Nursing in media saturated societies: Implications for cultural safety in nursing practice in Aotearoa New Zealand

Abstract

This educational piece seeks to apprise nurses and other health professionals of mass media news practices that distort social and health policy development. It focuses on two media discourses evident in White settler societies, primarily Australia, Canada, New Zealand, and the USA, drawing out implications of these media practices for those committed to social justice and health equity. The first discourse masks the dominant culture, ensuring it is not readily recognised as a culture, naturalising the dominant values, practices, and institutions and rendering their cultural foundations invisible. The second discourse represents indigenous peoples and minority ethnic groups as 'raced' – portrayed in ways that marginalise their culture and disparage them as peoples. Grounded in media research from different societies, the article focuses on the implications for New Zealand nurses and their ability to practise in a culturally safe manner as an exemplary case. It is imperative that these findings are elaborated for New Zealand and that nurses and other health professionals extend the work in relation to practice in their own society.

Keywords:

Cultural safety, racism, media, New Zealand, nurses

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It has been argued that, in modern societies, everyday living is media saturated (Chamberlain and Hodgetts, 2008; Silverstone, 2007) with people sharing experiences shaped by media-constructed representations of "relationships, health, illness, and death" (Chamberlain and Hodgetts, 2008: 1110) that are variously utilised throughout everyday life.

Health professionals; their training, workplace ethics, policies, and programmes, are not insulated from this media saturation with important implications for intercultural relations in their praxis (Black and Huygens, 2007; Puzan, 2003). In outlining those implications for intercultural relations in nursing praxis the article seeks to inform nurses in Aotearoa New Zealand and elsewhere and assist their culturally safe practice. Grounded in substantial research analyses of media constructions of relations between settler and indigenous peoples in Aotearoa New Zealand (Hodgetts et al, 2004; Moewaka Barnes et al, 2005; Nairn et al, 2012; Rankine and McCreanor, 2004) and elsewhere (Alia and Bull, 2005; Budarick and King, 2008; Harding, 2006; Poindexter et al, 2003), the article seeks to assist nurses to appreciate and address those impacts. After a brief discussion of 'culture' as conceptualised in relation to cultural -competence, -awareness, -sensitivity, and -safety we present the local definition of cultural safety (Nursing Council of New Zealand (NCNZ), 2011). Following an account of relevant features of media practice we describe two discourses that make, and have made, development and practice of cultural safety problematic (Ramsden, 2002). We identify implications of these research findings and outline two responses for nurses and the profession to enhance development and efficacy of culturally safe practice in media saturated societies.

'Culture' - definitions and consequences

'Culture' and how the concept is understood is central to any discussion of appropriate and effective health care in modern, pluralistic societies. Analyses of those discussions identify two very different understandings of 'culture' (Williamson and Harrison, 2010): a dominant approach focusing on the values, beliefs and traditions of target groups, treating them as fixed characteristics of the group (Williamson and Harrison, 2010). The second understands culture as a socio-political construction used to mark groups as 'other' than the dominant group and its hegemonic practices (Gray and Thomas, 2006). The former encourages an emphasis on practitioner knowledge of and skills for engaging with the 'others' (Loftin et al, 2013; Kumas-Tan et al, 2007) or their attitudes towards the particular group (Truong et al,

2014). Those emphases contrast with the latter understanding that, as instanced by Oda and Rameka (2012), encourages practitioners to reflect critically on both the systems in which they practise and their own culture, attitudes, and practices (Stockhausen and Serizawa, 2008).

Cultural safety - a nursing policy and practice

Cultural safety guidelines were first approved for New Zealand nurses in 1992 (NCNZ, 2011; Ramsden, 2000; Ramsden, 2002). Unlike cultural competence that emphasises "awareness, knowledge and skill" of the practitioner (New Zealand Psychologists Board, 2006: 5) cultural safety foregrounds the experiences of service recipients:

> "the nurse [is required] to practise in a manner that the <u>health consumer</u> determines as being culturally safe" (NCNZ, 2011: 4, emphasis added),

and categorises actions, practices, or services as unsafe if:

> "[it] diminishes, demeans or disempowers the cultural identity and wellbeing of an individual" (NCNZ, 2011: 7).

The NCNZ specifies that each nurse providing a culturally safe service:

> "will have undertaken a process of reflection on his or her own cultural identity and will recognise the impact his or her personal culture has on his or her professional practice" (2011: 7; see also Browne et al., 2009; DeSouza, 2008).

While that allows a practice or service to be categorised as culturally unsafe, the focus remains on the individual practitioner who is presumed capable of knowing and reflecting on their own cultural identity. There is evidence that this may be particularly difficult for members of the dominant group (Abrums et al, 2010; Puzan, 2003) who live in a world shaped by the values, beliefs, and practices of their own culture (Black and Huygens, 2007; McHoul and Rapley, 2001). Members of the dominant group have been shown to be affected by the colonising representations of indigenous and minority groups provided by media and the society (Browne, 2005; DeSouza, 2013; McCreanor and Nairn, 2002) and, if

mono-cultural and monolingual like the majority of Pākehā New Zealanders (Māori word for New Zealander of European descent), poorly equipped to identify the cultural character of their world (Bellett, 1995). A recent workforce report found 85% of New Zealand nurses identified as dominant group members (NCNZ, 2012) so it may be unwise to assume that all nurses will easily and effectively be able to undertake the self-reflection required for culturally safe practice (Southwick, 2001; Stockhausen and Serizawa, 2008). Recent immigrants who are overseas qualified (24% of the nursing workforce in New Zealand, NCNZ, 2012) and just beginning to adapt to the cultures of the new society are particularly vulnerable to media representations of indigenous and minority groups (Gregory et al., 2011).

Relevant features of media practice

Mass media, the storytellers and consequently, primary portrayers of the social worlds of modern societies, are simultaneously products and reproducers of the dominant culture (Fiske 2000; Silverstone, 2007), routinely utilising and re-presenting the social, political, and economic worlds imagined and sustained by the dominant group (Billig, 1995; Gabriel, 2000; Phelan and Shearer, 2009). In that cultural-discursive context, news is defined as challenges to or alterations of the status quo, as Fiske (2010: 139) explains:

> The state of equilibrium is not itself newsworthy, and is never described except implicitly in its opposition to the state of disequilibrium, which, typically, is described in detail.

Within the taken-for-granted authority of 'news' it is difficult to recognise that experiences of our own and other people's actions are located within "culture, discourse and history" (Monk et al., 2008, p.xix).

Further, these "socially and historically mediated processes" (Gray and Thomas, 2006: 78) both incorporate and shape derogatory representations of minorities (Cottle, 2000; Nick, 2004; Poindexter et al., 2003; Silverstone, 2007) and portray indigenous peoples as ongoing threats to and burdens on the established social order (Daniels, 2006; Furniss, 2001; Nairn et al, 2009; Simmons and Lecouteur, 2008; Thompson, 1954). Preconceptions of

indigenous people as primitive and violent are threaded through news stories (Nairn et al, 2012; Fiske, 2000) with items presenting both actual (Budarick and King, 2008; Harding, 2006) and latent (Daniels, 2006; Simmons and Lecouteur, 2008) violence for readers' interpretative work Surveillance of indigenous peoples, their organisations and practices, underpin such constructions - "keeping aboriginal people 'in their place'" (Harding, 2006: 231). Other negative characteristics - laziness, improvidence, dishonesty, and grasping opportunism - are commonly employed in fleshing out the representations (Furniss, 2001; Thompson, 1954). Finally, as primary portrayers of our social worlds media are primary sources of 'knowledge' about anyone not personally known. Hartley (1996: 207) says, in large, modern, complex societies:

> The only *real* (sic), contact with others is, paradoxically, *symbolic* (sic), and rendered in the form of stories, both factual and fictional, in the electronic and print media.

Discourse 1: Naturalising the dominant culture

Within routines of everyday life (Billig, 1995; Chamberlain and Hodgetts, 2008), Pākehā New Zealanders live in and engage with situations structured by the dominant culture in familiar ways. Fleras and Spoonley (1999: 81) put it:

> "majority groups conduct their public and private lives according to [what are taken to be] universally held and superior systems and values. Others are guided by culture; they are not."

Because the dominant group's ways are naturalised - their origins and justifications within the culture and interests of the group masked - that privilege becomes invisible. Such 'taken-for-granted' representations of the dominant culture, practices, and institutions require discursive resources and practices that enable people to experience the status quo as natural. Identifying changes or challenges to the status quo as 'news', simultaneously affirms and re-presents it (Ericson et al., 1987; Kress and Van Leeuwen, 1998) while concurrently legitimating the media focus on what is shown as deviant, marginal, or novel (Fiske, 2000; Gabriel, 2000; Nairn et al, 2012). The historically mediated character (Gray and Thomas, 2006) of this masking and naturalising is shown by its absence from New

Zealand's early colonial newspapers, when social and political priorities demanded that the 'civilized Britishness' of settler values and practices be routinely foregrounded (Colvin, 2010).

Discursive resources for constructing the dominant group as an aggregation rather than an ethnic group include: 'most of us', 'the public', 'New Zealanders', 'the nation', 'taxpayers', 'Kiwis', and 'us', 'we' or 'our' (Barclay and Liu, 2003; Nairn et al., 2011). The cultural trope of autonomous individuality with its presumption of personal responsiblity for achievements and failures underly all these. Choosing not to mark the dominant as a group is a 'production practice' (Fairclough, 1992) facilitating identification of the nation with the dominant culture and encouraging strong resistance to naming spokespersons, systems, or organisations as Pākehā:

> "we don't write about 'Pākehā leaders', 'Pākehā activists' or 'Pākehā MPs'. But 'Māori leaders', 'Māori activists' and 'Māori MPs' are part of the everyday news language" (Archie, 2007: 90).

Phelan and Shearer's (2009) study of the Pākehā-initiated conflict over ownership of the foreshore and seabed of Aotearoa New Zealand (2003-4) offers examples of both the practice and the discourse. Journalists (not sources) overwhelmingly employed the phrase "Māori issue" while "Pākehā issue" was not used independently. Articles referred to 'Māori' 44 times while 'Pākehā' were always subsumed in a larger national category. The epithets 'radical' and 'activist' were used extensively of Māori, obscuring the Pākehā political energy driving the conflict.

Studies of prospective, representative national samples of print and broadcast media reports on Māori/Pākehā relations (Moewaka Barnes et al., 2005; Rankine et al., 2008) identified no themes about Pākehā as a group but many negative themes about Māori (Moewaka Barnes et al, 2012). Media opposition to the development and implementation of cultural safety in nursing revealed other elements of the discourse: ridiculing change, labelling practices as 'politically correct', and naming cultural safety as a 'Maori takeover' that violated naturalised

common sense about Nightingale nursing and delivery of health services (Ramsden, 2002). Such publicity led to a major review of nursing education (2000-2001) throughout which the Nursing Council of New Zealand remained committed to culturally safe nursing practice.

Discourse 2: Derogating the indigenous and minorities

Mass media project and sustain relatively homogeneous imaginings of their society (Belich, 2001) inviting users to construct a sense of who "we" are through contrasting portrayals of 'others' (Cottle, 2000). Minority and indigenous peoples are constructed as "not us" (Banerjee and Osuri, 2000; Barclay and Liu, 2003), framed as failing to 'fit in' and allegedly threatening the security or way of life of the majority (Mindell, 1992 cited in Gray and Thomas, 2006: 78). A preference for White sources reinforces this mix of discursive resources and practices (McGregor and Comrie, 1995; Moewaka Barnes et al., 2005; Rankine et al., 2008)l, and is common in crime reporting where police over-label Māori and people from minority ethnic groups while ignoring or under-labelling Pākehā ethnicity. Similar processes occur in coverage of business (McCreanor et al, 2011) and sport (McCreanor et al, 2010). The portrayals may reassure audiences that the 'others' are being monitored (Fiske, 2000; Harding, 2006) but do not inform readers about minority cultures because reported actions are rarely placed in context. 'Explanations' highlight departures from dominant norms, and rely on presumed personal characteristics such as 'race'. Many 'Māori health' stories are framed within individualised deficit models (Robson and Reid, 2001) that do not acknowledge how health systems and practitioners influence outcomes (Hodgetts et al, 2004). Analysis of 44 newspaper items about 'Māori health' (Rankine, et al, 2008), showed that a crisis in Māori 'health was constructed by emphasising Māori over-representation in national disease statistics 'explained' by allegedly irresponsible individual lifestyles.

Reporting a literature review undertaken for *Lancet Oncology,* Wylie (2008) began: “Maori and Pacific Islanders are more likely to die from cancer than Europeans...”. The claim was fleshed out by contrasting mortality rates of Maori and Pacific men and women to their Pākehā counterparts. Lifestyle factors - “Maori and Pacific diet, smoking and diabetes” - dominated explanations of the findings, a reading the *Otago Daily Times* prioritised in the headline: “Lifestyle raises cancer death rate for Maori”. Two findings hinting at systemic problems for Maori and Pacific patients - higher European survival and Māori mortality rates despite equal levels of morbidity – remained unexplained.

Analysing media coverage of the 2003 report *Decade of Disparity,* Hodgetts et al. (2004) criticised widespread media blaming of individual Māori for their health status. Authors noted that, like the report, initial coverage included structural and systemic accounts of health disparities, but later commentaries ignored those explanations, favouring lifestyle and alleged inefficacy of Māori health services. Authors noted a disturbing pattern consistent with media practices discussed earlier: where a Māori offered a structural explanation there was always another speaker presenting a lifestyle-focussed account but no such 'balance' when non-Māori sources blamed health disparities on an alleged Māori refusal to take personal responsibility. Contradictory evidence that Māori exercised more than Pākehā and ate less fast food was ignored, as were more holistic and culturally-grounded Māori models of health (Hodgetts et al, 2004). These mass media practices and discourses structure the ubiquitous constructions of Māori, Māori/Pākehā relations, and health disparities in Aotearoa New Zealand (Moewaka Barnes et al, 2012).

However, some health research reports increasingly place Māori health data within historical, social, and political context that include colonisation and marginalisation (Robson and Harris, 2007). Trends are identified by comparing current and historical Māori data and reports emphasise the role of contextual variables like location, socio-economic status, and

policy (Becares et al, 2013). In these ways reports enable practitioners to understand and "evaluate the impact that historical, political and social processes have on the health of all people" (NCNZ, 2011: 10). Regrettably most news media stories prefer comparing indigenous health outcomes to those of the privileged, dominant group.

Consequences for cultural safety

Clearly the media saturation shaped by these practices and discourses will affect health practitioners' practice (DeSouza, 2013; McCreanor and Nairn, 2002) with implications for the pursuit of cultural safety in nursing (NCNZ, 2011; Ramsden, 2002) as understanding of and reflection on one's own culture, history, attitudes and life experience is central to cultural safety (Browne, 2005; Browne, et al., 2009; NCNZ, 2011). Ng (1995) sees such understanding and reflections as opportunities to challenge the status quo and make institutions more inclusive. Yet that has to occur within a media-saturated society (Silverstone, 2007) and a context of institutional scarcity where pressures to be efficient prioritise physical care over emotional care and intellectual work (Varcoe and Rodney, 2001). If nurses are to be culturally safe practitioners, and keep themselves safe, in these demanding situations the individualised reflective practice that presumes that techno-rational deliberation can adequately address the messy, unpredictable nature of nursing and midwifery practice (Greenwood, 1998) must be supplemented by more collective responses counteracting the corrosive effects of mass media production practices to which this article draws attention.

Persistent mismatches between the clientele and the nursing workforce: relatively small numbers of indigenous Māori (7%) and Pacific (4%) among the 48,563 nurses practising as of 31 March 2011 (NCNZ, 2012) with most identifying as either NZ European (68%) or other European (17%), makes the ability to practise in a culturally safe manner essential. However, achieving and maintaining culturally safe practice requires continuing professional

development and hopefully includes some co-operative interactions with people of comparable status living differently. In culturally just societies, some of those needs would be met through the mass media (Silverstone, 2007) but the cited research shows New Zealand is not such a society (Moewaka Barnes et al, 2012; Ramsden, 2002). So nurses must be able to recognise when efforts to become culturally safe are being undermined and marshall effective counters.

Responses

The authors are not presuming nurses, or other health professionals, would intentionally look to media for knowledge of their own or other peoples' cultures but have sought to explain how, in media-saturated societies, most of what we 'know' and how we think about people and practices in that society originates in the media (Hartley, 1996). As outlined, most 'knowledge' of non-culture-defining peoples (Black and Huygens, 2007) disparages and marginalises them through representations that prioritise unattractive anti-social characteristics in individuals understood as representative of their group (Nairn et al, 2012). For members of the dominant group, ongoing naturalisation and masking of the dominant culture is a further obstacle obscuring the culture they bear (Abrums et al, 2010) and concealing the cultural character of values, beliefs, and practices represented as 'how things are' or 'how it is done'. Nurses who are Māori, or who identify as a member of another non-culture-defining group, may more readily 'see' the dominant culture but still have to contend with its apparent naturalness and ubiquity. Together, the routine masking of the dominant culture and negative portrayals of Māori make it difficult for health practitioners to ensure their work with clients, whom media repeatedly represent as violent, sick, poor, non-compliant and primitive, is culturally safe (McCreanor and Nairn, 2002; DeSouza, 2008).

Two complementary responses - denying the dominant culture its ‘taken-for-granted’ character, and critically assessing mass media products - can assist in creating firmer foundations for culturally safe practice. The first undermines the normative elision of the Pākehā ethnic group with ‘New Zealanders’ and involves:

- Identifying dominant Pākehā culture as one culture among many in Aotearoa New Zealand.
- Acknowledging Pākehā ethnicity as one among many, not an unmarked norm of presumed universality.
- Identifying Pākehā culture as a regional variant of Western culture with polyglot origins, elements, and traditions.
- Being even-handed, identifying 'Pākehā spokesperson', 'Pākehā MPs', and 'Pākehā priorities' wherever 'Māori spokesperson', 'Māori MPs', and 'Māori priorities' are currently used.

Actions of this kind are most effective as part of a speech community: "[a] group of people who share at least one valued way of speaking and interpretive resources within which that way of speaking is located" (Fitch, 2001: 57), that is committed to more culturally just ways of representing events, situations and people. Motivated groups and individuals might implement this strategy in publications, workshops, conferences and other professional meetings and, in time, change the talk and ways of thinking of others.

Ongoing critical assessment of mass media, an everyday prophylactic, is the second action. Critical assessment, done by both individuals and groups, builds on questions like:

- From whose point of view is this story told?
- Who is present? How are they named and/or described?
- Who, of those present, is allowed to give their interpretation of the matter?
- Who is absent?
- Whose interests are served by telling the story this way?

These questions and others coming from experience in making the assessments, disrupt the apparent factuality of news and may encourage utilisation of indigenous and minority community media to access stories and cultural perspectives absent from mass media. Accessing media that tell the stories differently (Nairn et al., 2012), assists recognition of mass media framings underscoring impacts identified in the critical assessment.

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