want to work with?" And I think it was just being fearful of not being accepted. So I finally went, "OK, fine, I guess that makes sense". Sometimes someone needs to shake me. So I applied, and I have been there since February of this year; I still feel new there. And it has been completely fascinating. And, you know, everything that I learned about culture doesn't apply, and all these things that I read about, if you do this, it should work out this way, um, you know, doesn't always work out. Because, on the other end … people have their own biases, and maybe things that aren't entirely true that they bring to the table as well. I hadn't factored that in, and at times I can be naïve and self-centered where I think, so if I have progressed to this level of awareness, then everyone around me must have as well, and that's not true. There's other personal experiences where people maybe haven't overcome the hurt or the

negativity that they have experienced. So Cultural Safety would say, right? that I have to

be aware of that and maybe find out what that was, because maybe I'm violating, or

doing the same thing without even knowing that I'm doing it. Here's an example, kind

of across the board, patients would come in, and they just seemed to have, I would say,

kind of like a chip on their shoulder when they would come into clinic. So that's OK, I

can handle that; I'm not easily put off. But it was very odd, because everybody seemed

to have this chip on their shoulder. I thought, oh my goodness, is it something that the

clinic represents? Or what's going on here? Why is everyone just so down? So then I

started asking patients, not in those words I just used, but I would just ask them simple

questions while we were doing vital signs, or whatever, I would ask them, I would say,

"Oh, do you like coming to the clinic? Do you have any providers that you really like?"

It's interesting when you open up, or ask questions, especially open ended ones, the

information that you will get back. So I started hearing things like, "there's new

providers here every month." And you know it's true. In the last 4 years there have been

30 different providers. And so learning these things, and getting that understanding of

they don't expect that I will be here next month, or in a couple months. And sure enough

I would ask these questions of other clients and they would say, 'so how long are you

going to be here?' or they would say, 'Are you here on an IHS Loan Repayment

program?' So they had all these preconceived ideas of who I was, you know, because I

was a stranger, I was new, I was a health care provider, and they obviously knew there

was this IHS Loan Repayment program out there. And I would be truthful with them, I

would say, '"No I'm not on one of those loan repayment programs". It was helpful,

because I was sitting there thinking, "Oh, there's something wrong with these people.

Why are they not friendly. But now I understand, so and now we talk. I say, "Oh gosh, that must be really frustrating". You know you have to re-tell your story…I'm not fixing the situation. I'm not fixing that the staff turnover is high, or that the provider turnover is high, but they feel at least, that I am empathizing with them. And my intention is to be there, and I tell them, I plan to be here a couple of years. … So now that we're getting fully staffed again, we're trying to make those changes back to offer structure, better service, better care to the patients. All of this has been such a huge learning experience. You know in school, or in the safety of my office or classroom, I said I want to work with American Indians; I want to help eliminate these health disparities, really having no concept of what that meant, because I wasn't in that environment, and had no experience in that, so I am glad that I took the step to at least work with the population I desired. And now I am actually seeing what the real issues are and it's not because they don't have a clinic, it's not because they don't have technologies, it's not because they don't have any of those things that we are maybe thinking are obvious, it's that human connection that they are lacking. They don't feel like they are cared for, so I think that is really what needs to be explored more, and rebuilding that relationship between non-native health professionals and native people.

LD: What is your role at the clinic?

Angelita: Oh, my role there, I feel like everything. … So, my role there as a Clinical Registered Nurse, is I help facilitate patient care, work with the providers, check patients in for their appointments. We do nurse visits. The nurses are responsible for doing X-rays, labs, processing referrals, all the administrative stuff there; setting up appointments, processing, billing insurance. And that's just because it is a small facility. They just

don't have the volume of patients that would justify hiring an entire billing department.

We do have a billing person, but they rely a lot on us to code things correctly. Some

people would look at that as a disadvantage, but you know, working in a larger hospital

system you're really shielded from the process of things. You know you're told to just

check this box, do this, and I didn't really ask why things were that way. So for many

years, I just checked the boxes how I was told. But being in this role, where I am actually

with the patient from checking them in to referring them out, the billing process, I have

learned so much. And also, doing diagnostics, and then laboratory work, I think it's

important to understand our, the IHS and the Medicare system, and how you can help

people, or maybe seeing changes that need to be made. And I have learned that in this

small rural setting. I am just so glad to be there, so in that regard there is just a lot more

for me to learn. So that's one part of it, but the other part of it, because there aren't a lot

of people that are running out to these rural tribal settings to work, they really rely on the

people there to cross-train in other departments. So, recently they asked if I would be

interested in learning clinical applications in regard to electronic health systems. So I

told them I would, but they had to realize I really had no background in computers and

clinical applications, but I was willing to learn. … So, you asked what capacity I work

out there? Then I am also the Safety Coordinator, so I'll be heading from here to their

hotel for a safety emergency preparedness meeting that the tribe has. … I'm there, so I

want to be a part of helping and the solution.

…one of the other things that I am working on for my [DNP] program that has grown

from my experiences [in school], is, for the Master's part, I want to examine a culturally

relevant orientation for clinical staff. And then for my doctorate project, I want to do the

implementation portion of it. … so [last summer]I did a project, got a good grade, and I thought, is this something I can research and read about and work on for the next 2-plus years? And I was just like in tears thinking, "No". Then I am like what am I going to do? And it wasn't until, interestingly, I was on vacation; I was down on the Navajo Reservation, and we were doing a trail ride. In the Navajo culture you refer to each other as brothers and sisters, once you meet, which I think is really beautiful, because we all are brothers and sisters. And I don't mean that in a religious sense. … Our trail guide does trails in the summer when she is not in school, because she is in a PT program, which is a doctoral program now. So we were talking as we were riding trails, and I just really enjoyed talking with her, and she was talking about different stories, and how she got into physical therapy; she really sees that as a need on the reservation. And then she said something that just made so much sense to me, "You know", she says this to me like I should know this. She couldn't reach me, but if she could have she would have tapped me on the shoulder, "You know we are story tellers." And I thought, gosh, "That's so true". I mean Navajo culture is so rich on oral history. We, they don't write things down. And I know there are people working to preserve the culture by doing that, which is interesting. It's a paradox, because it is really not the Navajo way. But, in order to preserve it, I understand that usefulness. So she said, "Yes, we have so many healing stories to tell." And, you know, she was just so inspirational in having that conversation, because, I thought, you know she's right. Healing is not just medicine. It is not just treatment plans. It is sharing stories with one another, lessons, and then, also, that human connection. And then a few days later we were back here in Washington, and my husband had a biking event that ended in Vancouver, BC. So within a short period of

time, coincidentally another friend who was doing the same biking event introduced me

to one of her friends who is a PhD student …in an Arts and Education Program, and so

we were just chatting. I mean it was such a brief conversation, we didn't have that much

time to talk at all, and he said that the First Nations, the indigenous people, do a lot of

work with the nursing program, with using story telling in nursing care. And then he

made a comment, also, they are looking at different research methods that are not

Western influenced. They are looking at different cultures and how they research, well

our word is research, but how they conduct research. So he said that a lot of his work in

art education has been trying to identify what education will look like 20 years from now.

He said it won't look like it does today. So I was thinking about that encounter and then

[my trail guide] encounter, and that's how I came to wanting to pursue this culturally

relevant [doctoral project]…you know, as things are changing, how do we still maintain

that human connection with our patients? Well, we first have to be aware of who we are

working with. So I think that creating a culturally relevant orientation for health

professionals for the [tribe], you know, I want to focus on that group, but I think that it is

something that could be applied to not just tribal groups, but even outside of that. Each

area would have to be responsible for how they tailor that, because part of that would

mean you would have to solicit the help from your community members. But I think that

it is something that is very much needed. …I think that would be wonderful. I think that

it would indirectly improve patient outcomes. So I would like to examine patient

outcomes from 2013 and then in 2015. Are there any differences? Can you make any

connection between culturally informed clinical staff? So that is my area of interest and

that is how it applies to what I do.

…there are a lot of experiences that indigenous people across the world have and share of strong influence coming into their culture. I think about this often... our family like to visit national parks when traveling and we enjoy being outside. My husband is adopted by a Polish family and his parents tell him his background is French. So he is of European background and he just loves the national parks. …we were at Golden Spike and the Union Pacific; it is where the rails met during the early 1800s-1900s. It is a really culturally rich area in regards to that time period and the expansion into the West. They do a reenactment there during the summer… which is just phenomenal. So we watched it and he asked me what did I think about it and I don't know why I never felt comfortable enough to say this before, but, I said, "it is really odd after all these years, even when I was growing up, to go to a national park, because, at the point I realized that I was American Indian and being American … I am American …it is weird". I almost feel like an imposter sometimes and of course he looks at me and says "what are you talking about" and I said, "Because there is always an American Indian component to all the national parks and how progress was at the cost of hard work, money and lives and these whole cultures. Am I supposed to celebrate the success of that progress or am I supposed to be sad because it killed entire tribes and communities?" And then I become passionate about what I am talking…everything about me… I don't delineate me, work, family, activities; they are all who I am equally. So he is thinking about this and said, "Oh, I never thought about it like this- from that perspective". And I say "Of course, you haven't… I wouldn't expect you to." But at the same time he is open to hearing it. And, he says "Yeah you're right that would be weird"… so that's how I feel when I go to national parks, I feel weird. So that is how I feel but I'm OK. I can celebrate both

because the world is where it is and is probably the way it is supposed to be. And I go back and forth on how hard do I want to work to make change, you know, because it can be exhausting. I see a lot of people just become that person that goes to work and comes home and that's it. That's okay; I understand that because to turn your job into a calling is exhausting. I can't say that I haven't thought, "Okay I'm done." I truly believe my personal philosophy ties into closely with my nursing philosophy that I want to be for good and change however small that is. That is what I want to do. So I am committed to that and, if nothing else, when I am done here I know which side I was on. Yeah, that is interesting; being an American Indian is a very interesting position to be in.

LD: You have feet in several worlds. …Was there something you wanted to ask me?

Angelita: Yes actually, I wanted to hear your thoughts about the culturally relevant orientation for health professionals. Maybe some resource ideas.

LD: Well, what comes to mind when you say that, a really good place to start with any type of training is with self-awareness. …that is the Cultural Safety perspective. You have to start with knowing who you are and where you come from before you can learn about other people. And if you had a social worker come to work for you, that person has already done that work. But if you have a physician, they may not have and many nurses may not have yet.

Angelita: You reminded me of a moment in my ADN program where we were doing a culture session. And they asked us that question and I remember one of my classmates sitting next to me who was Caucasian European background. When they got to her -and she was a veteran, just the nicest person ever. She was so honest. But I think we were all kind of shocked when she goes, "Well I guess I am White, I never thought I had a

culture". I remember looking at her, "What do you mean?" And so I thought that was really fascinating. I mean it was a learning experience for the whole classroom. And maybe somebody else felt that way or thought that, but they just weren't brave enough to say that, but she just said it.

Shank and Villella (2004) suggest one evaluative criterion of qualitative research in education is illuminative fertility. This refers to "new, subtle, nuanced pictures of what were once familiar topics and areas. The degree of divergence, subtlety and nuanced insight that we receive is one measure of the *illuminative fertility* of the findings" (p. 50). The themes of positionality, embodiment, reflection, and the inherent tension in a Cultural Safety stance that emerge from the stories in the paradigm case and that consistently recur in each interview have transformative potential. Shank and Villella (2004) go on to say, "The other measure is in terms of difference that our findings make in practice" (p. 50). The elaboration that follows of these themes is done with examples from participants' own words. Reading about the difference that Cultural Safety has made in practice to these nurses and nurse educators is intended to provide illuminative fertility for the reader to inform teaching and practice.

Positionality

Within positionality are themes of self-identity, power differentials, advocacy and critiques of the status quo or meeting a need. Again, the participants' own words and stories more eloquently reveal meanings of the elements of positionality than explanatory prose. For June, a practicing Doctor of Nursing Practice (DNP), the lack of critical theories in her formal nursing education was a perceived need in order to guide her nursing practice. She embraced (and embodied) the themes related to positionality in her practice.

June, conversation October 2013.

June: I hadn't heard about [Cultural Safety] in school and I had just finished my DNP in Community Health. [I heard about it during a conference call on the job] …And you know it really resonated with me, because it felt like in the training, in my graduate training around cultural nursing theories I always felt that something was lacking, but I didn't know what. And so, when I was introduced to Cultural Safety, I thought, oh, this is addressing more critical issues. …I was starting to become introduced to some critical social theory outside of my formal education. It was on my own, that I found that. I took an online class that my friend was piloting and her area of expertise is women's studies. …in my nursing education classes we never talked about the root causes of social determinants or health disparities. ... I know that especially in the health field, we have really limited answers for things. We are… very Western, we're very like, you know, very biomedical. And so, um, I intentionally took classes outside the school of nursing and even outside the health sciences.

… I was volunteering for an anti-trafficking coalition, anti-human-trafficking, and raising awareness around this critical issue, a public health issue. I was thinking about doing my final project around the topic of trafficking. A lot of the literature that exists is in women's studies or social work, not a lot in nursing and or even in public health. So wanting to understand from a public health perspective, what makes them, what allows for this to happen, you know. So taking the public health perspective, upstream prevention, who are the victims of, or who population wise, who has those risks for being trafficked? And so, starting to understand the critical social perspective and also …being exposed to a lot of social workers and hearing them talk about things. We don't talk

about it like that in nursing. Like, what? "Patriarchy" like, what? And how is that related to anything? So do you see what I am saying?

… It was in my volunteer work, though I am paying a lot of money for my education so I want to learn this. And I didn't get a lot of answers in nursing or public health really. … And so, I would say talking about power, a cultural theory that addresses and acknowledges power dynamics would draw me in. … Because everything else [the cultural care theories were] very much, "Oh, we just need to be sensitive. Just be aware of what people eat, you know, and what people believe, and clothing and eye contact." Eye contact was a big deal, you know. Like if I were to summarize my undergraduate and master's training in cross cultural nursing, it's a list of the behaviors; it has nothing to do with me, as a person, as a person with certain positionality, which is another term I learned outside of nursing. So, some kind of framework that allows us to see patterns in population health, bringing power into it, not just, "People don't eat well so that is why they have diabetes". Oh! Actually, it has to do with power!

… Early in my career, I remember when I first learned about the whole advocacy aspect of nursing, how we as nurses can be can be advocates; like building a bridge between the medical world and communities. I would say that's always kind of driven me. I have always been very drawn to community health and drawn to social activism. So [Cultural Safety] seemed like a very nice fit for me. And believing that health is a human right, how can my practice inform my underlying belief. And also being a child of an immigrant family, it's very close to me. Yeah you know I am in that category and it is very personal too.

… So many of the nurses in power mimic the biomedical model, so [it is hard for them] even trying to understand some of the imbalance of power. They're like, "We just need to help those people, vulnerable marginalized people" instead of realizing that our health system could be contributing to their "other" health status. In general, I would say that there is a lot of work that we as health professionals need to do. I have been to several conferences in the past year and a half; there was one conference that I thought was well worth my time; and the keynote, it was on racism and it was the first time ever, and this group has been around for decades, and this is the first time they ever said the "R word". This was convened by the people who write the CLAS standards [Culturally and Linguistically Appropriate Services]. Does that give you any idea? So that is why I like to hang out with my social work friends; they talk about this all the time.

… In my job, working to develop a support program with nurses of color and under-represented nurses, I sought to approach my work as antiracist work, and health disparities in the context of and the research on the social determinants of health, of course. … So in my mind I think, how do we begin to introduce some of these concepts slowly, in a way that doesn't overwhelm people. I have encountered people all over the spectrum in terms of readiness to talk about these things. … the critical issues like privilege, oppression, power, and injustice. … so this is where they're at and how can I push this just a little bit.

… Well, and this is what I've learned…sometimes diversity is just an afterthought, even the word, I don't like it. But, whatever, if that is the word people want to use, then that is the word I'll use. So, it's just an afterthought or there's a lot of interest in diversity, *lately*. It is great people are starting to acknowledge health disparities, that is good. Okay,

that is step one. So we still have a lot more work to do. So…yeah… I don't know (sigh)…Yeah, so there's still a lot more work that needs to be done. And, I don't know… how do we create a space of safety to talk about these things in an honest way. I think, in my experience, not a lot of people know how to talk about race and that is the big… yeah, that is one of the most divisive identities. So instead of just bottling up... Yes it is okay to say "people of color". I think a lot about the meetings I have been to with leaders and the need for language to talk about these issues.

LD: I had that same experience teaching in the class I teach, Cultural Safety and Social Justice in Global Society, to students who had never been out of a pretty homogenous cocoon of experience. And I really do believe that it starts with self-awareness. To say what is your culture, what are your values? Even if they start to hear that they share values with someone who doesn't look like them or they have totally different values from someone who looks like them. That's eye opening and that's a beginning because for many they have never even questioned or even identified their own values, they simply have just been. I think that is what social work does in their training. They have made personal values identification be a part of their basic training. They are able then to start looking at others, but not as "other" others but, they can see the world, where, okay, I am me here and that is all it is. It's just that is my reality and I have to look at how I am looking at everything else.

June: Right, I think that is a way to do it, a way to integrate it into nursing. Especially, in light of all the changes in the health care system; like the webinar I just listened to, our nation is becoming so much more diverse with so many identities; it just is. And so, how are we preparing the nursing workforce, especially at the baccalaureate level, at least that

exposure to leadership in community health. The AACN talks about threading cultural

competence into all the classes but, if you don't call it out, it is just going to be ignored

and power won't change. … You have to cover it. You have to put it in every syllabus.

LD: You do, you have to put it in there or it's not there. It is that simple.

June: It gets lost and nothing changes. …

LD: I think that Leininger did us all a service by saying "Guess what, not everybody is

just like all the White girls." That is not enough, but she certainly started the ball rolling

[even if] from a very ethnocentric viewpoint. I think we can add another layer now, it is

definitely needed.

June: It makes me kind of wonder of what people will be saying about the work we are

doing right now. It is kind of exciting.

LD: it is

June: because I am sure there are things we cannot see right now. … I know I have a lot

against me. I am usually the only person of color in the room, honestly….

LD: They need to hear what you have to say.

June: Dig deep, speak out.

LD: Well, I am convinced that time and truth are on your side. You meet them where

they are and somehow there will be this miracle of transformation; I am convinced.

June: Yeah, I am holding out for that too.

Embodiment

Embodiment contains ways of incorporating Cultural Safety into personal life, clinical

practice, teaching and scholarship. On a non-material level, embodiment also includes the

intangible but real experience of resonance. Each of the participants experienced resonance with

Cultural Safety in some way. The Voyager, who was a former student of mine, expressed her experience of resonance by acknowledging Cultural Safety origins in New Zealand and an element of racial awareness, as well as observations about her own self-awareness to her response to the first inquiry, "When you think of CS what comes to mind?" As a mother, doctoral student, and nurse faculty in a community college, she embraced and embodied Cultural Safety in her personal life and her teaching of the next generation of nurses.

The Voyager, conversation September 2013.

The Voyager: I think about the nurses in New Zealand; I think about Dr. Ramsden who, sort of was the start of it, it appears, and the Maori nurses and the people in New Zealand. [I think of] this idea that it's the first non-White perspective; and I really fell in love with that. Even being White myself, I love the fact that it's a non-White perspective…because I think that voice hasn't been heard as much as it should be… it was this idea that went beyond diversity, into this idea of our patients feeling safe with us during their encounters, from their cultural perspective… I guess I fell in love with it for two reasons: you were in love with it, and that was kind of contagious, and the second reason was that it resonated with me.

…part of this journey is learning about your own history and your own past, and so the other thing that comes to mind in relation to that, is I have a great-great grandmother who is Native American Indian. And for some reason, ever since I was a small child I have been very interested in that culture and that particular heritage. And even recently, I was asking my mother about it and she's not sure, but maybe I'm only like 1/32nd [tribal group], but just the fact that I have known that little piece of history since I was a little kid, something about that has made it resonate with me. And Natives often in this

country, I mean there's a long history of oppression in this country; I think the idea of Cultural Safety, there's a strong connection there, for me.

…I think my attraction is an innate caring heart, a piece of my heart, for people who are underserved and underrepresented in society. I don't know necessarily where that came from, but it's been with me since I was a child.

… and it is such a theory ready for this time. In all of healthcare and medicine, we're trying to get away from the power differentials, because we recognize it isn't safe for the patient. I mean, if you want to study why mistakes happen in the hospital setting, for example, the whole purpose behind the team approach is because power differentials open us up to mistakes and miscommunication, right? And so, we're trying to not have this huge power differential between the doctor and the nurse, or the doctor and respiratory therapy, or the nurse and respiratory therapy or physical therapy. So you bring this Cultural Safety theory to that setting, and you layer on top of that, or you take a step back, and you bring it to the education of those healthcare workers, and, um, it's, I think, one of the places where the hugest impact can be made. Because, not only are you taking it to the next generation, and I feel like we are at the next generation of the younger healthcare workers, and physicians in particular, I've seen it. They're much more team oriented; there's not this power differential like you see with some of the older generation physicians. And I'm not complaining about them, but they were just trained in a different philosophy, right?

The Voyager goes on to describe how Cultural Safety is embodied in her teaching practice with pre-licensure nursing students:

… So, I talk about it being the first non-White perspective that I've encountered and the value in that. And I kind of let that flow out and we talk about that a little bit, because I'm in what's considered in our state as a poverty county, with very little color in the county; most of my students are White. So I sort of just let that sit with them for a little bit, because I think that's an important piece. And then I talk about it being the focus of safety, versus the competence or the diversity or the other ways of describing it, and try to see how that sets with them at a [visceral] level… And then I highlight the idea or the concept that the nurse has been culturally safe with the patient when the patient says they have. I got that from you, um, and so we talk about that. You can learn all of the different generalities about as many cultures that you can cram into your brain; you know that [religious group] don't do blood transfusions, or that [ethnic group] mothers may show up in the ER with 10 family members. I mean, you can generalize and memorize some of those things, and they may be valuable and they may be valid, but you can do that 'til the cows come home and it really doesn't matter because when you have an individual, it's what they say is culturally important to them and making them feel safe, and none of the rest of it matters. So to me it's so liberating, and I think, well maybe the students catch that it's liberating as well; because instead of memorizing and being told what you should know about another culture, it brings you right down to that core, one-on-one level with the patient, where you are opening up yourself to be in tune with what they are culturally trying to say to you. Beyond what they are complaining of medically, or pain, or whatever, you open "self" up to listening to the cultural perspective that they may not even know that they're trying to explain. And you're opening up yourself as the nurse to try to understand how you can make them feel safe. Because if you can't do

that, they may not accept any of your interventions, and if they don't accept your interventions, what really, have you accomplished? You may be able to give them an antibiotic, but what we know about the bio immune system, and stress, and the connection of mind/body/spirit; you've really just done a temporary fix. They might be back sick again, because maybe they're living in an environment where they're constantly stressing their immune system, and it might be culturally based; and you don't want to make that worse when you're meeting them at their very vulnerable moment. So, I highlight that.

LD: Have you had the opportunity to see any students practicing in a way that you thought was culturally safe?

The Voyager: …it was a gentleman who had some sort of abdominal surgery, and he was clearly a meth addict. I remember my student coming to me and saying something about how she recognized when she was first in the room that she was judging this person, and then she thought about. She didn't know about this person's culture, or cultural background, or what led him to those decisions or the lifestyle that he had chosen or maybe not chosen, but that had been a part of whatever, day by day over time, culturally had experienced, that had ultimately placed him in the position that he was in. And I remember the student coming to me and saying, "I want you to know that I thought back on what you said at this time, and I thought, 'How can I have this person feel safe with me?' Cause I thought maybe they wouldn't feel safe with me." That particular patient, there was a lot of critical stuff going on that day. That patient had a central line, was on TPN, and was on vancomycin; that was a critical patient. And, for [the student] to think

beyond the lines, the tubing, the beeping was amazing. This gal can be my nurse any day.

I told her that too.

Other students expressed openly their appreciation for the way in which Cultural Safety was

presented to the class:

> The Voyager: …I remember that it really resonated with her and she was so excited to, I
>
> can't remember what she said in her paper, but she came up to me after class and was
>
> just almost in tears saying, "Thank you so much for highlighting this." I remember at
>
> one point when I was talking about it, I must have almost been in tears myself, because
>
> [another] student wrote in their paper something about, "I'm really glad that you
>
> highlighted this and I could tell that you were almost in tears." And "I don't know what
>
> happened to you that made you want to cry when you're talking about it," but her point
>
> being that this topic is so personal and so deep for every person, and that that impacted
>
> her when I was talking about it. So maybe, you know, a deep embracing about the ideas
>
> of Cultural Safety, and when you present those, is part of it being very impactful for the
>
> people who are listening. So those are two instances that kind of come to mind.
>
> … I had to meet with the Vice President of Instruction at our college, and [the student
>
> evaluations are on] a four point scale, and I got, I think it was a 3.96... And he was like,
>
> "Man, I've been in teaching for 20-something years, and I never got a score like this!"
>
> And so I was of course beaming, and I don't know why it is that the students like me, but
>
> I think that part of it is, and part of why Cultural Safety resonated with me, is because I
>
> think we want to feel safe with people, right? And so I think my students want to feel

safe with me. And I think they see someone who is aware that students probably want to

feel safe with their instructor. And the fact that their instructor is passionate about a

concept like Cultural Safety, speaks to who the instructor is, right?

Further illustrating her personal resonance with Cultural Safety, the Voyager went on to share

that at the time she first heard of Cultural Safety she was raising the bi-racial children of a family

member in a rural setting that lacked racial diversity:

> The Voyager: So, that, I'm pretty sure had an impact when I [learned about it] in my
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> embracing Cultural Safety theory. It really resonated with me the idea of safety, just the
>
> fact that it is in the title or in the term. Versus cultural diversity or cultural competency,
>
> 'cause don't we all just want to feel safe? I mean, it's nice to feel confident, and
>
> competent, but that only comes when we feel safe. It's secondary, and safety is like so
>
> primary, it's [visceral] for us, for every person.
>
> … very practically, it means to me, that when I need care, there might be nurses that are
>
> culturally safe with me. That's really what it means to me. I want someone who, when
>
> they care for me, is going to be open to what my personal, cultural needs might be. I
>
> want them to be, whether they are from a completely different background from myself,
>
> maybe they would be interested in asking if I want prayer before surgery. Or maybe they
>
> would be open to anything that they might perceive about me from my culture that I
>
> would need as a part of holistic healing of self. I think that's mostly what it means to
>
> me. But then, it also means to me that if I share this, when I share this, I'm not the only
>
> one who receives that gift. But isn't that what we do as nurses? We want to help other
>
> people. And I want to help other people be able to have the gift of somebody being
>
> culturally safe with them. So if I can bring that to my students, and if I am lucky enough

to teach for the next 20 years; I think maybe I'm young enough that maybe I have 20

years left. What could be the ripple effect of that? And that brings me personal joy. So,

really, that's what it means to me.

Reflection

The practice of reflection on one's practice is evident in the responses of each of the

participants. Maraya expresses all of the themes common to the other participants, and clearly

illustrates the integral place of reflection that is embedded in her practice, her scholarship and

her life:

> **Maraya, conversation October 2013.**
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> Maraya: Drevdahl [2008], when I read her article, I just thought she is so right… she
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> talks about cultural competency…is a start but not effective because…cultural
>
> competency doesn't address accountability. Cultural competency is defined by the
>
> healthcare institution which might be different than what the individual or community
>
> wants… the cultural appropriateness might be defined differently by the patient or the
>
> community than what the health care institution thinks it is. And we don't know unless
>
> we ask. You know cultural competency doesn't necessarily address things that are
>
> invisible like religion. I think that with cultural competency sometimes we think only of
>
> race and ethnicity when there so many other categories of difference that we should look
>
> at.
>
> …I'm in advanced practice community health nursing …systems nursing practice. My
>
> focal area is culture and global health. And, for a long time I had felt that cultural
>
> competency, while it was a start, it was not quite enough. I couldn't articulate it but
>
> Drevdahl articulated it well for me. She said, because it doesn't address power

relationships, historical traumas, colonization, all these things that cultural competency doesn't quite get at, doesn't quite reach. And, I think that with time we have found that other categories of difference need to be attended to, like, sexual orientation or HIV status. But, at any rate, I became more involved with or interested in Cultural Safety because I was looking for a way to work with my patients who have so many differences. What I saw was that there was a power difference, say, between the patient and the health care provider or the community and the health care system. And I thought, what theory or practice addresses that power? What about those power differentials? And, I thought Cultural Safety…puts the emphasis on the patient and the family to define what is culturally appropriate care. That's really novel. All along we have been defining it when we can't define it because we are not that person. We don't know.

…I found Cultural Safety in my literature searches; one of the first things I found was Ramsden's dissertation (2003). What a great way to look at providing care for people who are different in some aspect from the health care provider. Her work was pretty seminal along with others. But, I thought this will get closer to what I need when working in clinical situations that are confounded by cultural or power differences.

…as part of my PhD program I have a fellowship that allowed me to attend conferences, but I wanted to interview these professors. I am so compelled by this theory that I want to learn more. So, I was able to visit several [New Zealand] campuses and several professors and ask them questions; which just fed my curiosity more. Another person who really affected me was Fran Richardson, on Whitireia, I read her dissertation [2010].

LD: I am intrigued by your saying that when you read about it, you learned about it, that it put into words for you something that you have been experiencing but not having the framework or the words for. Is that… am I hearing you correctly?

Maraya: Oh Very much! Yeah. Yeah!

LD: Other people have said that about their discovery of Cultural Safety.

Maraya: Oh really! I am glad to hear that.

LD: They were aware of the phenomenon that was not being addressed but they didn't know how to put it into words. And then, reading or learning about Cultural Safety resonated with them that need that they felt.

Maraya: And, I think if you're a nurse that has been marginalized in one way or the other, whatever it might be, you tend to see that because you might have experienced culturally unsafe care yourself. How do you teach this to students who really don't understand the effects of being marginalized in health care? Like, social determinants of health and you know, like phases of intersectionalities and so forth. I think if you don't understand that, then you might think, "Why is that patient being noncompliant?" You must go much deeper into it to understand what is going on.

…as a child I experienced health care that was not safe. And certainly my mother did. … and my father was a refugee; he wasn't from the U.S., and so…I think you can have cultural unsafety in education or the legal system or any system that is a service provider. So I think if you experience unsafety or a power differential …you can identify it in your patient a little bit better. Like you have encountered it before.

 … In terms of being an educator or a new novice educator, I teach about Cultural Safety. So I taught [an undergraduate nursing] class this summer on social justice and health

care. And I introduced the idea of Cultural Safety. But it was a class packed with a lot of concepts about social justice and so Cultural Safety just took up one class. That's all the time I had…it is one way of starting the ball rolling. At least people hear the word "Cultural Safety". I would love to interview academics and health care providers. To ask, "Have you ever heard of the word Cultural Safety?" I used it in my dissertation and I am afraid that if I ask my providers, "How do you provide culturally safe care?" They think I am saying culturally competent care. They don't know the difference between Cultural Safety and cultural competency. That's kind of a barrier right now.

… [Richardson's dissertation, 2010] talked a lot about power. You know, the differential in power between patients and providers at the individual level and systems, the communities. So, that's really compelling to me. And my research is on barriers and successes in achieving culturally safe care for a particular ethnic group. Because I think we can say, oh yeah, we want to provide Cultural Safety. Or I don't find that people say Cultural Safety because they aren't even aware. I don't find a lot of people who are aware of the concept. They say, "I want to provide culturally appropriate care." And, too many times that means what we as providers think is appropriate for the community. Like, I work with (immigrant) women; that means she doesn't eat pork she wears a hijab, she is very modest. Well … it is good to know some stuff. But, it is really about what are the dynamics that prevent her from getting the kind of health care that she really wants. That is what I am really interested in. And it is much deeper and much more difficult to get at. Because if you ask anybody "What are your cultural beliefs?" nobody is going to say that, "My cultural beliefs are that I construe time in this fashion", or "I am communitarian or individualist or that I am Catholic." Nobody is going to say that. So

how do we as providers get at that? And what are the barriers even if your patient says, "Well, you know, something culturally safe might be that you allow me to take my illicit street drugs." We can't do that as providers. So, what do we do when it doesn't match? That is what I am interested in.

… I came to a point where I felt moral distress at not being able to provide holistic care that felt culturally appropriate. I almost left nursing…I came very close to leaving nursing. But, here I am getting a PhD in nursing science. I didn't leave it. And, my question is when it comes down to decisions in health care, how do we make those decisions? Who has power to make that decision? And, I think that Cultural Safety allows more a patient voice to come in the picture. I think that it demands us to say, "What does the patient say, what does the patient desire?" Because the critical problems come when you have a scenario where at the patient, provider, or system level there is a decision to be made that there is disagreement. That sometimes manifests in a patient not being "compliant" or not adhering to care. Which is sort of judgmental, it's saying, "They're not doing what we ask them to do or think they should do." And, I know that providers have the best intentions. However, if your patient thinks differently than you and has different values, neither one is right or wrong, they're just different. How do we get them together? How do we make a plan…and who should make that decision. Sometimes we have to ask the court to come in. Things like vaccinations, futility of care, and end of life, assisted-suicide or abortion, all those things that are very charged from difference in values. That is where Cultural Safety can come in. But, it is very tricky, it's very tricky. I encounter it all the time.

… I believe that we are all connected and there is a higher spirit; that is a given for me. There is a greater spirit than I, a good great spirit. And how are we connected when my duty is to provide health care to somebody? How do I do that for somebody that I don't understand or even like? Like a drug addict, you know. How do I do that without compassion? Compassion is a good word. I'll give you this example. I had this homeless woman, very tiny. She looked like she was maybe 40-50 years old, but she was of childbearing age. And she was having premature labor, so she was kind of stuck in the hospital, and so I had some time with her. It was a slow day and she was my patient, so I asked her, "You know your baby might come pretty soon? Let's talk about what might happen." And I talked about how it might go fast because it was early. And that she was relinquishing the baby [for adoption] and what did she wish to do? I talked about birth and then I talked about when you are relinquishing…some people say that it is best to hold the baby so you can get through your grief; that outcomes are better if you hold the baby and research has shown this. And she said "No, no I'm not going to hold the baby." And I was like, "why not?" In my kind of arrogant way, you know, like "why not?" And she looked at me like to say, "Should I waste my time telling her or not. Or should I even go here with this nurse?" She looked at me long and hard. And I guess she decided I was worthy of talking to because she told me.

I asked her, "Where do you live?" She told me in a box on a hill. So I told her I could get social services and she said "No need". So, I said "Why not, you can get an apartment." She said, "They have rules I can't abide by." You know you can't have guests at your annexed housing or drugs or pets or whatever; I don't know what her barriers were. So she said "I've done that, been there. I am more comfortable doing

what I do." So I said, "Why don't you want to hold your baby?" And she looked at me long and hard, and she goes, "My mother was an addict and when I was eleven she sold me as a prostitute so she can support her drug habit." And then she looked at me and said, "I don't want to do that to my daughter. I don't even want to chance of doing it. I don't want to see her." I just about fell on the floor. You know, just knocked to my knees and I thought – Oh good lord. And I said to her that was the most kind, most motherly thing I have ever heard. You know, I was moved to tears. And I thought to myself I really didn't like this lady when she walked in. And when she said that, I thought, "Oh my gosh she is more profound and she thinking about more profound levels than I had been thinking." Here I was telling her research supports this, so if you don't grieve…but her grief was so profound and so deep, so longitudinal that … you know one would grieve losing a baby …her grief was worse if she thought she had a chance to make her daughter's life worse. And, I didn't understand that…it knocked me to my knees. So your question of what does it mean to me, it is like telling a story and it would be great if I could come up with something that would be patient-centered and culturally safe, come up with compassionate care for that patient even though the system wasn't designed to meet her need. We don't have effective treatment and intervention for patients who were eleven year old girls that had drug addicted moms and who were sold as prostitutes to support the parent's drug habit. We don't have that. And we certainly don't have the maternity care that supports a woman into labor with that history.

…There are several things that need to happen for the provision of culturally safe care. One is, we as health care providers need to learn how to be self-reflective, we need to turn the lens on ourselves. We need to learn again how to be in relation, or be with in a

compassionate way with our patients. And we need to know when to be objective and when to see our own subjectivity, as well as our patients'. I think being in relation to that person in a way that is compassionate is what moves the delivery and receipt of health care along…You see we have a lot of work to do.

Inherent Tension in a Cultural Safety Stance

For Niki, understanding and embracing Cultural Safety began with a personal focus. She has built upon this personal focus to educate others by publishing articles in scholarly journals (Flemmer, Doutrich, Dekker, & Rondeau, 2012; Flemmer, Dekker, & Doutrich, 2014) and writing a regular internet blog, *The We Belong Project* (http://thewebelongproject.com/). Her reflections and stories exemplify the inherent tension in the Cultural Safety stance that is honoring one's own truth even while honoring the truth of others who would deny your validity. Her response begins with the query, "What comes to mind when you think about Cultural Safety?"

Niki, conversation August 2013.

Niki: I've been thinking about that a lot, and I think, the ability to realize that you are living with a filter, the reflection piece, is the biggest message for me about Cultural Safety. And, I've noticed at least with my experience, my ability to practice with Cultural Safety is pretty much in correlation with my willingness to have an open heart. Looking at your own life with empathy I think is part of Cultural Safety, because you have to be able to look at your own filter kind of separate from just being your truth and look at it for what it is; it's a set of lenses, or filters, that affect your world view.

… I suspect that it's easier for people who are a little bit less mainstream, or are really introspective to identify with Cultural Safety right off the bat. That's my suspicion. So

being a gay woman living in a religious environment, I was living, what I thought, the truth of everyone around me, I took that on as THE one truth, and I did not realize that everyone around me has lenses and filters and their own culture. And when I took your class, I thought, "Oh, these are actually filters, and these are actually cultures, that I've been raised with, with everyone around me, that it's not THE one truth." Then I was able to look at what I had been trying to reject inside of myself, because the truth of who I am, and my culture, wasn't aligning with those around me. And so, being able to learn about it in a different way, is what really started me realizing the importance of Cultural Safety from a personal standpoint. And it's part of what saved me from myself.

LD: Can you think of any particular part of that class that had that affect?

Niki: Um, I think the inclusion, because I had never really had a teacher include sexuality as part of anything other than a simple context. So having a teacher bring up the one thing that was the biggest barrier to me fitting into the culture of those around me, not as something that needed to be changed, but rather embraced, was what made me realize that, "Oh my god, not everyone is like this."

LD: Not everyone's like…?

Niki: Not everyone has, is living with the one truth that who I am at my core, i.e., being gay, is a sin.

LD: And that was your first introduction to that?

Niki: Um, yeah, I mean, I had thought of that. You know, I knew that other people were living in the world who didn't think that being gay was a sin, but I didn't realize that they could also be very, very good, very, very spiritual people.

… The whole inclusion thing, is what really got me thinking. And all through

undergraduate, you know, my associate's degree, was like, culture was more of an ethnic or racism spectrum. It wasn't about a White woman, growing up in America, having a culture herself.

… So, now I am, I mean, Cultural Safety is just in, I feel like it's implementing in every fiber of my existence. It's not something I do at work. It's not something I do just at school. It's not something…you know, I feel like I'm living it more and more because I am providing Cultural Safety for myself, and that's what's making my life so much better.

LD: Can you describe how that looks? Say, in a typical day, or an event?

Niki: Yeah, um, it's still kind of abstract. I don't think that I'd call myself a novice, but I still think I'm pretty close to a novice. So like I get all of these ideas and it's really intellectual, and sometimes the implementation, especially at work, is difficult for me. But, I'm looking at Cultural Safety in terms of, I'm on this kick where I feel like empathy is a big part of that. And so, learning to look at my thoughts that I've had as perhaps, not necessarily THE truth, but as a result of messages from people and their cultures coming at me, has allowed myself to kind of… look at my beliefs or my thoughts as something other than my essential self and maybe something as, that I get to shape the way I want it to be, rather than something that's innately, THE truth.

LD: So you're really looking very critically at your own way of being?

Niki: Yeah.

LD: So, just in a context of a day, how might that impact you?

Niki: Um, well I live in a small town, and a religious community, so if someone were to say, um, like a homophobic remark, instead of taking that to heart and feeling the pain of

that, I instead, say to myself, "Wow! Their culture has told them that it's okay, or being gay is something to be less than, or something to make fun of, and they have a much different lens than I do." So it's able to, like, take it out of the emotional space and put it into the intellectual space, which then lets me feel better emotionally. Because I'm not taking on other peoples' culture so much into my own.

LD: And is that something that happens frequently?

Niki: Um, not daily, but not infrequently either; maybe a couple of times a month.

…And I don't feel like, as a nurse, that I can truly provide Cultural Safety for anyone else until I've provided Cultural Safety for myself. Because you can't realize other people have lenses until you realize you have a lens. So I'm looking at my own lens in my daily life, and trying to figure out what I want that lens to look like, or feel like, or be expressed in the world.

… I think, having that empathy for ourselves first of all. And being willing and courageous enough to look at the possibility that, what we believe, or our truth is, is actually just a set of cultures or beliefs that have been passed down, not actually THE truth. I mean, having the courage to just look at that in yourself is, is huge. And it's not surprising that most people don't do it, because it opens up a lot of old wounds. But once you're able to do that, it opens up a whole world for you and you can see other people and patients in a new light. That they're not necessarily, their beliefs don't define them. We're all just doing the best we can, and it's possible for us all to live in our own truth and live like that, and walk alongside one another. We don't have to be in conflict over our truth, or our filters, or our cultures. And so, I guess, first having empathy for yourself opens up the doors for you to have empathy and Cultural Safety for other

people. So for me, the biggest part of practicing with Cultural Safety is being willing to look at myself with Cultural Safety.

LD: And so you mention the writing and I know that you have published two articles (Flemmer, et al., 2012, 2014) and have a blog (Flemmer 2014). How did that come about? Can you talk about that a little bit?

Niki: Yeah. Part of it is that I wanted an outlet for my ideas and thoughts, and part of it was that I wanted to help anyone else who might not understand, as a patient or as a provider, um, you know I wanted to help providers in terms of very tangible things about how to treat women of sexual minority. I guess my main focus is patients. Wanting to help patients understand that they are good and whole just as they are, and that when they go interact with healthcare that it should be an experience of affirmation, rather than of something that needs to be fixed, or something that's wrong with them on a spiritual level. So, I really just wanted to make a difference and start the conversation, and help people think of things and, um, mostly it's a good way for me to share my story, and if it helps someone else I'm really happy for that.

LD: So, we're in the process of writing another article. You've already had one published. Can you talk a little about that, how that has evolved?

Niki: Yeah. I'm wanting to expand upon the idea of Cultural Safety in primary practice. And I love Dr. Ramsden's work. I feel like I understand it so much better after reading her dissertation. … So having read the whole thing gives me a new perspective. So, I like the idea of putting it through my filter, I guess is all it is; and identifying the key components I feel like are important. So, I'm wanting to talk about Cultural Safety in a more, I don't know if abstract is the right word…but the first paper I published, was

more about specific disease processes, but, um, taking a step back and looking at it in a more global way, and really focusing on the fifth element of connection, which includes the three Ps: power, protection and partnership.

… I really want to include that, because I feel like that's actually the biggest message of all in Cultural Safety. So with my five components, reflection and connection are the most important, and I feel like that's where empathy shows up the most as well, is in those two components.

LD: And so, again, who do you envision your audience to be?

Niki: I would like my audience to be, for that article, providers and possibly nursing instructors. But as a whole, also including patients, the general population.

LD: Have you had, any experiences with responses to your work, your writing particularly that stand out for you?

Niki: Not yet. I haven't had any, not that I can think of right of the bat. I've had the occasional person in my community who will say, "I really like your blog. I've been reading it." But I think, actually, I do think of someone. My mother is the one person who keeps saying how much she's learning about me and about sexual minorities. And it's fun to watch her adjust her lens and filter a lot. So that's a new experience for me.

LD: So, in your practice now, what's a typical day like, if there is one?

Niki: Well, I, a lot of my days are just assisting in the operating room. So I actually have little, to no, interaction with conscious patients. And one or two days a week I see patients for colonoscopy consults. So they come in and we're talking about the procedure and getting them set up for it. So that's all I'm doing right now. I'm not

doing any women's health. So, part of my blog is to have an outlet for the calling I have…I'm doing my big work on the side.

LD: So since you have been doing that, is there a particular event that you can picture that would illustrate that for you?

Niki: Not professionally. I don't even have a specific story personally yet. It's more of an alteration of energy, or alteration of relating to the world, and it's still very much in it's infancy for me.   So, uh, it's kind of rocky. It will come and then be real clear for several days or even several hours, and then it gets kind of confusing again, and then it gets real clear. So I'm still, I'm beginning to understand it, but the implementation is still a little rocky. A lot of it is a thought process that happens in my head. If someone does something that normally I would judge or feel was inappropriate ; trying to look at it as, their lens, and allow them to have that lens without trying to change it or having it be a threat to my lens, is kind of where I'm at with it now.

LD: Does that ever come up with your coworkers?

Niki: Yes. Trying to figure out how much to assert myself and how much to not assert my truth, and allowing them to have theirs…it's kind of, a little bit of, it's still confusing to me.   Welcoming people to have a different view of a situation versus trying to control them or the way they think, that's not Cultural Safety. So, I struggle with that, working with a few of my colleagues.

LD: Do you have an example of that?

Niki: There's a lot of homophobia and judgment against people who weigh more than someone might think that they should, overweight people. So, a lot of comments are

made, off the cuff, in the operating room. And there's a lot of comments made, and I'm trying whether or not I'm going to laugh it off because it's uncomfortable, or whether I'm going to say something; that's difficult.

… I just thought of an example of lack of Cultural Safety at my work where I didn't speak up and I wish I would have. On [charts for] patients that are having surgery, nurses will put a sticky note and they'll put, *Husband: Matt* and a [personal] phone number to call when the surgery is done. So this nurse that I know to be very conservative, and I want to say narrow-minded, but that's not culturally safe. But she comes down and has the word "Partner" in quotation marks with the number and it just infuriated me because no one would ever put "Husband" in quotation marks. That just enraged me. And I thought, not only is she putting it out there, she's putting it out there for every single provider that comes into contact with that patient today. And whereas they might not have treated her any differently, but now with just quotes, I felt like now with just the quotes, I felt like it just ruined so much of…, and I just hope the patient didn't see that. I don't know, it just felt so wrong… it just felt like the validation of that relationship was completely stripped.

… And we also had a patient, a few weeks ago, who is transgendered male to female. And on the surgery schedule itself, this patient was having a procedure that had absolutely nothing to do with reproductive organs, but on the schedule for everyone to see it said, "Patient is transgendered female." And I thought to myself, "Why should that matter? And why is it pertinent to everyone in the operating room, including people who aren't in that room that day?" You know, in that patient's mind, I just don't know

how they would have felt if they saw that. I don't know, that felt really inappropriate to me too.

LD: Well, you've taken on a big battle.

Niki: Yeah. And it's hard to know when to speak up and when to not. And I'm still in that phase that I don't know that much about transgendered individuals. And what one person finds offensive, another one necessarily wouldn't, but we're not providing Cultural Safety when we're not even having these discussions, you know?

… I'm in that information gathering phase where I'm kind of just learning a lot of stuff and I really do think that empathy is going to be a huge part of the way that I practice with Cultural Safety, or approach it. … I think the beauty of it is allowing ourselves to change and adapt, you know, change the tint on our lens or adjust our filter a little bit. Because the truth of who we are is always changing.

Summary

Each of the participants spoke through stories and reflections of the meaning of Cultural Safety to their practice and to their lives. Within each narrative representation of the conversations, the themes can be read in and between the lines. By considering positionality, embodiment, reflection, and the inherent tension in a Cultural Safety stance, nurses and nurse educators can consider how these narratives may inform their own thinking and practice. Chapter Five will discuss what Shank and Villella (2004) called "illuminative fertility" (p.50) as potential for nursing education suggested by this study.

CHAPTER FIVE

IMPLICATIONS FOR NURSING EDUCATION

As the final chapter of this dissertation Chapter Five restates the research inquiry, summarizes the methods and explores the findings in terms of implications for U.S. nursing education and practice. The themes expressed by the study participants are related to current literature reviews of relevent research. A visual model is offered to demonstrate how the research findings may be integrated into nursing culture and theory in the U.S. Finally, implications for U.S. nursing education are discussed.

Summary of the Study

The purpose of this critical hermeneutic phenomenologic study was to explore the meanings and experiences of Cultural Safety as expressed by five nurses in the Pacific Northwest of the United States who have adapted the New Zealand concepts, and to illustrate the potential for these perceptions to critique and inform U.S. nursing education and practice. The research inquiry explored how each nurse came to Cultural Safety, how each expresses Cultural Safety in practice and how each finds meaning in this practice. Cultural Safety, as defined by the Nursing Council of New Zealand (2011), is:

 The effective nursing practice of a person or family from another culture, and is determined by that person or family. Culture includes, but is not restricted to, age or generation; gender; sexual orientation; occupation and socioeconomic status; ethnic origin or migrant experience; religious or spiritual belief; and disability. The nurse delivering the nursing service will have undertaken a process of reflection on his or her own cultural identity and will recognize the impact that his or her personal culture has on his or her professional practice. Unsafe cultural practice comprises any action which

diminishes, demeans or disempowers the cultural identity and well-being of an

individual. (p. 7)

As described in Chapter Two, concepts of Cultural Safety are being adopted and adapted by

nurses internationally in order to better serve increasingly migratory, multicultural populations.

A comparison of Cultural Safety to Transcultural Nursing was made and a connection between

Cultural Safety and Critical Race Theory was suggested as way to inform U.S. nursing critical

thinking and experience. Discussions of each of these theories provided the theoretical

foundation for this study in Chapter Two.

In addition, in Chapter One, personal and professional narratives of who I am and what I

do grounded this inquiry in cultural safety and the hermeneutic phenomenology stance of being

connected to the topic by mirroring two of the three levels of inquiry with which I engaged the

research participants in dialogue: 1) what drew you to Cultural Safety? and, 2) describe how you

practice Cultural Safety. The third research inquiry, 'what does it mean to you to practice

cultural safety?' is described from my perspective in the Chapter Five discussion of future

implications of the research for U.S. nursing education and practice.

This interpretive hermeneutic study explored Cultural Safety as described by five nurses

recruited as colleagues and former students who were known to me to be currently teaching

Cultural Safety or to be actively engaged in Cultural Safety practice. After institutional exempt

status was obstained, informed consent was signed, and audiotaped dialogues were conducted,

transcribed and systematically analyzed by a research team with scholarly interest in the topic.

Four over arching themes were evident in the dialogues with each of the five participants:

positionality, embodiment, reflection, and the inherent tension in a Cultural Safety stance. In

order to relate these themes to U.S. nursing, they are discussed in the following section as they

appear in current literature reviews of nursing research. Included in this discussion are my own insights and reflections related to the themes.

Relationship of Findings to Prior Research and to Experience

The four themes of positionality, embodiment, reflection, and the inherent tension in a Cultural Safety stance were entered into the Washington State University Libraries electronic data base Cumulative Index to Nursing and Allied Health Literature (CINAHL) individually with other search terms "cultural safety" "nursing" and "research". A date limit of 2005 was set in order to capture the most recent research.

Positionality.

Using search terms *positionality and nursing and research* four articles were found but each of these was from another country. Each article discussed positionality in terms of the researchers' stance with their study fields and with participants, but did not relate the term to the nurse's stance in relationship to the patient. My study uncovered positionality as a concern of the participants personally in relationship to society and professionally in terms of how their patients are seen by other healthcare providers. For me personally, the discussions of positionality with the participants shed light on my whole life experience of being a female raised in the 1950s and 60s. I understand better my own motivations for teaching and doing research that examines issues of power and positionality. As June stated so clearly, "I would say talking about power, a cultural theory that addresses and acknowledges power dynamics would draw me in."

Positionality, as it relates to Cultural Safety and Critical Race Theory, is discussed by one recent qualitative researcher, Nelson (2007). An Australian occupational therapist (OT), Nelson uses Critical Race Theory as a lens to critique the predominantly White culture of OTs in his

country in relationship to indigenous clients and any persons of color. Nelson's study is

mentioned here to support the integration of Critical Race Theory with Cultural Safety to further

the understanding of positionality in health care, and to illustrate the lack of this focus in U.S.

nursing research.

Embodiment.

Using search terms *embodiment and nursing and research,* of the four articles found, one

was current research. The study examines written texts and interviews and:

> … interrogates the whiteness of the nurses' dominant culture and sheds light on nurses'
>
> relationships with normative discursive frames that reflect and perpetuate inequalities,
>
> discredit non-dominant practices, and leave little room for competing discourses. It also
>
> illustrates a blurring of religion and health-care, and the need for a reflective and
>
> informed stance as a basis for cultural competence (Lagerway, 2009, p. 155).

The term *embodiment* is described as a secondary theme referring to the specific tasks White

nurses carried out historically in a rural Native American setting to promote their ideal of

cleanliness. A recommendation from Lagerway (2009) for future research is congruent with the

stance of this dissertation, which may be related to the use of a similar thematic term:

> More nursing research is needed that takes a critical look at broad cultural
>
> discourses that shape nursing practice and at nursing's capacity for challenging and
>
> altering limiting discourses and the societal causes of health disparities. This line of
>
> research demands further study in a variety of settings and social and cultural contexts.
>
> The profession must interrogate its own dominant cultural discourses that perpetuate the
>
> conditions that cause disparities and nursing's relationship to them. (Lagerway, 2009, p.
>
> 166)

Lagerway's call for examination of dominant cultural discourses is addressed in Critical Race Theory which I propose can be a useful framework for nursing to incorporate into curricula.

Prior to my research, I took for granted my interest in and absorption with teaching Cultural Safety. After observing the passion and dedication with which each of the participants engage with and embody Cultural Safety in their professional and personal lives, I have come to realize more deeply that practicing Cultural Safety is a way of being as well as an ongoing process of becoming.

Reflection.

A detailed discussion of reflection in nursing practice with current literature citations was offered in chapter Two. Reflection is an essential practice for professional growth, as well as a component of Cultural Safety. Tanner (2006), Teekman (2000) and Thorpe (2004) are leading U.S., New Zealand and Canadian scholars (respectively) on the subject, providing models for teaching and evaluating reflection on practice. Prior to this dissertation, Doutrich, et al. (2012) are the only U.S. nursing scholars to specifically link cultural safety and reflection in practice. Chapter One of this dissertation is my extensive personal reflection about the meaning of Cultural Safety in my life.

Inherent tension in the Cultural Safety stance.

The terms used for this CINAHL search were *cultural safety and nursing and United States.* Of the seven articles found, three were U.S.-based research reports.   In addition to the articles cited throughout this dissertation by Doutrich, et al. (2012), and Mkandawire-Valhmu (2012), one new U.S.-based research article was by Moceri (2014). Moceri's qualitative study explored the experience of bias by Hispanic nurses in the workplace. She cited Cultural Safety as the framework for her study, using as her reference the Canadian National Aboriginal Health

Organization (2008) framework/description. Recommendations were made calling on health care organizations to reduce bias in the work place with conscious discussions of race and racism (Moceri, 2014). This is consistent with needs expressed by Angelita, June, the Voyager, and with my recommendation for incorporating the concepts of Cultural Safety and Critical Race Theory together to build upon Transcultural Nursing in order to address multicultural workforce and healthcare disparity issues in the U.S.

Choosing to Live in the Role of Advocate

Within positionality are themes of self-identity, power differentials, and critiques of the status quo or meeting a need. Embodiment contains ways of incorporating Cultural Safety into personal life, clinical practice, teaching and scholarship. Reflection is self-identified by participants as a conscious practice, as well as demonstrated in highly articulate narratives. As a critical process, the Cultural Safety stance has an inherent tension that is expressed in the desire for transformation in nursing education and practice which links to positionality and embodiment. There are overlaps and interplays between and among the themes that are inevitably part of the hermeneutic circle of understanding (Kincheloe & McLaren, 2003)

Each of the themes expressed by the five participants may be viewed in an encompassing theme of choosing to live one's life in the role of advocate. For example, for Niki, each day is a choice to first be her own advocate: "Cultural Safety is just in, I feel like it's implementing in every fiber of my existence. …you know, I feel like I'm living it more and more because I am providing Cultural Safety for myself."

For June and Maraya, advocating for clients and especially those who may be marginalized by the dominant culture due to ethnicity, race or socio-economic status is their compelling passion as nurses. June expressed how her self-identity is closely linked to her

critique of the status quo in health care, as well as how advocacy is linked to her role and identity as a nurse:

> I remember when I first learned about the whole advocacy aspect of nursing, how we as nurses can be advocates; like building a bridge between the medical world and communities. I would say that's always kind of driven me. I have always been very drawn to community health and drawn to social activism. So [Cultural Safety] seemed like a very nice fit for me. And believing that health is a human right, how can my practice inform my underlying belief. And also being a child of an immigrant family, it's very close to me. Yeah you know I am in that category and it is very personal too.
>
> … So many of the nurses in power mimic the biomedical model, so [it is hard for them] even trying to understand some of the imbalance of power. They're like, "We just need to help those people, vulnerable marginalized people" instead of realizing that our health system could be contributing to their "other" health status. In general, I would say that there is a lot of work that we as health professionals need to do.

For Maraya, "I think if you experience unsafety or a power differential …you can identify it in your patient a little bit better. Like you have encountered it before." For myself, the hermeneutic research process has brought me to a deeper understanding of how previously disconnected parts of my life are connected to my interest in critical practice and education. Asking three little questions about meaning to nurses passionately engaged in their own reflective growth as advocates for themselves and others has validated my work…"I must be blessed by angels, too."

Challenges in Choosing Advocacy

Heidegger's philosophical stance asserts that we as human beings exist in our worlds in a state of feeling unsettled with a desire to make it a more secure place (Dreyfus, 1991). For Angelita, this desire was linked to her embodied passion, "…to turn your job into a calling is exhausting. I can't say that I haven't thought, "Okay I'm done." I truly believe my personal philosophy ties closely with my nursing philosophy that I want to be for good and change." The unsettledness was expressed eloquently by the Voyager, who gave permission to use this quote:

> I would like to be called "the Voyager". This represents how I feel about my journey
>
> through life, learning, and my encounters with a variety of people from a variety of
>
> cultures. I thought about Traveler but Traveler would not be representative of my feeling
>
> that I am, at times, traveling through uncharted territory.

It is this uncharted territory of bringing critical awareness of the need to discuss race, sexual preference, income inequality, and other social justice issues to the context of safe patient care that drives my research and this dissertation.

Theoretical Implications for Nursing Education and Practice.

Implications for U.S. nursing education are offered with a proposed model for transforming current common U.S. concepts of cultural competence by integrating Cultural Safety with Critical Race Theory and Transcultural Nursing in order to be more effective in providing care to an increasingly culturally complex society. Figure 2 is a visual representation of this model.
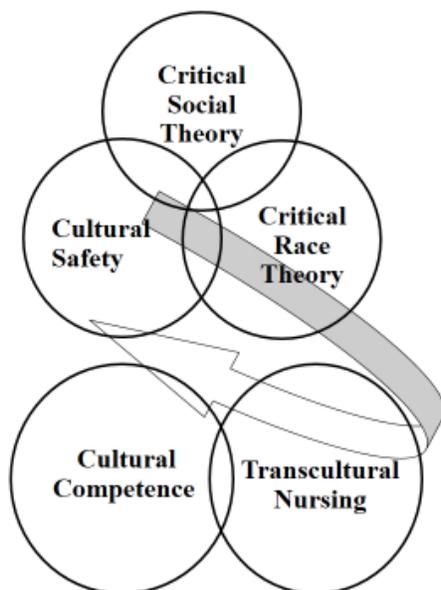
Figure 2: Integrating Cultural Safety with Critical Race Theory and Transcultural Nursing.

The image represents the overlapping similarities between Cultural Safety and Critical Race Theory described in Chapter Two that can inform the current U.S. models of Transcultural Nursing and cultural competence to move toward nursing practice that is more effective by the standards and values of the clients served. Building constructively on what already exists is pedagogically sound (Schunk, 2012) and may enable experienced nurses and nurse educators to incorporate unfamiliar concepts into their current teaching and practice.

Recommendations for Nursing Education

As the Voyager stated about Cultural Safety, "… it is such a theory ready for this time. In all of healthcare and medicine, we're trying to get away from the power differentials, because we recognize it isn't safe for the patient."

In her data collection among New Zealand nurses, Doutrich asked, where do we (in the U.S.) start to implement Cultural Safety? One response was, "Begin with your own broken treaties" (anon, personal communication, 2007). This is one meaning of Cultural Safety, that

all nurses need to be mindful of the cultures, beliefs and values of those upon whose land we reside and whom may have been have uprooted. Connecting historical, social, political and health issues with meanings and experiences of nurse educators helps to establish a foundation for incorporating reflection, Critical Race Theory and Cultural Safety in contemporary nursing education.

Conclusion

This dissertation has reported on a hermeneutic phenomenological study to uncover meanings in the experiences of U.S. nurses and nurse educators who have adopted and adapted Cultural Safety into their own practices and curricula. The study was informed by the philosophical writings of Heidegger whose influence on nurse scholars is seen in a contemporary body of interpretive phenomenological research including Benner (1984, 1994, 2009), Diekelmann (2001), Doutrich, et al. (2012), Ironside (2001), and Vandermause & Flemming (2011). The pioneering work of the New Zealand nurses to incorporate the transformative concepts of Cultural Safety into their education programs and nurse practice laws inspires and informs this study and my own teaching practice. The work of many U.S. nurse scholars and educators is parallel to some of the elements of Cultural Safety, but U. S. nurses have not yet adopted a framework that is effective in defining culture broadly and reducing health disparities between the dominant culture and multiple minority cultures. Cultural Safety combined with Critical Race Theory may offer such a framework to inform nursing cultural competence in the United States.

Bibliography

Aikens, C. A. (1920). Studies in Ethics for Nurses. Philadelphia: W. B. Saunders Company. Retrieved from http://books.google.com

American Association of Birth Centers (AABC). (2014, April). *Birth center accreditation.* Retrieved from American Association of Birth Centers: http://www.birthcenters.org/about-aabc/history

American Association of Colleges of Nursing (AACN). (2011, March). *AACN tool kit for cultural competence in master's and doctoral nursing education.* Retrieved April 17, 2011, from American Association of Colleges of Nursing: http://www.aacn.nche.edu/

American Association of Colleges of Nursing. (1997). *American Association of Colleges of Nursing.* Washington, DC. Retrieved March 20, 2011, from AACN position statement: Diversity and equality of opportunity. http://www.aacn.nche.edu/Publications/positions/diverse.htm

American Association of Colleges of Nursing. (2008). *Essentials for Baccalaureate Nursing.* Washington, DC. Retrieved March 20, 2011, from AACN position statement: Diversity and equality of opportunity.: http://www.aacn.nche.edu/Publications/positions/diverse.htm

Anderson, J., Perry, J., Blue, C., Browne, A., Henderson, A., Khan, K. B., . . . Smye, V. (2003). Rewriting cultural safety within the postcolonial and postnational feminist project toward new epistemologies of healing. *Advances in Nursing Science, 26*(3), 196-214.

Arieli, D., Friedman, V., & Hirschfield, M. (2012). Challenges on the path to cultural safety in nursing education. *International Nursing Review, 59*(2), 187-193. doi:10.1111/j.1466-7657.2012.00982.x

Arms, S. (1975). *Immaculate deception: a new look at women and childbirth in America.* Boston: Houghton Mifflin.

Barnsteiner, J. (2011). Teaching the culture of safety. *The Online Journal of Issues in Nursing, 16*(3). doi:10.3912/OJIN.Vol16No03Man05

Beery, T., & Workman, L. (2012). *Genetics and genomics in nursing and health care.* Philadelphia: F. A. Davis Company.

Benner, P. (1984). *From novice to expert, excellence and power in clincial nursing practice.* Upper Saddle River, NJ: Prentice Hall Health.

Benner, P. (1994). *Interpretive phenomenology: Embodiment, caring and ethics in Health and illness.* (P. Benner, Ed.) Thousand Oaks, CA: Sage Publications, Inc.

Benner, P., Sutphen, M., Leonard, V., & Day, L. (2009). *Educating nurses: A call for radical transformation.* Jossey-Bass.

Benner, P., Tanner, C., & Chesla, C. (1996). *Expertise in nursing practice: Caring, clinical judgment and ethics.* New York: Springer.

Bennett, M. J. (2000). *A development model of intercultural sensitivity.* Retrieved July 29, 2011, from University of Wisconsin: http://www.library.wisc.edu/EDVRC/docs/public/pdfs/SEEDReadings/intCulSens.pdf

Bobo, L. (2004). Inequalities that endure? Racial ideology, american politics, and the peculiar role of the social sciences. In M. Krysan, & A. Lewis, *The changing terain of race and ethnicity* (pp. 13-42). New York: Russell Sage Foundation.

Bowie, A. (1998). *Schleiermacher, hermeneutics and criticism.* Cambridge, UK: Cambridge University Press.

Britannica, E. (2014, February 25). *Weapon of mass destruction*. Retrieved from Encyclopaedia Britannica Online Academic Edition: http://www.britannica.com/EBchecked/topic/917314/weapon-of-mass-destruction

Brookfield, S. D. (1995). *Becoming a critically reflective teacher.* San Francisco: Jossey-Bass, Inc.

Calin, M. (1996). From RN to BSN: seeing familiar situations in different ways. Mezirow's theory of perspective transformation. *Journal of Continuing Education in Nursing*.

Calvillo, E., Clark, L., Ballantyne, J. E., Pacquiao, D., Purnell, L. D., & Villaruel, A. M. (2009). Cultural competency in baccalaureate nursing education. *Journal of Transcultural Nursing, 20*(2), 137-145 doi: 10.1177/1043659608330354.

Capra, F. (1989). *Uncommon wisdom: Conversations with remarkable people.* London: Fontana Paperbacks.

Carper, B. (1999). Fundamental Patterns of Knowing in Nursing. In E. Polifroni, & M. Welch, *Perspectives on philosophy of science in nursing, an historical and contemporary anthology* (pp. 12-19).

Clingerman, E. (2011). Social Justice: A framework for culturally competent care. *Journal of Transcultural Nursing*, 334-341. doi:10.1177/1043659611414185

Cochran-Smith, M. (2000). Blind vision: Unlearning racism in teacher education. *Harvard Educational Review, 70*(2), 157-189.

Coffman, M. J., Shellman, J., & Bernal, H. (2004). An integrative review of American nurses' perceived cultural self-efficacy. *Journal of Nursing Scholarship, 36*(2), 180-185 doi: 10.1111/j.1547-5069.2004.04032.x.

Collins, J., David, R., Handler, A., Wall, S., & Andes, S. (2004). Very low birthweight in African American infants: The role of maternal exposure to interpersonal discrimination. *American Journal of Public Health, 94*(12), 2132-2138. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1448603/

Commission for the Accreditation of Birth Centers. (2014, April). Retrieved from Commission for the Accreditation of Birth Centers: https://www.birthcenteraccreditation.org/

Coup, A. (1996). Cultural safety and culturally congruent care: A comparative analysis of Irihapeti Ramsden's and Madeleine Leininger's educational projects for practice. *Nursing Praxis in New Zealand, 11*(1), 4-11.

Covault, C. (2013). China's bold lunar plan. *Aerospace America*, 24-29.

Creshaw, K. (2009). Intersectionality, identity politics and violence against women of color. In E. Taylor, D. Gillborn, & G. Ladson-Billings, *Foundations of critical race theory in education* (pp. 214-246). New York and London: Routledge Taylor & Francis Group.

Creswell, J. W. (2008). *Educational research: Planning, conducting, and evaluating quantitative and qualitative research.* Upper Saddle River, New Jersey: Pearson, Merrill, Prentice Hall.

Cross, T. (1988). *Cultural competence continuum.* Retrieved 10 09, 2010, from nysccc.org: : http://nysccc.org/family-supports/transracial-transcultural/voices-of-professionals/cultural-competence-continuum/

Cross, T., Bazron, B., Dennis, K., & Isaacs, M. (1989). *Towards a culturally competent system of care, Volume l.* Washington, D.C.: Georgetown UniversityChild Development Center, CASSP Technical Assistance Center.

Cruess, S., Johnston, S., & Cruess, R. (2010). "Profession": a working definition for medical educators. *Teaching and Learning in Medicine: An International Journal, 16*(1), 74-76. doi:10.1207/s15328015tlm1601_15

Davidhizar, R., & Lonser, G. (2003). Storytelling as a teaching technique. *Nurse Educator, 28*, 217-221.

de Witt, L., & Ploeg, J. (2006). Critical appraisal of rigour in interpretive phenomenological nursing research. *Methodological Issues in Nursing Research*, 215-229. doi:10.1111/j.1365-2648.2006.03898.x

Dekker, L. (2014). Cultural safety and social justice in global society. *WSU Angel course*.

Dekker, L. J., & Doutrich, D. L. (2012). Responses of RN to BSN to reflective assignments. *The 12th WIN Annual Communicating Nursing Research Conference.* Portland, OR.

Delgado, R. (2009). Affirmative Action as a Majoritarian Device. In E. G.-B. Taylor, *Foundations of critical race theory in education* (pp. 109-116). New York and London: Routledge.

Denzin, N., & Lincoln, Y. (1994). *Handbook of qualitative research.* Sage Publications: Thousand Oaks.

Dewey, J. (1916). *Democracy and Education.* New York: The Macmillan Company.

Dewitt, J., Kamada, J., & Dekker, L. J. (n.d.).

Diekelmann, N. (2001). Narrative pedagogy: Heideggerian hermeneutical analyses of lived experiences of students, teachers, and clinicians. *Advances in Nursing Science, 23*, 53-71.

Discover Nursing. (2008). Retrieved Nov 15, 2010, from http://www.discovernursing.com/

Dossey, B. (2000). *Florence Nightingale, mystic, visionary, healer.* Springhouse, Pennsylvania: Springhouse Corporation.

Doutrich, D., Arcus, K., Dekker, L., Spuck, J., & Pollock-Robinson, C. (2012). Cultural Safety in New Zealand and the US: Looking at a way forward together. *Journal of Transcultural Nursing, 23*(143-150), 143-. doi:10.1177/1043659611433873

Doutrich, D., Dekker, L., Rasmor, M., Hoeksel, R., Ludeña, M., & Scott, L. (2014). Becoming a transformative nurse educator finding safety and authenticity. *Taking It Global, 47th Annual Communicating Nursing Research Conference.* Seattle: Western Institutes of Nursing.

Doutrich, D., Wros, P., Valdez, R., & Ruiz, M. E. (2005). Professional values of Hispanic nurses: The experience of nursing education. *International Hispanic Health Care, 3*(3), 161-170.

Drevdahl, D. J., Canales, M. K., & Dorcy, K. S. (2008). Of goldfish tanks and moonlight tricks, can cultural competency ameliorate health disparities? *Advances in Nursing Science, 31*(1), 13-27.

Dreyfus, H. (1991). *Being-in-the-world, a commentary on Heidegger's being and time.* Cambridge, Massachusetts: The MIT Press.

Duke, J., Connor, M., & McEldowney, R. (2009). Becoming a culturally competent health practitioner in the delivery of culturally safe care: A process oriented approach. *Journal of Cultural Diversity, 16*, 40-49.

Economic and Social Research Institute. (2012). *Minority population growth - the new boom, An analysis of America's changing demographics.*

ECRI Institute. (2009). *Culture of safety.* Retrieved from ECRI Institute: https://www.ecri.org/documents/patient_safety_center/hrc_cultureofsafety.pdf

Engle, A. C. (2008). Evaluating narrative pedagogy in nursing education in Hong Kong. *Nursing Science Quarterly, 21*, 261-267.

Flemmer, N. (2014). Retrieved from The We Belong Project: http://thewebelongproject.com/

Flemmer, N., Dekker, L., & Doutrich, D. (2014). Empathetic partnership: An interdisciplinary framework for primary care practice. *submitted.*

Flemmer, N., Doutrich, D., Dekker, L., & Rondeau, D. (2012). Creating a safe and caring health care context for women who have sex with women. *The Journal for Nurse Practitioners, 8*(6), 464-481.

Flood, A. (2010). Understanding phenomenology. *Nurse Researcher, 17*(2), 7-15.

Ford, C. L., & Airhihenbuwa, C. O. (2010). Critical race theory, race equity, and public health: toward antiracism praxis. *American Journal of Public Health, 100*(S1), S30-S35.

Ford, C., & Airhihenbuwa, C. (2010). The public health critical race methodology: praxis for antiracism research. *Social Science and Medicine, 71*(8), 1390-8. doi:10.1016/j.socscimed.2010.07.030

Freire, P. (1970). *Pedagogy of the Oppressed.* New York: Continuum.

Gebru, K., & Willman, A. (2010). Education to promote culturally competent nursing care - A content analysis of student responses. *Nurse Education Today, 30*, 54-60. doi:10.1016/j.nedt.2009.06.005.

Gibbs, K. (2005). Teaching student nurses to be culturally safe. *Journal of Transcultural Nursing, 16*(4), 356-60.

Giroux, H. (1992). *Border crossings: Cultural workers and the politics of education.* New York: Routledge, Chapman and Hall.

Graham, L., Brown-Jeffy, S., Aronson, R., & Stephens, C. (2011). Critical race theory as theoretical framework and analysis tool for population health research. *Critical Public Health, 21*(1), 81-93. doi:10.1080/09581596.2010.493173

Grant, L. F., & Letzring, T. D. (2003). Status of cultural competence in nursing education: A literature review. *The Jouranl of Multicultural Nursing & Health*, 6-13.

Greene, M. (1991). Teaching: The question of personal reality. In A. Lieberman, & L. (. Miller, *Staff development for education in the '90s* (pp. 3-13). New York: Teachers College.

Greenwood, D. A. (2009). Place, survivance, and white remembrance: A decolonizing challenge to rural education in mobile modernity. *Journal of Research in Rural Education, 24*(10), 1-6.

Group, C. S. (2006). *Opening our eyes-shifting our thinking. The process of teaching and learning about reflection in cultural safety education and practice: An evaluative study.* Wellington, New Zealand: Whitireia Community Polytechnic and Victoria University of Wellington.

Hall, J., & Fields, B. (2012). Race and microaggression in nursing knowledge development. *Advances in Nursing Science, 35*(1), 25-38. doi:http://dx.doi.org/10.1097/ANS.0b013e3182433b70

Harry, B. (1992). Developing cultural self-awareness: The first step in values clarification for early interventionists. *Topics in Early Childhood Special Education*, 333-352.

Hazel, P. (2008). Toward a narrative pedagogy for interactive learning environments. *Interactive Learning Environments, 16-3, 16*(3), 199-213.

Heath, H. (1998). Reflection and patterns of knowing in nursing. *Journal of Advanced Nursing, 27*, 1054-1059.

Heidegger, M. (1962). *Being and Time.* (M. J. E., Trans.) New York: Harper and Row (Original work published 1927).

Helms, J. E. (1995). *An update of Helms's White and people of color racial identity models.* Retrieved 10 10, 2010, from Ohio consortium of multicultural centers in higher education (OCMCHE): http://ocmche.org/conferences/helms1995.pdf

hooks, b. (1994). *Teaching to transgress: education as the practice of freedom.* London: Routledge.

Huntington, J. (2011). What would Florence do? Responding to attacks on public employees and collective bargaining rights. *The Washington Nurse, Summer*, 24-27.

Institute of Medicine (IOM). (2003). *Institute of Medicine findings and recommendations on health disparities.* Retrieved April 17, 2011, from American Medical Association: http://www.ama-assn.org/ama1/pub/upload/mm/433/iom.pdf

Institute of Medicine. (1999). *To err is human: building a safer healthcare system.* Retrieved from National Academy of Sciences: http://www.iom.edu/Reports/1999/To-Err-is-Human-Building-A-Safer-Health-System.aspx

Institute of Medicine. (2004). *In the nations's compelling interest: Ensuring diversity in the health care workforce.* Washington, DC: National Academy Press.

Ironside, P. (2003, May/June). Implementing and evaluating narrative pedagogy using a multimethod approach. *Nursing Education Perspectives, 24*(3), 122-128 ISSN: 15365026.

Ironside, P. (2003, Nov). New pedagogies for teaching thinking: the lived experiences of students and teachers enacting narrative pedagogy. *Journal of Nursing Education, 42*(11), 509-516.

Ironside, P. (2005). *Beyond method.* Madison: University of Wisconsin Press.

Ironside, P. M. (2001, Mar). Creating a research base for nursing education: an interpretive review of conventional, critical, feminist, postmodern, and phenomenologic pedagogies. *Advances in Nursing Science, 23*(3), 72-87 PMID: 1122505.

Jeffs, L. (2001). Teaching cultural safety the culturally safe way. *Nursing Praxis in New Zealand, 17*(3), 41-50.

Johnstone, M., & Kanitsaki, O. (2007). An exploration of the notion and nature of the construct of cultural safety and its applicability to the Australian health care context. *Journal of Transcultural Nursing, 18*(3), 247-256. doi:10.1177/1043659607301304

Joint Commision Standards on Patient Safety. (2010). Retrieved 10 10, 2010, from Joint Commission.org: http://www.jointcommission.org/PatientSafety/HLC/HLC_Joint_Commission_Standards.htm

Jootum, D., McGhee, G., & Marland, G. (2009). Reflexivity: promoting rigour in qualitative research. *Nursing Standard, 23*(23), 42-46.

Josewski, V. (2012). Analyzing 'cultural safety' in mental health policy reform: lessons from British Columbia, Canada. *Critical Public Health, 22*(2), 223-234.

Kaiser Family Foundation. (2005, July 14). *Cultural competency: a critical component to address reacial and ethnic health disparities for women.* Retrieved March 3, 2006, from kaisernetwork.org.

Kardong-Edgren, S., Cason, C. L., Brennan, A. M., Reifsnider, E., Hummel, F., Mancini, M., & Griffin, C. (2010, Sep-Oct). Cultural competency of graduating BSN nursing students. *Nursing Education Perspectives, 31*(5), 278-285.

Kennedy, H. P., Fisher, L., Fontaine, D., & Martin-Holland, J. (2008). Evaluating diversity in nursing education: A mixed method study. *Journal of Transcultural Nursing, 19*, pp. 363-370.

Kincheloe, J., & McLaren, P. (2003). Rethinking critical theory and qualitative research. In J. Kincheloe, & P. McLaren, *The landscape of qualitative research; theories and issues, 2nd ed.* (pp. 433-488). Thousand Oaks: Sage.

Kinsella, E. (2006). Hermeneutics and critical hermeneutics: Exploring possibilities within the art of interpretation. *Forum: Qualitative Social Research, 7*(3), 1-13. Retrieved from http://www.qualitative-research.net/index.php/fqs/article/view/145/319

Kinsella, E. (2009). Professional knowledge and the epistomology of reflective practice. *Nursing Philosophy*, 3-14.

Klaus, M., & Kennell, J. (1976). *Maternal-Infant Bonding.* St. Louis: C. V. Mosby Company.

Koro-Ljungberg, M., Yendel-Hoppey, D., Smith, J. J., & Hayes, S. B. (2009). (E)pistemological awareness, instantiation of methods, and uninformed methodological amibiguity in qualitative research projects. *Educational Researcher, 38*(9), 687-699. doi:10.3.102/0013189X09351980

Kubota, R., & Lin, A. (2009). *Race, culture, and identities in second language education: Exploring critically engaged practice.* New Yourk and London: Routledge.

Kuiper, R. A., & Pesut, D. J. (2004). Promoting cognitive and metacognitive refelctive reasoning skills in nursing practice: self-regulated learning theory. *Journal of Advanced Nursing*, 381-391.

Ladson, G. M., Lin, J. M., Flores, A., & Magrane, D. (2006). An assessment of cultural competence of first and second-year medical students at a historically diverse medical school. *American Journal of Obstetrics and Gynecology, 195*, 1457-62. doi: 10.1016/j.ajog.2006.06.051.

Lagerway, M. (2009). In their own words: nurses' discourses of cleanliness from the Rehoboth Mission. *Nursing Inquiry, 16*(2), 155-170.

Lambert, J. (2010). *Digital storytelling.* Berkeley: Digital Dinner Press.

Landsman, J. (2009). *A White teacher talks about race.* Lanham, New York, Toronto, Pylmouth, UK: Rowman & Littlefield Education.

Laverty, S. (2003). Hermeneutic phenomenology and phenomenology: A comparison of historical and methodological considerations. *International Journal of Qualitative Methods, 2*(3). Retrieved February 25, 2014, from http://www.ualberta.ca/~iiqm/backissues/2_3final/pdf/laverty.pdf

Leininger, M. (1995). *Transcultural nursing concepts, theories, research & practices* (2 ed.). New York: McGraw-Hill.

Leininger, M. (1997). Leininger's critique response to Coup's article on cultural safety (Ramsden) and culturally congruent care(Leininger) for practice. *Nursing Praxis in New Zealand, 12*(1), 17-23.

Leininger, M. (2002). *Culture Care Theory: A major contribution to advance transcultural nursing knowledge and practices*. Retrieved 9 11, 2010, from Journal of Transcultural Nursing: http://tcn.sagepub.com/content/13/3/189

Leonardo, Z. (2009). The color of supremacy. In E. e. Taylor, *Foundations of critical race theory in education* (pp. 273-274). New York: Routledge.

Lewis, A., Krysan, M., Collins, S., Edwards, K., & Ward, G. (2004). Institutional patterns and transformations: Race and ethnicity in housing, eduaction, labor markets, religion and criminal justice. In M. Kryson, & A. Lewis, *The changing terrain of race and ethnicity* (pp. 59-119). New York: Russell Sage Foundation.

Litowitz, D. (2009). Some critical thoughts on critical race theory. In E. e. Taylor, *Foundations of critial race theory in education* (pp. 291-309). New York: Routledge.

Lopez, K., & Willis, D. (2004). Descriptive versus interpretive phenomenology: Their contributions to nursing knowledge. *Qualitative Health Research, 14*(5), 726-735. doi:10.1177/1049732304263638

Ludlow, L., Enterline, S. E., & Cochran-Smith, M. (2008). Learning to teach for social justice-beliefs scale: An application of Rasch measurement principles. *Measurement and Evaluation in Counseling and Development, 40*, 194-214.

Lytle, S. L., & Cochran-Smith, M. (1992). Teacher research as a way of knowing. *Harvard Educational Review, 62*(4), 447-474.

Mackey, S. (2004). Phenomenological nursing research: methodological insights derived from Heidegger's interpretive phenomenology. *International Journal of Nursing Studies, 42*, 179-186.

Magidson, K., & Samuels, J. (2013, August 22). United States of America v. State of Texas. Corpus Christi, Texas. Retrieved from http://www.justice.gov/crt/about/vot/sec_2/tx_comp_sec2.pdf

Mantzoukas, S. (2007). Reflection and problem/inquiry-based learning: confluences and contradictions. *Reflective Practice, 8*(2), 241-253.

Meleis, A. (2012). *Theoretical nursing, development and progress* (5th ed.). Philadelphia: Wolters Kluwer|Lippincott Williams & Wilkins.

Mezirow, J. (1990). *How critical reflection triggers transformative learning.* Retrieved Sept 28, 2012, from Fostering critical reflection in adulthood, a guide to transformative and emanicipatory learning: http://www.graham-russell-pead.co.uk/articles-pdf/critical-reflection.pdf

Mkandawire-Valhmu, L., & Doering, J. (2012). Study abroad as a tool for promoting cultural safety in nursing education. *Journal of Transcultural Nursing, 23*(1), 82-89. doi:10.1177/1043659611423831

Moceri, J. (2014). Hispanic nurses experiences of bias in the workplace. *Journal of Transcultural Nursing, 25*(15), 15-22. doi:10.1177/1043659613504109

Momeni, P., Jirwe, M., & Ememi, A. (2008). Enabling nursing students to become culturally competent-a documentary analysis of curricula in all Swedish nursing programs. *Scandinavian Jouranl of Caring Sciences, 22*, 499-506. doi: 10.1111/j.1471-6712.2007.00554.x.

Morgan, J., Rawlinson, M., & Weaver, M. (2006). Facilitating online reflective learning for health and social care professionals. *Open Learning, 21*(2), 167-176.

Mortensen, A. (2010). Cultural safety: Does the theory work in practice for culturally and linguistically diverse groups? *Nursing Praxis in New Zealand, 26*(3), 6-16.

NASA.gov. (2006, December 6). *NASA images suggest water still flows in brief spurts on Mars.* Retrieved from NASA: http://www.nasa.gov/mission_pages/mars/news/mgs-20061206.html#.Uw02qoXXgwY

National Aboriginal Health Organization (NAHO). (2008). Cultural competency and safety: A guide for health care administrators, providers and educators. Ottawa, Ontario, Canada.

(NAHO), N. A. (2009, April). *Cultural competency and safety in First Nations, Inuit and Metis health care.* Retrieved December 2012, from National Aboriginal Health Organization: http://www.naho.ca/documents/naho/english/factSheets/culturalCompetency.pdf

National Center for Cultural Competence. (2004). *Curricula enhancement module series, National Center for Cultural Competence.* Retrieved March 18, 2014, from Georgetown University Center for Child and Human Development: http://www.nccccurricula.info/culturalcompetence.html

National Institutes of Health. (2012, November 8). *What was the human genome project.* Retrieved from National Human Genome Project: http://www.genome.gov/12011238

Nelson, A. (2007). Seeing white: a critical exploration of occupational therapy with Indigenous Australian people. *Occupational Therapy International*, 237-255. doi:10.1002/oti.236

Newman, M. (1992). Prevailing paradigms in nursing. In R. &. Shearer, *Philosophic foundations of science and theory* (pp. 185-190). Elsevier.

Nicoll, H., & Higgins, A. (2004). Reflection in preregistration nursing curricula. *Journal of Advanced Nursing, 46*(6), 578-585.

Nightingale, F. (1860). Notes on nursing: What it is, and what it is not. London: Harrison. Retrieved from http://books.google.com

Nursing Council of New Zealand. (2011). *Guidelines for Cultural Safety, the Treaty of Waitangi, and Maori Health in nursing education and practice.* Retrieved 3 17, 2014, from Nursing Council of New Zealand: http://www.nursingcouncil.org.nz/Publications/Standards-and-guidelines-for-nurses

Papps, E., & Ramsden, I. (1996). Cultural Safety in Nursing: the New Zealand Experience. *International Jouranl for Quality in Health Care, 8*(5), 491-497. doi: 10.1093/intqhc/8.5.491

Patton, M. Q. (2002). *Qualitative research and evaluation methods.* Thousand Oaks: Sage.
Porter, C., & Barbee, E. (2004). Race and racism in nursing research: past, present, and future. *Annual Review of Nursing Research, 22*, 9-37. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/15368766

QSEN. (2014, March 8). *Competencies*. Retrieved from QSEN Institute: http://qsen.org/competencies/

Ramsden, I. (2003). *Cultural Safety Kawa Whakaruruhau.* Retrieved 9 10, 2010, from Massey University: http://culturalsafety.massey.ac.nz/

Reardon, S., Grewal, E., Kalogrides, D., & Greenberg, E. (2012). "Brown" fades: The end of court-ordered school desegregation and the resegregation of American public schools. *Journal of Policy Analysis, 31*(4), 876-904.

ReimerKirkham, S., Baumbusch, J., Schultz, ,. A., & Anderson, J. (2007). Knowledge development and evidence-based practice, Insights from a postcolonial feminist perspective for transformative nursing practice. *Advances in Nursing Science, 30*(1), 26-40.

Richardson, F., & Carryer, J. (2005). Teaching cultural safety in a New Zealand nursing education program. *Journal of Nursing Education*, 201-208.

Richardson, S. (2004). Aoteaorora/New Zealand nursing: From eugenics to cultural safety. *Nursing Inquiry, 11*(1), 35-42.

Rodenborg, N. A., & Boisen, L. A. (2013). Aversive racism and intergroup contact theories: cultural competence in a segregated world. *Journal of Social Work Education, 49*, 546-579. doi:10.1080/10437797.2013.812463

Rolfe, G., & Gardner, L. (2006). Do not ask who I am...: Confession, emancipation and (self)-management through reflection. *Journal of Nursing Management*, 593-600.

Ruth-Sahd, L. (2003). Reflective practice: A critical analysis of data-based studies and implications for nursing education. *Journal of Nursing Education*, 488-497.

Salter, P., & Adams, G. (2013). Toward a critical race psychology. *Social & Personality Psychology Compass*, 781-793. doi:10.1111/spc3.12068

Sanner, S., Baldwin, D., Cannella, K., Charles, J., & Parker, L. (2010). The impact of cultural diversity forum on students' openness to diversity. *Journal of Cultural Civersity, 17*(2), 56-61.

Sawyer, R. (2011). Syllabus EdAd 514 Curriculum Design. *Fall*. Washington State University Vancouver, College of Education.

Sawyer, R., & Norris, J. (2012). *Duoethnography, Understanding qualitative research.* New York: Oxford University Press.
Schaub-deJong, M. A., Schonrock-Adema, J., Dekker, H., Verkerk, M., & Cohen-Schotanus, J. (2011). Development of a student rating scale to evaluate teacher's competencies for facilitating reflective learning. *Medical Education, 45*, 155-165.

Schön, D. A. (1983). *The reflective practitioner.* New York: Basic Books, Inc.

Schunk, D. H. (2012). *Learning theories an educational perspective* (6th ed.). Boston: Pearson.

Schwandt, T. (2000). Three epistemological stances for qualitative inquiry, 2nd ed. In N. K. Denzin, & Y. S. Lincoln, *Handbook of qualitative research* (pp. 189-213). Thousand Oaks: Sage Publications, Inc.

Seaton, L. (2010). *Cultural care in nursing: A critical analysis.* Sydney: University of Technology. Retrieved Jan 2013

Seidman, I. (1998). *Interviewing as qualitative research, a guide for researchers in education and the social sciences.* New York: Teachers College, Columbia University.
Severtsen, B. M., & Evans, B. C. (2000). Education for caring practice. *Nursing & Health Care Perspectives, 21*, 172-177.

Shank, G., & Villella, O. (2004). Building on new foundations: Core principles and new directions for qualitative research. *The Journal of Educational Research, 98*(1), 46-54.

Skeggs, B. (2008). The problem with identity. In A. M. Lin, *Problemizing identity, Everyday struggles in language, culture and education* (pp. 11-34). New York: Lawrence Erlbaum Associates.

Soest, D., Canon, R., & Grant, D. (2000). Using an interactive website to educate about cultural diversity and societal oppression. *Journal of Social Work Education, 36*(3), 463-479.

Solorzano, D. a. (2009). Counter-storytelling as an analytical framework for educational research. In E. Taylor, D. Gillborn, & G. Ladson-Billings, *Foundations of critical race theory in education* (pp. 131-147). New York and London: Routledge Taylor & Francis Group.

Srivastava, R. (2007). *The health care provider's guide to clinical cultural competence.* Toronto: Elsevier.

Staden, H. (1998). Alertness to the needs of others: A study of the emotional labour of caring. *Journal of Advanced Nursing, 27*, 147-156.

Tanner, C. (2006). Thinking like a nurse: A research-based model of clinical judgment in nursing. *Journal of Nursing Education*, 204-211.

Tatum, B. D. (2009). Teaching white students about racism. In E. Taylor, D. Gillborn, & G. Ladson-Billings, *Foundations of critical race teory in education* (pp. 275-288). New York: Routledge.

Taylor, E. (2009). Critical race theory and interest convergence in the backlash against affirmative action: Washington State and Initiative 200. In E. G.-B. Taylor, *Foundations of critical race theory in education* (pp. 117-128). New York and London: Routledge Taylor & Francis Group.

Taylor, E. (2009). Foundations of critical race theory in education: an introduction. In E. Taylor, D. Gillborn, & G. Ladson-Billings, *Foundations of Critical Race Theory in education* (pp. 1-13). New York and London: Routledge.

Taylor, E., Gillborn, D., & Ladson-Billings, G. (2009). *Foundations of critical race theory in education.* New York: Routledge.

Teekman, B. (2000). Exploring reflective thinking in nursing practice. *Journal of Advanced Nursing, 31*(5), 1125-1135.

Thomas, S., Quinn, S., Butler, J., Fryer, C., & Garza, M. (2011). Toward a fourth generation of disparities research to achieve health equity. *Annual Review of Public Health, 32*(1), 399-416. doi:10.1146/annurev-publhealth-031210-101136

Thorpe, K. (2004). Reflective learning journals: from concept to practice. *Reflective Practice, 5*(3), 327-343.

Transcultural Nursing Society. (2014, March). *Certification in transcultural nursing*. Retrieved from Transcultural Nursing Society: http://www.tcns.org/Certification.html

Trinh T, M.-h. (1995). No master territories. In B. Ashcroft, G. Griffins, & H. Tifin, *The post-colonial studies reader* (pp. 215-218). London: Routledge.

Tushnet, M. (2009). The "we've done enough" theory of school desegregation. In E. Taylor, D. Gillborn, & G. Ladson-Billings, *Foundations of Critical Race Theory* (pp. 99-108). New York and London: Routledge Taylor & Francis Group.

U.S. Department of Health and Human Services. (2014). *Healthy people 2020*. Retrieved from Healthy People.gov: http://www.healthypeople.gov/2020/default.aspx

United States Census Bureau, Population Division. (2000, January). *Population projections*. Retrieved August 24, 2011, from U.S. Census Bureau: http://www.census.gov/population/www/projections/usinterimproj/natprojtab01a.pdf

Vandermause, R., & Flemming, S. (2011). Philosophical hermeneutic interviewing. *International Journal of Qualitative Methods, 10*(4), 367-377.

Varcoe, C., & McCormick, J. (2003). Health care relationships in context: An analysis of three ethnographies. *Qualitative Health Research, 13*, 957-973.

Villarruel, A. (2004). Inroduction: Eliminating health disparities among racial and ethnic minorities in the United States. *Annual Review of Nrusing Research, 22*, 1-6.

Walsh Brennan, A. B., & Cotter, V. T. (2008). Student perceptions of cultural competence content in the curriculum. *Journal of Professional Nursing, 24*(3), 155-160. doi:10.1016/j.profnurs.2008.01.003.

Weaver, K., & Olson, J. K. (2006). Understanding paradigms used for nursing research. *Integrative Literature Reviews and Meta-Analyses*, 459-469.

Williams, L. (2008). *Improving student achievement through an after school knitting program: Cultural historical activity theory in an urban setting*. Retrieved Oct 5, 2010, from City Knits: http://www.cityknits.com/pdfs/NewResearch.pdf

Williams, R. (1999). Cultural safety-what does it mean for our work practice? *Australian and NewZealand Journal of Public Health, 23*(2), 213-214.

Williamson, M., & Harrison, L. (2010). Providing culturally appropriate care: A literature review. *International Journal of Nursing Studies, 47*, 761-769. doi:10.1016/j.ijnurstu.2009.12.012.

Willis, J. W., Jost, M., & Nilakanta, R. (2007). *Foundations of Qualitative Research.* Thousand Oaks, CA: Sage Publications, Inc.

Woods, M. (2010). Cultural safety and the socioethical nurse. *Nursing Ethics, 17*(6), 715-725.

Wynn, W. M. (2009). Community-graced research: the ethics of ethonographic crossings. Washington State University. Retrieved Oct 2012

Yurkovich, E., Hopkins-Lattergrass, Z., & Rieke, S. (2011). "Chaotic soup of politics:" A Native American Indian mental health perspective. *Mental Health, Religion & Culture, 14*(10). doi:Doi.org/10.1080/13674676.2010.547986

APPENDIX A

SYLLABUS: CULTURAL SAFETY AND SOCIAL JUSTICE IN GLOBAL SOCIETY

COURSE TITLE: Cultural Safety and Social Justice in Global Society
COURSE NUMBER: NURS 455
COURSE CREDITS: 3 semester hours
COURSE DATE: Spring Semester 2014
COURSE PREREQUISTE: Currently enrolled in the RNB program or by permission
COURSE FACULTY: Lida Dekker, EdD, MN, RN, PHCNS-BC, Instructor of Nursing
                              WSU Vancouver Office VLIB 210P
                              Office Hours: by appointment
                              Email: ldekker@vancouver.wsu.edu

CATALOG DESCRIPTION: Analyze selected concepts exploring balance of power in health professional relationships: cultural safety, social justice, and valuing diversity in global society.

COURSE DESCRIPTION: The focus of this course is the analysis of current concepts as they relate to health care practices in the care of individuals, families and groups. Emphasis is on current research exploring the values of cultural safety which acknowledges the balance of power in healing relationships, equity, inclusion and social justice in multicultural, global society.

COURSE OBJECTIVES / OUTCOMES FOR STUDENT LEARNING:

1. Analyze health care practices in the care of vulnerable and diverse populations based on current research evidence.
2. Analyze health care practices in the care of elderly, culturally and linguistically diverse, and economically challenged clients and their families based on standards of care from professional organizations (e.g. ANA, AACN) and relevant literature.
3. Integrate cultural, linguistic, and age-related competencies in the analysis of individual, family and group healing and health promotion needs.
4. Use effective teaching-learning principles to assist colleagues to increase the quality of their health care to individuals, families and global society to reflect the values of cultural safety, social justice, inclusion and advocacy.

INSTRUCTIONAL STRATEGIES: This course is taught using an on-line asynchronous format. Interactive on-line discussion will be expected weekly among all course participants. Student presentations, interactive discussion of case studies, and readings will focus the relevant theoretical content. Student input in the first weeks of the semester will help to determine relevant topics of focus.

REQUIRED TEXTBOOKS:
- Srivastava, R., (2007) The Healthcare Professional's Guide to Clinical Cultural Competence. Toronto, Mosby Elsevier
- Rose, Patti R., (2013) Cultural Competency for the Health Professional, Jones and Bartlett Learning, ISBN: 978-1-4496-1451-5.
- Office of Minority Health. (2001). *National Standards for Culturally and Linguistically Appropriate Services in Health Care.* Washington, D.C.: United State Department of Health and Human Services. (may be downloaded from http://www.omhrc.gov/assets/pdf/checked/finalreport.pdf)

RECOMMENDED TEXTBOOKS:
- Nies, M., McEwen,M, (2007) *Community/Public Health Nursing, Promoting the Health of Populations*, 4th ed., St. Louis, Saunders, Elsevier. **Or,** Other community health nursing text.
- Quad Council of Public Health Nursing Organizations, (2013), Public health nursing: Scope and standards of practice, 2nd ed., American Nurses Association: Washington, D.C. The phone number for ordering the ANA standards for both Community/Public Health Nursing and Psychiatric/Mental Health Nursing is: 1-800-637-0323. The web link: http://www.nursesbooks.org/Main-Menu/Standards.aspx Scroll down to the new edition. Also available as an e-book.
- In addition, relevant current readings will be available electronically supplemented by web-based sources of current information. Students will be expected to have access to current APA VI standards and guidelines for the presentation of their work. Use of the WSU library system is expected for scholarly searches and access to optional readings.

TOPICAL OUTLINE:
The following concepts and issues will be foundational each semester augmented by the additional interests of course participants. Additional interests could be additional concepts/issues or a more specific and in-depth exploration of one of the core concepts. Each semester the following core issues/concepts will be addressed: Social Justice, Valuing Diversity, Inclusion, Advocacy, Health Promotion/Risk Reduction, Cultural Safety, and Global Society.

EVALUATION PROCEDURES: (learning activities and percentages) **500 total points 100%**
The grade for this course will be based upon your accomplishments on the following required learning activities; the WSU grading scale will be utilized.

  1. **Participation/ Attendance**   **100 points = 20%**
All students are expected to fully participate in all course activities including asynchronous discussions & Studies, to engage in scholarly dialogue while respecting the viewpoints of others, to do their fair share of any group work, to monitor their own participation, to prepare for each activity so that evidence of prior reading & preparation is unmistakable, and to take responsibility for furnishing to the instructor evidence documenting their level of participation. This includes timely submission of Studies. The weekly content and participation provides the foundation for the other course learning activities.

2. Cultural Safety Integration Paper   **100 points = 20%**

Each student will submit a 2-3 page (maximum!) paper written in APA VI format and style that integrates understanding of the concepts related to cultural safety in a specific clinical setting or case study. This may describe how cultural safety is particularly well applied in a specific setting or a specific clinical case study, or may suggest how to improve a clinical setting or case care plan by introducing elements of cultural safety. At least 4 scholarly references should be cited. Detailed instructions and grading criteria are posted in the Lessons folder.

3. Studies   **200 points = 40%**

There are readings & activities to choose from to be completed throughout the semester. The number of required case studies or activities is equivalent to 4 as each is worth 50 points. Detailed instructions and grading criteria are posted in the Lessons folder.

4. Choose <u>one</u> of these activities (a, b, or c) for Final Project   **100 points = 20%**

Detailed instructions and grading criteria for each are posted in the Lessons folder. Use this opportunity to teach others what you have learned and discovered. (This can be an appropriate addition to your N495 CAPS e-portfolio.)

a. Analysis of a Healthcare Disparity Issue

Identify a healthcare disparity issue of interest to be developed into a scholarly project. This project could be an appropriate contribution to the student's electronic portfolio. Projects will emphasize the conceptual threads of the WSU RN-to-BSN program with some specific emphasis on poverty, aging, social justice, access to care, and valuing diversity in the global society as context for the healthcare disparity issue. The project will include assessment, development, implementation, and evaluation phases as well as an evidence table of relevant research findings. At least 4 scholarly references should be documented.

b. Duoethnography (to be done together with a classmate)

Spend time in dialogue with a classmate to discover each other's cultural roots. Through email, phone, Skype, or face-to-face interactions explore each other's family values and history. Share pictures, memories, and other artifacts that have meaning to each family. Discuss impressions with each other. Identify differences and similarities that are discovered. How do you see each other's family cultural values and background impacting your nursing practice or other important life choices? Choose a focus for your explorations. Look up scholarly research that relates to your discoveries. Present a digital story that includes personal photos, expresses your dialogues, your cultural values and how you relate this journey of discovery to your choice of focus (for example, to your nursing practice, or to a health disparity issue). At least 4 scholarly references should be documented.

c. Place-based Learning Project

Choose a community or neighborhood that has meaning to you, for example, your neighborhood, your campus, your workplace. Research the history of the land going back at least as far as the Native Americans who occupied that land prior to being displaced. What has transpired over time to result in the current occupancy and land use? Search county records, historical documents, first person accounts; use your local librarian and WSU reference librarian as resources. How has the history of this place impacted the health of the community who now occupy it and those who no longer occupy it? Incorporate principles of social determinants of

health, community health promotion, place-based learning to identify a meaningful project to express what you have learned. At least 4 scholarly references should be documented.

COURSE POLICIES:
1. All questions are welcomed. Sharing our questions and our answers is how we all learn.
2. Each student must achieve 73% of the available points in order to successfully pass the course. The total course activities are worth 500 points.
3. Submitted work may not overlap with other courses without the written permission of all the instructors involved.
4. Reasonable accommodations are available for students who have a documented disability. Please notify your instructor during the first week of class of any accommodations needed for the course. Late notification may cause the requested accommodations to be unavailable. All accommodations must be approved through Disability Services.

Schedule of topics: May change slightly after first few weeks depending on class input.

Weeks 1 & 2	Jan 13 - 26	Orientation to course, texts, on-line resources, "forming community" on-line postings, cultural competence self-assessment, exploring one's own values
Weeks 3 & 4	Jan 27- Feb 9	What is culture? What is race? What is cultural safety? In the US and Globally **Study 1 due**
Weeks 5 & 6	Feb 10 - 23	What are Culturally and Linguistically Appropriate Services?
Weeks 7 & 8	Feb 24 - Mar 9	Health Care Disparities: Women and Children in US and Globally **Study 2 due**
Week 9	Mar 10 - 16	Health Care Disparities: Elders in US and Globally **Cultural Safety Integration Paper due Mar 24**
Week 10	Mar 17 - 23	SPRING BREAK
Weeks 11 & 12	Mar 24 – Apr 6	What is a Family? **Study 3 due**
Week 13	Apr 7-13	Health Care Disparities and Social Justice: Pain Management **Study 4 due** (Note: Studies turned in after April 13 may not be revised/resubmitted)
Weeks 14 & 15	Apr 14 - 27	Post **Choice of Final Learning Activity** and give feedback to classmates .
Week 16	Apr 28- May 4	Last week to turn in written learning activities to Digital Dropboxes including Cultural Safety Integration Paper that was due end of Week 11. 2 points off for each week overdue. .

Appendix B

Certification of IRB Exemption

[PRIORITY]: Med

[SOURCE]: IRB - Primary Activity

[SUBJECT]: Certification of Exemption, IRB Number 13252

[BODY]:
MEMORANDUM

TO: Richard Sawyer and Lida Dekker,

FROM: Patrick Conner, Office of Research Assurances (3005)

DATE: 7/18/2013

SUBJECT: Certification of Exemption, IRB Number 13252

Based on the Exemption Determination Application submitted for the study titled INFORMING
NURSING EDUCATION: THE MEANING AND EXPERIENCE OF CULTURAL SAFETY
AS EXPRESSED BY NURSES IN THE PACIFIC NORTHWEST, and assigned IRB # 13252,
the WSU Office of Research Assurances has determined that the study satisfies the criteria for
Exempt Research at 45 CFR 46.101(b)(2).

This study may be conducted according to the protocol described in the Application without
further review by the IRB.

It is important to note that certification of exemption is NOT approval by the IRB. You may not
include the statement that the WSU IRB has reviewed and approved the study for human subject
participation. Remove all statements of IRB Approval and IRB contact information from study
materials that will be disseminated to participants.

This certification is valid only for the study protocol as it was submitted to the ORA. Studies
certified as Exempt are not subject to continuing review (this Certification does not expire). If
any changes are made to the study protocol, you must submit the changes to the ORA for
determination that the study remains Exempt before implementing the changes (The Request for
Amendment form is available online at
http://www.irb.wsu.edu/documents/forms/rtf/Amendment_Request.rtf).

Exempt certification does NOT relieve the investigator from the responsibility of providing
continuing attention to protection of human subjects participating in the study and adherence to
ethical standards for research involving human participants.

In accordance with WSU Business Policies and Procedures Manual (BPPM), this Certification of Exemption, a copy of the Exemption Determination Application identified by this certification and all materials related to data collection, analysis or reporting must be retained by the Principal Investigator for THREE (3) years following completion of the project (BPPM 90.01). This retention schedule does not apply to audio or visual recordings of participants, which are to be erased, deleted or otherwise destroyed once all transcripts of the recordings are completed and verified.

You may view the current status or download copies of the Certified Application by going to https://myresearch.wsu.edu/IRB.aspx?HumanActivityID=37738

Washington State University is covered under Human Subjects Assurance Number FWA00002946 which is on file with the Office for Human Research Protections (OHRP).

Review Type: New
Review Category: Exempt
Date Received: 7/17/2013
Exemption Category: 45 CFR 46.101 (b)(2)
OGRD No.: N/A
Funding Agency: N/A

Appendix C

WASHINGTON STATE UNIVERSITY
College of Education
Research Study Consent Form

Study Title: Informing nursing education: The meaning and experience of cultural safety as expressed by nurses in the Pacific Northwest
Researchers:
Lida Dekker, Graduate Student, Department of Teaching and Learning (360) 546-9269
Richard Sawyer, Director of Doctor of Education Program in Teacher Leadership, Department of Teaching and Learning, (360) 546-9658
You are being asked to take part in a research study carried out by Lida Dekker, doctoral candidate. Richard Sawyer is the doctoral committee chair.

What are my rights as a research study volunteer?
Your participation in this research study is completely voluntary. You may choose not to be a part of this study.
This form explains the research study and your part in it if you decide to participate. Please read the form carefully, taking as much time as you need. It is important that you understand that your participation is completely voluntary. This means that even if you agree to participate, you are free to withdraw from the study at any time; you may choose not to answer specific questions or decline to participate in any part of the study, without penalty. This study has been approved for human subject participation by the Washington State University Institutional Review Board. You cannot take part in this study if you are under 18 years of age.

What is this study about?
This research study is being undertaken to explore how selected nurses in the Pacific Northwest of the United States (U.S.) are adapting and incorporating concepts from New Zealand nursing of cultural safety into their clinical and education practices. The intention is to explore how each nurse came to cultural safety, how cultural safety is being expressed in practice and what are the meanings to each of this practice. It is hoped that this qualitative study will inform and critique nursing education, and inspire nurse educators to examine the potential of adapting and teaching cultural safety concepts to their students who can potentially reduce health disparities, as well as iatrogenic emotional and physical travesties as they provide nursing care in the future.
The purpose of this research is to explore two questions: (1) what are the meaning and experience of cultural safety as expressed by nurses in the Pacific Northwest of the U.S., who have adapted the New Zealand concepts; (2) How can cultural safety critique and inform U.S. nursing education and practice?

You are being asked to take part because you are a registered nurse and/or nurse educator who is practicing and/or teaching cultural safety.

What will I be asked to do if I am in this study?

If you take part in the study, you will be asked to participate in one or more dialogic interviews with the researcher, Lida Dekker. Taking part in the study will take approximately 2-5 hours during one or more interview sessions. The loosely structured dialogue sessions will be guided by open ended questions such as:

- The first inquiry will explore stories of "where you come from" by eliciting stories of your past that led you to become a nurse and to embrace cultural safety. Knowing your own history is an element of cultural safety and is also consistent with the Heideggerian hermeneutic stance that we are beings situated, in context influenced by our pasts.
- The second inquiry will ask what is being taught and/or practiced that you identify as cultural safety content; to elicit stories about your actual experiences, or a typical day.
- The third inquiry will ask you to reflect on what it means to you to teach and practice cultural safety.

 This set of three inquiries is intended to provide the opportunity for building a dialogic relationship that will enable the researcher (Lida Dekker) and you to reflect and to have the opportunity to share stories and impressions. You may request that any identifying stories or responses not be published. You will be given the option of being identified or not.

Are there any benefits to me if I am in this study?
The potential benefit to you for taking part in this study is the opportunity to reflect on your teaching experience and/or practice of cultural safety. There is no direct benefit to you from being in this study.

Are there any risks to me if I am in this study?
Sometimes reflection on oneself, one's past experiences, or on social justice issues may elicit strong emotion, or difficult feelings. Nurses are licensed health professionals who are aware of this potential in those they serve and in themselves. You may withdraw from the study at any time, and will be encouraged to seek professional counseling if the process of participating becomes emotionally problematic. You may choose to be identified or to remain unnamed. There is always the small potential for a personal story to be an identifier for a reader of the published research. You may decide if any information revealed during the data collection is to be excluded from analysis or publication of the findings.

Will my information be kept private?
The data for this study are being collected by digital recording and researcher notes during private dialogue interactions, transcribed by Lida Dekker and stored without your name directly identified. Some documents or other products of your teaching and practice may be collected with your consent. A team of education researchers will participate in data analysis without access to your identity. The results of this study may be published or presented at professional meetings, but the identities of all research participants will remain unidentified, unless you request to be publically identified. The data for this study will be kept for a maximum of 3 years.

Are there any costs or payments for being in this study?
There will be no costs to you for taking part in this study. You will not receive money or any other form of compensation for taking part in this study.

Who can I talk to if I have questions?
If you have questions about this study or the information in this form, please contact the researcher: Lida Dekker ldekker@vancouver.wsu.edu, (360) 546-9269, cell (360) 921-8120, or mail:
Washington State University Vancouver, Nursing, VLIB 210, 14204 NE Salmon Creek Avenue, Vancouver, WA 98686.
If you have questions about your rights as a research participant, or would like to report a concern or complaint about this study, please contact the Washington State University Institutional Review Board at (509) 335-3668, or e-mail irb@wsu.edu, or regular mail at: Albrook 205, PO Box 643005, Pullman, WA 99164-3005.

What does my signature on this consent form mean?
Your signature on this form means that:
- You understand the information given to you in this form
- You have been able to ask the researcher questions and state any concerns
- The researcher has responded to your questions and concerns
- You believe you understand the research study and the potential benefits and risks that are involved.

IMPORTANT **Statement of Consent:
"I hereby certify that I am 18 years of age or older. I understand the information in this form and give my voluntary consent to take part in this survey."

_____   _____
Signature of Participant   Date

_____
Printed Name of Participant
Statement of Person Obtaining Informed Consent: I have carefully explained to the person taking part in the study what he or she can expect. I certify that when this person signs this form, to the best of my knowledge, he or she understands the purpose, procedures, potential benefits, and potential risks of participation. I also certify that he or she:
Speaks the language used to explain this research**;** reads well enough to understand this form or, if not, this person is able to hear and understand when the form is read to him or her**;** does not have any problems that could make it hard to understand what it means to take part in this research.

_____   _____
Signature of Person Obtaining Consent   Date
Lida Dekker   Researcher
Printed Name of Person Obtaining Consent   Role in the Research Study