ALL AFLUTTER

(OR)

A TALE OF TWO WORLDS: THE CULTURAL SAFETY COMPONENT IN NEW ZEALAND NURSING AND MIDWIFERY EDUCATION

A THESIS SUBMITTED TO THE GRADUATE DIVISION OF THE UNIVERSITY OF HAWAI'I IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF

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BY

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Tania Rei, endlessly patient, refused to give up on a lost soul wandering in the murky swamps of bicultural politics. She pulled me back onto a path that led to a viable topic, teaching in the process a valuable lesson about boundaries and responsibility. The Women’s Studies Department graciously took me in and afforded me a wonderful opportunity to learn heaps.

Back on the home front, a dedicated and equally patient committee saw me through months of struggle and waited calmly for me to find my direction, then waited even longer for the new direction to take me somewhere.

And on an even more ‘home’ front, thanks to my family, who never stopped believing it’d all come together...someday.

Thanks to all, I only hope I’ve lived up to my end of the bargain.
A NOTE ON DIACRITICAL MARKS

I would like to apologize for the lack of proper diacritical marks in this paper - unfortunately the high-tech world of computers has left me, ironically enough, incapable of properly spelling many words and phrases in the text. For proper Maori spelling and pronunciation, I refer the reader to P.M. Ryan's 1994 Dictionary of Modern Maori, published by Heinemann Education in Auckland, or to any Maori dictionary.
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### CAST LIST*

*(in order of appearance)*

<table>
<thead>
<tr>
<th>Character</th>
<th>Description</th>
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<tbody>
<tr>
<td>MARGARET</td>
<td>A Maori woman in her mid-thirties, a nurse</td>
</tr>
<tr>
<td>GALLERY VOICE</td>
<td>A forty-something Pakeha man, a nurse educator, very knowledgeable and rather cynical, observing and delivering a running commentary on the proceedings from the gallery</td>
</tr>
<tr>
<td>ANNA PENN</td>
<td>A 25-year old Pakeha woman, an ex-nursing student, flamboyant and self-confident</td>
</tr>
<tr>
<td>ACE REPORTER</td>
<td>A male, approximately 34 year-old rumpled newspaper reporter, an 'old hand'</td>
</tr>
<tr>
<td>ALAN DONNOLLY</td>
<td>Father of the Average Conservative Family; in his fifties, an employee of Telecom New Zealand and a staunch Labour Party member</td>
</tr>
<tr>
<td>ANNE DONNOLLY</td>
<td>Mother of the Average Conservative Family; a part-time elementary teacher and active volunteer in the Protestant Church</td>
</tr>
<tr>
<td>DOUGLAS ENDICOTT</td>
<td>Assistant Director of the Christchurch Polytechnic; in his early sixties; professional but generally harried</td>
</tr>
<tr>
<td>WILLIE</td>
<td>A Nursing tutor, part-Maori in his mid-twenties; soft-spoken but very compelling</td>
</tr>
<tr>
<td>JULIA</td>
<td>A Nursing tutor, 22-year old Pakeha; she's bright and articulate, very passionate about issues of racism and discrimination</td>
</tr>
<tr>
<td>KAUMATUA</td>
<td>A Maori elder in his sixties, a wise and calming presence; he is generally deferred to by most people with whom he comes in contact because he is such an impressive figure</td>
</tr>
</tbody>
</table>
PROFESSOR GREELEY  
A widely respected woman, a Nursing and Women's Studies professor; brunette, slightly tall and a rather commanding presence - a result of years spent behind a university lectern; the students adore her

THE STUDENTS:  
All members of Professor Greeley's Culture and Society classes

LORA  
Half Maori, half Irish 20-year old, active in Iwi affairs and outspoken in class and social situations

DAVID  
Pakeha man, mid-twenties, a severe asthmatic who's often puffing on an inhaler, he has a blond ponytail and is slightly effeminate

AMY  
Pakeha woman, 32 years old, worked for a decade as a bank teller, decided last year to go to nursing school; she's adapted very well to Polytech, the other students don't seem to notice the age difference; she has an eight-year old son at home

ROSE  
Samoan woman, 21 years old with a quiet voice; she is a poet and is well-respected by the other students who usually fall silent when she speaks

JOE  
A second generation Chinese man, 23, enjoys music and parties but is at the same time a serious student; he is often tapping out rhythms on tables, chairs, desks, etc. with imaginary drumsticks

MALAMA  
A Samoan man, 22, tall and muscular, loud-voiced and boisterous, often cracking good-natured jokes; also extremely bright and often consulted by the others on questions pertaining to class

BRONWYN  
Daughter of the Average Conservative Family, a rebellious offspring - a Communist cardholder, with a punk haircut and
outrageous clothes, but rather soft-spoken in class and when studying

VOICE II
Another observer in the gallery, a late-twenties gay man (he should not be played as overly flamboyant), half Pakeha, half Chinese; passionate and occasionally very theatrical; a government employee in the Ministry of Maori Affairs

VOICE III
The third gallery observer, a Maori woman in her mid-thirties, attractive with long hair, forceful and occasionally defensive, used to being judged on her appearance and not her talent and intelligence, both of which are considerable; she's an anti-racism activist and consultant

HINA WRIGHT
A part-Maori businesswoman, mid-thirties

MIKE BLANCHARD
A Pakeha professor of economics, early fifties

NURSES
Five nurses, four women and one man, of varied ages and ethnicities, they wear scrubs, hairnets and surgical masks and spend much of their time onstage running in circles

PATIENT
A Polynesian woman in her mid-thirties, very pregnant

CHILD
A boy of nine or ten years, at least part Polynesian

DEMONS
Four outlandishly dressed men and women wearing colored facepaint and devil horns in their wild hair

TEENAGE BOY
A sixteen-year old boy, part Polynesian

MAN
An attractive, muscular Polynesian man in his mid-twenties, well-dressed and confident
* Please note: All characters in this play are entirely fictional, with the exception of three. Anna Penn is in fact a 25-year old nurse who failed out of Christchurch Polytechnic. All lines ascribed to her character come directly from statements written by Penn herself and published in the New Zealand press. Another exception is John Hercus, the Director of Christchurch Polytechnic. He does not appear in the play, but his name is mentioned. He is in reality the Director, but for logistical reasons I have chosen to portray the Polytech's side of the story through a fictional Assistant Director, Douglas Endicott. It is important to note that the character of Douglas Endicott does not represent the Polytech in any official capacity. Neither do any of the other fictional characters in the play.

The third individual whose character is not a fictitious representation is Irihapeti Ramsden. She also does not appear directly in the play, but is often mentioned. She is in fact the architect of cultural safety, and was the Maori Representative to the Nursing Council. She is a freelance educationalist and consultant. I had the opportunity to meet Ms. Ramsden and (as is apparent in the manuscript) I have a huge amount of respect and admiration for her and for her work.
SETTING

Well above the stage (approx. 10 feet), set against the back wall, is a suspended gallery. It has the appearance of the observation gallery of a surgical theatre, with windows (represented by slender dividers) and seats in tiers. A concurrent narrative occurs on this level with observers (the Gallery Voices) commenting on events onstage but not interacting until the last scene. For the last scene, the gallery should lower hydraulically to just above stage level, such that the gallery viewers can step down and join those on the stage.

Projected onto the scrim below the gallery is the figure of a large white bird, reminiscent of an egret, which progressively rises higher across the scrim until the last scene. It should be noticeable, but not distract attention from action onstage.

Onstage, there are two central sets - the Donnelly home and Katz cafe. The Donnelly home, set stage left, should be a table and three chairs with a bench with sink to the side. Katz cafe, set stage right, consists of two low, well-used sofas and a few chairs configured around a central coffee table strewn with mugs, wineglasses and ashtrays. A funky, modern chandelier is suspended low over the table.

Moveable sets include:
Ace Reporter’s desk - a large, functional metal desk with laptop computer and telephone, stacked with papers.

Douglas Endicott’s office - a large wooden desk with telephone and a large ‘inbox’; as well as a carafe of tea with sugar and creamer for use during the meeting in Act I. A group of four chairs sits on the other side of the desk, during the meeting Douglas pulls his desk chair around to join the others.

Marae Meeting House - several mats placed on the floor, two carvings stand upstage of the people on the floor.

Surgical set - during the last scene, an operating table with IV’s and assorted contraptions should be wheeled onto stage right, accompanied by a rolling tray set with surgical instruments (scalpel, clamps, etc.).
The scenes portrayed in this play cut right to the heart of the reasoning behind the cultural safety program. Anna Penn's performance at the Christchurch Polytech and her subsequent flirtation with fame in the New Zealand media represent for me the crux of the bicultural debate. Penn stands like a beacon in the night, warning others of the rocky terrain ahead. Biculturalism is not easy. Nor is multiculturalism, or any situation in which people of different backgrounds, cultures, advantages are forced to live together and communicate.

Of course, the value of cultural safety goes beyond the training of nurses and midwives. I have been caught between several analogies for the power of the cultural safety program. The really critical facet of the cultural safety debate as I see it is the control of discourse - not merely who says what, but who decides what the topic of discussion will be, who sets the boundaries of the conversation or explodes them. Working within the system, the cultural safety component and its proponents have taken a step toward reclaiming control over discourse. They are imploding the parameters of health and well-being as defined by government at large, and inscribing a personal and multicultural persona on the stone facade of institutional health care. It is for these reasons, out of sensitivity to the power of control over discourse, that I
have presented my thesis in its current format. I make no claims to any rare insight into the cultures of Aotearoa or the ideologies of her citizens. I have written a play in order to present my ideas through many mouths - issues as complex as cultural safety, biculturalism, social revolution, and feminist discourse (all of which have cropped up repeatedly in the creation of this document) defy a single interpretation or representation.

At the same time, I find it hard to shake the nagging voice in my head crying for some sort of order, some unifying theme. And so I have compromised between my resistant self and the little academic inside: I use an analogy that suits them both. I see cultural safety as a bird - two wings beating powerfully to lift it above the rooftops and carry it far into the morning sky. One wing represents the improvement of Maori health care, climbing back up to an equal or advantaged status relative to the dominant culture. The other wing, moving in synchronicity, bears the force of Maori control over government policy and discourse (with powerful women at the helm), insuring equal influence in a health care system that should by definition aid all peoples equally.

My use of analogy follows a methodology of sorts inspired by Greg Dening, Pacific historian at the University of Melbourne in Australia. In a forum at the University of Hawai’i, he espoused the notion of metaphor instead of
methodology, pointing out that metaphor gives the author “room to squirm”. The topic of cultural safety makes a lot of people squirm, myself included. Dening also uses an ideology of theatre in his writing, similar to metaphor in the room it allows for uncomfortable spaces. I have elected to adapt both these methods in my work.

The analogy of the bird permits the topic to soar above the tangles of appropriation and the rigid (many would argue patriarchal) structure of methodology. I have constructed the thesis itself as a performance script; taking, of course, certain liberties with the format as all good post-modern scholars should. Within the structure of the play are titular references to the theatre of health care. We trace the path of a patient from admission to a hospital into the operating room, the surgical theatre. The action onstage at some points parallels this process. The play as a whole is revealed in layers: the educational action occurs onstage, explaining basic information about cultural safety and its history; meanwhile, in the gallery, the observers provide a running commentary on the metanarrative contained in the debate - issues of power, control, and sovereignty.

This particular analogy of a surgical theatre fits nicely into an uncomfortable patient’s vision of health care: the patient is admitted based on his or her particular history [(im)Patient History], subjected to a number of tests to
determine the cause of the problem, 'prepped' for surgery, and then anaesthetized. The patient lies unconscious in the center of the theatre with no idea what is happening to his or her body. The doctor, mysterious and powerful in mask and gown, crowned with a light around his head, is attended by a host of silent nurses, knowledgeable and efficient, but having very little contact with the patient. In our scenario, as is often the case in large teaching hospitals, observers stand behind plate windows overlooking the scene. Family and surgical students watch in awe, curious but helpless to reach out to the patient.

The scenario of the surgical theatre provides a handy metaphor for the inaccessibility of the western health care system to people outside the mainstream culture. The process is sterile, mysterious, laden with a power outside the layperson’s control or comprehension. The mystery, the impenetrability of the inner sanctum of health care leaves patients feeling helpless, and does not encourage them to return. This inaccessibility is one of the main reasons Maori and other minority cultures do not participate in the health care system and therefore have lower health standards than the dominant, mainstream culture - the majority that is defining the system.

Much of the information in the Appendices focuses on the Maori people specifically, with peripheral mention of other minority cultures in
Aotearoa/New Zealand. I have prioritized the topic this way because the cultural safety program was implemented under the auspices of the Treaty of Waitangi, to improve the government’s attention to bicultural obligations. The program was designed by a Maori woman, Irihapeti Ramsden, in response to her people’s concern over appalling health standards and their fear of and/or distaste for the existing health care system. The program itself, however, once implemented throughout the system, stands to benefit all people of Aotearoa/New Zealand whose cultural, ethnic, religious, spiritual, gendered, sexual or economic identities differ from their caregivers.
PREFACE TO THE PROLOGUE

Included in the following Prologue is the text of a letter written by Anna Penn and published in the Christchurch Press on 10 July 1993. It was widely distributed, especially among television, radio and print media journalists. The widespread attention devoted by these media to the cultural safety program fueled the debate; largely biased, one-sided reporting fanned the flames for over two years. The letter is included to provide a context for the play, and is presented in the same language and format as it appeared in the Press. The text itself has been edited for length in an attempt to adapt it for the stage. The Privacy Act necessitated the exclusion of phrases referring to specific names, indicated by [---] appearing in the text.

A note of explanation: Anna Penn was denied entry to her second year of nursing school at Christchurch Polytechnic because she failed a unit called "Culture and Society". This unit included two parts. Part I consisted of three assessable elements: attendance and participation in preparation sessions arranged prior to the student hui, attendance and participation at the student hui, and demonstration of an understanding and competence in the skills and knowledge covered in the sessions of preparation for the hui. Part II included the completion of an end-of-unit written examination. The entire
unit represented 90 hours of study; Anna Penn failed Part I (most of the study hours).

The Culture and Society unit at Christchurch Polytechnic was designed to fulfill the standards of cultural safety. It was intended “to help the student in later nursing practice to care for individuals, families, groups and communities in ways that are socially and culturally relevant” (Christchurch Polytechnic, 21 July 1993, “Report...” p. 45). The skills taught in the unit are meant to help nurses develop a holistic approach to health care and make them better able to administer to people from different social and/or cultural backgrounds. The course outline also claims that the course material “aims to include and develop an understanding of the position, rights and aspirations of the indigenous people as tangata whenua as embodied in the Articles of the Treaty of Waitangi” (Polytechnic Report).

The fact that a Nursing Studies curriculum includes a unit which aims to provide students of all backgrounds with a grounding in the Treaty as it relates to their work is pretty exceptional. The fact that some version of this unit is present in every Nursing curriculum across Aotearoa/New Zealand represents a major coup - and the fact that Anna Penn was unable to pass the unit is quite telling in terms of the nature of biculturalism as it is seen today.
Many people do not want to see or understand the appalling disparities in Aotearoa/New Zealand in terms of income, health, social justice, or any of the indices of a healthy and equal population. The ability of government and the general public to ignore or gloss over concerns about inequality on all fronts has led to the current situation. In order to clarify to some extent the relation between the social, cultural, and physical health of a people and the colonial structure that governs them, I have included at the conclusion of the play four Appendices which briefly address issues of biculturalism and the health of the tangata whenua.

Appendix I outlines an understanding of the concept of ‘health’, Appendix II attempts to outline the state of health of the tangata whenua in Aotearoa/New Zealand, and touches on some of the causes of current health standards. Appendix III takes a bird’s-eye view of some of the past attempts at improving Maori health, the efforts that led up to the creation of cultural safety. Much of the information concerning Maori health standards borrows heavily from Mason Durie’s essential work Whaiora: Maori Health Development, published in 1994. His text is thorough and clear-sighted, deftly illuminating the sources of political, social, economic, environmental and cultural disruption that have led to health conditions today. Appendix IV discusses the Treaty of Waitangi, the founding document of bicultural
Aotearoa/New Zealand, and emphasizes different conceptions of the Treaty as it relates to indigenous health and well-being.
PROLOGUE

Lights up on stage right; the Meeting House of a Marae in Otautahi. It is the gathering of the Hui Waimanawa, a meeting of Maori nurses and health care professionals. People sit around the floor on mats. All appear to be involved in a passionate dialogue. MARGARET is standing and is on the verge of tears.

MARGARET: At this hui we’ve been discussing all manner of responsibilities of nurses, of the safety of our patients. At polytech we’re taught about clinical safety, ethical safety, legal safety... (she starts to choke up). But what about culture? What about cultural safety?

Lights down stage right, up on the gallery. GALLERY VOICE stands at the edge, pontificating animatedly.

GALLERY VOICE: Ah, there’s the rub. What about cultural safety? What about those countless numbers who never make it through the front doors of a hospital or clinic? What about all the Maori, Pacific Islander, Asian, poor, elderly... what about all those people so misunderstood by the system? Why don’t they count? Why has government for so long written them off as statistics? Is there no way for the system to accommodate? To make an attempt to understand? ahem... (he unrolls a scroll, begins reading)

Welcome, my friends, to our gallery fair.
Join us, suspended and learning mid-air,
For tales of an idea so revolutionary and bold,
It’s been difficult for most Kiwi folk to uphold.
An end to racism, injustice, ill health and bad law?
Why, it’s crazier than anything Parliament saw.
We’ll hear of one woman, Ms. Ramsden herself,
Who couldn’t leave her people stuck up on a shelf.
She’s bringing ‘em in, polishing them off,
Making health care accessible, telling bigots ‘Sod off!’
We’ll see how compassion and endless toil
Are breaking new ground on indigenous soil;
How strong, clever people tapping an ancient source
Are slowly but surely reclaiming discourse.
So tune in your minds for a quick education
Of how health care and culture have shaken the nation!
Lights down on gallery, spot comes up on ANNA PENN standing center stage, reading aloud from a newspaper. Her voice is professional, clipped, but can't escape a slightly whining tone. She is reading the text of her letter published in the Christchurch Press. She paces as she reads, occasionally perching on the edge of a chair centerstage.

ANNA: Ahem...
To: John Hercus, Director, Christchurch Polytechnic.

Dear John,

I am writing in reply to your letter of the 2nd of July 1993 in which you outlined the reasons for not allowing me to continue my Nursing Studies Years Two and Three.

Initially I cried and was angry, but then I laughed and am now resigned.

In my naive ignorance I had faith in you to differentiate fact from fiction, professionalism from professional bias.

I am the victory of a kangaroo court impersonating institutional bureaucracy. But, ultimately I am the victim of white middle class bandwaggoners.

In your Polytechnic bid to bend over backwards to be culturally sensitive, I feel you have forgotten that we live in a democratic society where freedom of speech is a civil right, not an allowance.

The Nursing Department’s stance of cultural safety has got to the point where they are telling lies and expecting us to listen to these untruths. I refused to do this and as a consequence I now find myself in a position.

The issue of culture in New Zealand is a highly sensitive one and because of your sworn allegiance to the Treaty of Waitangi, which is a creditable one, and because my questioning of some points at a Hui, I feel I have been made an example of by the Nursing Department to intimidate and ensure future compliance of students in the area of cultural safety.

My problems with nursing started when a tutor [---] stated that Samoans were not violent as we as a society were taught to believe.

I disagreed with this by saying that there is a high incidence of violence in their culture, especially between male and female. I then wrote to the police statistician in Wellington and requested statistics on all violent crime in the last five years. The statistics, and I am aware of the argueability of statistics, backed what I had said.
In my opinion there were huge inconsistencies when dealing with individual failure of students and I believe whether you passed or failed, in certain instances, depended entirely on whether you were liked or disliked by particular tutorial staff. An example of this is my failure of the Culture and Society Unit for which I was placed on report one day, probation the next, and when I failed the Hui resit, suspended. This happened all in two weeks which makes a mockery of the Student Handbook procedure outline.

It would seem to an outsider reading this that I spent a large amount of time trying to find fault with the Polytechnic’s nursing system and with the Polytechnic’s treatment of minority groups (which I might add I found patronising and condescending) - not so.

But I will also add that I was highly unimpressed with tutors talking about certain life experiences during class which I found inappropriate to the nursing studies course. [---] One tutor’s comments pertained to personal sexual accomplishments in finding the “G” spot in a woman’s vagina to aid female orgasm. [---] This sounds as though it is dealing with an inferiority complex.

[It is my disagreement with people such as this that I feel caused my probation and ultimately my not being allowed back into the program.]

I feel the Nursing Department had become used to compliance in their students, most of whom are middle class, white females. I came into the picture and threatened their knowledge base with different knowledge and an enquiring mind.

Instead of talking about the intellectual motive behind what I was saying and trying to explain and discuss it with both parties participating and learning, they preferred to send me off because of their personal and educational inferiority and the Hui gave them the excuse they needed.

With regards to the Hui .... I maintain my original stance. That is, that we as students were to be held as a captive audience to listen to “their” side with no chance to question or debate issues. This, in my opinion, is another example of an inferior education base afraid of an enquiring mind.

In your letter of 2 July you have stated that I failed Part A and B of the required criteria for a Pass. The examples given were “interrupting and interjecting while others were speaking”. This insinuates more than once, with which I disagree totally. You also claimed had I not missed five hours of Hui preparation I would have been aware that this behaviour was not appropriate.
Again, I strongly disagree with this insinuation. Regardless of any preparation, I was not prepared for what I feel were the sexist and racist remarks spoken by the Kaumatua.

In your recent letter you referred to him as the “Polytechnic’s Kaumatua” his “Mana” his “Integrity” and “National Standing”. When I read this, John, I laughed long and hard.

The man of “Mana” and “Integrity” and “National Standing” stood up in front of 160 students and various others and [made vicious comments pertaining to women][---]. I find his remark, as a woman, totally abhorrent, disrespectful, culturally insensitive and inappropriate, so at this point I left the room.

When being told that the European settlers had thrown the Maori printing presses into the river shortly after landing in New Zealand, I raised my hand to ask a question. I asked “I was taught to believe that the Maori language was a narrative one and not a written one”. At this point, the Kaumatua stood up and suggested I go to the library and read the history of New Zealand because the statement was the truth so (she mimics the voice of the Kaumatua) “stick that in your pipe and smoke it”. Rather an intimidating way to answer a question I thought.

Furthermore, he went on to say that all new settlers in New Zealand were either “Catholics, freemasons, or convicts”, which I disagreed with, for as he would know his Whakapapa I know my genealogy and this statement was a gross generalisation.

Lastly, when your Kaumatua stated “I’m not anti white, I’m pro Maori”, when asked by myself if he would find that statement in reverse racist, i.e. “I’m not anti Maori, I’m pro white”, he accused me of being a white supremacist.

At the conclusion of the Hui, each student had to stand and say thank you and say how they felt. I said that I “beg to differ with some of the points that had been said”. Directly after this I went to see him and said I hoped I had not offended him in any way and was sorry if I had. At which point he kissed my cheek. I thought nothing of it until six weeks later after I was failed for the Hui. At the same time the students’ Hui evaluations had been collected, in which many students had remarked on my and other students behaviour on the Marae.

I feel you all know very little about me and now is the time to give you an insight into someone that you have cut out of your course without taking
into consideration the whole facts. Cut me out in the era of cultural sensitivity without saying “hey, what about the right to question and inquire”.

I was brought up in your average kiwi family. Being the daughter of a policeman is hard, they tend to be black and white. So for me to come out with a questioning mind was quite a feat and one which I am proud of.

My parents split apart when I was nine, my father leaving for another woman, who relevant or not, happened to be the sister of one of the women involved in my case [---]. This totally destroyed my mother and her four daughters’ stability. Four daughters whose high positive energy turned to anger, which I didn’t escape.

I spent eighteen months in a Girls Home because I felt cheated but mostly because I was angry. Angry at something that was out of my control.

It must please Christchurch Polytechnic greatly to have rid itself of a woman with a past. A past which has taught her to be strong, independent, and able to question authority. You can now maintain your “fit and proper” middle class status quo.

When I was sixteen a woman [---] allowed me to start voluntary work at Jubilee Hospital. The following year was one huge transformation, both emotionally and psychologically.

It is my belief that unless you have been to the point of hating yourself for who and what you are, you can never really understand the work it takes to get to the point of being able to say “Hey, I’m okay”.

I then went back to school as an adult student because I wanted to be a nurse. I lived in Queenstown and Australia. Then came home to train.

I came home to train when I was stable enough to cope with study. Came home to train when my anger was channeled positively. I came home to train because all I have wanted to be for years is a nurse.

You have taken that chance away from me because I questioned a Kaumatua whose statements I wished to discuss.

I feel that old anger of being a victim, when I believe I have done nothing wrong.

I am not plying for sympathy, I am stating exactly how I feel.
I am resigned now to the fact that it does not matter how good your intentions are or how right you are, it comes down to personal professional bias.

As I stated in earlier correspondence to you, I feel nursing is a fantastic chance to install into a large group of women confidence, assertiveness, fearlessness and questioning when in doubt.

I feel [instructors] actively encourage submissiveness of women. An example of this is [a lecturer’s] comment of “Don’t be so masculine Anna”. Perhaps my youthful idealism is wasted in a time where political bandwagoning has more punch than honesty.

So, to conclude, John, I feel I speak not only for myself but for all students who have been screwed by the system. I am a total believer in what you give out you get back. Therefore, I say to all those guilty of perpetuating compliance in women, within the Polytechnic Directorate, and the Nursing Department, with the utmost compassion and sincerity I hope you all rot in hell alongside corruption, sexism, racism, and classism.

Perhaps I can be considered Christchurch Polytechnic’s contribution to the Year of the Woman.

Yours sincerely,
Anna Penn

She sighs, smiles to herself, turns on her heel and marches out of the spotlight and offstage.
ACT I - THE INCIDENT

Scene I

The stage is in darkness, except for a spotlight stage left on Ace Reporter at his desk at the Christchurch Press. He speaks into a telephone, taking intermittent bites of a powdered donut and brushing in vain at the powdered sugar on his shirt front as he shuffles through stacks of paper on his desk. He is obviously a busy, important man.

ACE: Yes, Miss Penn, I have it right here. Are you certain you’d like me to print an article on this letter in the Press? These are some pretty serious allegations. A more thorough reporter might verify this story before running it, but if you say it’s accurate, well...that’s good enough for me. Yes, ma’am....all right then, I’ll make sure it’s in the next edition. Thank you very much, Miss Penn. You bet. Ta.
(hanging up) Stop the Press!

Lights down.

Scene II

Home of the Donnolys, an Average Conservative Family. Alan and Anne are seated at the breakfast table, pages of the paper strewn between the two of them, each reading a section.

ALAN: Humph. Bleedin’ liberals are at it again.

ANNE: What’s that, luv?

ALAN: Maoris. First the fisheries. Then the educational system. Now it’s the bloody health care system!

ANNE: Keep your voice down, luv, you’ll wake Grandma. What’s all the fuss?

ALAN: Christchurch. They kicked out this poor Pakeha woman because she failed a Maori hui! Of all the nerve. I don’t need my bloody nurses to be
trained in Maori language. Next thing you know, they’ll be doing that spooky war dance in the maternity ward.

ANNE: Haka, Alan, it’s called a haka. And why would they do it in a maternity ward?

ALAN: Political Correctness. Bullocks. I’m writing a letter to the editor. Who’s responsible for these programs getting into the Polytechnics, anyway? As if I didn’t know. Liberal, activist, Maori-coddling pushovers, the whole lot of ‘em. I’m voting National this year.

ANNE: Take it easy, sweets. Mind your blood pressure.

Scene III

Office of the Assistant Director, Christchurch Polytechnic. Asst. Director Douglas Endicott is seated at his desk, on the telephone. His tie is undone, his shirt rumpled. He looks as though he hasn’t slept in days.

DOUGLAS: Yes, I saw it. I’ve been on the phone all night. People are furious. Mm-Hmm. Well, of course we’ll have to prepare an official response, but we need to do some serious investigating first. We’ll have to order an administrative review, talk to all the lecturers and tutors. And our Kaumatua, of course. The poor man did not need this kind of publicity. After all he’s done for these students, this is the kind of recognition he gets.... I know...I called him first thing this morning to apologize and warn him. I think we should schedule a faculty conference this afternoon. Meanwhile, I’ve drafted an initial response for the papers...it was picked up in the North Island papers this morning. Yes.... And not one reporter called here to ask us for our side of the story. I had to call them. I’ve got a meeting now with the fellow from the Press, the tutors and the Kaumatua. (sighs) Okay, I need to get ready for this interview. Hang in there, John. Okay, I’ll see you this afternoon. Good on ya. Ta.

Hangs his head in his hands for a moment, picks up a pen and scratch pad and writes. He is interrupted by a knock at the office door. He gets up to open it and Willie, Julia, the Kaumatua and Ace file in.

DOUGLAS: Come in, come in...Thank you all for coming. Anyone care for a cuppa? All nod in agreement as they take seats in the chairs clustered
downstage of the desk. He pours five cups from a carafe, passing them around with the cream and sugar.

Everyone knows each other? Conferees nod and exchange brief pleasantries.

Now, you all know why we’re meeting today - we need to get to the bottom of things, and we need our side of the story to get into the mainstream media. That’s why I’ve invited Ace here to join us. Ace, I assume you received my faxed rebuttal? The letter was drafted by myself, John Hercus, and those present here.

ACE: It came in this morning. Your version is remarkably different from Penn’s. You say she raised her fist and said something about white supremacy? She never mentioned that. She said she felt that she was being discriminated against because she was Pakeha.

WILLIE: I believe the phrase she used was ‘I’m not anti-Maori, I’m pro-White’.

KAUMATUA: In response to my assertion that I’m not anti-White, I’m pro-Maori.

JULIA: Which he only said because she told him his rhetoric was anti-White.

DOUGLAS: As you can see, Ace, the issue gets very complicated. There is no recording of the events on the marae that day, and no one remembers for certain exactly what was said. What concerned me, what it really all boils down to, is a lack of respect for our Kaumatua and for tikanga Maori.

JULIA: She had no respect for anything to do with the hui. And she had no concept of marae protocol. She missed five out of nine hours of hui preparation. She arrived late that morning after a night on the town, and behaved disrespectfully, and if you ask me, outrageously, on the marae.

WILLIE: It’s important to note that the hui was not the first time Anna has run into trouble. There’s nothing in her official file, but I’ve had chats with her about her behavior and attitude in my Culture and Society class. She was often rude to other students, myself, and other tutors; she had problems expressing her convictions without offending or insulting someone. She could be a really disruptive person to have in a classroom, especially dealing with such sensitive course material.

DOUGLAS: I assume you’ve seen our prepared statement, Ace. It’s unfortunate that it took us 12 days to compile, but there were many legal and
ethical considerations involved. And we wanted to be sure we had investigated all of Penn's allegations. Of course, the delay has allowed all manner of uncorroborated stories and untruths to be batted around. We hope that the official response will serve in some manner to counteract that.

ACE: Yes, well...with 32 pages plus appendices, I hope you don't expect us to print it in its entirety.

DOUGLAS: Of course, not, no.... But you will write a story on it? It's critical that we fend off this crude attack on the integrity of the institution.

ACE: I understand the urgency of your situation, Doug. And yes, we'll run the story. As will the other major papers, I expect. But I don't know how far this rebuttal will go in terms of appeasing the constituency. Everyone's pretty upset about this cultural safety program. It's going to take a little more than a long letter to convince them that this is a good way to spend their tax dollars.

DOUGLAS: I'm aware of that. We've been discussing the situation at length. Our program will be undergoing an extensive review and overhaul. We'll be seeking community input. And Irihapeti Ramsden, the architect of the program, will be spending some time in Christchurch to help us get the program back up and running.

ACE: Choice! I would love to interview the woman responsible for the whole program. She's become quite a national figure.

DOUGLAS: Oh, I'm sure she's got plenty she'd like to say to you, Ace.

KAUMATUA: I think Ms. Ramsden could teach us all a little something. I would just like to add before we adjourn this meeting that we need to keep sight of the central issues in this whole mess. The Treaty of Waitangi is really at the heart of all this. Cultural safety is an attempt to instill in our nurses and midwives a sense of respect for other cultures and an awareness of the power politics between the health care system and the country's patients. We are trying to make the system safe for all patients. Frankly, if cultural safety has functioned to sift out a student like Anna Penn, who is a potentially dangerous nurse, I feel the program is working. That's not to say that improvements aren't necessary, but the component has proven itself a valuable part of our curriculum.

ACE: And on that note, I'd better get back to the office. We go to press soon, and I'd like to get this story out today. Thank you all for meeting me. (chuckling) I know you're all very busy.
DOUGLAS: Thanks, Ace. We appreciate your patience in waiting for a response.

ACE: No sweat. Hey, it’s your necks on the line, not mine.

DOUGLAS: Yes. Well. Thanks for the encouragement. (smiles wanly).

ACE: Ah, she’ll be right. Anyway, at least the folks’ll know your side of the story, eh?

DOUGLAS: I suppose you’re right. We’ll be in touch, Ace.

ACE: Cheers, all. Stage lights down, lights up on the gallery behind the scrim. The Gallery Voice is vociferating.

GALLERY VOICE: Penn is a fine example of how the game ought not to be played - blatant disrespect for other cultures, manipulation of one’s privileged position to specifically injure another party - these are exactly the behaviors that cultural safety seeks to address. People like Penn are dangerous, especially if placed in a position in which they are responsible for the comfort and care of individuals from other walks of life. Her story seems to me the ideal justification for a cultural safety program - it should exist if for no other reason than to ensure that unsafe practitioners are not at the bedsides of unwell people.

Scene IV

Donnolly home in the evening. ALAN is seated at the dinner table, dishes still in front of him. He is reading the paper as ANNE washes dishes at the nearby sink.

ALAN: Ah, I see the Polytech finally got around to answering that Penn girl’s accusations. About bloody time. Not that they’ll have anything worthwhile to say, probably just bureaucratic babbling.

ANNE: The Polytech Assistant Director...what’s his name?


ANNE: Right. His wife used to have tea with the mothers on Thursdays when the kids were babies. They seem like very intelligent people.
ALAN: That's exactly the problem. Perfectly reasonable people getting brainwashed by all this “Honour the Treaty” rubbish. And then students like Penn get kicked out for questioning the system. And of course Endicott can’t stand up for her. He’s the Assistant Director, he has to stand behind the institution and the Kaumatua, no matter how unfairly she was treated. It’s ridiculous, I tell you. It’s like living in some kind of fascist state. We’re not even allowed to speak our minds anymore.

ANNE: *(smiling wryly)* You certainly don’t seem to have much trouble with that, luv. Will you read me the article? My hands are wet.

ALAN: 22 July, 1993. The Dominion. “Student took risk of failure in hui conduct says report.” You’re sure you want to hear all this? (ANNE nods) Okay, then.

“Christchurch: The student at the centre of a row over ‘cultural safety’ in Christchurch Polytechnic’s nursing courses chose to risk failing by her behaviour, the polytechnic’s report into the row says.”

ANNE: Which is what I’ve been saying all along.

ALAN: *(pretending not to hear)* “The report, issued yesterday, says Anna Penn ‘has subsequently demonstrated such flaws of judgment that she would not be welcomed back as a nursing student’.

In issuing the report, the polytechnic council unanimously expressed confidence in the director, the Polytechnic elder, and the staff of its department of nursing and health education.”

ANNE: Of course. They can’t really forsake their Kaumatua, now, can they?

ALAN: Which is exactly what I’ve been saying all along, if memory serves me. *(he pauses and raises his eyebrows)* If I may continue?

ANNE gives him a brief mock curtsy and gestures for him to continue.

ALAN: “The report, by Mr. Endicott, endorses the department’s assessment of Ms. Penn as having failed the first-year nursing course.

It says the polytechnic was reluctant to comment earlier on the row because early news reports, including interviews with members of the directorate, were ‘inaccurate and unbalanced’.
The report says Ms. Penn failed year one because she failed the culture and society unit, not because she 'failed a hui'. A pass for both parts of this unit was needed.

Ms. Penn failed all three sections of part one:
- Attendance and participation in preparation for a hui.
- Attendance and participation in the hui.
- Demonstration of an understanding and competence in the skills and knowledge covered in the sessions—"

ANNE: Now that doesn't sound so hard to do. How did the poor girl manage to fail?

ALAN: If you'd only let me finish, we might just find out.

ANNE: (sarcastic) Begging your pardon, your lordship.

ALAN: "...Part two was a written examination, which Ms. Penn passed.

The report says she failed because she did not attend all of the preparation sessions, she had not demonstrated the required understanding and competence of what was covered in those sessions and because her behaviour at the hui was 'insensitive and disrespectful'.

The report quotes from students' evaluations of the hui. They cover reactions to the kaumatua at the hui and the behaviour of other students.

The report says the evaluations, with a few exceptions, indicated appreciation and respect for the kaumatua. It says 54 comments were made about the behaviour of Anna Penn and a group of students associated with her, reporting embarrassment, disappointment and doubt about their motives, attitudes and actions."

ANNE: So do you think that all of those students were overreacting? Or were they brainwashed like the Ministers in your alien conspiracy tales?

ALAN: Oh, for Heaven's sake, Woman! I bring home one Tattler because I think it's humorous, and I'm never going to live it down. Are you going to let me finish reading this, or not?

ANNE: Of course. And I won't interrupt again.

ALAN: Thank you. To continue---
ANNE: Unless I have something important to say. (she giggles). Go ahead, luv.

ALAN: (louder) ...To continue ---"Quotes included: ‘I felt let down when they spoke out so drastically about white supremacy’; ‘I consider them unsafe to be nurses’; and ‘The kaumatua was stimulated by the challenging questions and not offended’.

The report deals individually with several, but not all, allegations made in a letter by Ms. Penn to Mr. Endicott this month outlining her complaint with the department.

A copy of the letter, with several names and comments blacked out, appeared in the report. Mr. Endicott said yesterday that the deletions had been made on legal advice.

Mr. Endicott responded in the report to Ms. Penn’s query as to whether the kaumatua should have been involved in her hui resit by saying there was no evidence to suggest the elder had pre-judged the issue. ‘Furthermore the decision was not his.’

The kaumatua failed Ms. Penn on the resit, though the head of the Maori studies department, and a part-time tutor passed her.

In a letter to Ms. Penn this month, Mr. Endicott said: ‘The kaumatua is the polytechnic’s kaumatua [elder] ... he has the final determination in all matters of Maori culture, protocol, and partnership issues affecting the polytechnic.’

ANNE: As well he should.

ALAN: “The report says the kaumatua confirms he used the phrase: ‘I am not anti-white, I’m pro-Maori’ in conversation with Ms. Penn but goes on to ‘absolutely reject’ it was a racist comment.

Other allegations covered include ones about favouritism for Maori and Polynesian students, the way Ms. Penn’s suspension, probation and appeal were handled, and comments and behaviour of nursing department staff. Mr. Endicott rejects almost all the allegations and disagrees with Ms. Penn’s interpretation of the rest.”

You see? I told you he’d stick up for the kaumatua.

ANNE: It sounds very reasonable to me, luv. It sounds like this Penn woman really blew it. She doesn’t sound like she would have very nice bedside manners.
ALAN: The way to improve bedside manners is not by pounding students' heads full of Maori folk tales and language and then kicking them out if they don't accept it unquestioningly! I'm going to write a letter to the editor. I don't want my tax dollars paying for this kind of rubbish.

ANNE: I'm not sure you understand completely what cultural safety is, Alan. Why don't we go and hear the talk by Irihapeti Ramsden next week? It's free, at the Polytechnic. And then if you still don't agree, you can talk to her directly.

ALAN: (slightly grumbling) Okay. And then I'll write to the paper.

ANNE: Right then, it's settled. And maybe I'll call Lynette Endicott and invite her over for tea. I haven't seen her in so long....

Lights down.

END OF ACT I

NOTES

i from Cate Brett's North and South article, "Putting Penn to Paper", Oct. 1993.
ii ibid.
Scene I

The lights come up on a classroom with four desks and a professor’s table. LORA, DAVID, JOE and AMY are seated at the desks. PROFESSOR GREELEY, a well-loved Nursing prof, stands at the front of the class, pacing and reading from a book in her hand. The students also have copies in hand. The text is Keri Hulme’s The Bone People, and the students listen with rapt attention. PROF GREELEY reads the part of Kerewin, LORA reads the doctor, and DAVID narrates.

PROF. GREELEY, DAVID, LORA:

Firstly

"Is it possible to diagnose a condition without hospitalisation or intrusive tests?"

A brisk woman, as young or as old as Kerewin:

"In your case, not surely. I’ve made a tentative diagnosis, but without a biopsy or other explorative operation, I can not tell you definitely. The pain you describe, the weight loss and waning appetite, the site and form of the probable tumour, are all pointers, but there could be explanations other than carcinoma."

"Could similar symptoms be initiated by stress and mental discontent?"

The woman shrugs.

"I don’t know. The way the human organism reacts to stress and anxiety is extremely variable."

"If I have stomach cancer, how long will it be before I die, given that I won’t accept any form of treatment?"

"That is impossible to answer without knowledge of how far the disease has progressed. Even then, it is uncertain. You might live for a year and longer, or succumb within the month. It depends on many factors, not least your desire to live."

Kerewin smiles. The dark violet shadows under her eyes give a strange highlight to that smile.

"What is your objection to hospitalisation and treatment?"

The doctor is curious but dispassionate.

"Primarily, that I forgo control over myself and my destiny. Secondly, medicine is in a queer state of ignorance. It knows a lot, enough to be aware that it is ignorant, but practitioners are loath to admit that ignorance to patients. And there is no
holistic treatment. Doctor does not confer with religious who does not confer with dietician who does not confer with psychologist. And from what I can learn about cancer treatment, the attempted cure is often worse than the disease....'

"What you are saying basically is that you have no trust in doctors or current medicine."

"Right on."

(She sets the book down on the desk and continues)

This scene from Keri Hulme’s book The Bone People eloquently expresses some of the most powerful intangible barriers to health care in Aotearoa/New Zealand. Much has been written about western health systems and their inability to reach indigenous or minority cultures. The sterile paradigm of western science often does not allow for alternative worldviews or alternative methods of healing. Some progress has been made in the last few decades toward minimal expansion, for example, the acceptance of techniques such as acupuncture and the resurgence of midwifery intervention in maternity wards. However, impressive barriers remain between clinical health care and the dispossessed patients who perhaps are most in need of its attention. Who can think of some barriers, either visible or invisible, to health care?

LORA: A lot of people are intimidated by the whole experience of hospitals and clinics. I mean, think about it. They’re usually housed in giant, colonial buildings with impressive stone fronts and receptionists with grim faces. I spent half my childhood in hospital with asthma, and even I’m still nervous about visiting the places.

DAVID: And even if you do get past the stone facade, so to speak, you’re still faced with people who have no idea what your background is, who usually don’t give a shite where you’re from or who you are. The last time I was in a doctor’s office, the nurses kept calling me “miss”. (he pulls on his ponytail) I’m used to it by now, but I can’t imagine being rural Maori, or a recent Asian immigrant, and trying to get across whatever my particular problem was.

LORA: Or being an urban Maori woman in the delivery room with some pakeha doctor trying to give you back the placenta, telling you it’s culturally appropriate to bury it, when you don’t know or care about what he’s saying.

AMY: Any time someone’s in an unfamiliar situation, it’s difficult to be comfortable and communicate easily. Even the first day of this tutorial, remember how bloody hard it was for us all to get across our points? Even educated urbanites like ourselves had trouble in an unfamiliar situation. Visible barriers can be the actual spacial arrangement of the room, the
building, the giant stone faces of the buildings, the obviously hostile people facing you. Invisible barriers can be anything from your own mood that day to your past experiences to language difficulties to personal discomfort or unfamiliarity. I think the most important factor in any situation, though, is the communication between service provider and the customer. Whether it’s at Uni or in hospital, people providing a service need to be aware of all the differences between themselves and the people they’re supposed to be helping.

JOE: Right you are. And that’s what cultural safety is all about, eh?

PROF. GREELEY: Precisely. In Aotearoa the issue of cultural and spiritual barriers to clinical health care has been at the center of the battle to improve health standards of indigenous and other minority populations. Cultural safety is one program which seeks to redress the intimidating nature of the health care system and make it more accessible to those outside the mainstream culture. The problem is particularly acute for the tangata whenua, who have the worst statistics in terms of health standards in the country. All the reasons you’ve mentioned are among the explanations for the inadequacy of the current health care system to treat all fairly. For next week you’ll see that you’ve been asked to prepare a composition concerning barriers to health care. I want you all to think of every experience you or your family and friends have had with doctors or nurses and analyze it for sources of tension or miscommunication. Tell me in one thousand words as much as you can about the causes and how things could have gone more smoothly. We’ll discuss the compositions in next week’s tutorial. Questions?

(The four students, who have been furiously scribbling in notebooks as the prof detailed the assignment, shake their heads and start packing their books away. PROF. GREELEY continues.) Right then, we’ll see you next week. Have a great weekend.

[A brief overview of health statistics of the tangata whenua in Aoteroa is provided in Appendix II.]

Scene II

Lights up on Katz, an intimate cafe. At two tables, a cluster of varsity students are seated and lounging. We recognize LORA, DAVID, JOE, and AMY from Prof. Greeley’s class, along with ROSE, BRONWYN, MARI, and MALAMA. Several are smoking cigarettes; cups half-full of assorted drinks are scattered among piles of textbooks and knapsacks. As the lights come up, a burst of
laughter is dying down and ROSE stands up, book in hand. As she reads, everyone pays close attention, nodding.

ROSE: Listen up, everyone. I found this poem in our Lit. book. It explains so well what we’ve been talking about in class. It’s by Hinewirangi Rosemary Kohu. She’s Ngati Kahungunu, Ngai Tamarawaho. Have a listen...

**Barriers**

Kia ora

Hinewirangi speaking

Who?

Hinewirangi

What?

Hinewirangi

Can you spell that?

I reckon I can,

can you?

No,

will you spell it please?

_H I N E W I R A N G I_

Oh, Yes,

High knee we rah gee

_N o_

Hinewirangi

Will high knee do?

No,

call me Rose"

LORA: That’s beautiful, Rose. *(she pauses)* So what’s your real name? *(laughter)* Really, though, that’s exactly what we were talking about at Uni today. I think you all had the same discussion in Greeley’s ten o’clock tut, right? *(the others nod)* It’s just like so many anecdotes of indigenous people struggling with the system - it’s almost funny at first. After all, we’ve all dealt with incompetence over the telephone at some point or another. Just look at poor David with his ponytail, he gets abused all the time! *(everyone laughs and pulls David’s hair)*. But if you read into it a little more you can sense so much of her fatigue, frustration, and resignation when she says, ‘No, call me Rose’. I think this is a perfect example of one of the major causes for poor indigenous health standards. I think I’ll use it on my next test for Greeley’s class.
JOE: Straight up, Lora. The thought of dealing with this sort of ignorance daily is exhausting. And if the fullah on the other end of the line can’t even spell or pronounce your name - would rather mangle it into an unrecognizable Anglicization - how on earth will the bank teller understand your question; how will the counselor understand your predicament; how will the doctor ever understand your affliction?

MALAMA: You know whom I really respect? Irihapeti Ramsden. She’s the (he holds his fingers up to indicate quotation marks) “nursing educationalist” who pioneered cultural safety, right? She works so hard to expose the inaccessibility of health care for people outside the dominant culture. I heard her talk last week at Uni, and she kept talking about how people’s disregard for the Treaty of Waitangi is one of the prime reasons for Maori poverty and poor health. A majority of the public health issues facing Maori today stem from conditions of poverty, oppression, and colonization; conditions that theoretically should not be a problem, had the Treaty been put into practice from the hour of its signing.

[The text of the Treaty of Waitangi is reproduced in Appendix IV, accompanied by a brief analysis of the differences between the English and Maori versions.]

BRONWYN: Yeah, I went to that talk with my folks. My pa has been on and on about “poor Anna” and the bastards at the Polytech, so Mum made him go to the talk. I really think she convinced him, though. She has a way of presenting the facts of the health care system so that it seems so obvious that something’s got to change, and that Nursing is the perfect place to start. Pop can’t stop talking about how much mana he felt that night exuding from the stage. I didn’t think he even knew what the bloody word meant! He’s had to completely rethink his position on the Treaty and all the related issues. It’s amazing what one woman can do!

Lights dim on stage, come up on the gallery.

GALLERY VOICE: I knew that Bronwyn girl looked familiar! It’s the Donnollys’ daughter! Hoo! Sounds like her ol’ pop has changed his tune.

VOICE II: Have you heard Ms. Ramsden speak before? She’s amazing. A whole lot of mana wrapped up in one powerful woman. And so unassuming. She sure convinced me. And she’s convinced government, too. She’s doing more to reclaim indigenous sovereignty in this country than most I know.

VOICE III: And you wonder why so many people in Aotearoa are terrified of her! Powerful Maori woman, appointed to the Nursing Council, next thing you know, she’s convinced the whole government to start mandating
cultural safety in the nationwide nursing exams! Bloody beautiful! It’s about
time someone came along who could see the problems and know enough
about the system to actually institute change. She’s regaining control of the
discourse, garnering power from under the noses of the racist bureaucracy!

VOICE II: It’s pretty obvious from people’s reaction to the program and to the
Penn incident that maybe the mainstream isn’t quite ready for such radical
change. People are outraged at the notion of educating our nurse trainees in
anything other than clinical knowledge...

GALLERY VOICE: But don’t you see? That’s exactly why we need these
programs! Half the bloody country doesn’t even realize there’s a problem!
You go out on the street, ask an average Pakeha what’s the biggest problem
facing Maori today, I wager he’ll answer something completely insensitive
and racist, like: “gittin’ their lazy arses off the dole, that’s the biggest problem”.

VOICE III: Aw, you don’t give the masses enough credit. Sure there’s racists
out there - heaps of ‘em. But folks are waking up to the plight of indigenous
people. Especially the government, and that’s a bloody good starting point!
And it takes people like Irihapeti to get them to acknowledge the problem and
start finding remedies. And to finally start shelling out the money to make
up for centuries of oppression!

VOICE II: It’s this argument for restitution that has been employed in the past
few decades and has led to government initiatives to improve Maori public
health. These invisible barriers of poverty and cultural difference that the
kids were talking about earlier have made the health care system largely
inaccessible to people outside of the dominant culture. Many Maori cite
feelings of acute discomfort in encounters with doctors, nurses, clinics and
hospitals. But listen, I think they’re about to tangle with this very topic...

Lights back up to full onstage.

LORA: You know, Rose, that poem by Hinwirangi is such a good example of
the difficulty of communicating with a person in power who’s from a
different cultural background than you. I was reading an interview with
Irihapeti in The Dominion, and she was telling the story of a young woman
she met when she was nursing full time. This woman told the nurses that
her baby wasn’t immunised, even though the service was free of charge.
When they asked her why not, the woman said that she had taken her baby to
the medical centre and had received such a look from the nurse there she felt
“as though she was poor and wasn’t looking after her baby properly”.

ROSE: It’s like the excerpt Greeley read from The Bone People today. So many
patients outside the dominant culture just don’t feel that the system works
for them. "Doctor does not confer with religious who does not confer with dietician who does not confer with psychologist," leaving individuals whose health and worldview rely on all these factors feeling displaced and uncomfortable.

MALAMA: Bloody hell, Rose. (to the others) No wonder she always aces her tests. You got that memorized already?

JOE: Now, look - you've made her blush. I have to admit, it stuck in my head too. (Rose looks thankfully at Joe, still blushing)

MARI: Well, you all can quote beautiful passages all night, but I need to study for the Culture and Society tut tomorrow. Which is why I thought we were here....

AMY: Right you are, luv. This is all related to the course, but probably won't be on the test. Kawa Whakaruruhau will certainly be, though.

LORA: You Pakeha just like to say the name of the program. "Kawa whakaruruhau, Kawa whakaruruhau...."

Everyone laughs goodnaturedly - this is obviously a conversation they've had before. AMY pretends to hide her face, then begins to intone 'Kawa whakaruruhau' over and over, like a mantra.

BRONWYN: (sighing) Hoookay. Kawa Whakaruruhau, the Bible of Cultural Safety in Nursing Education in Aotearoa. Compiled by Irihapeti Ramsden, based on extensive discussion and research by a number of nurses and nursing educators. It was the document that originally defined and described the proposed program. 'Where it all began', I suppose.

JOE: This woman knows her shit! Right. (he reads from a notebook on the table). Ramsden wrote of the necessity to redefine the philosophy of nursing (and eventually health care in general) in Aotearoa/New Zealand.

Lights dim slightly on stage, a spot comes up on VOICE II, standing at the edge of the gallery, reading from a sheaf of papers. He is very theatrical with much arm waving and rolling of the letter 'r', as though Cultural Safety had been rewritten by Shakespeare. The other gallery members groan and occasionally heckle, but are still interested in the passage. Meanwhile, JOE reads the same passage, inaudibly, to the assembled crowd at Katz.

VOICE II: ahem...

It is an appropriate time to move forward 100 years and discard the ideas (necessary in the time of
Florence Nightingale, but dangerously irrelevant now) that nurses give service irrespective of nationality, culture, creed, colour, age, sex, political or religious belief, or social status.

Clearly in a population in which people are rapidly becoming more educated to take responsibility for their own health, the idea of the nurse ignoring the way in which people measure and define their humanity is unrealistic and inappropriate.

Within this century alone many human beings in many countries have engaged in war in order to maintain these fundamental parts of their lives. People are still prepared to die in order to maintain their cultural, religious and territorial integrity. It is not the place of the nursing service to attempt to deny the vital differences between people however altruistic the rationale may be.

...from the Introduction to Kawa Whakaruruhau, page number 1.

A round of applause from the gallery, spot comes down and the lights come back to full on the students.

MARI: So Ramsden's criticism of the nursing profession extends generally to all the western health care system as we know it in Aotearoa today. The frightening rifts between levels of health of Maori and non-Maori prove the need for immediate attention, immediate change. The cultural knowledge and sensitivity of those outside the mainstream need to be introduced at the bedside of the patient, where they can inform the practice of medicine, ease the patient's discomfort, and begin to dress the wounds of 150 years of neglect.

MALAMA: My, my the girl can talk! And she's got some serious convictions! C'mon, Mari. Tell us how you really feel. (he chuckles) It's that ol' Winston Peters, isn't it? He's got you all riled up! (MARI rolls her eyes with a disgusted look on her face) Seriously, though, I reckon you've said it all. We know where the problem lies, so now it's up to us to pass this bloody course, get out there, and make the world safe for humanity! Or at least the health care system. I feel like we need capes and masks or something. Duck into the nearest telephone booth, come out culturally safe!

BRONWYN: I wish it were that easy! But it's not, especially for us poor Pakehas! (everyone laughs, making pretend pity sounds. MALAMA plays an imaginary violin) And, since I've got so much hard work ahead of me, I need
to get home and get to work. Especially if I want to go to the “Garbage”
concert this weekend.

JOE: Yeah, I’d better head out too. So much to do!

*Everyone mumbles in agreement and begins packing their things. Lights go
down as all wish each other good luck, see you tomorrow, etc.*

END OF ACT II

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NOTES


ii in Witi Ihimaera (Ed), (1993), *te Ao Marama, Contemporary Maori Writing*, Reed Books, Auckland, p. 56.

ACT III - THE BIRTH OF CULTURAL SAFETY

Scene I

The curtain comes up on HINA WRIGHT, a part-Maori woman in a spotlight stage left. She is in her mid-thirties, dressed in a business suit. She reads from a newspaper in a clear, strong voice.

HINA: Christchurch Press, 17 July 1993, Letters to the Editor

Sir,--When I require hospital care, one of my concerns is for the medical treatment I am given. My other is for the care I receive from the hospital staff. I have an expectation that my doctors and nurses are qualified professionals, but their subject marks are of no significance to me, and neither is the fact that they may have required extra coaching to achieve their qualification. What is important to me, as I lie ill, vulnerable and worried, is the manner in which my doctors and nurses relate to me; their empathy, their respect for me, the uniqueness that is me, and the particular needs that are mine. These skills are personal qualities which I see as essential in people selected to train in the caring professions - qualities to be enriched and developed through the learning opportunities afforded by cultural input into training.--Yours, etc.,
HINA WRIGHT.
July 15, 1993.¹

She freezes, and a spot comes up on MIKE standing stage right. He is Pakeha, in his early 50's, and dressed much like the typical Hollywood version of an English professor - tweed jacket, faded blue jeans and a turtleneck. He also reads from a newspaper. As he reads, the spot fades on HINA.

MIKE: Christchurch Press, 16 July 1993, Letters to the Editor

Sir,--Congratulations to Anna Penn for publicly exposing this example of racism at the Christchurch Polytechnic (July 10). For too long policymakers have pursued through the State services and our learning institutions policies of racial bias or separatism under the guise of "cultural sensitivity." These policies are dividing our people. New Zealand is a multi-cultural nation and, as such, has people of very many ethnic origins. Multiculturalism excludes nobody through culture or race, looking on each person as an individual. This equality gives all, regardless of their origins, "equal" rights to health, education, job opportunity and law. Current policies do not always recognise this equality. Racism in New Zealand will continue to worsen until the Government and its agencies abandon their bicultural
policies and acknowledge that, as New Zealanders, we are all one people.—
Yours, etc.,
MIKE BLANCHARD
July 14, 1993.

He freezes; the stage lights go down as the lights on the gallery come up. The
observers are in animated discussion, with two members standing and
addressing the audience.

VOICE II: In the pages of the New Zealand papers, opinions from every
imaginable viewpoint have emerged on the topic of cultural safety and
biculturalism. But what we haven’t heard is a concrete explanation, or any
kind of understanding, of the cultural safety program and the reasoning
behind it. Apparently it’s up to us to set straight the course of events leading
to the Nursing Council’s implementation of cultural safety in official policy.
If we look back in on our delivery in process, perhaps we can explain a little of
just what’s going on for those poor, puzzled blokes in the audience out there.

GALLERY VOICE: The delivery itself, of course, can be traced back to the
moment of conception... pro-choice arguments aside. (Groans from other
gallery members.) Prior to the actual fertilization of the miasma of emotion
and conviction that bred cultural safety, a century and a half of inequality,
oppression, and marginalization led to the appalling situation of Maori
people. Poor health, poor treatment, poverty in general - these were the
conditions that led the pioneers to seek a safe harbor.

VOICE II: We’ve heard a little from the students about the cultural safety
program and Irihapeti Ramsden, its architect. We know these Nursing
students are being trained in Culture and Society - trained to know
themselves and their own culture and to understand differences between
themselves and their future patients. We’ve heard from Anna Penn, the
Nursing student who was not passed on to her second year of studies due to a
number of behavioral and academic concerns. We heard her side of the story
- she contends she was booted because she ‘failed’ a hui.

GALLERY VOICE: We also heard that the real reason is quite simple. In my
humble opinion, she’s just a massive pain in the arse...

VOICE II: (Cutting off GV) Anyway, we know for certain that something was
wrong. A great number of people came into the fray on behalf of Anna.
Maybe this was because of media misrepresentation, maybe she’s just cute and
appealing. Maybe she had a reasonable case. At any rate, she certainly
brought many important issues into the light. We’ve heard some of ‘em.
Now per’aps we’d better explain things from the get-go...
GALLERY VOICE: A brilliant idea, Holmes... And here to assist us in the narration...

Lights up onstage, with a spot on the gallery. NURSES and PATIENT rush onstage as GV introduces them. They begin to set up for an emergency delivery, running in circles as though they were on a vaudeville stage instead of a surgical theatre. PATIENT continuously screams and groans as though in labor. Through the rest of the Act, the observers must yell to be heard over the mayhem on the stage, but the mayhem should not be loud enough to obscure the commentary.

GALLERY VOICE: ....We have our very own surgical theatre troupe. As we observe from the gallery, a very painful birth occurs down in the operating room. We are extremely fortunate to be allowed to witness such a beautiful event. Usually only medical staff and family are allowed in during delivery. But since this is such a monumental event, they've allowed in a few very special guests - we up here, and about (scanning the audience, pretending to count) ...three hundred of our closest friends.

Now, if you will all please direct your attentions to the stage below, the contractions seem to be coming closer now.

VOICE II: We earlier witnessed a critical scene from a hui at the Otautahi meeting house in which the idea of cultural safety first cropped up. Subsequent hui, meetings, strategy sessions and teas focused on the issue of making health care more accessible to people of all cultures, focused specifically on nurses and midwives and how to teach them about culture, differences, racism, and intolerance.

VOICE III: (Rising to join in) ...And how not to continue the fearful prevalence of said sins amongst health care professionals. Well, they set Irihapeti Ramsden on the job - she was already a prominent name, and the Maori Representative on the Nursing Council. She drew up a proposal for instituting cultural safety in Polytechnics, in Nursing and Midwifery degree programs. And, lo and behold....

GALLERY VOICE: ...it was accepted by the Nursing Council and instituted nationwide as a mandatory part of training, and as twenty percent of the State Nursing Final!

Onstage, the PATIENT screams agonizingly then sighs and leans back on the operating table. The NURSES cheer, one of them holds a baby doll aloft and they all applaud. One Nurse carries the baby off, the others hover around the new mother, fanning and massaging her. During the following narrative, one of the nurses leads the PATIENT off, then comes back to fuss and restore the operating room. Before long, the CHILD enters, wailing, led by the
original PATIENT, who then exits again. The nurses then spring into action, administering giant pills, wrapping him in blankets, singing to him, etc.

VOICE III: As we know, however, the blush of new motherhood quickly wore off, and the first growing pains set in. The young program ran into devilish obstacles at every turn.

Enter the DEMONS, crazily dressed, wielding giant crayons and reams of paper. They chase the CHILD, who is now screaming, around the stage, while the nurses try to protect him.

VOICE II: Some Nursing students, mostly Pakeha, had quite a problem with the program. They felt they were being forced against their will to study courses in Maori culture and racism awareness, among others, that were not entirely relevant to their degree.

GALLERY VOICE: As though no other degree program has ever required irrelevant classes! (Starts laughing uncontrollably)

VOICE II: (Stares reproachfully at GV) That's entirely beside the point. These classes were highly relevant. Anna Penn proved that! But I'm getting ahead of meself. The classes, unfortunately, were not taught according to a universal curriculum, and were in some instances presented by professors with no prior training in these issues. The program required a visit to a marae, preferably only after the second year of a Nursing program. Christchurch Polytech, where Anna Penn was enrolled, unfortunately scheduled the marae visit during the first year, when some students were not adequately prepared for such an intense cultural experience.

The DEMONS have cornered the CHILD, swarmed round him while he lies on the floor and the NURSES stand aside, terrified. The DEMONS perform a brief interpretive dance over the form of the child, then run offstage. The NURSES pick up his limp form and lay him on the operating table. They start rushing about, doing a series of madcap tests and fluttering around. In the midst of the flurry, the CHILD slips under the table and is replaced by a stronger TEENAGE BOY. The NURSES seem oblivious to the change.

GALLERY VOICE: Anna Penn was one such student. She missed most of the preparatory classes and, as we heard, acted out a wee bit during the hui and offended rather a lot of people. This was one more notch against her, and she was not asked back for a second year.

VOICE II: Unfortunately, the Polytech was not failing just anybody, as we have seen. Anna was not about to take this verdict lying down.
One of the DEMONS runs back onstage, picks up the TEENAGE BOY and holds him like a limp ragdoll out in front of her. He does not struggle, obviously weak from illness. She proceeds to dance a jig around the stage, holding the boy out as an unwilling partner.

VOICE II: As we have heard, Anna went to the press. And the presses loved it. Suddenly other students came forward, people who had also failed out of Nursing programs, all of them unfairly dismissed.

GALLERY VOICE: ...Or so they claimed. Like Mr. Peter Adams, who said that he also failed a hui, but it was because he only spent one night at the marae instead of two. He then said that in order to make up for the failure, in order to pass the course, he was forced to “rub noses with a roomful of Maoris” to show his cultural safety. If a hongi is all it takes, for God’s sake, why couldn’t Anna pass? (muttering) ...Rubbing noses with a roomful of...Ignoramus! .... Just ridiculous! Of course, since everyone at Christchurch was so occupied with Anna’s tantrum, we may never hear their side of the Peter Adams story.

VOICE III: Too true. Other claims went unchallenged. The papers printed stories based on rumor and personal complaints from people who had failed years before. And New Zealand society ate it up. Conservative folk everywhere were outraged at the extent to which Maori policies were being implemented by government, at the gains made in legislation by minorities.

VOICE II: (Holding a newspaper) And I quote...
"Sir, -- A Maori reported on National Radio, ‘Though marae justice may prohibit an elder from speaking on that particular marae, he may speak on any other and would most certainly be invited to speak on his’.
“It seems odd that Maoris do not have the power to banish Maoris from their culture, yet they have government-supported power to banish Europeans from European culture, as in the case of Anna Penn.
“Does this mean Maoris have denigrated Europeans into a laughing stock of gutless wonders?”
Signed, H. Castle, Palmerston North.ii

GALLERY VOICE: Outrageous! Of course, the so-called takeover was largely in their minds. Maori remain the poorest, least healthy, most incarcerated segment of the population. But society being racist as it is....

VOICE II: (Obviously irritated) Sir, I must apologize, but this has gone on quite long enough. I thought we were trying to inform the audience here of an historical situation. You seem to think this gallery is your personal soapbox.
GALLERY VOICE: *(With feigned innocence)* Well, someone needs to tell them the real story. Oppression, colonialism, imperialism, racism--

VOICE II: --Look, they're not idiots. They get the picture. We'll tell them the basic story, they'll draw their own conclusions. How does that sound?

VOICE III: *(Rolling her eyes exaggeratedly)* Both of you need to focus. Need I remind you that we're in the middle of a performance here?

VOICE II: Fine. I think this is an important enough topic to let his little commentary slide. But we need to have a talk later, you! *(pointing his finger at GV)*

GALLERY VOICE: *(Shrugging)* ... As I was saying before being so rudely interrupted....

VOICE III: As we were saying... *(she glances back onstage, where the DEMON has left the TEENAGE BOY back in the care of the NURSES, who administer all kinds of remedies to try and revive him)* ... cultural safety became the topic on everyone's lips. Well, almost everyone. As Miss Herewini and Mr. Harding demonstrated, everyone had an opinion, and few seemed to agree. Anna appeared on the Holmes show, she and Ms. Ramsden were interviewed in virtually every newspaper and journal in the nation.

GALLERY VOICE: They even took up the cultural safety issue on 'Shortland Street'!

VOICE II: I remember those episodes.... *(Sighs)* Of course, as always happens, eventually everything died down. People found other things to argue about over their DB Draughts...

GALLERY VOICE: *(interrupting, feigning outrage)* Lion Red, thank you!

VOICE III: Oh, for Heaven's sake.

VOICE II: *(pretending not to hear GV)* And Anna left the country, moved to Australia. Leaving the dedicated proponents of cultural safety to pick up the pieces.

One of the NURSES onstage drops a surgical tray, and they all cluster around, putting the instruments back where they belong. The TEENAGE BOY is sitting up on the operating table, looking stronger, flexing his biceps and admiring them.
VOICE III: Amazingly enough, the Nursing Council did not scrap the program.

GALLERY VOICE: Government does something right for a change!

VOICE II: And the program went back to the proverbial drawing board. 'Retooling', I think they call it in television.

VOICE III: Only this was a little more serious than a Seinfeld episode, and a lot more work! (Looking down at the boy posing) My, my, they certainly are resilient at that age!

VOICE II: Good thing! Because the program had a long way to go in the eyes of the New Zealand public. For a country so rich in cultural diversity, the notion of multiculturalism or biculturalism has been quite hard for a lot of people to accept.

GALLERY VOICE: At least, thanks to the cultural safety program, most people know what it means! Or have at least heard the word before. And that's a start!

VOICE III: And now the program is back, freshly revamped. Better defined curriculum guidelines, stricter advisement on timing of marae visits, culture classes, and everything else involved. As a matter of fact, I have the revised guidelines right here. I'd like to share the principles of cultural safety with the audience, if you two don't mind. There are eight categories...

GALLERY VOICE: (interrupting, grabbing at the document) Gimme that! I want to read it! We both know I'm much better at public reading than you!

VOICE III: (holding the papers out of his reach, wrestling with him) Well, honestly! I never! Who the hell do you think you are, you egotistical, selfish....

VOICE III and GALLERY VOICE become engaged in a tug of war over the document, until VOICE II steps in and wrenches it out of both of their hands, carries it off to the side while they settle down and glare at each other, and begins to read very theatrically. During the commotion, the TEENAGE BOY has slipped offstage and been replaced by a stunningly handsome MAN. The MAN stands centerstage and poses while the principles are read, "vogueing", pirouetting, flexing, generally showing off with a new move every time a new category is read. The NURSES stand in a semi-circle behind him, beaming like proud mothers.)

VOICE II: Ahem...
The categories of cultural safety in nursing and midwifery education are:
2. The relationship between nurses and midwives and those who differ from them by age or generation.
3. The relationship between nurses and midwives and those who differ from them by gender.
4. The relationship between nurses and midwives and those who differ from them by sexual orientation.
5. The relationship between nurses and midwives and those who differ from them by socioeconomic status.
6. The relationship between nurses and midwives and those who differ from them by ethnic origin.
7. The relationship between nurses and midwives and those who differ from them by religious or spiritual belief.
8. The relationship between nurses and midwives and those who differ from them by disability.

GALLERY VOICE and VOICE III have regained their composure, and have been fascinated by the spectacle below them. They grin broadly, and look sheepishly at each other.

VOICE III: And there you have it. He did a pretty good job of the reading, too. Don't you think?

GALLERY VOICE: (conciliatory) He did. Pretty straightforward stuff, isn't it? It's not about nurses having a cultural checklist, or about Maori taking over the hospitals. It's about the oppressed and dispossessed getting a fair shake; it's about making good health accessible and desirable to everyone. And it's about taking control of people's wellbeing out of the hands of a few racist bureaucrats and giving it back to the people most directly impacted. Why is it so hard for people to grasp?

VOICE II: Well, people are going to get another chance, since the new guidelines will be implemented at all the polytechnics. And they'll be accompanied by improved support for teachers of the different units. Training for professors, greater availability of Maori tutors for Treaty units, generally a better understanding among professors of how to teach sensitivity sensitively!

GALLERY VOICE: You two are such optimists. Sure, there's a new program, and Ms. Ramsden has done wonders touring the country, speaking to concerned citizens, redrafting the guidelines with the Nursing Council. But it's still New Zealand society that these schools ultimately have to deal with.
And who knows how long it'll take the world at large to realize what a great idea this is, what an absolute necessity it is?!

VOICE II: I hate to admit it, but you’re right. There’s no way to know how the country will react to the new, mature creation. Only time will tell, I suppose. Meanwhile, we can sit back and admire the results. (he raises an eyebrow suggestively, leans over the edge of the gallery, sighs, and gazes at the MAN.)

VOICE III: And we’ve witnessed some good signs here tonight - take the students, for example. They’re in the thick of the new program - and loving it. Maybe there’s hope for our people yet - if this new crop of nurses and midwives can implement the ideals of the program, and teach their successors....

GALLERY VOICE: There just might be a chance....

As GV finishes speaking, the lights dim on the gallery. The observers sit and look intently at the events below, suddenly serious. The NURSES and the MAN have returned to the operating table. The MAN lies on the table, the nurses grouped around him. They are very professional, with their masks on as though in the thick of surgery. The entire stage is in silence from this point on.

As the lights dim on the gallery, PROFESSOR GREELEY enters leading LORA, DAVID, AMY, ROSE, BRONWYN, MARI, JOE, and MALAMA. They wear surgical masks and are obviously on a field trip to the operating room as part of their class. PROF GREELEY gestures and mouths explanations of various devices in the operating room, some of the students jot down an occasional note in their notebooks. The NURSES carry on, from time to time holding up a surgical tool as PROF GREELEY explains its purpose.

Suddenly, VOICE II stirs and stands up, knocking over a chair accidentally. The sound is huge in the silence, and everyone onstage looks up at the gallery simultaneously, noticing the figures there for the first time. There is a moment of mutual recognition, then the gallery slowly begins to lower toward the stage. The STUDENTS, PROF GREELEY and the NURSES begin to move in slow motion upstage toward the gallery, the MAN gets up from the table and follows. They all move centerstage as the VOICES step off their platform.

As the lights go down, everyone onstage can be seen stretching their hands towards each other, across the last few feet that separate the observers from those on the stage. The bird on the scrim is illuminated in the darkness and slowly moves up to the very top of the wall and across the ceiling. A blinding
spotlight scans the faces of the audience (momentarily blinding them) as the sound of rushing wings fills the theatre and the curtain falls.

CURTAIN

NOTES
i The letters read by HINA WRIGHT and MIKE BLANCHARD are actual letters to the editor from the Christchurch Press, July 16 and 17, 1993. Only the names have been changed.
ii Another actual letter from the Christchurch Press, with a different name.
Any discussion of Maori health statistics must begin with an attempt at understanding an alternative conception of health. Although limited by my own personal worldview and concept of ‘health’, Mason Durie’s definition has provided me a certain insight. In a chapter on Maori Health Perspectives, he outlines a few of the more prominent perspectives that emerged during the 1970’s and early 80’s. The most widely acknowledged of these was a four-sided health construct, called the whare tapa wha, or four-sided house.

This model basically integrated four dimensions necessary for health and well-being, representing them as the four walls of a house - each integral to the structure as a whole and all four necessary to ensure “strength and symmetry”. The four walls consisted of taha wairua, the spiritual side; taha hinengaro, the thoughts and feelings of an individual; taha tinana, the physical side; and taha whanau, or family. The model emerged in 1982 at a training session for fieldworkers in the Maori Women’s Welfare League research project entitled Rapuora. Durie drew upon the concept and presented it in his text in a clarifying table, recreated in Table 1. The Government’s Public Health Commission has also used the whare tapa wha model in setting goals for betterment of Maori health, specifically in its strategic plan document titled He Matariki (1994-1995). The publication is a
collection of the PHC’s advice to the Minister of Health, and bases its goals for
whanau wellbeing on the “four cornerstones of health”, parallel to the model
described below.

<table>
<thead>
<tr>
<th>Table 1: Whare Tapa Wha Model of Health</th>
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<tbody>
<tr>
<td><strong>Taha Wairua</strong></td>
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<tr>
<td>Focus</td>
</tr>
<tr>
<td>Key Aspects</td>
</tr>
<tr>
<td>Themes</td>
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</tbody>
</table>


The Whare Tapa Wha model serves well to demonstrate the tapestry of a
Maori understanding of health. Mind, body, spirit, family all weave together
to form each person’s identity; a healthy individual relies on the strength of
all four walls to support daily existence. It is for this reason that a picture of
Maori health is difficult to paint relying on statistical clinical data alone.
Understanding the disenfranchisement underlying high rates of certain
diseases and higher risk categories is a critical stepping stone on the path to
improved health.

NOTES
Auckland, pp. 67-81.
Specific data on Maori health standards have traditionally been compiled in comparative studies with statistics of non-Maori populations. One early systematic tabulation was a special report produced by R. J. Rose for the Department of Health in 1960. The following year the Hunn Report was released as an Appendix to the Journal of the House of Representatives. Both studies revealed a definitive gap in Maori health standards relative to citizens of European ancestry.

Table 2 outlines the shocking disparities between Maori and European populations between the years of 1950-1959. The statistics, focusing on four integral indicators of the health of a population, come from the Hunn Report, the table was arranged by Durie.

<table>
<thead>
<tr>
<th>Table 2: Maori vs. Non-Maori Health Statistics, 1950's</th>
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</thead>
<tbody>
<tr>
<td><strong>Maori</strong></td>
</tr>
<tr>
<td>Life Expectancy (1951)</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Birth Rate* (1956)</td>
</tr>
<tr>
<td>Infant Mortality* (1956)</td>
</tr>
<tr>
<td>Death Rate* (1959)</td>
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</table>

*per 1000 births or deaths
The discrepancies are astonishing - 150 years after the signing of the Treaty of Waitangi, the indigenous people of Aotearoa continued to face staggering odds in quality and length of life. In the following decades the situation improved dramatically, but Maori continue to rank at the bottom of measurements of national health. Eru Pomare published a comparative study of Maori health in 1980 and again in 1988. The first covered the years 1955 to 1975, the second compiled information from 1970 to 1984. The second study showed a marked improvement in the health standards listed above: fertility rates were reduced; life expectancy improved by 2.8 years for males and 3.5 years for females; mortality rates declined by nearly 25 percent.

In the 1994 publication Our Health - Our Future: Hauora Pakari, Koiora Roa, the Public Health Commission reported even more favorable indicators for Maori population expansion and life expectancies. The report states that a Maori child born in 1994 “can expect to live nearly two-and-a-half times as long as a child born in 1894”. The same child will likely be taller, healthier, at lower risk of chronic infection, and will have a greater chance of reaching adulthood with both parents still alive. Although fertility rates today are comparable between Maori and non-Maori, Maori mothers tend to be younger than non-Maori by as much as a decade. Table 3 highlights the drastic improvement in population gains, life expectancy, and mortality over the past century within the Maori population itself.
Table 3: Maori Population, Life Expectancy, and Mortality (1896-1991)

<table>
<thead>
<tr>
<th>Year</th>
<th>Maori Population</th>
<th>Maori Life Expectancy at birth (years)</th>
<th>Crude death rate (per 1000)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td></td>
</tr>
<tr>
<td>1896</td>
<td>42,650</td>
<td></td>
<td>35</td>
</tr>
<tr>
<td>1901</td>
<td>45,549</td>
<td>35</td>
<td>30</td>
</tr>
<tr>
<td>1936</td>
<td>82,326</td>
<td>46</td>
<td>46</td>
</tr>
<tr>
<td>1986</td>
<td>404,778</td>
<td>68</td>
<td>72</td>
</tr>
<tr>
<td>1991</td>
<td>511,278</td>
<td>68</td>
<td>73</td>
</tr>
</tbody>
</table>


Despite a significantly positive trend among these major indices, disturbing patterns have cropped up in other areas - particularly in health problems related specifically to socio-environmental factors. Problems have appeared in mental health and in smoking-related diseases, with psychiatric admissions increasing among Maori. Lung cancer has also increased dramatically among Maori, while remaining at the same level for the rest of the population.

The roots of current health problems facing Maori run deep into the fabric of the social and political climate in Aotearoa/New Zealand. The inability of the government or the health care system to stem the steady rise in socioeconomic-related illness is indicative of a deeper, more disturbing trend. Continuing disparities between Maori and non-Maori health standards
indicate profound failures in the current political and health care systems to adequately address the needs of a changing population. Something is obviously wrong; clinical health statistics are not the only symptom.

Many of the modern inflictions now evident among Maori are directly attributable to the low socioeconomic standing of the indigenous population in relation to the rest of the country. In the 1990's Maori live increasingly in urban settings; fewer than 50 percent of Maori adults own their own home (as compared to 75 percent of non-Maori), and two-thirds live in overcrowded conditions. These two factors alone have been linked to infectious diseases, respiratory problems, and mental health illnesses. vi

Poverty is another major factor impacting social illness. The annual median income for Maori over age 15 was $11,001 in 1992, and over 75 percent of Maori received less than $20,000 annually. vii Unemployment rates among Maori have skyrocketed to 23.8 percent among males and 24.7 percent for females. For younger Maori, aged 15 to 24, the rate is 36.7 percent. viii Unemployment and poverty level income lead to more socioeconomic disease, including psychiatric and alcohol- and drug-related illnesses, currently some of the most pressing health issues for the population.

The list of socioenvironmental inflictions continues: Maori represent a disproportionately large segment of the prison population in Aotearoa/New
Zealand; Maori hospitalized for mental health conditions far outnumber non-Maori. Drug, alcohol and tobacco use are exceedingly high among Maori, as are rates of suicide, unintentional injury, and domestic violence - all public health issues, all of special concern for Maori.

NOTES
iii Mason Durie, p. 131.
v ibid, p. 56.
vi ibid, p. 63.
vii ibid.
viii ibid.
APPENDIX III
A BRIEF HISTORY OF MAORI HEALTH MOVEMENTS

The beating wings of the bird of cultural safety soar on the breezes and airstreams of other pathbreaking programs. In Whaiora: Maori Health Development, Mason Durie reports three phases of Maori health leadership: the first, 1900-1930, he calls Mana rangatira; the second, 1931-1974, Mana wahine; and the third, from 1975-1992, is titled Mana Maori. We will highlight a few of the more successful programs - those that, if not exactly paving the way, at least cleared a footpath for the cultural safety program through the forests of institutional racism and indolence.

MANA RANGATIRA

The Mana rangatira period embodied active Maori participation in shaping health policies, mainly on a local level. In 1900, The Maori Parliament (formed in 1892 to work towards a greater degree of Maori autonomy under the colonial government) created nineteen elected Maori Councils which were assigned certain public health responsibilities, such as sanitary regulations for meeting houses and water supplies. At the same time, the Department of Health was established by the national government, with Maui Pomare (father of Eru Pomare, author of the Hauora texts) serving as the first Maori medical officer. He worked closely with the Councils, acknowledging their roles as vehicles for health promotion, disease
prevention, and data collection. In 1902, the Maori census showed a 70 percent increase in vaccinations, mainly a result of the efforts of Pomare and the Councils. In 1920 the DOH was reorganized and a Division of Maori Hygiene was established, directed by the now-famous Dr. Peter Buck, Te Rangihiroa. He established even closer relations with the Maori Councils by turning them into Health Councils, with special districts and the power to authorize village committees to enforce health and sanitation laws.

The early period of Maori input into health regulation was short-lived, however, and in 1930 the Division of Maori Hygiene was abolished, along with all Maori health leadership at the national level. This trend was particularly disturbing because the Tohunga Suppression Act in 1907 had outlawed all traditional Maori healing practice, placing the indigenous peoples firmly within a western concept of health care. Maori women were discouraged from entering the nursing practice due to their lack of objectivity in dealing with their Iwi. It was during this period of virtual abandonment of Maori participation by the government that the women of the communities picked up the slack.

MANA WAHINE
Dorie’s Mana wahine era, obviously named for the efforts of Maori women to bring better health to an ailing population, is typified by the work of the
Women’s Health League and the Maori Women’s Welfare League. The Women’s Health League, or Te Ropu o Te Ora, was established in 1937 in Rotorua. It was formed from a collection of local health committees created in the region by Miss Robina T. Cameron. The local groups had been working to bring a Pakeha understanding of health into the home, including care of children, the home, dietary advice, and disease prevention.

The League’s main objectives were promotion of understanding and discussion between Maori and Pakeha women, preservation of Maoritanga (particularly arts and crafts), recording of births and deaths in the community, encouragement of gardening and growing fruit trees, increasing involvement on the Marae and improvements of the Pa, and to aid “members in sickness or misfortune”.iv The League was largely successful in raising awareness in rural communities and has continued its service through the present. By 1943 there were over twenty League branches operating throughout the region, and in 1986 they opened a Health Centre in Tunohopu.

On the heels of the Women’s Health League, another women’s organization was formed. In 1951 the Maori Women’s Welfare League was born, also an amalgamation of smaller welfare committees. These activist women, however, were sprinkled throughout the country, originally intended to merge under the direction of Nurse Cameron and the Women’s Health
League. Due to concerns over government domination and manipulation of their objectives, however, the Women's Welfare League opted to remain independent. Its goals were much the same as those of its predecessor, but the Welfare League's voice extended to include concerns over education, housing, and discrimination against Maori, and soon became an active advocate for establishment of safe health care through accessible, culturally sensitive clinics. 

The Welfare League continued through subsequent decades to be an ardent voice for change and equal rights, and remains a conspicuous force in Maori affairs today. Individual women and men also achieved prominence during this period of health and welfare development by specializing in different medical fields and as administrators. These representatives were few and far between, however, and little attention was paid to their unique cultural understanding. During the third of Durie's phases, however, the cause of Maori rights was to rise to center stage, with health issues as the locus of much of the debate.

MANA MAORI

In 1975 Whina Cooper, a past president of the Maori Women's Welfare League, led a march from Te Hapua to Wellington to protest alienation of Maori lands. 5,000 marchers joined her; the event has been inscribed in the
retina of the New Zealand eye as one of the watershed events of the Maori activist movement. Led by women, the march has also been heralded as a key chapter in the Maori feminist movement. This assertion of Maori identity proved especially powerful since it came in the same year as the creation of the Waitangi Tribunal. This body was formed by government to address claims of Maori under the Treaty of Waitangi, and was one more indication of the strength of a unified Maori voice. Beginning almost immediately, the government began in earnest to redress the wide disparities in income, health, and quality of life between Maori and non-Maori.

In 1981 and 1982 the Maori Women's Welfare League research unit conducted their Rapuora study, a first in terms of methodology and relevance. The goal was to collect information on the health and lifestyle choices of Maori women, and the entire process was performed by Maori women with a Maori framework. The information was then used to make recommendations to government, calling for marae health centers to provide primary and traditional health care and to promote health concerns among Maori communities. Rapuora itself became a health movement, with health centers, or whare rapuora, established at marae and urban centres in the 1980's. Several initiatives were developed in the following years by individuals and communities, including localized health clinics and
educational programmes. In 1992, a DOH directory listed over 140 separate Maori health initiative organizations.\textsuperscript{vii}

A resurgence in traditional healing also emerged during the early 1990's, as health activists in community settings were providing safe ground for practitioners and patients. The Tohunga Suppression Act had been repealed in 1964, and in 1987 the DOH had provided a list of guidelines to hospitals and other practitioners for use in dealing with traditional healers and health workers, or kai awhina. Hui and meetings in 1992-93 birthed a network of recognized healers and a support system for practitioners who had been long banned from the dominant system.

BICULTURALISM AND HEALTH CARE

Along with community initiatives and a resurgence in traditional practices, the 1980's and 90's saw a renewed commitment of government resources to the betterment of Maori health and welfare. These programs, while not altogether successful, 'broke in' government officials to the notion of bicultural health institutions, clearing a path for the cultural safety program. A significant question in devoting resources to this end is that of the nature of biculturalism as it relates to government institutions. Compelling arguments can be made for the creation of bicultural institutions, parallel institutions, or completely separate Maori institutions. Each presents a
different view of federal responsibility and of the essence of biculturalism itself. The Department of Health attempted several programs aimed at improving Maori health and accessibility of existing health care facilities.

The DOH issued bicultural directives in the mid-80’s for hospital boards as an avenue toward instituting biculturalism. Four general approaches were evident in the hospital initiatives: the first was an attempt to increase cultural awareness for health professionals through training; the second involved increased health awareness among Maori communities, accomplished through educational outreach programmes; third, the hospitals established health programs geared specifically toward Maori patients.

Two examples of parallel Maori programs were Te Whare Paia in Auckland and Te Whaiora in Te Awamutu. The institutions, Carrington and Tokanui Hospitals respectively, provided funding for parallel State-funded clinics to operate concurrently with existing western-style psychiatric services. The alternative clinics catered to Maori patients, and met with a warm reception. Political disagreements over the breadth of hospital control over the Maori programs (probably inevitable) made for lengthy and painful adjustments, but the programs were reordered became the base for programs in hospitals across the nation.
The fourth general approach to hospital biculturalism was development of liaisons between the institutions and the Maori community. viii The roles of these individuals were numerous: to keep local communities informed of changes and happenings; to include local Maori representatives and organizations in hospital decisions affecting the community; to support hospital staff in dealing with Maori patients and programs; to assist Maori patients in accessing the hospital services; and to perform advocacy and educational work in the communities, among many other responsibilities. These liaison officers were in essence performing much of the legwork that would later be required for the cultural safety program, in terms of breaking new ground in relations between health care facilities and local Maori communities - relations that would prove vital in establishing advisory panels and crucial community cooperation for the initiation of the new cultural component.

The general approaches utilised by the hospitals and area health boards were not always successful, but they represented an important step in the acknowledgment of government’s responsibility for Maori health and welfare under the Treaty of Waitangi. It was precisely this responsibility (spiced with a fair dose of guilt) which led the Nursing Council in 1992 to accept and integrate cultural safety as a means of addressing the inaccessibility of health care for Maori. All of these programs, along with their counterparts, can be
imagined as the hatchling feathers of our metaphorical bird, preparing to test its young wings.

NOTES

2Durie, pp. 43-44.
3Ibid., p. 44.
4Ibid., p. 48.
5Ibid., p. 50.
6Mason Durie includes in Whaiora an extensive list of some prominent Maori practitioners and administrators between 1931 and 1975. (Durie, pp. 52-53).
7Durie, p. 55.
8These four general approaches are discussed in further detail in Durie, pp. 107-115.
APPENDIX IV
THE TREATY OF WAITANGI: IN SICKNESS AND IN HEALTH
TEXTS OF THE TREATY OF WAITANGI

THE TREATY IN ENGLISH

Her Majesty Victoria Queen of the United Kingdom of Great Britain and Ireland regarding with Her Royal Favour the Native Chiefs and Tribes of New Zealand and anxious to protect their just Rights and Property and to secure to them the enjoyment of Peace and Good Order has deemed it necessary in consequence of the great number of Her Majesty's Subjects who have already settled in New Zealand and the rapid extension of Emigration both from Europe and Australia which is still in progress to constitute and appoint a functionary properly authorized to treat with the Aborigines of New Zealand for the recognition of Her Majesty's Sovereign authority over the whole or any part of those islands - Her Majesty therefore being desirous to establish a settled form of Civil Government with a view of the necessary Laws and Institutions alike to the native population and to Her subjects has been graciously pleased to empower and to authorize me William Hobson a Captain in Her Majesty’s Royal Navy Consul and Lieutenant Governor of such parts of New Zealand as may be or hereafter shall be ceded to Her Majesty to invite the confederated and independent Chiefs of New Zealand to concur in the following Articles and Conditions.

Article the first

The Chiefs of the Confederation of the United Tribes of New Zealand and the separate and independent Chiefs who have not become members of the Confederation cede to Her Majesty the Queen of England absolutely and without reservation all the rights and powers of Sovereignty which the said Confederation or Individual Chiefs respectively exercise or possess, or may be supposed to exercise or to possess, over their respective Territories as the sole Sovereigns thereof.

Article the second

Her Majesty the Queen of England confirms and guarantees to the Chiefs and Tribes of New Zealand and to the respective families and individuals thereof the full exclusive and undisturbed possession of their Lands and Estates, Forests, Fisheries and other properties which they may collectively or individually possess so long as it is their wish and desire to retain the same in their possession; but the Chiefs of the United Tribes and the individual Chiefs
yield to Her Majesty the exclusive right of Preemption over such lands as the proprietors thereof may be disposed to alienate at such prices as may be agreed upon between the respective Proprietors and persons appointed by Her Majesty to treat with them in that behalf.

Article the third

In consideration thereof Her Majesty the Queen of England extends to the Natives of New Zealand Her royal protection and imparts to them all the Rights and Privileges of British Subjects.

(Signed) W Hobson Lieutenant Governor

Now therefore We the Chiefs of the Confederation of the United Tribes of New Zealand being assembled in Congress at Victoria in Waitangi and We the Separate and Independent Chiefs of New Zealand claiming authority over the Tribes and Territories which are specified after our respective names, having been made fully to understand the Provisions of the foregoing Treaty, accept and enter into the same in the full spirit and meaning thereof in witness of which we have attached our signatures or marks at the places and the dates respectively specified --

Done at Waitangi this Sixth day of February in the year of Our Lord one thousand eight hundred and forty.

THE TREATY IN MAORI

Ko Wikitoria te Kuini o Ingarani i tana mahara atawai ki nga Rangatira me nga Hapu o Nu Tirani i tana hiahia hoki kia tohungia ki a ratou o ratou rangatiratanga me to ratou wenua, a kia mau tonu hoki te Rongo ki a ratou me te Atanoho hoki kua wakaaro ia he mea tika kia tukua mai tetahi Rangatira - hei kai wakarite ki nga Tangata maori o Nu Tirani - kia wakaaetia e nga Rangatira maori te Kawanatanga o te Kuini ki nga wahikatoa o te Wenua nei me nga Motu - na te mea hoki he tokomaha ke nga tangata o tona Iwi Kua noho ki tenei wenua, a e haere mai nei.

Na ko te Kuini e hiahia ana kia wakaritea te Kawanatanga kia kaua ai nga kino e puta mai ki te tangata Maori ki te Pakeha e noho ture kore ana.

Na, kua pai te Kuini kia tukua a hau a Wiremu Hopihona he Kapitana i te Roiara Nawi hei Kawana mo nga wahi katoa o Nu Tirani e tukua aiane, amua atu ki te Kuini, e mea atu ana ia ki nga Rangatira o te wakaminenga o nga hapu o Nu Tirani me era Rangatira atu enei ture ka korerotia nei.

Ko te Tuatahi

Ko nga Rangatira o te wakaminenga me nga Rangatira katoa hoki ki hai i
DIFFERENCES IN INTERPRETATION

The difference between the English and Maori versions of the Treaty of Waitangi has been the subject of much discussion. Briefly, the Treaty consisted of a Preamble and three articles: the first article provided for the transfer of sovereignty, the second insured a continuation of existing property rights, the third offered citizenship rights. The text was drafted in English and then translated by Henry Williams, a missionary whose unfortunate manipulation of the translation process, however unintentional, led to a
century and a half of misunderstanding. Instead of choosing equivalent Maori terms for the all-important term ‘sovereignty’, he included instead a transliteration of the word ‘governorship’, kawanatanga, which led Maori signatories to believe the issue at stake was one of administrative authority, not an actual transfer of individual or national sovereignty.

The English translation of the Treaty focused more intensely on Article One, while the Maori version emphasized Article Two. In the Maori translation the second Article went beyond the notion of inalienable property rights with the phrases ‘tino rangatiratanga’, implying for Maori the entrenchment of chiefly power and authority; and ‘taonga katoa’, stated in English as ‘other properties’, but encompassing social and cultural properties (such as language) in the Maori understanding.

The mistranslation and subsequent abuse of the Treaty of Waitangi holds special importance in the arena of health care. Article Two, with its guarantee of protection for taonga, can be construed as a guarantee of good health, encompassing the ‘treasures’ (a literal translation of taonga) of personal and tribal physical and spiritual welfare. This argument has been recognized by the government, but was not officially accepted since it implies that the
health of Maori requires protection above and beyond the health of all New Zealanders.

Article Three, however, has a much more direct application in health struggles. By insuring equal citizenship rights, the Treaty infers equal treatment and equal protection from the government. This equity under the law also guarantees that there will be no significant gaps between Maori and non-Maori (European settlers at the time of signing) in health, income, educational opportunities, or any facet of life. Given past and present incongruities between Maori and non-Maori quality of life, a highly persuasive case can be made for restitution.

NOTES


2 Mason Durie, (1994), Whaiora: Maori Health Perspectives, Oxford University Press, Auckland, p. 84.
<table>
<thead>
<tr>
<th>MAORI TERM</th>
<th>Meaning</th>
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<tbody>
<tr>
<td>HA A KORO MA A KUI MA</td>
<td>lit.: the breath of life from the ancestors; understanding that good health is linked to them</td>
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<tr>
<td>HAKA</td>
<td>dance (old)</td>
</tr>
<tr>
<td>HINENGARO</td>
<td>the mind as a dimension of health perspective</td>
</tr>
<tr>
<td>HUI</td>
<td>gathering, meeting</td>
</tr>
<tr>
<td>KARAKIA</td>
<td>forms of words necessary for ritual acts, incantations</td>
</tr>
<tr>
<td>KATOA</td>
<td>all; every; completely; total</td>
</tr>
<tr>
<td>KAUMATUA</td>
<td>elder; old man; adult</td>
</tr>
<tr>
<td>KAWA</td>
<td>protocol of dedication</td>
</tr>
<tr>
<td>KAWANATANGA</td>
<td>Crown principle of self-government (transliteration of 'governorship' used in Treaty)</td>
</tr>
<tr>
<td>MANA AKE</td>
<td>uniqueness of individual and family</td>
</tr>
<tr>
<td>MANAAKITANGA</td>
<td>caring</td>
</tr>
<tr>
<td>MARAE</td>
<td>meeting area of whanau (family) or iwi (tribe); focal point of settlement; central area of village</td>
</tr>
<tr>
<td>MATE ATUA</td>
<td>diseases with no apparent ordinary explanation; infectious diseases (thought to be from the gods)</td>
</tr>
<tr>
<td>MATE TANGATA</td>
<td>injury or illness due to human activities (ie, warfare)</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>MAURI</td>
<td>life-sustaining principle in people and objects (including language)</td>
</tr>
<tr>
<td>PAKEHA</td>
<td>non-Maori, European, Caucasian</td>
</tr>
<tr>
<td>RANGATIRATANGA</td>
<td>Crown principle of self-management; interpreted in Maori as sovereignty</td>
</tr>
<tr>
<td>TANGATA WHENUA</td>
<td>local people, aborigine, native</td>
</tr>
<tr>
<td>TAONGA</td>
<td>property; treasure; apparatus; accessory</td>
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<tr>
<td>TAONGA TUKU IHO</td>
<td>cultural heritage</td>
</tr>
<tr>
<td>TE AO TUROA</td>
<td>physical environment</td>
</tr>
<tr>
<td>TINANA</td>
<td>the physical dimension of health</td>
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<tr>
<td>TOHUNGA</td>
<td>expert; specialist; priest; artist</td>
</tr>
<tr>
<td>TURANGAWAEWAE</td>
<td>indisputable land base, necessary for good health</td>
</tr>
<tr>
<td>WAHINE</td>
<td>woman</td>
</tr>
<tr>
<td>WAIRUATANGA/TABA WAIRUA</td>
<td>spirituality/the spiritual dimension of health</td>
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<tr>
<td>WHAKARURUHAU</td>
<td>shelter; protector; storm cover</td>
</tr>
<tr>
<td>WHANAUNGATANGA</td>
<td>the extended family; family ties, family cohesion</td>
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<tr>
<td>WHATUMANAWA</td>
<td>open and healthy expression of emotion</td>
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* All definitions are from Durie’s *Whaiora* text (1994) or from P.M. Ryan’s *Dictionary of Modern Maori* (1994).
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