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"Rewriting" Cultural Safety Within the Postcolonial and Postnational Feminist Project

Toward New Epistemologies of Healing

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The concept of cultural safety, developed by indigenous nurses in the postcolonial climate of New Zealand, has not been widely examined in North America. In this article we explicate the theoretical and methodological issues that came to the forefront in our attempts to use this concept in our research with different populations in Canada. We argue that this concept prompts us to "think critically" about ourselves and our patients, and to be mindful of our own sociocultural, economic, and historical location. This critical reflection has implications for how we live, relate to one another, and practice in our various professional disciplines. On the basis of our findings, we discuss how the concept might be rewritten within a critical postcolonial and postnational feminist discourse. **Key words:** *critical inquiry*, *cultural hybridity*, *cultural safety*, *feminism*, *postcolonialism*, *postnationalism*

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POSTCOLONIAL discourses, which have as their architects scholars such as Edward Said,[1,2] Stuart Hall,[3,4] Homi Bhabha,[5,6] Leela Gandhi,[7] Paul Gilroy,[8] and Gayatri Spivak,[9] among others, have led us to reflect on what we mean by the concept of *culture*. Far from being a neutral concept defined as a set of beliefs and practices by members of a particular group, we now recognize that the term *culture*, which rarely operates in isolation from constructions of *race*, is imbued with social, political, and historical meanings. Such understandings have led us to question previous theorizings, and to reflect on how the culture concept might be drawn on in practice disciplines such as nursing. Rather than focusing on exotic belief systems of people from different ethnocultural backgrounds, and treating each group as a distinct entity, we are challenged, instead, to examine the unequal relations of power that are

the legacy of the colonial past and neocolonial present, and the ways in which the cultures of dominant groups have redefined local meanings, and dictated social structures, including health care delivery systems.[10–15] The critical lens of postcolonial scholarship has added another dimension to our understanding of the ways in which Western biomedical cultures and ideologies have shaped health care discourses, and silenced other voices.

Cultural safety, a concept developed by indigenous Maori nurse leaders in New Zealand, meshes well with this emergent discourse. Concerned with structural inequities, limited life opportunities, and unequal access to health care,[16,17] Papps and Ramsden[18(p494)] in their explication of cultural safety address "power relationships between the service provider [primarily descendants of European settlers] and the people who use the service," and link nursing practice and education to more abstract postcolonial theorizing. In the postcolonial climate of Aotearoa/New Zealand, cultural safety extends the notion of transcultural nursing, with its focus on understanding the health beliefs and practices of different ethnocultural groups,[19] to include an examination of power inequities, individual and institutional discrimination, and the dynamics of health care relations in the postcolonial context.[18] Rooted within postcolonial theory, cultural safety was meant to provide a critical lens through which to examine health care interactions between the Moari people of New Zealand and White settlers.

Purpose: The purpose of this article is to use our research findings from 2 recently completed ethnographic studies, to explicate the theoretical and methodological issues that came to the forefront in our attempts to transport the concept of cultural safety into our research with different populations in Canada. On the basis of our findings, we propose how cultural safety might be rewritten within a critical postcolonial and postnational feminist discourse. This article is not meant to provide an exhaustive report of research findings, but rather we use our findings to address conceptual and theoretical issues.

While one might expect the concept of cultural safety to have similar utility with other indigenous peoples as it does in New Zealand, the question as to whether it could be transported to other contexts has been pursued by different scholars.[20–22] Although Canada bears similarities to New Zealand in so far as their indigenous peoples share experiences of colonization, Canada also has an explicit multicultural policy to recognize and respect the cultural heritage of all people, including European settlers and people of colonized societies who have immigrated to Canada throughout Canada's history. It is within this multicultural context that we drew on the concept of cultural safety for our research. As Canada's population has become increasingly diverse, health professionals have grappled with concepts to enable them to provide efficacious care to clients. Cultural safety was seen as one concept that might be taken up in practice, but that required further exploration through research. A central question in our research was whether particular behaviors in the clinical context could be recognized as culturally safe or culturally unsafe. This article sheds light on the conundrums of making the link between abstract concepts, such as cultural safety, and everyday practical reasoning in clinical settings

Overview: We have organized this article into 4 sections to provide insights into the background of our research, the actual research, and the interpretation of cultural safety in our research. We begin with a brief discussion of cultural safety, postcolonialism, and postcolonial feminism, as a way of framing the research. Second, we provide an overview of the research project. Third, we present data to examine the interpretive processes we use in coming to decisions about cultural safety, or conversely, what might be considered culturally unsafe. We discuss the conundrums that confront health care professionals in plural linguistic settings, when communication practices between patient and health care professional are

interpreted as key to creating a culturally safe space. We go on to question how the concept of cultural safety might have currency for making sense of the suffering of Euro-Canadian patients of comfortable means, who, for a variety of reasons, are unable to get access to the resources they need. This being the case, we examine, in the fourth section, whether cultural safety can be drawn on as an explanatory resource in our understanding of everyday human experience in multicultural contexts. While recognizing the utility of the concept within particular historical contexts, we are mindful, as Gandhi[7(p124)] points out, that "After colonialism, it is imperative to imagine a new transformation of social consciousness which exceeds the reified identities of the rigid boundaries imposed by national consciousness. Postcolonialism, in other words, ought to facilitate the emergence of what we might, after Said, call an enlightened 'postnationalism.' "* We therefore propose the rewriting of cultural safety within a critical postcolonial/postnationalist feminist scholarship that transcends the boundaries of race and nationalism, to emphasize realignments that expose our common humanity and vulnerabilities. The opening up of such a space to foster the negotiation of hybrid cultural meanings, and new epistemologies of human suffering and pathways to healing,† might be a step forward in working, collectively, toward transformative social practice.

*As Gandhi[7] writes, "The vast majority of postcolonial critics and theorists seem to agree that the discourse surrounding 'postnationalism' offers a more satisfactory reading of the colonial experience and, simultaneously, the most visionary blueprint for a postcolonial future."[7(p124)] Postnationalism has grown out of a critical suspicion within postcolonialism of what might be called "identitarian" politics.[7(p126)] These processes result in preservation and perpetuation of essentialized racial/ethnic/cultural identities, which postnational interpretations seek to disrupt.

†We use the term *healing* to mean making whole, spiritually, mentally, and physically—and making whole after the traumas of the colonial experience.

BACKGROUND TO THE STUDY: CULTURAL SAFETY AND THE POSTCOLONIAL-FEMINIST DISCOURSE

What is cultural safety?

There is a growing body of literature on cultural safety, yet there remains the challenge of defining it. The meaning of cultural safety becomes clear more in terms of the definition of culturally unsafe practices, such as "any actions which diminish, demean or disempower the cultural identity and well being of an individual."[23(p7)] On the other hand, cultural safety includes those actions that recognize and respect the cultural identity of others and take into consideration their needs and rights.[23] Wood and Schwass[24] developed their model on cultural safety in terms of "3 Ds" (Diminish, Demean, Disempower) and "3 Rs" (Recognize, Respect, Rights), where the "Ds" define culturally unsafe practices and the "Rs" define culturally safe ones, which are applicable to all cultures.

The concept of cultural safety has been developed and promoted primarily through a focus on nursing education. As put by Wright,[25(p23)] "cultural safety is unashamedly about nurses' power to support healing." The promoters of this concept encourage nurses to reflect on their own personal and cultural history and the values and beliefs they bring in their interaction with patients, rather than an uncritical imposition of their own understandings and beliefs on patients and their families. Similar to the concerns of cultural safety, transcultural nursing[19] also encourages nurses in having a knowledge base about different cultures that would enable them to respond to their client's needs.[26] While both transcultural nursing and cultural safety consider nursing education as the foundational stone, transcultural nursing has developed more within a multicultural context as compared to cultural safety arising out of the bicultural relationship between the Maoris and the descendants of British colonists in New Zealand.[16,17]

Dyck and Kearns have argued that

> The notion of cultural safety, as negotiated by Maori, draws attention to the links between their health and their positioning within processes of historical and social change which have subordinated their culture, and materially disadvantaged them as a people. Within this wider contextualization of Maori health status, the notion of cultural safety challenges the dominant "white" practices of health care.[20(p142)]

Clearly, the concept of cultural safety was not meant as a "cataloguing of culture-specific beliefs" of the Maori people, but rather, was linked to the postcolonial project, with its recognition of power imbalances and inequitable social relationships, a legacy of the postcolonial past and neocolonial present. As Ramsden,[16] the nurse leader who coined the term, said in a paper presented at the Transcultural Nursing Conference in Sydney,

> Historians will describe this period in the Pacific as post-colonial . . . In common with indigenous peoples the world over; the Maori of Aotearoa are beginning to recover sufficiently from the horrors of the colonial experience to carry out a process of analysis and examination of the New Zealand health service. It has not stood up well to scrutiny in local or in international terms.[16(p5)]

In keeping with this perspective, Polaschek[27] has reinforced that "Cultural safety involves recognizing the position of certain groups such as Maori within a society. It is how this group is perceived and treated that is relevant rather than the different things its members think or do." [27(p452)]

In Canada, a few researchers have used the concept of cultural safety to examine health care involving Aboriginal peoples. For example, Browne and Fiske[28] used cultural safety as an interpretive lens for connecting the dynamics of everyday health care encounters involving Aboriginal women to wider social issues related to Aboriginal-State relations, dominant conceptualizations of Aboriginality, and routine racializing practices. In another study, Browne and Smye[29] used the concept of cultural safety to examine how discourses perpetuated in health care literature continue to represent Aboriginal women as objectified "Other" despite researchers' efforts to mobilize notions of cultural sensitivity. In Smye and Browne's research,[30] cultural safety served as a reflexive tool for analyzing mental health policies from a postcolonial vantage point, revealing the "taken-for-granted" processes and practices that continue to marginalize Aboriginal voices and needs. Together, these studies highlight cultural safety's unequivocal call to health care providers, planners, policymakers, and researchers to unmask, challenge, and transform mis/representations of Aboriginal peoples and accompanying culturalist discourses. The postcolonial framework of cultural safety therefore provides us with direction for making visible the historical, social, and political situatedness of health care relations.

Postcolonial scholarship

We discuss, now, central tenets of postcolonial scholarship, in which the concept of cultural safety is embedded. Anderson,[14] drawing on Quayson,[31] suggests that there is no single definition of the *postcolonial*. Studied from the angle of different disciplines the term is infused with a variety of interpretations, and is recognized as transcending geographical boundaries and chronological periods.[32,33] Although subject to different definitions, an understanding of the postcolonial converges on the critical analysis of the experience of colonialism, past and present, and how conceptions of race, racialization, and culture have been constructed within particular historical and colonial contexts.[10–15,31–35] As Reimer and Anderson[15] have argued,

> Definitionally, postcolonialism refers to theoretical and empirical work that centralizes the issues stemming from colonial relations and their aftermath. Its concern extends to the experiences of people descended from the inhabitants of these territories and their experiences within the "first-world" colonial powers . . . Overall, the project of postcolonialism today centers on theorizing the nature of

colonized subjectivity and the various forms of cultural and political resistance.[15(p3)]

Central to the postcolonial project is the unmasking of colonizing practices to show how race and culture have been constructed as "rational" categories to locate non-European peoples as the essentialized, inferior, subordinate Other. This analytic process reveals the construction of Other not as a neutral category, but as the process by which Other comes to be seen as inferior against the backdrop of European civilization and physical appearances.* Thus race, used as a marker of physical characteristics, and visible appearances, becomes conflated with culture, with certain groups being seen as the inferior, uncivilized Other, whose cultural traits are inherently linked to their physical appearances.

Postcolonial-feminist scholarship

We turn now to a few highlights of postcolonial-feminist scholarship, the perspective that informed our research. What is sometimes seen as missing from postcolonial inquiry is an analysis of the complex social relations, including gender relations, that is made explicit in the work of Black feminist scholars. Anderson[14] has noted, for example, that

> Post-colonialism provides a theoretical perspective from which to contest the historical construction of the racialized and cultural "Other" through the processes of colonization. Black feminism† pushes us to analyze gender, "race" and class relations as simultaneous forces, and to examine knowledge production from different social and political locations. . . . Black women from ex-colonial societies inhabit different realities; from within these realities there are . . . different claims to truth. . .. Thus post-colonial and Black feminist perspectives cannot be extensions of critical perspectives developed within a Euro-American tradition.[14(p18)]

The intersections of gender, class, race, age, and other social relations are seen as necessary axes of analyses to explicate the complex nexus of everyday meanings and realities. Several scholars have noted the extent to which the experiences of the colonized are subject to the *simultaneous forces* of class, race, and gender oppression—no single source of oppression can usually be identified.[36–38] These social relations do not belong to a past era, but are the substratum of contemporary discourses, and unwittingly infuse the ideologies and theories that are often drawn upon to make sense of the Other in everyday encounters, including those in health care settings.

Postcolonial feminist scholarship, which bridges both postcolonial and Black feminist scholarship, opens the door to an inclusive analysis to shed light on how colonial and neocolonial practices are being played out in contemporary social life within plural contexts. We begin to understand how the discourses of globalization and neocolonial policies, health care reform driven by neoliberal economic policies with accompanying ideologies of scarcity and efficiency, shape the landscapes of oppression in everyday social life. We will argue later in this article that these multiple forces expose the vulnerabilities that intersect our collective humanity. Thus, the line between "colonized" and "colonizer" must be redefined along the axes of complex sociopolitical and economic relationships. *The colonizer* becomes a more elusive concept as we examine the restructuring and movement of global capital, new information technologies, and new forms of thought that define the "new" elite; as well as those discourses that inform of the "marginalized." As McConaghy[39] writes,

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*We recognize that "Othering" can be done in other contexts. This does not mitigate the impact of Othering through the processes of colonization and neocolonization. It needs to be held up to critical scrutiny in any context in which it occurs.

†Anderson states, "I use the term 'black' not as a biological category, but as a 'political' category . . . By this I mean that the term 'black' is used by people of different shades of skin colour in a show of solidarity and coalition to resist labels such as 'visible minority' which, unwittingly, designate people as marginal with minority status and, therefore, inferior."[14(p15)]

> It is no longer always useful to present dichotomies of the coloniser and the colonised to illustrate the differential power relations and life experiences of those in colonial contexts . . . An important task is to better understand the specific nature of specific oppressions at specific sites: to understand current forms of oppression.[39(p8)]

In our studies, we found that new markers define "the dispossessed"; the symbols of oppression are being renamed, as the so-called colonizer takes on the characteristics of 'the colonized' in terms of the ability/inability to gain access to resources that would ease human suffering. In other words, there are no "hard" categories; instead, we are reminded that social categories are fluid and dynamic across time and histories. White men and White women, Black women and Black men, may inhabit the categories of "oppressed" or "oppressor," depending on historical and socioeconomic positioning. This is not to minimize histories of colonialism and oppression, and the importance of critical race and gender analyses, but rather, to examine intersecting social relations and different forms of oppression in different historic epochs, and to draw attention to the emerging "new colonialism" along the axes of a complex set of social and economic relations. Therefore, the analytic concepts we use must have the power to explicate the complexity of the issues that shape human experience, if we are to understand human suffering and explore pathways to healing in contemporary social life, and if we are to move toward a transformative agenda that ensures all people are equitably served. We turn now to the research that forms the basis of this discussion.

THE RESEARCH

It is against this background of a postcolonial feminist discourse and the concept of cultural safety, that the 2 studies to be discussed here were conceptualized. This 3-year project included 2 ethnographic studies. Consistent with the purposes of the study, and the theoretical framework, ethnographic methods of inquiry inclusive of feminist ethnography[40–43] were drawn upon in the design of the research. Study I was hospital-based. The intent was to extend our understanding of how patients and practitioners from linguistically and culturally different backgrounds negotiate decision-making during this time of health care reform. A further purpose was to find out the perspectives of health care providers in caring for a diverse patient population. Study II was home-based. We focused on how patients managed their health care in the home on discharge from hospital. We especially wanted to find out the sources of support and health practices they used. In both studies our intent was to examine the broader structural issues that influence the experiencing and management of illness; we also explored the extent to which the concept of cultural safety could be used as an explanatory resource in interpreting our findings. The university-based ethics review board, and the participating health care agencies, approved the protocols for both studies.

Although the concept of cultural safety is relevant to everyone, we wanted to examine this concept in relation to people experiencing the upheavals of migration and resettlement, at the same time that they had to deal with illness and hospitalization. By way of comparison, we included people who were not migrants. For practical purposes (mainly because of the complexities in doing research with people from different linguistic backgrounds) we limited our sample to Canadians of South Asian and Chinese ancestry who have immigrated to Canada, and Canadians of European ancestry who were born in Canada. Including other groups would have meant securing additional funds for interpreter and translation services, which did not seem possible or realistic at the time. Indigenous peoples were not included in this study. As part of the larger program of research on "Culture and Health," 2 of the authors are conducting research studies with indigenous peoples, and are exploring the concept of cultural safety in relation to the historical and political

contexts of their lives. Their findings are reported elsewhere.[28–30]

Methods

Recruitment

The research was conducted in 4 hospitals in a metropolitan region with a diverse population. In recognition of the objectives and theoretical framework of the studies, agency personnel were invited to join the research team and actively help shape the methods used to inform potential participants of the studies, to support the involvement of unit-based health care providers, and to participate in the analysis and dissemination of findings.

In preparing for recruitment, we developed letters outlining the procedures, and the interview guides. These materials, along with pamphlets in English, Cantonese, and Punjabi, explained the studies and procedures to potential participants and were distributed to health professionals who assisted with recruitment. Those who wished to hear more about the studies could do so without committing themselves to participating. They gave permission to be contacted by a member of the research team so that they could hear more about the research in their preferred language, and sign the consent form to participate if they so wished.

A purposive sample of 56 health care professionals and 60 patients was recruited to Study I. Thirty-eight patients participated in Study II. Twenty-five patients who participated in Study I also participated in Study II. (See Table 1: Health professionals, Table 2: Study I patient participants, Table 3: Study II patient participants, Fig 1: Health professionals—Length of stay in Canada, and Fig 2: Health professionals—Place of birth.)

Data collection and interviewing process

In Study I data were collected through participant observation of a patient in interaction with the primary health care provider, in-depth interviews with the primary health care provider, and in-depth interviews with patient participants. In Study II, the interviews with the patients at home were occasionally supplemented by data provided by kin. The framing of interview questions as broad-based "trigger questions" to stimulate conversation, was consistent with the methodological perspective used in these studies. Participants' responses to questions generated more in-depth exploration of a particular area. The questions addressed various aspects of the patients' experiences in hospital, their knowledge about what was happening, and their expectations of both the process and the outcomes of hospitalization and care in the home. Questions included, for example, "Could you tell me about why you came to the hospital?" and, posthospitalization, "What was it like for you since you came home from the hospital? What were your expectations about the care you would get when you got home? Were these expectations met?"

Staff caring for patient participants in the hospital were asked about their perspective on the care-giving, care-receiving experience, with equally broad-based questions.

Table 1. Health professionals

	N (56)	%
Gender		
Male	7	12
Female	49	88
Professional role		
Nurse	50	90
Other professionals	6	10
Educational level		
Diploma	39	70
Degree	16	29
Masters/PhD	1	2

Table 2. Study I patient participants ($N = 60$)

	Nationality			
Gender	Chinese ($n = 24$)	Indo- ($n = 24$)	Anglo- ($n = 10$)	Other ($n = 2$)
Male	12 (50%)	12 (50%)	5 (50%)	0 (0%)
Female	12 (50%)	12 (50%)	5 (50%)	2 (100%)

Table 3. Study II patient participants ($N = 38$)

	Nationality			
Gender	Chinese ($n = 16$)	Indo- ($n = 15$)	Anglo- ($n = 6$)	Other ($n = 1$)
Male	8 (50%)	7 (46%)	3 (50%)	1 (100%)
Female	8 (50%)	8 (54%)	3 (50%)	0 (0%)

Interview guides were used for both patients and health care provider interviews. In the training and orientation of research assistants it was emphasized that the guides were to help rather than direct; that the goal was to invite the participants to talk freely about what was important to them. Research assistants were encouraged to bring their questions and experiences to the biweekly team meetings that were held during the project.

The interviews were conducted in Cantonese, Punjabi, or English by interviewers who were fluent in these languages. The interviews in Cantonese or Punjabi were translated into English, and transcribed. Back-translation was done on 5 randomly selected transcripts, to ensure that the translations reflected the content of the interview in the original language in which it was conducted.

Data analysis and the development of conceptual categories

As is common in ethnographic research, data collection and analysis are iterative processes. Because of the large quantity of data that was being collected, it was decided to use the QSR NUD*IST 4 software for managing the qualitative data. All the interviews and field-notes were coded by 3 people: 2 primary independent coders and a third person who met with one of the primary coders to review both sets of coded data and explore and write notes about discrepancies. This joint coding was not done in an effort to nominate one understanding of the data as a correct one, but rather to highlight and follow up on differences. This process brought an enriching dimension to the analysis by including multiple interpretations and cross-referencing. The primary investigator and all the coinvestigators read all of the transcripts and were all involved in the coding process. From the micro coding, topics were identified, which later were clustered into larger conceptual domains named as *code categories*.

In all, we developed 15 code categories, each composed of subcategories, reflecting the perspectives of patients on their illness experience in the hospital and transition to home and on supportive relationships with family and others, and professionals' perspectives on health care reform and the impact on caring for diverse patient populations.

The 15 categories were

- Baseline data (eg, sociodemographic characteristics of participants)
- Support networks (eg, formal and informal)
- Explanatory models (eg, patients' and health professionals')
- Health care system organization
- Illness-health management

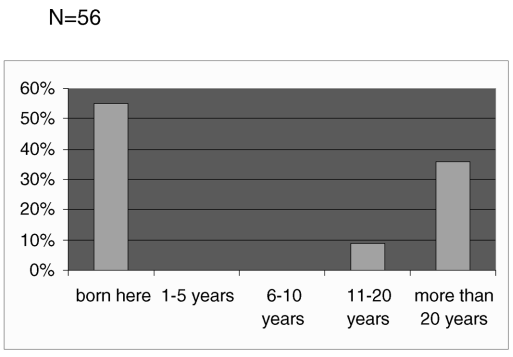

Fig 1. Health professionals—length of time in Canada.

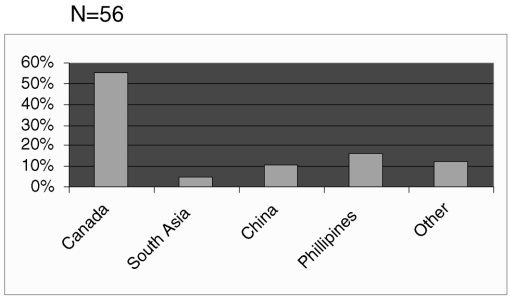

Fig 2. Health professionals—place of birth.

- Safety (eg, physical, emotional, and cultural of patients and staff)
- Environment (eg, hospital and home environment)
- Communication (eg, between staff and patient)
- Health care professionals' work in relation to patient care
- "Construction" of patient (eg, by self; by health care provider)
- Affective responses (eg, to illness and hospitalization)
- "Racialization" (eg, by patients, by nurses, and in relation to cultural safety)
- Relationships (eg, patient to patient, interprofessional dynamics)
- Research methodology
- "Theoretical snips"

These categories were not discrete. That is, data were coded into more than one category, but the code categories provided a useful way of organizing large amounts of narrative data. Furthermore, by discussing and developing these categories, the research team was able to come to a common understanding of the main concepts that were being expressed in the data.

INTERPRETING AND READING CULTURAL SAFETY

The process of interpretation, and the conundrum of "reading" cultural safety

In the conceptual phase and planning of this research, we had thought it possible to identify and name "culturally safe" and "culturally unsafe practices." In fact, in our initial attempts to code the data, we developed a category for cultural safety, suggesting an assumed transparency of the concept. Yet, we were first alerted to the complex interpretive processes that underpin the understanding of cultural safety in the early phases of the research. While we expected the outcome of the research to promote an understanding of this concept in a plural context, the very process of conducting the research had the potential of engendering feelings of cultural "un-safety" in research participants. As we pointed out in an earlier article, "A researcher's effort to conduct culturally safe research may be perceived as not culturally safe by the participant, depending on his or her interpretive lens and the contextual cues and sociopolitical circumstances of the encounter."[22(p229)]

A critical issue for us was the recruitment of participants to the study. The very act of categorizing people as South Asian, Chinese-Canadian, and Anglo-Canadian, not only risked essentializing people, but also suggested to people that they were other than Canadian. Many people resisted the categories we had constructed, and told us quite bluntly that they saw themselves as Canadian.* The issue here is that what was interpreted by us as research designed to promote culturally safe practice, in itself had the potential to marginalize people. In the process of applying a set of a priori categories, we were, as McConaghy[39(p242)] describes, "predetermining subjectivities" and thereby limiting the range of subject positions available to those from racialized ethnocultural populations. As participants exerted agency, they disrupted the predetermined subject positions we had inadvertently set up with our sampling categories.

But this issue of interpretation did not stop here; it extended to how cultural safety was read into the research data.

Coding and interpreting cultural safety—language, access, and cultural safety

Polaschek[27(p453)] in reiterating a definition of cultural safety states:

*Members of the research team did not approach study participants. Rather, a hospital employee circulated letters, asking if people wanted to hear more about the study. Those who wished to hear more, so informed the hospital employee. It was at this point that a member of the research team approached the potential participant, and it was at this point that some people challenged us about the categorizations we used, and announced they were Canadians.

Nursing practice that is culturally unsafe includes "any actions which diminish, demean or disempower the cultural identity and well-being of an individual." Culturally safe nursing practice involves "actions which recognize, respect and nurture the unique cultural identity of the Tangata Whenua, and safely meet their needs, expectations and rights."

How might this concept, grounded in the postcolonial politics of New Zealand, be interpreted within the Canadian context, when conducting research with people from different ethnocultural and linguistic groups? While Polaschek has outlined what should be considered unsafe, actual research texts point to the complexity of its reading.

Some of the most poignant accounts from patients and practitioners focused on their communication with one another. In fact, the issue of communication was one of the most compelling stories we heard from the participants in the studies. As this nurse puts it:

Nurse: The only time I find it really frustrating is when they get angry at you because you can't communicate with them, . . . there are occasions when that has happened, you know, when they really are trying to tell you something and you really can't understand it even though you want to.

What do such statements tell us about cultural safety? First, they suggest that the inability to communicate with a patient is distressing to the practitioner. Later we will note that patients who could not communicate in English were equally distressed as they could not get access to the care they needed. In many ways we were not surprised that communication emerged as a pervasive issue for both patients and nurses. These exemplars suggest that there is a need to look at communication as a key process we rely on to make sense of, and make visible, what embodies cultural safety or the experience of culturally safe care. Communication, in its many forms, becomes our entre, or point of access, for inquiry. In this article, then, communication provides a way of examining the nature of relationships between patients and health care professionals and a means for exploring influences on the care delivery process. Yet, rethinking communication through the analytic lens of cultural safety prompted us to assert that, as the data illustrate, communication is not simply about language, and therefore solutions are not simply about interpretation. There were instances where patients who were not able to converse with care providers in English did feel safe. They spoke of feeling respected, and observed that efforts were being made to ensure they received necessary care. On the other hand, there were instances when patients were able to converse with care providers, yet they indicated that they felt vulnerable. Nonetheless, as we will see from the following vignettes, being able to speak with a health professional, and being understood, were key factors in getting the help that patients needed.

When communication was possible, some patients spoke with admiration of the health professionals who cared for them. Take this vignette, for example:

Interviewer: Sometimes people feel that because they cannot speak the language or they are of a different culture and they may be Chinese or Indian or European and feel themselves different and they feel that they may not be able to communicate and therefore they feel unsafe.

Patient: No, I did not feel this at all. I could understand them and the nurses and doctors did not make me feel that I am Punjabi and they did not treat me different because of this. They helped me with the bathroom, medications and everything that I wanted and the doctors all say hello when they came . . . The nurses were there twenty-four hours for you, whenever you want them.

This woman saw herself as being able to communicate with health care providers, and could therefore get the help she needed. Others, unable to communicate in English, were not able to access this care, as this other Punjabi-speaking woman notes:

Patient: I was thinking that a lack of English is a barrier because I could not speak the language that they spoke and it was hard. My daughter-in-law went and she was able to speak and she was alright . . . .

The shortcomings in health care were sometimes constructed as structural issues (eg, cutbacks in government spending) over which health professionals had no control. And, even when patients seemed unable to get the help they needed, they rationalized this as being due to nurses' workload, as this woman suggests:

Patient: That's why the nurse is really busy, it's understandable so they are taking a lot of time on the different patients like they have so many patients to take care of so basically you are on your own.

Nurses in particular were seen as "run off their feet" due to funding cuts and staff shortages. At the same time, issues in communicating with health care providers were uppermost for those patients who could not communicate in English.

The quandary for us was that cultural safety did not announce itself in the transcripts—it was not a "thing" that could be "found," *but became interpretive work on our part*. Should this issue of communication be read as central to the concept of cultural safety, even though in our initial coding of the data, *communication* and *cultural safety* were not necessarily analyzed as overlapping categories? From what these patients had to tell us, their "safety" depended to a large extent on their ability to communicate with health care providers, rather than on feelings of being diminished, or demeaned.[27] Feelings of disempowerment may well have resulted from inability to communicate with health care providers, but the question that arises is whether such feelings might also be read as being demeaned.

As we reexamined the data to get a handle on the concept of cultural safety, it became evident that *any* code category could illuminate the concept, depending on *our interpretation*. We decided that data coded as patient communication with health care providers and people's experiences of seeking help were informative of the barriers they experienced in getting help, and we questioned if this had anything to tell us about cultural safety. Take this vignette between a Cantonese-speaking patient (Mrs Lee—a pseudonym) and an interviewer, for example. What does it tell us about cultural safety?

Patient: I went to see my family doctor and all he gave me was some stomach medication. It didn't help. I found that I got dizzy quite easily. And I had a slight fever. A little one. So I came to the emergency and was hospitalized.

Interviewer: What did they tell you when you were in the emergency?

Patient: Didn't tell me anything. I was in the hospital. I don't speak the language you know. The biggest problem is that we Chinese don't speak the language. So after I was hospitalized they gave me antibiotics in an IV, I couldn't take it. I am so skinny now. My teeth are very loose now.

Interviewer: Are you able to communicate with the doctors in the hospital?

Patient: No, that is the biggest problem. I can't communicate with them. That is why my illness is so severe right now. If I am able to communicate with them then I would be able to ask them some questions. Everywhere I go someone is leading my way. I was like a dead body, going wherever people want me to go. They asked me if I understood, and I said, "I don't know."

Interviewer: You were saying that your son was helping you translate.

Patient: My son helped me translate a bit but he doesn't (know) a lot. He is not very old. He is also very afraid. He is able to tell me the simple things. He told me that there was a shadow in my lung and said that they were going to cut a part out. So I believed my doctor. I really thought something was wrong. But really I don't know how to express it . . . I thought something was really wrong so I let them take it out. The nurse said it was okay;

it would heal easily and told me to sign. So I quickly signed.

Interviewer: So you were not able to communicate with the doctors or specialists? Did they offer you a translator?

Patient: No, nothing.

Observation of this same patient in communication with health care providers gives us another insight into how one might make sense of the ways in which communication practices between health care providers and patients may contribute to our understanding of cultural safety. Following is the interviewer's account from her fieldnote observation of Mrs Lee's interaction with a health care provider:

So while we were talking, near the end, at the end of the interview, the doctor and I guess the . . . resident, came in to talk to the patient, and when they came in, they did not introduce themselves, but they just sat down in front of the patient, and spoke directly to the patient's son, and the son translated the information to the mom, but listening into the conversation I found that the son had missed out a lot of information that the doctor gave to the patient, and the patient had a lot of questions for the doctor which the son did not ask, one, because of the language because the son was not familiar with the terminology and the doctor seemed to be in a rush to get the information across and to leave.

The doctor told the patient that she should go for an x-ray. . . and explained to the patient that because she was not willing to do further diagnostic examinations, they were not able to find out what was wrong with her and the father was also there but did not participate in the conversation with the doctor and partly because he cannot speak English.

What does this have to tell us about cultural safety? The inability to communicate in the language of the health care provider not only reduced Mrs Lee's opportunity to get the information she needed, but may well have compromised her biomedical care. Do the issues in this vignette pertain only to the verbal communication between health care provider and patient, or are they overlaid by other relational issues? What does our analysis of this vignette tell us about the culture of health care?

What adds to the complexity of this vignette, is that interpreter services *are* available in the hospitals in which the hospital-based study was conducted. Despite fiscal restraint, hospital administrators have allocated resources for acquiring interpreter services, in full awareness of the pitfalls of using family members as interpreters. So a pertinent question that arises is, why are these services not used when patients are obviously in need of them? A number of issues became apparent that influence communication practices between health professionals and their patients.

First, there were instances when staff members said they were too busy to seek out the resources, due to cutbacks resulting from health care restructuring. They were aware that an interpreter was needed, but other clinical priorities took precedence over seeking out these services. We need to question, however, whether time constraints are acceptable as explanations for not seeking out interpreter services. Should such rationale be taken at face value or might we interrogate the extent to which race, class, culture, and gender may unwittingly be a subtext for deciding who needs help, and who does not, and what the priorities are at any given moment in time?

Second, we found there were instances when *staff members did not judge the situation as warranting interpreter services*—clearly the case in the above scenario—which raises questions about the knowledge that practitioners draw on to arrive at such decisions. It also raised questions about practitioners' practice values. For example, nurse-patient interaction and "knowing" the patient have considerable history in nursing as core values and cornerstones of practice. What would cause a nurse to devalue practice activities to the extent that an interpreter would be seen as unnecessary?

Although the foregoing vignette with Mrs Lee could be interpreted as a "micro level" communication practice at the institutional level, and clinicians' knowledge, or lack of

it, about providing care within a plural clinical context, it *is the broader sociopolitical context that dictates the knowledge that is required for what is accepted* as "necessary clinical knowledge." Inadequate knowledge of the complexity of communicating across linguistic boundaries—a "gap in knowledge" so to speak—cannot be seen simply as an *inadequacy* on the part of the clinician, but rather, is a reflection of *relevant knowledge*, taught in the health disciplines, accepted as the standard of competent practice, and taken up in professional practice standards. But what are the ideological roots of these "criteria of relevance" and how do they inform us about what is valued, and who is valued? As noted earlier, cultural safety was prompted by a concern to alleviate processes that demean or devalue persons. Our analysis of communication processes led us to consider that cultural safety is associated with seeing people as "persons of value." If we take this further then we must also value, through the education of practitioners, institutional practices, and standards of practice, the activities that enable us to communicate this message.

Third, we observed that around the clock need for communicating with patients called for anticipatory planning, including in-depth and thorough patient assessments, as this patient's (Mrs Singh—a pseudonym) account suggests:

I know that because I didn't speak English I had limited ways of telling them about my pain, and where it is, and what kind of pain and other things that I wanted to say and one cannot say or explain what I needed to tell them. I can only tell them "pain" and they would give me pain medicine, but not all.

Mrs Singh's story informs not only about the lack of interpreter services that minimized her opportunities for competent and optimum pain management, but also about the knowledge of practitioners, their skills of assessment and clinical judgment, and their ability to anticipate a patient's need, and plan accordingly. This observation suggests that communication practices, and how interpreter services are used, reflect particular knowledge bases that may be integrally related to the concept of cultural safety.

Fourth, we noted that even when interpreters are used, there is no guarantee to the patient that (s)he is being heard, as this patient tells us.

Interviewer: Well they'd have to get an interpreter sometimes.

Patient: But even if you get it interpreted, its different thing, if they say to use or you say this through the interpreter, it's different, it still makes some difference, yeah.

Fifth, the issues around communication between health care providers and patients are even more complex than the foregoing vignettes suggest. At present, there are approximately 80 language groups[44] in the Western Canadian city in which this study was conducted. If one argues that the largest groups and the most frequent users of health care services should have access to interpreter services, or that they have a right to these services, then minority rights are denied. Yet, to argue that everyone has a right to interpreter services, and to subsequently expect that people from all language groups should have 24-hour access to interpreter services in *all* health care institutions is a daunting administrative task, not to mention the economic cost of such a service. While there are several mechanisms in place to ensure access to interpreter services for the majority of groups, the challenge of providing these services in a consistent and equitable manner should not be underestimated.

Yet, we conclude from our interpretation of the data that people's ability to communicate with one another is fundamental to a feeling of safety, as reinforced by this Cantonese-speaking patient:

Interviewer: So you feel that if there was a Chinese-speaking nurse to look after you in the first few days . . .

Patient: The feeling is more comfortable. That is, you feel safer.

Interviewer: Could you say more about why it would make you feel safer.

Patient: Mainly that it gave me a sense of closeness, a feeling of closeness. . .. Like when I said, like the wound is "stingy" (in Chinese), you wanted to tell the nurse, but how would you say it in English, right? Examples like this.

Through language, people are able to negotiate meanings and come to shared understandings. Without language, the potential to develop relationships is minimized. Yet, the foregoing discussion suggests that communication is a complex issue, located within broader structural processes, and cannot always be achieved. If we subscribe to the notion that cultural safety is interwoven into people's ability to communicate with one another, we are faced with the conundrum of how to communicate with people from all the linguistic groups represented in the large urban areas of Canada. Under such circumstances cultural safety in clinical practice becomes an elusive concept—some people would have access to culturally safe care, but it would exclude others. We contend, however, that even though the possibility of providing around the clock interpretation for all patients might seem remote, the clinical skills of the practitioner, and anticipatory planning in clinical practice, will do much to relieve the distress of patients who are unable to communicate in English.

The reading of cultural safety in plural linguistic settings was not the only issue we puzzled over. We turn briefly to 2 further issues that inform us of the complexity of drawing on a concept in a plural setting that seems geared to the particular circumstances of one group, and which assumes that "oppression" is manifested in a particular way. As we will show from the following vignettes, in a plural society we need to explicate the different contexts of experience.

The essentializing gaze—nurses' reports of patients' construction of them

The discussion of cultural safety in New Zealand is based on the assumption that health professionals are from the dominant White group, and patients are Maori. While this may be the case in New Zealand, many of the nurses who participated in our interviews were women of Color—from groups that have been colonized (see Figs 1 and 2). Some spoke of their experiences of discrimination in caring for White patients who did not want to be cared for by a person of Color. In such cases, it was the health care professional who felt demeaned, disempowered, and culturally unsafe. Take, for example, what this nurse had to tell us:

Nurse: Yeah and I've also had a patient who at one point he didn't mind me because he couldn't see out of one eye and out of the other eye, well, he had surgery in it and he was joking and everything and then when he figured out that I was Asian, I was doing everything wrong.

Interviewer: So how did you feel about it?

Nurse: Oh it, that was, you know, that happened in my second week (laughs) and it was horrible and I just sat there and I'm like what is going on . . . But then I found out that this is, you know, this is what you've got to expect, I'm so used to just nobody saying anything right . . . Or yeah we find out that they are prejudiced but we do our care and that's it.

Such exchanges bring to light the complex dynamics of culture and race as they are played out in health care settings. The supposition that it is the White health professional who subordinates the patient of Color is challenged in an era when societies and health care workforces are increasingly diverse. As illuminated in other studies,[45,46] the construct of race is powerfully deployed in health care settings to counter traditional nurse-patient roles by subordinating nurses of Color. Racialized micropolitics of power operate in such a way that power is not held in certain professional positions per se, but rather is negotiated in each particular encounter and context, and is mediated by the social signifiers of race, gender, culture, age, and class.

Reading cultural safety into the discourse with patients of Euro-Canadian descent

While linguistic differences between patients and health care providers may have heightened the difficulties patients experienced, speaking the same language was no guarantee that people would get the help they needed. For a variety of reasons, some English-speaking patients of European ancestry, who, on first appearance seemed able to navigate the health care system, had difficulty accessing appropriate care. If we follow the model of cultural safety developed within the New Zealand context, these patients' experiences might well be "written out" of the cultural safety discourse. Yet, the concepts and frameworks we use for conducting research should have explanatory power for all of our research participants. We were puzzled, for example, about how to make sense of the following account within the discourse of cultural safety. This woman (Mrs Jones—pseudonym), in her senior years, is speaking about her husband, also in his senior years. Recently discharged from hospital, at the time of our home visit, the Joneses were experiencing great difficulty managing Mr Jones' care in the home. These are Mrs Jones' words:

Patient: I mean it's hard because I am not sure if I am doing the right thing, uh, a social worker didn't come up to speak to us, and he was in the hospital for five days . . . *Nobody came to speak to us to offer, ask questions, offer assistance of any kind*. . .. I really don't know whether they are too busy or what, I mean you read enough in the paper about all this home care that's available and *none of it has been available to us* . . . . And exactly that is where we are at right now because, you know, I don't want him to be a prisoner in his own home you know he needs a little bit of a quality of life.

When we first met the Joneses in the hospital, they seemed well-off, and one might have assumed that they would have had no difficulty in managing Mr Jones' care on discharge home. Yet, without knowledge and understanding of how the system "really works," and how to navigate an increasingly complex health care system to get the homecare services they were entitled to, Mr Jones' care in the home was compromised.

As we pondered over Mrs Jones' account, and the accounts of other White patients, we questioned if these examples could tell us anything about cultural safety. At this time of health care restructuring[47] that is increasingly driven by neoliberal economic policies, those unable to navigate the system for reason of age, language, class, or for other reasons, usually find themselves at a special disadvantage. Thus feelings of disempowerment, dislocation, and marginality emerge along the axes of a variety of contemporary social forces, and health care professionals and patients alike are enmeshed in these social relations. Nurses, for example, experience moral distress when there is a disjuncture between what they feel they ought to do, and what they can do within the constraints of time and resources. Administrators, trying to stretch their depleting resources, are caught in the dilemma of priority setting, and resource allocation. We therefore started to ponder how cultural safety might be rewritten to allow us to examine these complex issues. A critical postcolonial postnational feminist perspective, with the emphasis on the intersectionalities of gender, race, class, age, and other social relations in shaping experience, and their location in the broader sociopolitical context, illuminate these complexities.

REWRITING CULTURAL SAFETY: CRITICAL INQUIRY FROM A POSTCOLONIAL POSTNATIONAL FEMINIST PERSPECTIVE

From the perspective of critical inquiry, we begin with people's experiences, and work back to explicate the context of that experience[48]; we are prompted to ask questions such as "what is it about

health care that leaves people from across various backgrounds, including those from 'dominant ' Canadian groups, feeling "unsafe?" A postcolonial feminist perspective provides us with the theoretical lens to examine histories of colonization and new forms of neocolonialism, but it does not stop there; it helps us to explicate the varied intersecting social relations of people's lives. Take the situation of Mr and Mrs Jones, for example. In our conversations with Mr Jones in the hospital, he appeared financially "well off" and "in charge." White, fluent in English, the "typical" Canadian, so to speak, from the so-called dominant cultural group, one might have assumed that he would have had no difficulties getting access to the resources he needed to manage his care upon his discharge from hospital. And, it might well be that he projected a similar image to hospital personnel, and was therefore assessed as not in need of help in the home, even though, as Mrs Jones pointed out, no one came to talk with them about what they would need upon discharge home.

As we interviewed the Joneses at home it became apparent that they were in distress. Lacking an understanding of how to access resources, presumably lacking a network of support that would ease the *transition to home*, they too, seemed to have difficulty getting the help they needed. While their so-called White dominant social location might have excluded them from the cultural safety discourse as crafted in New Zealand, this social location was interrupted not only by illness, but by age. As an aging couple in a rapidly changing health care system, they may be out of step with the strategies that are now needed to navigate an increasingly complex health care system.

The situation of the Jones' prompts us to reflect on the ways in which race, class, age, and gender relations operate as subtexts in clinical encounters. Not only are there assumptions about immigrants, who have extended families to interpret for them, it might also be assumed that White, middle class persons have resources at their disposal, men have women to look after them, and might therefore be overlooked in the allocation of resources reserved for those seen to be in greater need. The question that arises is whether the concept of cultural safety interrupts such assumptions. Ironically, unquestioned assumptions about fixed, binary categories may disenfranchise not only those who have historically been oppressed, but also those who are seen to occupy positions of privilege.

What is apparent from the above vignettes is that Mrs Singh, Mrs Lee and her son, and the Joneses, all experienced difficulty in getting access to the resources that would alleviate their suffering, but for different reasons. The social contexts of their lives are different. *It is this context that must be examined, explored, and responded to*. A critical postcolonial postnational feminist perspective directs us to explicate these different contexts of suffering. This is not to say that such a perspective glosses the sentence of history of those who have suffered subjugation, diaspora, displacement, suffering, and humiliation.[5] Nor does it gloss over questions as to why some patients may not be seen as deserving interpreter services even when such services are available to enable patients to communicate their needs to health professionals. There is the nagging question of the ways in which racialization operates in health care settings, sometimes unwittingly, to ration the time that is allocated to patients, and to set priorities for care.

However, in opening up a path to healing and a postnational discourse, we might take note of this statement from Gandhi,[7] drawing on Stuart Hall, "black politics can no longer be conducted in terms of an uncompromising antithesis between a bad, old, essential white subject and a new, essentially good black subject."[7(pp128,129)] In the context of this article, this quote suggests that polarized politics between the colonized and the colonizer will not serve to create hybrid, cultural spaces for transformative practice. In fact, Gandhi, drawing on other postcolonial scholars, suggests that colonization has brutalized and

dehumanized the colonizer as much as it has the colonized. She argues:

> This emphasis on the victimisation of the victor is not intended to elide the palpable suffering of those directly oppressed by colonialism. Rather, its objective is to facilitate a complex system of cross-identification—of ethical hybridity—connecting former political antagonists. Relatedly, an analysis of the "contaminated" victor needs to be complemented by an analysis of the victim as a sometimes-collaborator, sometimes-competitor, with the oppressive system. . . . These arguments form the basis of Fanon's objection to the racialisation of thought continued by the rhetoric of anti-colonial cultural essentialism.[7(p138)]

From this perspective, cultural safety speaks to all of us, but not in terms of static, essentialized, cultural categories. It is constructed in context, and it is a way of bringing postcolonial discourse into clinical practice, not as a set of concrete standards for practice, but as a way of questioning how we are positioned in relation to our patients and in relation to the system of health care delivery in which we practice. Consideration of the concept helps us to shift the gaze back and forth between the patient and the health professional, both in relation to interactions between the two and as individuals, each coming with their own experiences and histories that influence their exchanges. Critical self-reflection and critical questioning of how cultural safety intersects in the provision of competent health care are recognized as crucial components of competent practice. We contend that the analysis is incomplete when such reflection occurs without an appreciation of both our postcolonial historical heritage and the present context in which health care is delivered.

We conclude that in rewriting cultural safety, a critical postcolonial postnational feminist discourse pushes us to question all of our vulnerabilities and our common humanity. But we must be cautious not to confuse the creation of hybrid cultural spaces—the "third space"[5]—with "new colonialisms" and new systems of domination that are emerging in our contemporary world. For example, in reflecting on the process of globalization, which links us to the broader sociopolitical context, we are reminded of the growing global hegemony of the English language with the associated deeply rooted underlying assumption that professional and business exchanges occur in the English language.

To what extent do these notions shape the everyday interactions between patients and health care providers? Is there the expectation that patients ought, in fact, to be able to communicate in English? And might this underpin resistance to securing interpreter services even when there is an obvious need? This line of questioning prompts us to examine how systems of dominance permeate, sometimes unwittingly, everyday health care encounters, and raises a set of ethical questions about our practice—What is moral? What is just?

Notions of what is moral and just allow us to interrogate the assumptions that might, unwittingly, underpin interactions with patients in different contexts. Thus, incompetent management of Mrs Singh's pain, when unpacked, may indeed be read/interpreted as accruing from the fact that she may have been categorized/racialized/dismissed as a non-English speaking immigrant woman, or Punjabi woman; the lack of assessment of Mr Jones' needs as he made the transition from hospital to home may also be read as categorization/racialization of the competent White male. While such categorizations raise moral and ethical questions about how people are viewed, it is noteworthy that such categorizations can work both ways—to privilege or to exclude—in this case, both patients ended up feeling *unsafe.*

Gilroy,[8] in writing Against Race tells us:

> . . . the current disruption of race-thinking presents an important opportunity. There is here a chance to break away from the dangerous and destructive patterns that were established when the rational absurdity of "race" was elevated into an essential concept and endowed with a unique power to both determine history and explain its selective unfolding . . ..

Black and white are bonded together by the mechanisms of "race" that estrange them from each other and amputate their common humanity.[8(pp14,15)]

We join with Gilroy in arguing for a scholarship that will transcend our tribalism, and that will open up the space for dialogue that will move us closer to transformative practice. The concept of cultural safety, when refracted through the lens of a critical postcolonial/postnational feminist discourse, holds promise, we believe, for opening up such a space.

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