Abstract

Canadian nurses and nursing students are required daily to interact with and care for individuals of diverse cultural backgrounds in a manner that assures high quality, respectful care. While international practicums are being employed by some nursing schools to prepare nursing students for this challenge, there is a scarcity of literature examining the success of such programs. This qualitative study explores nursing students' accounts of culture before, during, and after an international practicum, to explore how the notion of 'culture' is developed in nursing students taking part in an international practicum.

This study was designed using a critical cultural framework, the premise of which is that we see individuals not as simply belonging to a particular cultural group, a cultural “other”, but that they be recognized as residing within a unique historical, social, economic and political context that is unlikely to be identical to that of any other member of their cultural group. The research was conducted using interpretive description as the research methodology. Purposive criterion sampling was employed to select participants.

This research emphasized the complexity of the notion of culture. It has been suggested that these practicums can be problematic in terms of the cultural understanding they instill in students, perhaps even reinforcing the essentialist notions of culture that we are attempting to replace.

The importance of self-reflection to reveal personal biases, values and assumptions, as well as the recognition of the sociopolitical influences on the lives of individuals emerged as key factors in facilitating a critical cultural understanding of culture. This research highlighted the need that nurse educators be supported in their own journey toward an understanding of the concepts of `culture` and `cultural safety`. 
The findings of this research support the idea that nursing students, for the most part, retain their essentialist views of culture, even during and after participation in an international practicum. It emphasizes the need to rethink how nursing students are prepared pre-departure to approach their practicum with a critical cultural eye, and the importance of daily reflection and guided discussions during the practicum.
Preface

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CHAPTER ONE
Introduction to the Study

Today, nurses and nursing students are, with increased frequency interacting with patients/clients, as well as other nurses, of different ethnic and/or cultural backgrounds than their own, regardless of their workplace. In Canada there is growing awareness of, as well as significant debate about, how to adequately prepare/educate nursing students to provide quality nursing care for people of diverse backgrounds and cultures (Maltby & Abrams, 2009).

According to the Statistics Canada Ethnic Diversity Survey (2003), Canada has a very diverse and multicultural society. Only 46% of the survey respondents reported being of British, French, and/or Canadian ethnic origin, 19% reported European heritage, while 13% claimed non-European origins, such as Asia, Africa, Central and South America, the Caribbean, Australia and Oceania; the most prevalent being from China and India.

The notion of "culture" is poorly understood, as is the term 'cultural safety'. A void in the literature exists as to how and what nursing students learn about culture, as well as the best ways for them to learn how to be culturally safe in clinical practice. The purpose of this study is to further explore nursing students' accounts of culture before, during, and after an international practicum, to examine how this experience shaped their understanding of culture and cultural safety.

It is an ethical imperative that nursing students learn to provide culturally safe care (Canadian Nurses Association [CNA], 2008; Polaschek, 1998). The Aboriginal Nurses Association of Canada (2009) asserts that cultural safety "...is in alignment with the advocacy role of nurses and the nursing profession" (p. 25). All nurses are required to provide "compassionate care" and build "trustworthy relationships" so that they might fully grasp their clients' health needs and concerns (CNA, 2008). By doing so, nurses will be able to provide the
information necessary for clients to make independent informed decisions, as well as provide care that respects the dignity of the client. This type of ethical care will only occur when nurses and nursing students are able to critically reflect on their own values, beliefs and attitudes, and bring to caregiving an open mind free of stereotypes, assumptions and judgments.

**Background to the Problem**

There is considerable literature supporting the teaching of cultural sensitivity and cultural competence to nursing students as a way of assisting nurses to care for people from a diversity of backgrounds. The term cultural sensitivity is identified by several authors as referring to an attitude that can be developed in nurses toward those of other cultures (Foronda, 2008; Hughes & Farrow, 2006; Ruddock & Turner, 2007; Turner, 2005). According to Ruddock and Turner, cultural sensitivity requires being open and respectful to the characteristics of different cultures, particularly in the way that they differ from the culture of the nurse who is providing care.

Cultural competence takes this idea one step further by focusing on the importance of the provision of nursing care that takes into account the cultural characteristics, traditions and beliefs of the patient. Unfortunately, we know that the living out of both of these concepts runs the risk of supporting the stereotyping and racialization of different ethnic groups because of the way in which the notion of ‘culture’ is often taken up; ways that tend to homogenize groups of people within ethnocultural categories (Almutairi & Rodney, 2013; Culley, 2006). To address this problem, critical cultural approaches and the notion of cultural safety hold promise in nursing education. A critical cultural approach shifts how culture if often understood and taken up as a static, ahistorical entity to culture as dynamic and ever-changing (Reimer Kirkham, Van Hofwegen, & Harwood, 2005) and ethnocultural groups as composed of individuals with separate and unique identities and experiences which have been shaped by particular
sociocultural, political, and historical realities. Students are encouraged to engage in critical self-reflection to uncover their own values, beliefs and biases as they enter into the nurse-client relationship and to examine and address power dynamics inherent in those relationships (Richardson & Carryer, 2005).

International practicums provide an invaluable opportunity for nursing students to be immersed in a foreign culture and faced with the realities of cultural similarities and differences on a daily basis. Unfortunately, there is little literature that examines how to prepare students to be culturally safe practitioners when taking part in such experiences. Recent literature would suggest that, although students do receive education in the area of culture and ‘difference,’ essentialist notions of culture are difficult to eradicate (Gibbs, 2005; Gregory, Harrowing, Lee, Doolittle, & O'Sullivan, 2010). Gregory et al. conducted a study with nursing students enrolled in a course designed to encourage "critical reflection about contextual influences on health and illness in a low-income African country" (p. 2). Their findings indicated that all but one student retained essentialist views of culture before, during, and after the course. Students were taught about cultural competence but somehow veered toward essentialism when attempting to put the theory into practice. Although they did not provide answers as to why this was the case, Gregory et al. point out that most nurses, including nurse educators, have been educated to consider those who are different as "other." Consequently, an unconscious and often racist bias exists that serves to perpetuate and support the beliefs, values and attitudes of the dominant culture.

Problem Statement

It is essential that nursing students develop an understanding of cultural safety and how to provide culturally safe care. There is very little literature that examines whether this is occurring, either through international practicums or other clinical experiences within cultures
that are foreign to the nursing student. An understanding of how such practicums can better contribute to the development of cultural safety in nursing students will support these initiatives and provide impetus to develop educational strategies to adequately prepare nursing students for such experiences.

Purpose

The purpose of this study was to explore nursing students’ interpretations of ‘culture and difference before, during and following an international practicum. The purpose was also to inform the educational preparation of nursing students entering these experiences so they might practice in a culturally safe manner.

Research Questions

The research questions that guided the study were:

- What are nursing students’ perceptions of ‘culture’ and ‘difference’ before the international practicum experience, within the experience, and following the experience?
- What do nursing students perceive as influencing/ shaping their attitudes and beliefs about culture and difference?
- Do students see the practicum experience as changing their perspectives in any way?
- Do the students see the Global Health Course at Thompson Rivers University (TRU) as helpful in preparing them for this experience?

Definition of Terms

For the purpose of this study a nursing student refers to a student currently enrolled in a Bachelor of Science in Nursing program. The term patient refers to a person who is receiving care from a health care professional. Patient was the most often used term by the study participants as well as by the majority of the literature.
**Thesis Overview**

This thesis is presented in five chapters. Chapter One has provided an overview and background to the problem, problem statement, the purpose of the study, the research questions, as well as a definition of terms. In Chapter Two a review of the research literature is presented with regards to: understanding health inequity and equity; power imbalances between the nurse and patient; culture; culturalism, essentialism and constructivism; cultural sensitivity, cultural competence and cultural safety; nursing education: teaching culture and cultural safety; and barriers to cultural safety education. Chapter Three provides an overview of the research method used, and demographic information of the research participants. In Chapter Four the research findings are presented. Chapter Five provides a discussion of the research findings and further exploration of the literature, as well as recommendations for future research and for nursing education.
CHAPTER TWO

Literature Review

Nurses, including nursing students, are increasingly being required to care for patients of differing ethnocultural backgrounds, whether in Canada or abroad. As nursing educators it is our responsibility to teach our students to provide culturally safe care. International practicums are sometimes employed in nursing education as a means of supporting the ability of students to provide care with people who are different from themselves in an unfamiliar setting.

While considerable literature exists about the importance of teaching students to provide culturally sensitive and culturally competent care, there is a scarcity of literature aimed at the value of teaching students to provide culturally safe care. In this chapter the literature is examined to determine the importance of moving beyond teaching nursing students about cultural sensitivity and cultural competency in nursing care, and to focus on cultural safety as the guiding principle for the development of nursing curriculum; specifically international practicums. First, I will discuss the sources of health inequity and power imbalances experienced by individuals belonging to ethnocultural minority groups. Then I will examine the concepts of culture, cultural sensitivity, cultural competence, and cultural safety. Lastly, I will discuss the difficulties encountered by nurse educators when teaching nursing students about culture and cultural safety.

Health Equity and Disparities

Canada has long been engaged in a policy of multiculturalism aimed at honouring and perpetuating the distinct ethnic cultures of the various immigrant populations in the country. Habib (2012) suggests that this policy has supported "Canada's racist/imperialist interests to marginalize non-whites, immigrant women, and other minorities", disguising race and class inequality in "the languages of 'diversity' 'plurality' and 'liberal democracy'" (p. 5). Browne et al.
(2009) support this point of view, stating that multiculturalism "has masked the historically mediated unequal power relations and the impact of dominant culture positions" (p.169). The very act of singling out ethnic groups as being different, as multiculturalism supports, has served to de-emphasize any differences within these groups, painting all members of an ethnic group with the same cultural brush. By doing so, Canadians of white European descent have been set apart as the dominant culture, and anyone not of this group has been identified as a "minority" or "other" (Anderson et al., 2003; Habib, 2012).

Unfortunately multiculturalism has also contributed to inequities in access to health services and disparities in the health status of certain ethnic and minority groups (Browne & Fiske, 2001; Browne et al., 2009; Habib, 2012). In Canada, although the central tenet of the Canada Health Act is that there should be equal access to health care by all Canadian citizens, some groups continue to face significant barriers to accessing adequate health care (Johnson et al., 2004). However, the inability to access healthcare by various groups often is credited to perceived individual characteristics attributed to the people of these groups, such as laziness, an easy-going nature, or irresponsibility (Browne & Fiske, 2001; Browne & Smye, 2002; Browne & Varcoe, 2006; Habib, 2012; Johnson, et al., 2004).

There is evidence that discriminatory practices and attitudes that exist in the health care system can act as a barrier to health responsibility (Browne & Fiske, 2001; Browne & Smye, 2002; Browne & Varcoe, 2006; Habib, 2012; Johnson, et al., 2004). Inequity in health care access between the dominant culture and ethnocultural minorities can be a result of imposing the definition on a minority group as "other." Doing so reinforces "positions of domination and subordination, particularly when health care is provided by members of the dominant group to members of a typically subordinated or marginalized group" (Johnson et al., p. 256).
Power Imbalances between the Nurse and Patient

Irihapeti Ramsden puts forth the notion that there exists a power imbalance between the nurse and the patient that can lead people to distrust and avoid health services (Ramsden, 2002). Simply needing a service provided by the health care system that they cannot provide for themselves places the patient in a disadvantaged position of lesser power, and those who are providing the medical and nursing care in a position of greater power (Woods, 2010). According to Ramsden, the culture of nursing is perceived by the patient as being 'exotic' and different from their own. There is an assumption that the nurse possesses a body of knowledge that is unknowable to the patient, thereby enhancing the power that lies with the nurse in the healthcare relationship. Distrust from the patient arises from such power being consciously or unconsciously "reinforced by unsafe, prejudicial or demeaning attitudes and wielded inappropriately by health workers" (Ramsden, p. 3).

Culture

Culture remains difficult for nurse educators and nursing students to define. An essentialist notion of culture, that of culture as an unchanging and rigid set of beliefs, practices, values, qualities and characteristics attributed to particular ethnic or religious groups of people prevails in nursing literature (Almutairi & Rodney, 2013; Culley, 1996; Gray and Thomas, 2006; Reimer Kirkham et al., 2002; Gregory et al., 2010; Johnson et al., 2004; Smye, 2004; Smye, 2012). It is important to begin shifting this essentialist mindset to a constructivist understanding of culture; "a notion of culture as a dynamic process understood contextually through historical, social, political, and economic lenses" (Gregory et al., p.1) to capture the complexity of the notion of ‘culture.’ Kirkham, et al. (2002) support this view, adding that culture is "embedded in fields of power relations" (p.225), i.e., it is highly relational. Nurse educators must look beyond
surface characteristics of ethnic groups and begin to recognize the complex culture that is embodied by each individual if they are to effectively teach their students to provide culturally safe care.

**Culture, Culturalism, Essentialism and Constructivism**

As noted above the notion of ‘culture’ is difficult to define; it is complex. Smye (2012) notes that unfortunately "culture is commonly presented as comprising the beliefs, practices, and values of particular ethnic or religious groups" (p.63). This essentialist view of culture leads health care workers to adopt culturalist attitudes toward individuals who are members of recognizable groups--for example, people who are defined by their ethnicity, age, gender or sexual orientation. By defining individuals in these ways there is a risk that sources of inequity (e.g., barriers to access to health care associated with social, historical and other factors) will be obscured.

**Culturalism.** In a culturalist orientation, ‘culture’ tends to be taken up in a manner that shifts attention away from a recognition of the ways in which political, economic and historic forces shape health and health care. Smye (2012) describes culturalism as being "insidious," inconspicuously shaping attitudes toward specific groups of individuals, with potentially negative consequences for their health and well-being. She states that "culturalism masks the way in which culture is transformed through the historical, social, and political contexts in which it is used. In this way, it obscures the dynamic, ever-changing quality of culture" (p.63). When historical, social and political forces are eliminated as significant influences on health inequities, the blame for these inequities then falls on cultural characteristics, such as lifestyle and behaviour. "...[C]ulturalist explanations embedded in healthcare discourses erase social, economic and political issues as significant problematics in health service delivery" (Browne &
Smye, 2002, p.36). Such culturalist attitudes significantly impact the ways in which individuals are perceived when seeking health care; individuals' health issues are attributed to their perceived cultural traits, and inequities that have shaped an individual's health status are obscured. Culture becomes problematized when the dominant healthcare system arbitrarily assigns blame for an individual's or group's health issues to their cultural disposition.

**Essentialism.** Essentialist definitions of culture are prevalent in nursing literature; culture often is presented as having a definable essence with inherent features, traditions, customs and characteristics to be memorized which are seen as unchanging over time (Campesino, 2008; Culley, 1996; Gray & Thomas, 2006; Gregory, et al., 2010; Reimer Kirkham, et al., 2002; Smye, 2004). Culture is conflated with ethnicity to the point that the terms are interchangeable. Such static, essentialist notions of culture, while difficult to dismiss entirely, reinforce stereotypes and encourage health professionals to view particular groups as being different than "normal", or as "other" (Almutairi & Rodney, 2013; Campesino; Smye, 2004). Gregory et al. state that it is common for nursing students to be taught that they will provide culturally competent care if they are able to learn a fixed set of common traits and knowledge shared by a particular ethno-cultural group. Unfortunately, this desire to know and understand the cultural characteristics of a group of people enforces an essentialist and often racist view of individuals within these groups.

**Constructivism.** From a constructivist view, culture is ever changing and is, according to Gray and Thomas (2006), "a set of complex interactions to be examined and engaged" (p.77). From this point of view culture is in a constant state of flux and can only be known, or constructed, by the nurse in the moment through meaningful interaction with, and the establishment of a relationship with, the patient. This idea challenges how we take up the notion
of culture in nursing education. Gray and Thomas suggest we lead nurses and nursing students "into an interactive, exploratory space with themselves and patients ...facilitat[ing] meaningful connection and communication" as we explore the notion of culture (p. 77). Nurses and nursing students must recognize the autonomy of the individual; that each person, regardless of their cultural background, possesses the ability to determine their own beliefs and attitudes, even if these are contrary to those commonly attributed to that person's particular culture (Gregory, et al., 2010). An individual's culture can only be known through the process of active engagement and relationship-building.

**Culture, Cultural Sensitivity, Cultural Competence and Cultural Safety**

**Cultural sensitivity.** Foronda (2008) presents a concept analysis in which she identifies five key components of cultural sensitivity: knowledge, consideration, understanding, respect and tailoring. “Knowledge” refers to the necessity of understanding the cultural differences and values of the person from another culture. “Consideration” is aimed at taking into account the other person’s background, language and beliefs, including such factors as diet and customs. “Understanding” reflects the necessity to truly understand the importance of the other person’s culture to their way of being and doing. “Respect” refers to the appreciation and regard demonstrated to the other person’s needs and cultural expectations. Finally, “tailoring” is the altering or adapting of one’s own mindset or behaviours in order to meet the needs or expectations of the other person.

Cultural sensitivity, by this definition, is taken up in a way that suggests a static concept of culture that is grounded in the theory of essentialism (Gregory, et al., 2010). An essentialist view of ‘culture’ is described by Gregory et al. as “a fixed ‘essence,’ comprising a rigid set of defining qualities that exist independent of human perception and are unchanging over time”
Peoples’ beliefs, traditions and actions become defined solely by their culture with little recognition of individual autonomy; culture is unique and people operate only within the confines of its dictates. Gregory et al. also refer to this as “othering,” a concept that sets a person apart based on characteristics they attribute to that person or groups of people, such as racial characteristics. Consequently, relationships with that person are with the ‘culture’ rather than with the individual. Duffy (2001) states that othering places the emphasis on “the unique, the exotic, and the unusual” (p.489). This view of culture can lead to stereotyping, a process which holds that cultural groups are internally homogeneous and therefore members of each group should be treated in the same manner (Duffy; Hughes & Hood, 2007). Ironically, cultural sensitivity can in fact lead to attitudes that are insensitive and presumptuous, promoting quick judgments and stereotyping (Turner, 2005).

**Cultural competence.** Cultural competence builds on the concept of cultural sensitivity. It has been suggested by some that cultural sensitivity is an attitude, while cultural competence is the behaviour reflected by this attitude (Hughes & Hood, 2007). A culturally competent nurse therefore acts with cultural sensitivity in practice, and is able to provide care that is congruent with the client’s cultural patterns of thought, communication, customs, beliefs and values (Campinha-Bacote, 2002; Cuellar, Brennan, Vito, & de Leon Siantz, 2008; Maltby H. J., 2008). Waite and Calamaro (2010) define cultural competence as “a set of skills and behaviours that enable the nurse to work effectively within the cultural context of a client (individual, family or community)” (p.74).

It was Leininger who first proposed the idea that clients should be approached and treated differently based on their ethnic characteristics (Duke, Connor, & McEldowney, 2009). However, although Leininger’s work in transcultural theory challenged the importance of linking
culture and health, its limitation was the primary focus on knowing the characteristics of different ethnocultural groups, rather than on ‘the process’ of developing cultural competence. Campinha-Bacote (2002) proposes that cultural competence must extend beyond simply the knowledge of the characteristics of different ethnic groups. To this end, she has developed and refined a model of cultural competence that is widely used by health professionals. Campinha-Bacote’s model addresses the “process” factor of cultural competence; in other words, it provides an ongoing framework that can be used by health professionals to ensure that they are providing culturally competent care. It is important to note that, according to Campinha-Bacote, cultural competence is not an end-point, but a continual process of striving to provide care that is congruent with the cultural context of the client.

In Campinha-Bacote’s (2002) cultural competence model the process of cultural competence is broken down into five constructs: cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire. Cultural awareness is developed through the examination of one’s own cultural beliefs and values. This is considered a necessary step to uncovering any biases and prejudices that may negatively impact one’s interactions with an individual from a different cultural background. Cultural knowledge refers to the process of becoming educated about the ways in which different cultures view the world around them and, subsequently, how this view shapes their values. It also includes the necessity of educating oneself about the specific biological and physical attributes of different cultures. Cultural skill involves the ability to conduct an assessment in a way that relevant cultural data is collected. It also describes the ability to conduct a physical assessment that is relevant for ethnically diverse clients. Cultural encounters is the process of interacting with several members of a cultural group in order to determine which values and beliefs appear to be shared within the group, and
which ones are held only by the individual. Campinha-Bacote believes that these diverse one-on-one encounters will prevent stereotyping and racial bias from occurring. Finally, cultural desire is the sincere motivation of the nurse to work with clients of different cultures. The nurse must progress from simply being politically correct to allowing genuine caring to underscore their actions and communications in order to ensure that the client feels valued as a person, and is not just seen as a member of a cultural group.

Cultural competence has formed the basis for many nursing education programs, many of them based on Campinha-Bacote’s (2002) cultural competence model aimed at preparing new nurses to be able to function proficiently in a multicultural world. However, the difficulty with the concept of cultural competence is the tendency for nurses to define a client only in terms of their ethnicity without regard for other aspects of the person’s identity and the contextual factors that shape/influence identity and health and wellbeing and health care. Ultimately, the cultural context of the client becomes overgeneralized and stereotyped, as rules are set out that dictate how to treat a person of a particular ethnic background (Kleinman & Benson, 2006; Willen, Bullon, & Good, 2010). Cultural competence alone also does not address power, or structural challenges such as the impact of socio-political, historical and economic inequities related to “difference” (Almutairi & Rodney, 2013).

Cultural safety. The term 'cultural safety' was first proposed in the early 1990s by Irihapeti Ramsden, a Maori nurse educator in New Zealand, in order to identify and deal with the health inequities experienced by the Maori people. She asserted that the Maori suffered health disparities due to discriminatory health practices and policies arising from a prevalent neo-colonial mindset (Ramsden, 2002). The term 'cultural safety' was developed by Ramsden and other nurse educators and adopted in 1996 by the Nursing Council of New Zealand (Nursing
Council of New Zealand, 2009). The primary purpose for the development of this concept was to educate nurses to provide health care to Maori (the Indigenous people of New Zealand) in a manner that engenders trust and respect and promotes a sense of ‘cultural safety’; this with the aim of improving the health status of Maori and decreasing health disparities between Maori and Pakeha (white, non-Maori). Ramsden (1996) points out that “the attitude a nurse portrays, if it is one of criticism, blame or assumption, whether expressed knowingly or unknowingly, may make a person feel demeaned and engender feelings of reluctance either to seek health care or to return to a particular health service” (p. 492). The client in this case will not experience cultural safety.

The concept of cultural safety has since been examined by several authors from New Zealand as well as from other countries, specifically Canada. The value of cultural safety is being recognized, and considerable effort is being put into interpreting its meaning in the Canadian context where multiculturalism is a professed value (Reimer Kirkham, et al., 2002; Smye & Browne, 2002). Multiculturalism, while attempting to honour the many cultural groups that form the Canadian population, tends to emphasize difference and the essential characteristics of each ethnocultural group, leading to stereotypical and racist notions of the individuals within these groups.

Cultural safety is not synonymous with cultural sensitivity, nor is it about the knowledge of cultural characteristics and practices, as suggested by Leininger in proposing the theory of transcultural nursing, that underscores the concept of cultural competence (De & Richardson, 2008; Polaschek, 1998). The idea that cultural groups are homogeneous, and that members of particular groups should be treated equally, needs to be challenged. Cultural safety requires that a person be respected and treated as an individual and not solely as someone who shares the physical attributes of a specific cultural group. “When culture is viewed through an individual’s
global lens, stereotypes about cultural groups begin to erode and be replaced by individual identities” (Duffy, 2001, p. 489).

The Nursing Council of New Zealand (2009) provides the following definition of cultural safety:

The effective nursing practice of a person or family from another culture 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 wellbeing of an individual (Nursing Council of New Zealand, 2009, p.4).

Cultural safety pushes beyond the concept of cultural sensitivity and the importance of gaining ‘cultural’ knowledge to include the following ideas, which I explain in more detail below: i) cultural safety begins with the nurse who engages with self-reflection, to gain an understanding of the beliefs, values and assumptions they hold that underlie their approach to the client (De & Richardson, 2008; Gibbs, 2010; Nursing Council, 2002; Ramsden, 2002; Reimer Kirkham et al., 2002; Smye, 2012; ii) cultural safety is a bicultural concept, i.e., both the nurse and the client have a culture. Therefore the nurse must have an understanding of his/her own culture. In addition they must work to gain knowledge about those aspects of the client that are important to understand in the provision of care and the promotion of client health and well-being (De & Richardson; Gibbs; Ramsden; Reimer Kirkham et al.; Smye); iii) power
differentials in the nurse to client relationship must be understood and addressed (De & Richardson; Nursing Council, 2002; Polaschek; Ramsden; Reimer Kirkham et al.; Smye); iv) health, healthcare and a person’s identity are influenced/shaped by context, i.e., sociocultural, political and historical factors (references) and clients who are victims of such factors should not be blamed for their current plight (De & Richardson; Nursing Council, 2002; Polaschek; Ramsden; Reimer Kirkham, et al.; Smye); v) cultural safety requires that we as health care providers take action to improve the status quo (De & Richardson; Nursing Council, 2002; Polaschek; Ramsden; Reimer Kirkham et al.; Smye); and vi) care is deemed culturally safe by the recipient of that care (De & Richardson; Nursing Council, 2002; Polaschek; Ramsden; Reimer Kirkham, et al.; Smye). Therefore, cultural safety is both a process and an outcome.

For nurses to establish a culturally safe relationship with their clients it is necessary that they critically analyze their own cultural beliefs and assumptions and recognize how these affect their interactions with their clients. This process of reflectivity is essential for nurses to be able to recognize their own reality, stereotypes and assumptions that they bring to relationships with clients (Browne & Varcoe, 2006; Nursing Council of New Zealand, 2009; Papps & Ramsden, 1996; Smye, 2012; Smye & Browne, 2002). In this way there is a greater likelihood that they may remain open-minded and unbiased in their attitudes toward those for whom they provide care.

Cultural safety also embodies the idea that nurses recognize the culture of nursing and the health care system as being unique. Ramsden (2002) asserts that the culture of the nurse is "exotic" and not normal to the client, leading to a power gradient that is inherent between the nurse and the client. Smye (2012) states that nurses should be concerned about the influence that the culture of nursing and other aspects of the healthcare system have on continuing and
promoting marginalizing factors and inequities that relegate clients to a lower power status. This power gradient jeopardizes the likelihood that the client will receive culturally safe care. For example, it is important that nurses be aware of the imbalance of power between themselves and their patients so that they might recognize when they are imposing their beliefs and values on their clients about the “right” decisions to make (Anderson, et al., 2003; De & Richardson, 2008; Duffy, 2001; Polaschek, 1998; Warren, 2003). According to Ramsden (2002), “[c]ultural safety is concerned with the transfer of power from service providers to health care consumers, addressing issues of power imbalance” (p. 110). In order to be culturally safe, nurses must be aware of the power imbalance that exists between the nurse and client, and recognize that clients have the right to determine the course of their own health care, as well as what an acceptable health status is for them, without pressure to choose a particular course of action. It is ultimately not up to the nurse, but instead the client to determine whether or not the care they are receiving is culturally safe.

Becoming culturally safe requires nurses to critically understand that health and well-being and peoples’ identities are shaped/influenced by social, political, historical and cultural factors. Regardless of their culture, each individual is subject to social, historical, political and economic forces that greatly influence their lives, and more particularly their health status. The interplay of these factors, combined with individual characteristics, such as gender, sexual orientation, age, religion, ethnicity, economic status, etc., have shaped/influenced the health of the individual (Anderson, et al., 2003; Browne & Varcoe, 2006; Brown, et al., 2009; Duffy, 2001; Papps & Ramsden, 1996; Ramsden, 1993; Reimer Kirkham, et al., 2002; Smye, 2012). What may be perceived as an individual's cultural characteristics may in fact arise from discriminatory historical and social processes, and in fact have little to do with their culture. For
example, the reluctance of an Aboriginal person to seek medical care from a physician or hospital and who instead seeks advice from a traditional healer may be seen as being ignorant of, or unwilling to accept, the benefits of modern medicine. The actual reason may be rooted in a lack of economic means to pay for or access health services, or a mistrust of mainstream medicine due to historical issues of oppression.

Cultural safety requires that nurses unmask structural forces in order to identify the inequities and injustices that have led to people's health status, and to cease blaming an individual's health problems on their culture. Rather, they should place blame where it belongs, squarely on the shoulders of the structural inequities that have shaped the lives of that individual and their ancestors (Anderson, et al., 2003; Browne, et al., 2009; Browne & Varcoe, 2006; Duffy, 2001; Papps & Ramsden, 1996; Ramsden,1993; Reimer Kirkham, et al., 2002; Smye, 2012).

**Nursing Education: Teaching Culture and Cultural Safety**

Canada is a multicultural society with an increasingly global nature. According to Duffy (2001), globalists and demographers predict increasing levels of immigration to North America and Western Europe as death rates on these continents outstrip the birth rates and population numbers cannot be sustained or increased internally. Nursing students are providing health care to individuals from increasingly varied cultural backgrounds, and in addition, are in educational and practice settings with an increasingly diverse population of students and health care professionals, respectively. Nursing students must be educated to be culturally safe in all encounters and in particular with clients, whether they are from another country or simply from a different social background.
The terms cultural sensitivity, cultural competence, transcultural nursing and cultural safety are poorly understood and a source of confusion for nursing students (Gibbs, 2005; Papps & Ramsden, 1996). It is important that nursing students understand the critical differences between these concepts. It is also crucial that they are given the opportunity to develop their own ways of being culturally safe in order to ensure that their interactions with patients are based on trust and respect, and preserve each patient’s sense of dignity and personhood (Gibbs). Gibbs recommends that cultural safety education be incorporated throughout undergraduate nursing programs so that cultural safety becomes integrated into the student’s thinking and is naturally incorporated into every aspect of their nursing practice. Gregory et al. (2010) point out that the primary obstacle to the widespread adoption of cultural safety teaching into undergraduate nursing programs is the retention of essentialist notions of culture by many nurse educators.

Duffy (2001) points out that traditional cultural sensitivity and cultural competence education focused on learning about the “other” to ensure appropriate assessment techniques and interventions (Papps & Ramsden, 1996). ‘Cultural safety’ education, on the other hand, requires critical reflection by the nursing student to encourage an understanding, or "demystifying" of their own culture, attitudes, beliefs and practices; to reinterpret, reorganize and even reject the student’s perception of their own culture as it is juxtaposed with other cultures (Duffy, p.491). According to Duffy, ‘cultural safety’ education should be based on the premise of equity[^1] and shared power between members of different cultures. In this way, students learn that the power gradient between the nurse and patient should be eliminated, and an interactive relationship should be created through the process of co-learning and co-creating (Duffy). Cultural safety

[^1]: Here I would depart from the perspective of Duffy and argue that cultural safety be associated with the concept of equity rather than equality [yes!] because of the primary intention of Ramsden and others in using cultural safety – to point to health inequity and its associated root causes, e.g., e.g., colonial and neo-colonial processes and practices, poverty etc. In this way, when thinking about “shared power between members of different cultures,” resources, as one example, would be considered differentially for different groups dependent on different need at any given time.
education prepares students to work in a global society by teaching them to continually reflect on their beliefs, to critique the mainstream presumptions of “right,” to not blame a person's culture for health issues caused by historical and social processes, and to develop inclusiveness by listening to both their heads and their hearts (Duffy; Papps & Ramsden). "A nurse who can understand his or her own culture and the theory of power relations can be culturally safe in any context" (Nursing Council of New Zealand, 2009, p. 4).

**International practicums.** There is a considerable amount of literature examining the effect of international practicums on nursing students' understanding of culture. The vast majority of these, however, are focused on the development of students' cultural sensitivity and/or cultural competence, which reinforce essentialist attitudes of culture in the nursing students. Although there is very little literature that examines how international practicums influence the development of culturally safe attitudes in nursing students, Gregory et al. (2010) did study the effects of an international practicum on nursing students' understanding of culture. They suggest that nursing pedagogy is responsible for developing essentialist understandings of culture in nursing students, even in those students who participate in international practicums. Excerpts taken from students' journals indicate that all but one student had essentialist concepts of culture reinforced by participating in an international practicum. "An essentialist understanding potentially compromises care by inhibiting relationships between nursing students and patients, masking power structures and structural inequities, and making culturally safe care challenging, if not impossible" (Gregory, et al., p.13). While the majority of students participating in the international practicum retained essentialist notions of culture and did not develop culturally safe attitudes, Gregory et al. place the blame on nursing pedagogy and curriculum, rather on the practicum experience. Because nurse educators design and teach the
international practicums, the student participants' cultural learning is inextricably linked with the cultural views of the course designers and instructors.

**Barriers to ‘cultural safety’ education.** While it is acknowledged by many that nursing students should be receiving education in cultural safety, barriers exist to ensuring that this occurs. Research has shown that many nurse educators feel a lack of preparation for teaching cultural safety (Gibbs, 2005; Wepa, 2003). While they are supportive of teaching the concept, many educators do not feel familiar enough with the concept of cultural safety, nor have they been given adequate tools, to integrate it into the curriculum. They also feel a lack of energy to implement changes in their teaching, as well as isolation and a lack of support from fellow faculty to develop strategies to put cultural safety curriculum into practice.

Gregory et al. (2010) suggest that the majority of nurse educators continue to teach essentialized concepts of culture despite a move within nursing education to teach culture from a critical constructivist point of view. Too often culture is equated with ethnicity or the overt characteristics of a particular group of people, rather than the critical notion that "culture [is] a dynamic, power laden process created by people in relation to one another, their environments, and sociopolitical and historical contexts" (Browne, et al., 2009, p.173). This critical conceptualization of culture is essential to understanding and implementing cultural safety into nursing education and practice. In order for nurse educators to fully incorporate cultural safety into their teaching and practice they must be given the time and support to explore and develop their understanding of a critical cultural perspective of culture (Browne, et al.). When nurse educators are not provided with the tools to understand and integrate a critical conceptualization of culture into their teaching, the result is a curriculum based on a simplistic, essentialized understanding of culture. “The challenge... [is]...how to engage with ideas about culture without
reproducing the very culturalist discourses that we aim to disrupt" (Browne, et al., 2009, p.173). The unfortunate conclusion is that nursing students then integrate a limited understanding of culture into their practice.

**Conclusion**

It is commonly believed that nursing students move through a cultural learning continuum as they strive to achieve cultural safety in their nursing practice. Guidelines for cultural competency and safety have been set out by The Nursing Council of New Zealand (2009), as well as the National Aboriginal Health Organization (2008) which outlines this learning continuum. They identify cultural awareness, where students begin to recognize difference, as being the start point. This is followed by cultural sensitivity, during which students begin to reflect on their own attitudes and assumptions and begin to understand how these impact others. The end point of the continuum is cultural safety, which is the ability to provide care that is deemed safe by those receiving the care. "Awareness, sensitivity, and competence provide students and faculty with a beginning place in which to develop an appreciation of the complexity of 'culture'“ (Aboriginal Nurses Association of Canada, 2009, p. 25).

Unfortunately, there is a scarcity of research regarding outcomes associated with teaching cultural safety in terms of nursing practice. In addition, practicum experiences (such as international practicums) have not been evaluated for their ability to provide students with the kind of experience that would enhance their ability to think further about ‘culture’ and ‘difference’ and the relationship to health equity and inequity. As I indicated in Chapter 1, it was therefore my intent in this study to explore nursing students’ interpretations of culture and difference before, during and following an international practicum experience.
In Chapter Three, I provide an overview of the research method employed in my study, as well as a description of the theoretical framework that guided the research. The research design is then described, including the sampling plan and recruitment procedures, as well as the inclusion and exclusion criteria for the study. Ethical considerations and how they were dealt with are provided. Procedures for data collection and analysis are detailed, including a description of the rigor and credibility standards employed during the research.
CHAPTER THREE

Research Methodology and Methods

Cultural safety is a relatively new term in the Canadian nursing context, and particularly in terms of Canadian nursing education. It was my expectation that this study would contribute to the literature by examining areas that have not been adequately investigated. While literature exists that looks at the development of cultural competence in nursing students through participation in international practicums, there is a significant need to further our understanding as to whether this cultural competence actually reflects the principles of cultural safety. To do this, it is my belief that we must further examine nursing students' understanding of how power affects the relational and contextual factors of individuals within a culture as well as their own role in perpetuating power inequalities when caring for these individuals.

Theoretical Framework

It was important to design this research within a critical cultural framework. The term culture has long been defined in narrow terms, such as the songs, dances, food, and traditions of a particular ethnic group. Such discourses about culture risk placing those who are different into a position of inferiority (Browne & Varcoe, 2006; Dutta & de Souza, 2008). As I have indicated earlier in this thesis, a critical cultural perspective views culture in a more complex, multidimensional manner. It is important to recognize that an individual is indeed shaped by the cultural group in which they live, however a critical cultural perspective emphasizes that individuals function within their culture differently, depending on their specific circumstances and the forces at work in their lives. From a critical cultural perspective, culture is understood as “a relational aspect of ourselves that shifts over time depending on our history, our past experiences, our social, professional and gendered location, and our perceptions of how we are
viewed by others in society” (Browne & Varcoe, Critical cultural perspectives and health care involving Aboriginal peoples, 2006, p. 10). The critical cultural perspective requires that we see individuals not as simply belonging to a particular cultural group, a cultural “other”, but that they be recognized as residing within a unique historical, social, economic and political context that is unlikely to be identical to that of any other member of their cultural group. Because nurses in western society have been socialized to view culture in narrow terms, it is necessary that they examine their own beliefs and assumptions about culture in a critical manner in order to shift to a broader perspective of culture. Only by acknowledging the uniqueness and constantly shifting nature of each individual’s situation and context will it be possible to begin to understand their true culture. I chose the research design for this study with such goals in mind.

**Research Design**

I was interested in exploring the development of culturally safe cultural competence in nursing students participating in an international practicum and refining knowledge about how they came to recognize the power relationships that affect the health care and the treatment of individuals. The development of relationships with, and perceptions of others, is a very personal and unique experience, and therefore it was important that participants were able to examine and describe their own realities.

A qualitative research design was chosen for this study because the purpose of such research is “to provide a rich, contextualized understanding of human experience through the intensive study of particular cases” (Polit & Beck, Generalization in quantitative and qualitative studies: Myths and strategies, 2010, p. 1452). Qualitative research attempts to make sense of phenomena by exploring the meanings that people bring to them (Pugsley, 2010). The students participating in the international practicum each experienced their own reality and perspectives
of the phenomenon of cultural competency. These were discovered through the use of narratives and a focus group, and conveyed through written analysis that was made rich with excerpts from participant contributions.

The development of cultural safety in nursing students participating in an international practicum is a complex issue that has significant implications for the clinical setting, both internationally and locally. As such, the individual experiences of nursing students participating in these practicums required exploration so that their individual thoughts and feelings might be determined and subsequent commonalities identified. Interpretive description was chosen as the methodology for this qualitative study as it facilitates the discovery of underlying meanings with the goal of understanding how individuals experience a particular phenomenon. This analysis, in turn, informs nursing knowledge which can be applied to the context of the clinical practice environment (Thorne, Reimer Kirkham, & MacDonald-Emes, Interpretive description: A noncategorical qualitative alternative for developing nursing knowledge, 1997; Thorne, Interpretive Description, 2008). According to Thorne (2008), interpretive description encourages the type of interpretive thought processes that nurses routinely employ. Formal sampling, data collection and data analysis methods, therefore, allow for the researcher to “work within pressing problems of his or her own disciplinary field and to generate credible and defensible new knowledge in a form that will be meaningful and relevant to the applied practice context” (Thorne, Interpretive Description, 2008, p. 51)

**Sampling Plan**

The sampling method for this research study consisted of purposive criterion sampling. Such sampling requires that participants meet a set of predetermined criterion. In this case, the criterion was that participants were Thompson Rivers University School of Nursing students
enrolled in NURS 3390 and participating in the international practicum in Lesotho, Africa in 2011. As these were very specific criterion and they applied to only 10 individuals, criterion sampling provided the best method for recruiting participants for this project. "The logic of criterion sampling is to review and study all cases that meet some predetermined criterion of importance" (Patton, 1990, p. 176). Thorne, Reimer-Kirkham and MacDonald-Emes (1997) recommend that theoretical sampling be used when employing interpretive description. In this process sampling is an ongoing procedure, guided by the data and categories that become evident as the grounded theory emerges (Polit & Beck, 2008). The data analysis itself then acts as a guide for further sampling to develop more complex understandings of the phenomenon (Thorne, Reimer Kirkham, & MacDonald-Emes, Interpretive description: A noncategorical qualitative alternative for developing nursing knowledge, 1997). In the case of this research study, however, there was no opportunity for further sampling as the data analysis took place, so criterion sampling remained a better sampling procedure than theoretical sampling.

The sample population used for this study was limited. It consisted of 10 Thompson Rivers University School of Nursing students who were enrolled in NURS 3390 and who went to Lesotho, Africa from April 27 to June 1, 2011. This was appropriate as it is common for qualitative research to use small, non-random samples (Polit & Beck, Nursing research: Generating and assessing evidence for nursing practice, 2008). For qualitative research random samples are generally not preferred as desirable participants have specific characteristics and qualities that make them well-suited to a specific research project. Generalizability was also unlikely; however this is not a key component of qualitative studies. The aim of qualitative research is to explore and uncover meaning, discovering the multiple realities of the participants.
**Inclusion and exclusion criteria.** The definition of the sample population defined the inclusion and exclusion criteria for this research study. Participants were required to be students of the School of Nursing at Thompson Rivers University, enrolled in NURS 3390, who were going to Lesotho, Africa for their international practicum in 2011 and who agreed to participate in the study.

**Recruitment procedure.** Two weeks before departure the nursing students participating in the international practicum to Lesotho, Africa were e-mailed a letter of information that outlined the research project, informing them of the confidentiality measures that were in place and the voluntary nature of their participation, and inviting them to participate in the research project. Due to the lengthy nature of attaining ethical approval from the ethical review boards at both the University of British Columbia and Thompson Rivers University, it was necessary for students to be informed of the research project and provided with an electronic consent form by a member of the faculty of nursing who was not involved with the international practicum following their arrival in Lesotho. Students who elected to participate in the research project then emailed their consent forms to the Thompson Rivers University faculty member from whom they had been received.

**Ethical considerations.** Before recruitment of participants for the research project began, ethical approval was received from the University of British Columbia Behavioural Sciences Screening Committee for Research and Other Studies Involving Human Subjects, as well as from the Thompson Rivers University Research Ethics Committee on Human Subjects. A Letter of Information describing the nature and parameters of the research study, as well as the Informed Consent form explaining the consent process, was e-mailed to the 10 students participating in the international practicum in Lesotho by a Thompson Rivers University School of Nursing
instructor who was not involved in the research project. Students were provided with an explanation of the study and informed of the voluntary and confidential nature of their participation. Students who agreed to participate were asked to e-mail their consent to the nursing instructor from whom the email had been received. The consent process was designed in this manner to ensure that students did not feel coerced into participating due to my being both the researcher as well as one of their instructors during their practicum in Lesotho.

The consent included permission to transcribe participants’ written narratives, as well as audiotape and transcribe their statements during a focus group to be held following the practicum, and the subsequent reporting of this data. Participants were informed that their participation in the research project was completely voluntary and that they were able to withdraw from the study at any time after it had commenced. Students were also informed that I would have no knowledge of who had agreed to participate, and would have no access to their narratives until after their final grades for the course had been submitted. Further, they were informed that their decision to participate or not participate in the research project would in no way affect their grades or their status as a student in the School of Nursing at Thompson Rivers University.

Every effort was made to ensure the anonymity of the participants. Participants put their names on the narratives they submitted and were also know to me during the focus group. When transcribing the narratives and the focus group code names were used instead of the students’ real names, and only I had knowledge of the match between the code names and real names. The original data sources and electronic transcriptions will be stored in a locked filing cabinet for five years, at which time they will be destroyed in an appropriate manner. The findings of this research project may be presented at conferences or published in academic manuscripts, in which
case all participants’ names and any potentially identifying details will be changed to protect their identities.

Subject risk was considered minimal for this research project. If any participants became upset, distressed or disturbed during the course of the research they would have been supported by myself or my co-instructor of the practicum while in Lesotho, and/or referred to appropriate counselling services at Thompson Rivers University once back in Canada. It was not anticipated that participants would experience any more discomfort or incapacity due to participating in this research project than those students who did not participate.

**Procedures and Data Collection**

Several data collection techniques were employed for this research study, including written narratives and a focus group, as well as reflective journaling and field notes. The participants were asked to complete a narrative reflecting their beliefs and attitudes toward culture before departing for Lesotho, while they were in Lesotho and following their return from Lesotho. A focus group was also conducted after students had returned from their practicum in Lesotho.

**Narratives.** Participants were asked to complete a short narrative before, during and following their time in Lesotho. They were provided with a list of questions to help guide their reflections on their attitudes and beliefs about culture. Examples of these questions are:

- Think of a time when you cared for a patient whose cultural background was different than your own:
  
  i. How do you define the notion of ‘culture’ - what does it mean to you in terms of who you are and how would you define it in terms of the particular person or persons you are thinking of?
ii. What was it like to care for a person from a culture different than your own?

iii. What did you see as 'cultural' aspects of care?

iv. How do you think 'culture' affected the care the patient received, or did it?

v. How do you think the person experienced their care?

Focus group. A focus group was conducted with research participants approximately 4 months after their return from their international practicum in Lesotho, Africa. Focus groups are an effective means for people to communicate verbally their ideas and understandings of a particular phenomenon (Polit & Beck, Nursing research: Generating and assessing evidence for nursing practice, 2008). A location was determined at Thompson Rivers University for the focus group, and light refreshments were served. The duration of the focus group was approximately one hour. The session was audio-recorded, and then subsequently transcribed. I did the transcription as my typing skills are proficient and it was more likely that I would be able to identify the voices and provide accurate context than would a transcriber who is unfamiliar with the participants.

Reflective journaling and field notes. In qualitative research the researcher is considered a tool that is integral to the research process. According to Thorne (2008), the researcher’s thought processes are often influenced by ideas, discussions, and inquiries during the process of formulating their research question, and this continues throughout the research process. She states that in order to maintain the integrity of the inductive reasoning process, it is important to explicitly recognize and understand the ways in which the researcher has been influenced and biased throughout the development and carrying out of the research. The researcher must be positioned within the ideas that are generated during the research process. In this way bias within the study can be interpreted and countered.
I engaged in reflective journaling and field notes during the international practicum in Lesotho as well as following the focus group and during data analysis. These writings included my personal viewpoints, understandings, experiences and insights about the research project as it unfolded in order to provide context for the research process. This process allowed me to interpret and counteract bias within the research study (Thorne, Interpretive Description, 2008). My thesis supervisor also provided invaluable support in guiding me in this process.

**Data Analysis**

Interpretive description relies on the inductive reasoning process that is the cornerstone of all qualitative research. Thorne et al (1997) recommend that researchers immerse themselves in the data before the coding process begins, and prior to any formulation of classifications or linkages. They emphasize that data analysis is not simply a process of jumping into sorting and coding, but requires an open mind that examines and re-examines the data to refine, reconceptualise and challenge the ideas and themes that emerge (van Wiltenberg, 2007). The researcher must become intimately familiar with the data collected from each individual, uncover themes within this data, and synthesize knowledge that will in turn be used to analyze individual data. Questions aimed at uncovering what is happening and what is being learned should be asked (Thorne, Reimer Kirkham, & MacDonald-Emes, Interpretive description: A noncategorical qualitative alternative for developing nursing knowledge, 1997; van Wiltenberg, 2007).

A process of constant comparative data analysis is consistent with interpretive description and was used to analyze the data in this research project. Commonalities and patterns in the data were discovered through the comparison of themes present in one individual’s data with those from another individual (Polit & Beck, Nursing research: Generating and assessing evidence for
nursing practice, 2008). Thorne et al (1997) suggest that the commonalities identified through constant comparison of individuals’ data are more representative of the greater truth about the phenomenon than the themes that exist within an individual’s data. It is these commonalities that can then be brought back to the individual to determine if they truly fit with their own sense of the phenomenon.

In order to accomplish such analysis in this study, the narratives and the focus group audio-recording were first transcribed. Following the transcription the data was read, re-read, reflected on and analyzed. Characteristics of one piece of data were examined and compared to those of other pieces of data to determine if they “fit” with each other (Polit & Beck, Nursing research: Generating and assessing evidence for nursing practice, 2008). Fit allows the researcher to compare pieces of data and sort them into categories. Substantive open coding was used to capture the essence of the data (Polit & Beck, Nursing research: Generating and assessing evidence for nursing practice, 2008). Data was broken down, and actual words of the participants were used to examine the similarities and differences within the data. From the open coding analysis of the data, categories emerged. Once the categories were determined, selective coding began, during which only the data that was related to the core variable was coded. Theoretical codes that examine how substantive codes are related to each other were then developed. Theoretical codes are the emergent theory that allows the researcher to “weave the broken pieces of data back together” (Polit & Beck, Nursing research: Generating and assessing evidence for nursing practice, 2008, p. 523).

Throughout the process of coding it was imperative that the researcher maintain a commitment to reflexivity. Reflexivity involves the act of self-reflection and analysis of one’s own belief systems in order to identify their biases, values, assumptions, and emotions that may
influence the analysis of the research data (Polit & Beck, Nursing research: Generating and assessing evidence for nursing practice, 2008). As well, the researcher must be continually scrutinizing their own responses to the data, as well as their reactions to the study participants. I attempted to accomplish this by continually referring to my field notes throughout the data analysis process.

**Rigor and Credibility**

Thorne, Reimer Kirkham and MacDonald-Emes (1997) assert the importance of rigor to an interpretive description in both the conducting of the research as well as in its reporting. It was my intention to conduct my research in a rigorous manner so that I could portray the thoughts, experiences and viewpoints of the participants in a way that was both credible and defensible.

There is considerable debate in the literature as to the meaning of “high quality” qualitative research, as well as the preferable methods to ensure that a qualitative inquiry is indeed trustworthy (Polit & Beck, Nursing research: Generating and assessing evidence for nursing practice, 2008). I was privileged to be able to engage in fieldwork with my students on their international practicum in Lesotho for 5 weeks. Prolonged engagement is important for building rapport and generating trust with participants so that they are more likely to impart accurate and useful insights that are rich in depth (Polit & Beck). Another way in which I strove to ensure the trustworthiness of my research inquiry was through method triangulation. Data was obtained from the participants’ narrative reflections as well as by transcribing their verbal contributions during a focus group. Finally, investigator triangulation was employed in an attempt to eliminate bias and bring different perspectives to the data interpretation. My interpretations of the data were verified by my thesis supervisor.
While it is important to recognize the futility of eliminating all bias from the research process and findings, I made every effort to identify my own values, beliefs and biases in order to better understand and portray the true voices and their meaning (Thorne, Reimer Kirkham, & MacDonald-Emes, Interpretive description: A noncategorical qualitative alternative for developing nursing knowledge, 1997). As I have indicated earlier, to accomplish this I kept a reflective journal and field notes throughout the international practicum as well as field notes for the focus group that was conducted following the practicum. This provided me with a means to retrace the thought processes that had occurred and to ensure that analyses and conclusions are defensible.

**Summary**

This chapter has provided an overview of the study design as well as the theoretical framework in which the design was situated. An overview of interpretive description was provided along with the sampling plan, recruitment procedure, methods of data collection and analysis, and the means by which rigor was maintained. As I proceeded through this process and reflected on the data, my understanding of the impact of international practicums on students’ understanding of cultural safety developed and transformed. As I indicate in the chapters that follow, I now realize not just the importance of international practicums for nursing students, but also the necessity of assisting students to overcome their biases and assumptions and to guard against the development of essentialist attitudes in the process.

It is often difficult to generalize the findings of qualitative research. Thorne (2008), however, asserts that if the research is credible and valid then the results should necessarily be considered “probable truth” (p.229). It is my hope that the results of this study will add insight and stimulate further investigation of this topic. In chapters four and five I will discuss the
findings of this research study, as well as the implications that international practicums have for the continued development of cultural safety understanding in nursing students.
CHAPTER FOUR

Findings

When I initially began conceptualizing what was meant by cultural safety and how this applied to nursing student practice in the context of an international practicum, I found myself wanting to explore further than the scope of the existing literature. Although the concepts of cultural sensitivity and cultural competence have been a focus of research in nursing over the past several decades, literature concerning the emerging concept of cultural safety and its use with nursing students participating in international practicums is sparse and the experience poorly understood. In this chapter I present my findings from an analysis of data collected with nursing students during and post an international practicum experience.

As stated previously, the primary aim of this research was to explore how nursing students develop their concept of take up the notion of culture and negotiate difference during and following an international practicum, to inform the preparation of nursing students entering these experiences and support culturally safe practice.

Thorne (2008) puts forth the idea that findings should be organized and presented "such that something below surface meaning – beyond the self evident – can be explored and elucidated" (p. 175). I have attempted to draw on this principle of interpretive description by presenting the analysis of the findings as themes. Each of these themes is examined in the context of current literature. A discussion of the findings is integrated into the findings. Through the analysis the following five themes were identified across the interviews: 1) Culture and Knowing the Individual; 2) The Complexity of Culture; 3) Culture as Difference; 4) Culture and Caring; 5) Culture as Relational.
Culture and Knowing the Individual

The findings of this study suggest that students thought a great deal about the notion of culture during their international practicum experience, as reflected in the following written exemplar,

The biggest thing that [name of the place] has shown me is really how culture is personal to the person. Even people that live in the same country, raised under the same religion and attended the same school, will have different views on culture. As a result, it is really important to listen to your patients. [Name of the place] has taught me not to assume anything and to expect everything.

Many students in the study noted the importance of getting to know an individual person beyond their ‘culture’; knowing something about a person’s ‘culture’ was not enough. As Smye (2012) notes, we cannot know who a person is simply because they know their ancestry or their ethnocultural background; their culture does not provide a ‘framework’ for their behaviour.

Another student's reflection also points to the individual nature of culture,

I would define the concept of culture as completely individualized. I think it depends on where one is from and is based on a set of values and norms. These values and norms may be rooted in history and change over time.

Rather than assuming knowledge of an individual's culture, this student and others recognized that relationship with the individual client was important. In a similar vein, another student recognizes this in the following exemplar,

I think now that I have seen a culture that is so different from my own, I will be more aware of the importance of understanding culture, not just recognizing it. If I want to
help people to make a healthy change in their lives, I have to attempt to understand
where they are coming from.

Several students saw the importance of ‘getting to know’ the client as essential to being able to
discard predetermined cultural categories and definitions, and focus on the true culture embodied
by that individual.

**The Complexity of Culture**

Culture is complex and not easily defined (Reimer Kirkham, et al., 2002; Smye, 2012); it
is not static, but ever changing, "shifting and contextual across the spaces of time and place"
(Reimer Kirkham, et al., p. 225). In keeping with the perspective of Reimer Kirkham, one
student notes this complexity in the following,

*My understanding of culture has changed a lot since completing this trip to [the name of
the country]. Being so immersed in a culture so different than our own has made me
realize how much culture encompasses. It is not only values and morals but language,
beliefs, history, religion and much more. I feel that in order to really understand culture,
one must experience it and have an open mind.*

This student expresses the perspective that culture is complex and multifaceted, resisting
categorization and definition, and can only be understood by interacting with it. As Browne et
al., (2009) note, culture is a "dynamic, power laded process created by people in relation to one
another, their environments, and sociopolitical and historical contexts" (p.173).

As an educator with a commitment to and interest in how to create dialogue within
nursing education around the notions of ‘culture’ and ‘difference,’ it was my hope that the
students participating in the international practicum would begin to recognize the important role
of culture and its intersection with historical, social and political forces in shaping/influencing
healthcare and health. However, although a few students did seem to understand ‘culture’ in this way, in this study many of the students took up the notion of ‘culture’ as isolated from the context, as noted in the following written exemplar,

I believe that cultural views surrounding women and gender roles have shaped the way women are treated in the hospital.

Here the student blames ‘culture’, instead, for example, the dominance of patriarchy as well as gender roles, for the way women were treated within the practicum setting. Another student writes similarly in the following,

If anything (the international practicum) made me appreciate the differences that cultures have between each other, and it also made me more ‘used to’ being surrounded by a different culture than my own all of the time; after a while it was normal and not as eye popping to see so many black people around, or livestock or shacks everywhere.

This student conflates culture with ‘race’ and ‘shacks’. Although culture was seen as complex it also was framed in terms of the ‘other,’ who was often defined by visual cues, language accents, or, as Gregory, Harrowing, Lee, Doolittle & O'Sullivan (2010) note, the ‘exotic’ other.

**Culture as Difference**

The notion of ‘culture’ is often conflated with ‘difference’ so that all difference becomes ‘cultural’ (Browne, et al., 2009; Reimer Kirkham, et al., 2002). Many students in this study grappled with this issue as noted in several of the exemplars in this section. In the following, one student explains their effort to work within another culture with respect for this ‘difference,’

You work so hard to respect their culture and work to please both yours and theirs, that you may make it sometimes awkwardly obvious that they are different from you,
perhaps different from the majority of people around you both, and that this difference requires ‘special treatment’ or something like that.

Here the student associates ‘difference’ as ‘cultural difference’ and recognizes the awkwardness that can arise when we work with people who are different from ourselves; when the ‘other’ requires what might be deemed as different or “special treatment.”

‘Culture’ as ‘difference’ also carried with it potential risk. Following the international practicum several of the participants in this study placed the blame for continued ill health on the ‘culture’ of the people there. As one student noted,

I think that their culture is very relaxed, which makes it hard for anything to be accomplished in the health care system. I think that the stigmatization around HIV/AIDS has caused the disease to increase in numbers because of people not seeking treatment. The relaxed [name of the place] culture is causing people to get sicker and sicker and eventually die rather than getting better.

While this student recognized that the stigmatization of HIV/AIDS in [name of the country] has a significant influence on whether or not people access treatment, the relaxed nature of the [name of the people] was targeted as responsible for things not being accomplished within the health care system to curb the progress of disease and prevent death. When the students were asked about what they had observed in the health system where the practicum was located they were clearly distressed at what they had witnessed, and confused as to why what they deemed as poor health practice seemed to be the norm. A student relays such an experience in the following,

One example is in the delivery room where the nurse roughly pushes down on the woman’s abdomen while she is in labour, telling her that she’s a bad pusher and putting her down. It was difficult to see such a painful, brutal thing taking place, and the first
time I saw it, I thought maybe the nurse was just mean or having a bad day. But hearing similar stories from other students made me realize that it was a cultural issue. But honestly, I have no idea how that kind of thing comes to be common practice. That shows how powerful culture is, I suppose.

Here culture was clearly associated with the practices of the nurses rather than with the educational background and/or experiences and/or other possible contextual features (lack of skilled nursing staff etc.). In the following reflection a student provides a similar perspective,

The [name of the people] culture has affected every aspect of their health care system, I think. How health professionals communicate with foreigners, patients and each other, how they care, how they view their responsibilities, how they carry out their work, are all affected by their culture’s methods of doing these things. Communication is slow and relaxed but soft spoken and with little eye contact or physical touch; caring can be nonexistent, at least in the way we think of caring; work ethic is lacking and the routines and tasks very flexible and made non-taxing.

Several students participating in this study made sense of practices that might be deemed as unsafe or poor practice as stemming from ‘culture’ rather than looking to the contextual features of nursing practice and/or health care in their international practicum locale. This exemplar also points to the potential danger of international or other practicum experiences when students are not adequately prepared to examine their conception of culture and their colonial attitudes toward the country and the people in it. There is also danger in not preparing students for what they might witness and/or not providing the opportunity to debrief in a setting in which these kinds of observations can be discussed and used to further student thinking in this regard.
Culture and Caring

In this study, many of the students discussed culture in relation to caring, as is noted in the following interview exemplar,

I define culture as where someone comes from, what kind of home, family, values and beliefs one lives within. I would consider my own very general culture to be Canadian, Russian, Christian, rural, etc. The patient I am thinking of would be Canadian, First Nations, rural, etc. While these ‘titles’ are very general, the aspects underneath them are way more diverse and lead to others.

Although students often conveyed ‘culture’ as shared traits, values and beliefs of particular group, they also understood culture as associated with health and well-being. The following statements from two students are reflective of their understanding of the importance of getting to know a person and their ‘culture’ to provide effective nursing care,

I have realized how important it is to learn and understand another’s culture. I have realized that there is a huge link between culture and health. If I am aware of a patient’s culture I can better care for them because I am aware of their values, beliefs, actions, behaviours and mannerisms.

and

Each time I live in another culture and interact with those of another culture, I learn so much about that culture, so that if the opportunity of caring for someone of that culture comes about, my nursing care can be embedded in what I have experienced already.

Although an understanding of the complexity of the notion of ‘culture’ is not evident in these examples (i.e., ‘culture’ has been reduced to the individual values, beliefs etc.), the link between
culture and health and the importance of health care that fits with the experience of the patient was important to these students.

‘Culture [and Health]’ as Relational

It is important to recognize that many of the nursing students who took part in the international practicum began to form attitudes reflective of an understanding of the relational aspect of culture as well as health. They began to see that social and economic inequities, not ‘culture,’ had an enormous impact on health care and health. As demonstrated in their narratives, it became evident to the students that the poor health care that some of the people in the international practicum experienced was related to economics, resources, and geography. A student reflects on this in the following,

I do not believe that the [name of the people] receive the same care and the reason is money. Individuals who have enough money can afford pads, soap and cloths which all improve quality of care. In addition, some of the wealthier [name of the people] will actually go all the way to South Africa where health care is a great deal better.

This was echoed by another student,

All [name of the people] do not receive the same care. We spent some time in the military hospital. And the care there was almost the same as in Canada as far as resources and equipment. It was explained to us that this disparity was due to the necessity that the military needs to protect the country and therefore they must be looked after properly. I can understand this, but it still felt wrong that everyone in the country doesn’t receive this type of care.

Another student also expressed a similar view,
If a [name of the people] has sufficient funds, they can pay for their nursing care, treatment and transportation surrounding their health care needs. If they do not, they cannot receive care, unless they have military connections and receive care at the military hospital, or go to a government-funded health clinic. Differences in finances, employment and place of residence/distance from a health care facility all pose differences to the [name of the people]’s abilities to receive health care.

All of the student narratives reported above reflect an understanding of the role that social and economic inequities play in determining the type of health care a [name of the people] receives. One student expressed obvious discomfort with this knowledge and noted how wrong it was that some of the people were deprived of adequate health care because of their social status. Such statements demonstrate a beginning recognition of the role that social and economic factors play in shaping the healthcare received. The international practicum began to demonstrate and reinforce for some nursing students the importance of understanding culture in context; to see culture beyond individual values, beliefs and attitudes to the intersection of culture with historical, social, economic and political realities.

**Summary**

How we understand 'culture' influences our ability to recognize and move beyond essentialist impressions of others and create culturally safe interactions that honour the uniqueness of each individual. The findings from this study emphasize the complexity of the notion of culture as well as the difficulty we have in developing a solid understanding of the role of culture in how we understand and interact with others.

The nursing students who participated in this international practicum were challenged to examine their understanding of culture in this setting in the context of providing nursing care.
The complexity of culture was revealed as they reflected on the omnipresent nature of culture in caring relationships, as well as the dichotomy that exists between the cultural homogeneity of the [name of the people] people and the unique cultural characteristics of each [name of the people] individual. These findings have illuminated the unique opportunities to learn about culture presented by the international practicum as well as the concurrent challenges of facilitating the students' development of culturally safe attitudes.

Nurse educators can develop international practicums for nursing students with an enhanced awareness as to how the students' understanding of culture and cultural safety can be facilitated. With this in mind, in chapter five I present a discussion of the findings and recommendations for the development of future international practicums for nursing students.
CHAPTER FIVE  
Discussion and Recommendations

As the findings of this study and other research has demonstrated, although it may be the desire of nurse educators to enhance students' understanding and appreciation of other ‘cultures,’ by providing educational opportunities within different cultural contexts such as in Africa, there exists the danger that students will maintain, and even have reinforced, culturalist attitudes through educational practicum processes (Gregory, et al., 2010). There is the risk that ill health and health behaviours be attributed to cultural differences rather than to the contextual factors that shape healthcare and health. In addition, by teaching ‘culture,’ we run the risk of reinforcing colonial attitudes of difference and inferiority, whereby the focus on culture serves to reinforce existing stereotypes regarding, for example, various ethnocultural groups in Africa. On the other hand, attachment to ‘culture’ as an acknowledgement of difference can serve to engage with culture in ways that honour the importance of unique shared ways of being within a sociocultural group, and advances the political agenda and/or cause of particular groups by virtue of this attachment.

Culture, Culturalism, Essentialism and Othering

In this study, culturalism was manifested in a number of ways. As one student noted, “If I am aware of a patient’s culture I can better care for them because I am aware of their values, beliefs, actions, behaviours and mannerisms.” Despite caring for many people while participating in the international practicum, this student retained the essentialist attitude that one need only know the characteristics of a group of people to be able to understand the needs of any individual member of that group. In addition, although understandings of culture and how it was taken up were varied, static notions of culture were not eliminated or addressed through student participation in an international practicum. While students gave thought to why certain attitudes
and actions occur (such as pushing forcefully on a labouring mother's abdomen to speed up the delivery process), some erroneously assigned the cause to 'culture,' rather than recognizing the multiple intersecting forces shaping healthcare and health such as poverty, lack of education, historical factors, and so on.

**Troubling Culture: Repositioning Culture as a Living Thing**

As a nurse and educator, I am acutely aware of the reality that some recipients of health care do not always receive culturally appropriate or respectful care. More recent evidence also suggests that students in the health professions may graduate with essentialized notions of the concept of culture, regardless of being exposed to education in this domain. In addition, faculty members often, albeit unwittingly, contribute to such perspectives (Gregory, et al., 2010; Varcoe & McCormick, 2007). Often difference is reified and ‘othering’ occurs; practices that run the risk of marginalizing individuals, groups and communities that do not belong to mainstream or dominant groups or who live beyond the borders of the western world (such as in Africa where people may be portrayed as the ‘exotic other’). Such attention to difference serves to further inequities in the health and health care of these individuals and socioeconomic groups. The findings of this study also point to the risk associated with this kind of essentialism. As educators, we are challenged to integrate the notion of culture into our curricula to facilitate the comprehensive understanding of the dynamism associated with culture and its relational attachments. The danger during this process lies in erroneously creating a static set of cultural characteristics that is then indiscriminately assigned to every member of a socioeconomic group.

**Teaching Culture: Cultural Safety – a Critical Cultural Perspective**

As noted above, the student experience with the international practicum exemplifies the danger that exists when ‘culture,’ is taken up as the shared values, beliefs, attitudes, traditions
and so on, of a group outside of the historical, social, political and economic realities of peoples’ lives. It is not surprising that several nursing students in this study tended to understand ‘culture’ in this way. According to Gregory, et al. (2010), "nursing students are typically taught that understanding the common knowledge shared by a particular ethno-cultural group leads to culturally competent care" (p. 1-2). However, given some of the other perspectives voiced by students, it is my view that the notion of cultural safety holds promise if, as educators, we are able to engage with the complexity of this concept and convey culture as a dynamic living reality. The Aboriginal Nurses Association of Canada (2009) asserts that "[s]tudents require assistance to develop a constructivist understanding of culture" (p. 25). A constructivist understanding resists essentializing. As one student noted: “Even people that live in the same country, raised under the same religion and attended the same school, will have different views on culture... [name of the place] has taught me not to assume anything and to expect everything.

Valuable lessons about cultural safety can be incorporated 'in the moment' during an international practicum. This can be as easy as pointing out that culture is not responsible for a person's poor health, but the inequities they and their ancestors have been subjected to, creating rich discussion about culture. When observing poor health care practices and limited access to health care, discussion can be initiated examining what about the history of a people has led to these conditions. Smye (2004), in her doctoral dissertation, states that "by acknowledging the inequities in health care delivery... , cultural safety draws attention to the issues embedded within the social and political context of health care delivery" (p.81). Opportunities are plentiful during an international practicum to observe health inequities and in turn create rich dialogue with students about the historical, political, economic, and social forces that have led to these conditions. It is my view that such discussions will encourage students to reflect on similar
issues of inequity when caring for all patients, regardless of the context, thereby giving them the ability to provide culturally safe care in their nursing practice.

**Recommendations**

The goal of this research was to determine to what extent nursing students understand the concept of cultural safety, and how well they integrate this concept into their interactions with members of a socioeconomic group other than their own while participating in an international practicum. The findings of my research, as well as those of Gregory, et al. (2010 reveal that nursing students have a very limited, if not erroneous, understanding of cultural safety, and have difficulty applying it to their practice. I have discussed the barriers that nurse educators experience when attempting to understand and integrate cultural safety into their teaching. If these barriers are not overcome, it is unrealistic to expect that nursing students' understanding and integration of cultural safety into their practice will improve.

**Personal reflection: the starting point.** As Varcoe and McCormick (2007) note, "[B]eginning with ourselves is prerequisite to assisting students to begin with themselves" (p.455). If nurse educators are to embark on the process of adopting cultural safety into their teaching, it is imperative that they engage in an ongoing process of reflexivity to help them identify their own privileges and biases. Maintaining a continuous state of self-reflection and recognition of their responses to other people and situations as they go about their daily activities encourages discovery and questioning of their own attitudes and prejudices. Being able to share these reflections with students leads to an equalizing of power between teachers and students, and creates a classroom environment more conducive to the sharing of personal insights and experiences (Varcoe & McCormick).
Networking and dialogue. It has been shown that the concepts of 'culture' and 'cultural safety' are poorly understood by both nurse educators and nursing students (Brown, et al., 2009; Duffy, 2001; Gibbs, 2010; Gregory, et al., 2010; Reimer Kirkham, et al., 2002; Smye, 2004; Wepa, 2010). If nurse educators are to integrate cultural safety into their teaching in a meaningful and appropriate manner, they must be given the opportunity to network and dialogue with other nurse educators (Varcoe & McCormick, 2007; Wepa). This could take place through various means, such as workshops, conferences, and teaching communities. Such opportunities to share and learn from others would be particularly useful for new educators, who may find the concepts of culture and cultural safety difficult to understand, and even more difficult to convey to their students. Teaching and learning cultural safety for faculty as well as students requires self-reflection as well as the support garnered from exchanging ideas and teaching strategies with others.

Shared understanding of language. The literature on cultural safety in nursing contains a set of vocabulary that is not easily grasped by all. Throughout the process of conducting this research and writing about it I continually struggled with the nuances and meanings of terms such as 'culture', 'culturalism', 'othering', 'racism' and 'essentialism', as well as the differences between 'cultural safety', cultural competence' and 'cultural sensitivity'. A meaningful discussion of cultural safety can only take place once all participants share an understanding of the vocabulary being used, allowing them to fully engage in the dialogue. Varcoe and McCormick (2007) state that "[r]eflexively examining the stereotypes, myths, and assumptions that underlie our... language invites new and more diverse ways of seeing the world" (p.456).
**Integrating cultural safety into the classroom.** In a perfect world all nursing students would understand what it is to be culturally safe, and would allow that knowledge to shape and guide their interactions with patients and colleagues as they move through the nursing program, graduate and begin their practice. Gibbs (2010) suggests that this can only be accomplished by integrating cultural safety throughout the entire nursing program. When cultural safety is woven into all aspects of nursing education, it becomes an integral part of every nursing student's practice, and is expressed both consciously and unconsciously in all interactions with patients and colleagues. "Cultural safety does not then become something you 'have to do,' it becomes something you 'want to do' because it becomes a part of you" (Gibbs, p.358).

There are many ways in which cultural safety can be integrated into nursing education. Readings that identify ways in which socioeconomic and political forces create power differentials that lead to significant health inequities could be used as starting points for rich discussion (Mkandawire-Valhmu & Doering, 2012). In a safe, accepting environment students would also be encouraged to reflect on their own cultural biases and assumptions, and to recognize the role these play in creating power imbalances in the health care setting. Experiential learning opportunities, either locally or internationally, have the potential to be powerful methods that can be employed to facilitate an understanding of cultural safety (Mkandawire-Valhmu & Doering; Varcoe & McCormack, 2007).

**Ensuring cultural safety in international practicums.** Gregory, et al. (2010) suggest that nurse educators, for the most part, incorporate essentialist notions of culture into their teaching. Because of this there is great danger that culturalist attitudes of nursing students participating in international practicums will be reinforced rather than diminished. A study by
Gregory, et al. supports the belief that nursing students during past international practicums, for the most part, continue to maintain an essentialist view of culture.

Although there is very little literature that examines effective methods for teaching and maintaining culturally safe attitudes in nursing students participating in international practicums, I contend that with the proper pre-departure education, as well as daily reflection and guided discussions during the practicum, students will come to view health inequities in a critical manner. For example, Mkandawire-Valhmu and Doering (2012) write about a nursing practicum in Malawi for which they provided instructor support. While there the students took part in a variety of experiential learning activities in settings such as a tertiary hospital, a mental hospital, and other health centers, both rural and urban. Students journaled about their experiences and took part in faculty-mediated discussions. Faculty encouraged students to view their experiences through a postcolonial feminist lens during which the students identified the socioeconomic and political forces in Malawi and discussed their influence on health (Mkandawire-Valhmu & Doering). Such guidance is necessary if students are to move away from essentialist notions of culture and approach their experiences with culturally safe attitudes. Throughout these activities students should be "encouraged to continually reflect on their own relationship with the 'other,' their position of privilege in relation to the people they encountered and how these might affect their interactions with patients in practice" (Mkandawire-Valhmu & Doering, p.86).

**Study Limitations**

The international practicum provided by the School of Nursing at Thompson Rivers University was purposively chosen as the subject of this research due to its proximity, as well as its excellent reputation. However, due to limitations of a beginning researcher and graduate
student, as well as time limitations due to the necessity of submitting applications to two ethics committees, only two data collection approaches were employed. As I am a nursing instructor with the Thompson Rivers University School of Nursing potential bias in the research findings is unavoidable. Efforts to uncover this bias included taking field notes and doing reflective journaling throughout the international practicum.

**Implications for Further Research**

As there is very little research aimed at examining how nursing students take up the notion of 'culture', several areas for research were identified. They include determining effective methods for incorporating cultural safety education into nursing programs as well as looking at the most effective ways to ensure that nursing students taking part in international practicums do not retain or develop culturalist attitudes, but begin to incorporate cultural safety into their interactions with others.

**Development of cultural safety knowledge in nurse educators.** To ensure that nurse educators are not teaching essentialized notions of 'culture', but are encouraging students to view culture through a critical lens, they must be able to dialogue and brainstorm with other nurse educators the ways in which to accomplish this. Meaningful tools need to be developed to measure how effective these methods are at building knowledge of cultural safety and developing teaching strategies that can be employed in the classroom and in practicums. It is pointless to expect that nursing students will emerge from their programs with the ability to incorporate cultural safety into their practice if nurse educators are not first given an understanding of the concept, as well as the ability to pass this knowledge on to their students.
Development of culturally safe attitudes in nursing students through international practicum. Nursing students run the risk of having essentialized notions of culture reinforced through international practicums. They need strong education as well as personal support both before and during the practicum aimed at developing culturally safe ways of understanding and interacting with members of another socioeconomic group. To this end, a tool must be developed to measure how well nursing students participating in an international practicum take up the concept of cultural safety, as well as to what extent they are able to incorporate it into their practice both during the practicum and after they return to their home country. We also need to know more about the kind of personal support students as well as faculty need to be able to engage consistently in culturally safe practice.

Summary

The purpose of this study was to explore how the notion of 'culture' is developed in nursing students taking part in an international practicum. Students submitted reflective journaling before, during and after an international practicum, as well as participating in a focus group following the practicum. An attempt has been made to describe their understanding of culture before the practicum, and how this was impacted by their experiences in various health care settings in the foreign country.

In general, people have a tendency to conflate the notion of culture with ethnicity, leading to culturalist views of members of distinct sociocultural groups. The findings of this research support the idea that nursing students, for the most part, retain their essentialist views of culture, even during and after participation in an international practicum. Findings of this research recommend that nurse educators be supported to solidify their own understanding of cultural safety, as well as develop effective strategies for developing a similar understanding in nursing
students. If international practicums are to be recognized as valuable cultural experiences for nursing students, there must be some evidence that students are being encouraged to give up their essentialist views of culture and develop a culturally safe approach to their interactions with others.

This research only scratches at the surface of what is needed to make available a complete picture of the role that international practicums play in the development of cultural safety in nursing students. International practicums have immense potential for exposing nursing students to very real and obvious examples of health inequities that are a result of oppressive historical, social, political and economic forces. Nurse educators must strive to develop teaching strategies that allow for the most effective incorporation of these practicums into nursing education. In this way we can ensure that nursing students are given the most effective opportunities for developing their understanding of cultural safety as well as the ability to incorporate it into their practices.

This study has offered an exploration of how nursing students' understanding of 'culture' is shaped and influenced by participation in an international practicum. It has suggested that these practicums can be problematic in terms of the cultural understanding they instill in students. If not carefully designed with critical and social justice perspectives cultural safety in mind, it appears likely that students will have essentialist notions of culture reinforced as they perceive people they are caring for as exotic and 'other.' This study has proposed potential solutions to this problem. It is hoped that future research will provide strategies that nurse educators can employ to ensure that international practicums are developing future nurses whose practices embody the concepts of cultural safety.
REFERENCES


  
  *Journal of Nursing Education, 47*, 298-304.


  
  *Journal of Cultural Diversity, 16*(2), 40-49.


Appendix A

Email for Initial Contact with Students

Dear Student,

You are receiving this email because you are participating in the TRU NURS 3390 international practicum in Lesotho. NL, one of your instructors, is conducting a research study to examine the effects of international practicums on nursing students’ understanding of ‘culture’. You are invited to participate in this research project.

Please read carefully the attached Letter of Invitation as well as the Informed Consent Form. It is important to know that your participation in this project is completely voluntary and will in no way affect your experience in Lesotho or your mark for NURS 3390. As your correspondence will be only with me, Ms. L will be unaware of who is participating in the research project until after the marks for the course have been submitted to the TRU Registrar. Because of the need for anonymity we ask that you refrain from discussing this project with others in your practicum group, or within the vicinity of your instructors, NL and WM.

If you agree to participate in this research project you will be asked to complete 2 narratives, one as early as possible in your practicum, and one at the end of your practicum, and submit them to the School of Nursing secretary upon your return to Canada. I will send you 2 sets of questions that will guide you in writing these narratives, which should take no more than 30 minutes each to complete. Following the practicum you will be contacted to participate in a 1-2 hour focus group to discuss the effects of the international practicum on your attitudes and beliefs about ‘culture’.

The research process is described in more detail in the attached Letter of Invitation and Informed Consent Form. Please read these and send me an email reply indicating if you are willing to participate in this research project. If you give your consent you will be asked to sign a consent form when you return to Canada.

Thank you for taking the time to read this and for considering this research project. It is hoped that the results of this project will contribute to expanding the knowledge of how students’ understanding of culture changes when they participate in an international practicum. Such knowledge will potentially assist in the development of future cultural education for nursing students.

Sincerely,

CL
Dear Participant,

You are now nearing the completion of your time in Lesotho. By now you will have completed your first narrative for the research project being conducted by NL, exploring the effects of an international practicum on nursing students’ attitudes and beliefs about culture. Please remember to complete the second narrative either before leaving Lesotho or immediately after returning home. I am attaching again the list of questions that should be used to help guide your narrative. Both of your narratives should be submitted to the School of Nursing secretary after you have returned to Canada and they are completed.

I sincerely thank you for the time you have taken to complete the narratives during your busy practicum in Lesotho. You will be contacted after you return to Canada to request your participation in a focus group at a later date. The data collected from your narratives and the focus group will hopefully contribute to building the nursing knowledge of the development of cultural attitudes in nursing students.

I wish you safe travels as you continue your journey.

Sincerely,

CL
Appendix C

Informed Consent Information Letter

To students who are participating in the Thompson Rivers University NURS 3390 International Clinical Practice Experience in Lesotho, Africa:

This letter is to inform you that NL, one of the instructors who will be accompanying you on your trip to Lesotho, will be conducting research to examine students’ beliefs and attitudes regarding ‘culture’ in the context of their participation in an international practicum experience. The research is to form the basis of her thesis as she completes her Master’s degree through the University of British Columbia. As a participant in the NURS 3390 Clinical Practice Experience in Lesotho, you are invited to participate in this research project. Your insights into how students understand culture in the context of an international practicum will be valuable to the research project as well as to the development of future cultural education for nursing students.

If you consent to participate in the research project you will be asked to complete a short narrative about your cultural beliefs and attitudes as early as possible in your Lesotho practicum, as well as a second narrative at the end of your time in Lesotho. Each narrative should take you approximately 30 minutes to complete. Finally, you will be asked to participate in a 1-2 hour focus group to discuss the effect of the international practicum in Lesotho on your cultural beliefs and attitudes. Please see the Informed Consent Form for further information about this project.

Consent to participate in the research project being conducted by Ms. L is completely voluntary, and students taking part in the NURS 3390 Clinical Practice Experience in Lesotho are under no obligation to participate in the research project. As well, participants may withdraw from the research project at any time simply by not completing the next phase of the study and notifying CL by email of their withdrawal. It is important to know that participation or lack of participation will in no way affect students’ learning opportunities while participating in this course. Ms. L will be unaware of who the student participants are throughout the practicum in Lesotho, and participants will remain anonymous to her until the final evaluations for the course are completed, and students’ marks have been submitted to the Thompson Rivers University Registrar.

The Informed Consent Form is also attached to this email. Please read it thoroughly and then send a reply indicating if you would like to participate in this research project or not. I am happy to answer any questions that you may have about the consent process.

Thank you for your consideration of participation in this research project.
Appendix D

THE UNIVERSITY OF BRITISH COLUMBIA

Informed Consent Form
[An Examination of Nursing Students' Understanding of 'Culture' in the Context of an International Practicum Experience]

Note: The University and those conducting this project subscribe to the ethical conduct of research and to the protection at all times of the interests, comfort, and safety of subjects. This form and the information it contains is given to you for your own protection and full understanding of the procedures, risks and benefits involved in this research project. This consent form, a copy of which has been given to you, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more details, feel free to ask at any time. Please take the time to read this carefully and to understand any accompanying information.

I have been asked by VS of the School of Nursing of The University of British Columbia, telephone number xxx-xxx-xxxx, to participate in a research project entitled: An Examination of Nursing Students' Understanding of 'Culture' in the Context of an International Practicum Experience which encompasses the following:

Principal Investigator: VS, PhD, PhD, MHSc, BA, RN, Assistant Professor with the School of Nursing at the University of British Columbia, telephone number xxx-xxx-xxxx

Co-Investigators: PR, PhD, RN, Associate Professor with the School of Nursing of the University of British Columbia, telephone number xxx-xxx-xxxx
   MSM, MSN, BSN, RN, Associate Professor with the School of Nursing of Thompson Rivers University, telephone number xxx-xxx-xxxx
   NL, BScN, RN, Lecturer with the School of Nursing of Thompson Rivers University, telephone number xxx-xxx-xxxx

Purpose: The purpose of this research is to look at how students’ understanding of culture changes as a result of participating in an international practicum. You are being invited to take part in this
research project because you are enrolled in NURS 3390 at Thompson Rivers University and will be travelling to Lesotho, Africa for an international practicum. This research project forms the basis of the Master’s Thesis to be completed by NL.

**Study Procedures:** If you consent to participate in this research project you will be asked to complete 2 narratives. Two sets of questions will be emailed to you that will guide you in the writing of your narratives. The first is to be completed as early in your Lesotho practicum as possible, and the second is to be completed at the end of your time in Lesotho. Each of these narratives should take approximately 30 minutes to complete. Following your return from Lesotho, a 1-2 hour focus group will be held with all research participants to discuss the influence of the international practicum on their perspectives of culture.

For each narrative you will be provided with a set of questions to assist you in framing your response. Upon returning to Canada you will submit your two narratives to the secretary in the School of Nursing office at Thompson Rivers University. She will provide you with an envelope into which you will place your narratives, which you will seal and then place your signature across the envelope’s seal.

Approximately 3 weeks after returning from Lesotho you will be invited to participate in a focus group that will take place at Thompson Rivers University. The focus group discussion will be audio-taped for later transcription.

**Potential Risks:** There is a minimal level of risk to you if you consent to participate in this research project. It is possible that you will experience emotional distress due to the self-reflective nature of the narratives, or because of the impoverished conditions that you will be witnessing. It is not expected, however, that you will experience any more distress than you would if you were not participating in the research project. While in Lesotho, if needed, counselling will be provided by WM or NL as there will be no other available options. If you continue to, or begin to, experience emotional distress when back in Canada you will be referred to the counselling department at Thompson Rivers University for assistance.

**Potential Benefits:** It is anticipated that your participation in this research project will expand the knowledge of how students’ understanding of culture changes when they participate in an international practicum. Such knowledge will potentially assist in the development of future cultural education for nursing students.

**Confidentiality:** Every effort will be made to maintain your confidentiality throughout and following the research project. Prior to the completion of NURS 3390, narratives will be stored securely and confidentially in the School of Nursing office at Thompson Rivers University. The narratives and the focus group audio-tapes will be transcribed and all names will be changed to protect your confidentiality. Original data sources will be stored in a locked filing cabinet in the office of Dr. VS at the University of British Columbia. Computerized transcripts will be kept on a password protected flash drive as well as on the password protected computer of NL until data collection and analysis is complete, at which time it will be erased in a confidential manner. All original data will be kept for 5 years and subsequently destroyed in a confidential manner. Subjects will not be identified by name in any reports of the completed study.
For the purposes of confidentiality, as well as data integrity, students are encouraged to refrain from discussing the study with each other, or from discussing it in the presence of NL or WM. We encourage all participants in the focus group to refrain from disclosing the contents of the discussion outside of the focus group; however, we cannot control what other participants do with the information discussed. For this reason only limited confidentiality can be offered for comments made during the focus group.

**Remuneration/Compensation:** Light refreshments will be provided during the focus group. There will be no other remuneration or compensation offered for participation in this research project.

**Contact for information about the study:** If you have any questions or desire further information with respect to this study, you may contact VS or one of her associates at the telephone numbers listed above.

**Contact for concerns about the rights of research subjects:** If you have any concerns about your treatment or rights as a research subject, you may contact the Research Subject Information Line in the UBC Office of the Research Services at xxx-xxx-xxxx or if long distance e-mail RSIL@ors.ubc.ca.

**Consent:** Your participation in this study is entirely voluntary and you may refuse to participate or withdraw from the study at any time without jeopardy to your standing in NURS 3390.

Copies of the results of this study, upon its completion, may be obtained by contacting NL at xxxxx@xxx.ca.

My signature on this form indicates that I understand the information regarding this research project, including all procedures and the personal risks involved, and that I voluntarily agree to participate in this project as a subject.

I understand that my identity and any identifying information obtained will be kept confidential.

I understand that I may refuse to participate or withdraw my participation in this project at any time without consequence simply by not completing the next phase of the study. My involvement or non-involvement in this project is in no way related to my status as a student in the School of Nursing at Thompson Rivers University.

I understand that the results of this research project may be presented in various venues, or published in manuscripts, but that my identity will at all times remain confidential.

I understand that I may ask any questions or register any complaint I might have about the project with either the Principal Investigator named above or with MSM of the School of Nursing of Thompson Rivers University, telephone number, xxx-xxx-xxxx. If I have any questions or issues concerning this project that are not related to the specifics of the research, I may also contact the Research Subject Information Line in the UBC Office of Research.
Services at xxx-xxx-xxxx or if long distance e-mail to RSIL@ors.ubc.ca.

I have received a copy of this consent form and a Subject Feedback form.

Name: (Please Print) __________________________________________________________________________

Address: ______________________________________________________________________________________

______________________________________________________________________________________________

Participant’s signature __________________________________________________________________________ Date ______________________

Investigator and/or Delegate’s signature __________________________________________________________________________ Date ______________________

I agree to have audio data collected during the focus group which will be transcribed and used only for the purposes of this research project and will be destroyed by VS in August, 2016 in a confidential manner.

Signature __________________________________________________________________________ Date ______________________
Appendix E
Nursing Students’ Understanding of ‘Culture’ Research Project
Narrative Reflection Questions

First Narrative (To be completed as early as possible during your practicum in Lesotho)
• Think of a time when you cared for a patient whose cultural background was different than your own:
  i. How do you define the concept of 'culture' - what does it mean to you in terms of who you are, and how would you define it in terms of the particular person or persons you are thinking of?
  ii. What was it like to care for a person from a culture different than your own?
  iii. What did you see as 'cultural' aspects of the care this individual received?
  iv. How do you think 'culture' affected the care the patient received, or did it?
  v. How do you think the person experienced their care?

Second Narrative (To be completed at the end of your practicum in Lesotho)
Now that you have completed your international practicum in Lesotho, please share some of your thoughts and feelings on your experience caring for the people of Lesotho. Feel free to provide specific examples if it helps to illustrate your thoughts.
• How would you now define the concept of ‘culture’?
• Has your experience in Lesotho influenced your perceptions of ‘culture’? If so, in what ways?
  • What has your experience in Lesotho taught you about your own beliefs and values?
  • In what ways have you witnessed ‘culture’ affecting the health care of the Basotho people?
  • In your experience, do all Basotho people receive the same health care? If not, please share what you believe are the reasons for the disparity.
• What factors about ‘culture’ do you feel shape the health care of the people of Lesotho?
• How do you feel that your understanding of ‘culture’ will shape the care you provide for individuals in the future?