Article

Critical Ethnography, Cultural Safety, and International Nursing Research

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Abstract

Critical qualitative methodology provides a strategy to examine the human experience and its relationship to power and truth. Cultural safety is a concept that has been applied to nursing education and practice and refers to interactions that acknowledge and respect the unique cultural background of patients. It recognizes power inequities between caregivers who belong to dominant cultures and patients who may belong to oppressed groups. Culture is interpreted from a critical constructivist perspective as a fluid relational process that is enacted contextually. The purpose of this paper is to examine the congruence between and

among critical methodology, cultural safety, and the conduct of nursing research in low- and middle-income countries by nurses from high-income countries. It is argued that if cultural safety is important and relevant to education and practice, then it might be appropriate to address it in research endeavors.

Keywords: critical qualitative methodology, cultural safety, international nursing research

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Introduction

Critical ethnography is a qualitative research methodology that enables the researcher to not only study and understand society, but also to critique and potentially change that society through his or her work. It is a methodology that is well suited to health research, given the contemporary perspective of health as a sociopolitical phenomenon influenced by issues of power and dominance (Cook, 2005). Use of a critical qualitative research method that emphasizes holistic human experience and its relationship to power and truth offers the opportunity to closely examine health challenges from the perspective of those who live with them daily. However, when researchers conduct studies in contexts and cultures with which they are unfamiliar, questions may arise about the ability to give authentic voice to participants without objectifying their knowledge or putting them at risk for unanticipated or unpleasant repercussions.

As a Canadian nurse researcher engaged in a study about the impact of HIV education on Ugandan nurses, the first author was concerned about the effects of her status as an outsider who was relatively inexperienced in international health research and her naiveté about the influence of the research setting on these issues. She was particularly interested in the concept of cultural safety and its potential role in the conduct of research in the Ugandan setting. Cultural safety, briefly, refers to

> fostering an understanding of the relationship between minority status and health status as a way of changing nurses' attitudes from those which continue to support current dominant practices and systems of health care to those which are more supportive of the health of minority groups. (Smye & Browne, 2002, p. 47)

Does the concept of cultural safety apply to the conduct of nursing research? If so, is there congruence between critical ethnographic methodology and cultural safety? In this article, we outline basic principles of critical ethnography and cultural safety. In the context of the research study, we explore differences and similarities of selected elements to the notion of cultural safety in nursing. We then discuss the merits of applying the concept to nursing research, citing illustrative examples from the study.

Critical ethnography

Qualitative research is directed at the discovery of meaning, rather than cause and effect, and typically focuses on process and context. The study is usually conducted in a natural setting and analysis is inductive, with the researcher paying particular attention to discourse and behavior of participants. In addition, the researcher is the data collection instrument and makes no attempt to avoid, in fact generally is dependent upon, relationships with the participants in an attempt to gain the emic, or insider, perspective (Rubin & Rubin, 2005). Ethnography is a qualitative approach in which the researcher explores aspects and meanings of a group's culture, including values, behaviors, and beliefs. The critical ethnographer examines that culture through the lens of power, prestige, privilege, and authority (Creswell, 2007) in response to an ethical responsibility to address unfairness or injustices and attempts to achieve positive social change (Brown & Dobrin, 2004; Carspecken, 1996; Hammersley, 1992; Madison, 2005).

A focused critical ethnographic approach was applied in this study to better understand the factors that shape the experiences of Ugandan nurses as they provided HIV care in resource-challenged settings. Despite the increasing popularity of critical ethnography as a research methodology, there is limited description of it in the literature. Carspecken (1996) offers an approach to critical ethnography in educational settings that has been noted as useful for nurse researchers. However, most of the published research using Carspecken's method has been conducted in Australia by nurses from that country or other high-income countries (as defined by The World Bank, 2010) in clinical settings such as renal dialysis and intensive care that utilize complex technologies, or in health promotion practice (Cook, 2005; Hardcastle, Usher, & Holmes, 2006; Smyth & Holmes, 2005). There is no reported research in which nurses from high-income countries conducted studies using this approach in low- and middle-income countries (LMIC) with colleagues who face severe resource constraints. Furthermore, nurse researchers have not articulated linkages between cultural safety and critical ethnography in the conduct of research in LMIC.

Qualitative research using Carspecken's (1996) method is intended to facilitate the explanation of social action that takes place in particular social sites. Its purpose is to reveal oppression and inequality to support efforts for change, and to avoid contributing to oppression in the conduct of the study. Carspecken noted that meaning is constituted within action and that agents are influenced by cultural conditions (e.g., social conduct, norms) and resources or constraints (e.g., economic or legal factors). Cultural power is the influence wielded by certain members of the social group regarding the behaviors of other members. Carspecken suggested that cultural power intersects economic and political power to render some groups dominant over others. However, culture can be created by group members as they resist the structures that constrain them in the enactment of their values. Thus, cultural structure may determine action in some cases, but it may also be changed through opposition to that structure. It is through the analysis of these systemic power sources and relationships that critical qualitative research findings are fully understood and utilized to create change.

An important aspect of Carspecken's (1996) approach is the interpretation of meaning and the importance of communicative structures used during interaction. He described critical epistemology as an understanding of the relationships among power, thought, and truth claims. A truth claim, defined as "an assertion that something is right or wrong, good or bad, correct or incorrect" (p. 56), is validated by consensus from the group and is fallible over time. The researcher understands the significance of social interactions by first observing behavior and verbal discourse, followed by the generation of meaning through researcher-participant dialogue. In this way, knowledge is created, and validity and trustworthiness are enhanced.

Cultural safety

Cultural safety is concerned with the provision of health care services in a manner that is respectful of and sensitive to the unique cultural background of the recipients of those services. As Dion Stout and Downey (2006) so eloquently stated, "cultural safety finds expression in caring spaces that are equality seeking and rights oriented" (p. 327) and contributes to health for indigenous peoples. Originating in the work of Maori nurse educators in the 1980s in response to the harmful effects of colonization on the health of Indigenous peoples in New Zealand, cultural safety was defined by the Nursing Council of that country in terms of the awareness and practice of individual nurses and midwives (Nursing Council of New Zealand, 2005). Ideally, the recipient of nursing services evaluated the effectiveness and quality of the care, and was empowered to contribute to improving outcomes.

Cultural safety education was introduced into nursing curricula in New Zealand in an attempt to change nurses' attitudes and behaviors from indiscriminate support of dominant health care practices toward affirmation of the cultural identity of each client (McGrath & Phillips, 2008). Following the specific application of cultural safety to the health care of the Maori people of New Zealand, advocates of the concept have promoted its consideration for use in other contexts and settings. A number of authors have suggested that cultural safety is an essential component of high quality health care delivery in such culturally diverse countries as Canada and Australia (Anderson et al., 2003; Browne, Fiske, & Thomas, 2000; Dion Stout & Downey, 2006; Johnstone & Kanitsaki, 2007; Williams, 1999), and that it should be a standard of practice when caring for any patient (Polaschek, 1998). It is apparent that cultural safety is a concept that is gaining currency in nursing education and clinical practice; the question we raise here is whether or not there is a role for cultural safety in the conduct of nursing research.

The research study

In our research project we focused on the impact of a 6-month education program about HIV care on the lives of 24 Ugandan nurses and nurse-midwives. We had been approached by the senior nursing administrator of a large referral hospital to conduct a study of the outcome of her efforts to secure a professional development opportunity for the nursing staff. It was agreed that we would explore the effects of completing this intensive and comprehensive learning activity on all aspects of participants' lives, including the professional, social, and personal. Details of the study findings have been published elsewhere (Harrowing, 2009).

Because we sought to reveal and understand issues of power, politics, and justice associated with the challenges facing Ugandan nurses in their provision of care to persons with HIV disease, we chose to use Carspecken's (1996) critical methodology in a focused examination and exploration of these topics. Given that this type of inquiry may place participants at risk, we were sensitive to the need to promote a safe environment in which they would feel confident and comfortable describing their experiences. General aspects of some ethical concerns related to the global health research process that were identified during this study have been discussed elsewhere (Harrowing, Mill, Spiers, Kulig, & Kipp, 2010); in this article we focus on the concept and practice of cultural safety and its relevance to the use of Carspecken's approach in the conduct of nursing research in international settings.

Intersections between critical ethnography and cultural safety

What, then, are the connections between and among the underpinnings and process of Carspecken's (1996) critical ethnography, cultural safety, and the conduct of nursing research in LMIC by researchers from high-income countries? The question is an important one because research findings are intended to inform nursing education and practice. If educators and practitioners are articulating the need to bring cultural safety to the foreground of practice, should not researchers also be considering the need for such a lens? Because nurses are increasingly involved with the study and care (or lack thereof) of patients and their diverse backgrounds and settings, it seems reasonable to consider the potential for congruence in foundational principles that might guide, or undermine, the process. Furthermore, nurses share an ethical responsibility to promote justice and to work collectively and individually to bring about social change for all people (Canadian Nurses Association, 2008). Given the evidence that suggests patients do not always receive care that makes them feel safe and respected, it behooves nurses to re-examine their understanding of culture as well as their approaches to caring for people who may feel marginalized by the implementation of standard services. Such effort might well have important implications for nursing care provided to all people, not just members of distinct ethnic or racial backgrounds.

To explore possible answers to the question posed above, critical ethnography and cultural safety are compared and contrasted across three foundational elements: the aims and approaches of each process; embedded perspectives and definitions of culture; and aspects that are relevant to the research process including determination of the research question, recruitment, consent procedures, attention to language, and consideration of the risk of repercussions for participants. Examples from the current study are used to illustrate the enactment of these elements and the challenges and outcomes we encountered.

Aims and approaches

The choice of a critical methodology positions the researcher to examine social inequities, with a goal of creating positive social change. Merely increasing knowledge is not the goal of this research; rather, the aim is to move toward political action that can redress the injustices found or constructed during the research process (Kincheloe & McLaren, 2005; Wallerstein & Duran, 2003). Madison (2005) observed that the criticalist moves from "what is" to "what could be" (p. 5) to contribute to emancipatory knowledge and the discourses of social justice.

Similarly, cultural safety was identified by Maori nurse educators in New Zealand in an attempt to expose and correct inequities in health care service access and delivery to members of the indigenous culture (Polaschek, 1998). It was considered essential that members of the dominant White culture become aware of the historical, political, and social oppression that manifested in poor health outcomes and negative encounters between the Maori peoples and health care providers in that country. Cultural safety was to be enacted at the level of the individual nurse through his or her increased awareness of and sensitivity to culturally appropriate behaviors and attitudes, as determined by the Maori patients themselves, and knowledge of theories of power relations (Nursing Council of New Zealand, 2005). The voice of Maori nurses also can be perceived as representative of members of other marginalized groups who have been silenced by alienation in one form or another. In bringing awareness of the various forms of oppression imposed by members of a dominant culture, strong congruence with the philosophical stance of critical ethnography is apparent. Furthermore, the aims of the methodology and cultural safety correspond with the ethical responsibilities of nurses to identify and address social change in order to reduce inequities for the vulnerable populations of the world.

Two events that occurred early in the study raised questions about cultural safety and study methodology. One concerned informed consent and is discussed later. The other had to do with the choice of the qualitative paradigm for the project. Although we had designed the project with little thought for the cultural safety issues that might arise, the concept came to the forefront as we proceeded through the process of obtaining ethical approval at the Ugandan institutions. Several weeks went by as the first author attempted to contact and meet with the people who could assist her through the necessary steps. Many queries about the relevance of conducting a critical qualitative study were voiced during her presentation to the medical school ethics review committee. We began to understand that our assumptions about the committee members' knowledge of and degree of comfort with qualitative methodology were inaccurate. They eventually approved the study protocol, but we were left with the sense that they did not fully support a qualitative approach. Informal conversations later revealed that the relatively small number of researchers in Uganda available to supervise graduate students dictates that research projects be carried out in the most efficient manner possible with minimal use of resources. Qualitative research was deemed to take a long time and use considerable resources, and therefore was not the design of choice. Indeed, the first author was asked several times by participants why she did not just provide them with a survey instrument and collect data quickly. We had many conversations about the rich contributions of their narratives to outsiders' understanding of the complexities of their experiences. This encounter with another way of engaging with the world challenged our interpretation of culture and meaning, and forced us to pay attention to perspectives we had not considered. We had been prepared to rationalize the use of a qualitative approach versus a quantitative one based on the reasons widely discussed in the literature, but we had not considered such a pragmatic argument.

Reflecting on the process of gaining approval, we were struck by the fact that no one directly articulated the reasoning behind the hesitation to grant approval. Rather, questions were posed and reworded, as if to guide us gently to the answer. We found this circuitous approach different from the more direct approach we would have expected in a North American committee meeting. Although this situation may not have held implications for the cultural safety of participants, it did highlight our lack of understanding of the local context and our blinders regarding other worldviews. We realized that one cannot ever be completely prepared for all eventualities; one can only be alert and flexible, ready to notice subtle clues and inquire into participants' expert knowledge and understanding of their lives. Cultural safety is enhanced by awareness of the limitations of one's own thinking and the need to learn about visible and invisible aspects of the culture of others.

Perspectives and definition of culture

Many definitions of and approaches to studying the concept of culture are based on an essentialist viewpoint, which focuses on ethnic and racial differences and reinforces the social practices that institutionalize the dominant approach to health care (Gray & Thomas, 2006). Proponents of the essentialist framework emphasize the presumed shared features of a group that differentiate it from the norm of English-speaking Christians of European descent, thereby constructing a "bicultural situation of Self and Other, Us and Them" (Reimer Kirkham & Anderson, 2002, p. 6) in which difference is interpreted as inferiority. When applied to nursing practice, this viewpoint not only leads to an emphasis on the minutiae of the nurse-client relationship rather than the big picture; it also diverts attention from the connections between systemic oppressions and historical exploitation and colonialism (Gustafson, 2005). Gray and Thomas (2005) noted that nursing's uncritical acceptance of assumptions about culture and cultural competence has resulted in the perpetuation of cultural stereotypes and a false sense of comfort and confidence in our knowledge and ability to care for members of various cultural groups.

Using a critical constructivist perspective, on the other hand, the researcher depicts culture as a fluid, relational process that is contextually enacted, and encourages the exploration of social, historical, political, and economic factors in the creation of networks of cultural meaning (Browne & Varcoe, 2006; McGrath & Phillips, 2008). Rather than focusing on cultural Others, examination is required of one's execution and interpretation of behaviors and practices and their contribution to and influence on maintenance of certain norms. A strong argument has been made for the need to transform our understanding of culture from an essentialist perspective to a critical one that focuses on structural inequalities and the dynamics of the health care relationship between provider and recipient (Gustafson, 2005; Reimer Kirkham & Anderson, 2002). According to Ogilvie, Burgess-Pinto, and Caufield (2008), it is the emphasis on the societal origins of oppressive attitudes rather than on the behaviors of the individual nurse that extends the transcultural competence of practitioners to a culturally safe approach. This awareness begins with the nurse's reflection on his or her personal and cultural history, values, and beliefs and continues with the situating of those understandings within a framework of power imbalances, institutional discrimination, and colonizer-colonized relationships. It is in the identification and discussion of inequities that new dimensions of comprehension emerge and can be enacted. Failure to employ a critical cultural perspective will almost certainly result in further marginalization of patients who do not belong to the dominant cultural group.

Carspecken (1996) does not explicitly address the concept or meaning of culture. References to culture tend to focus on "cultural commodities" (p. 200), artifacts and practices that the researcher is advised to examine for symbolic or cultural meaning and their contribution to the construction of identity. Carspecken discusses the connection between cultural forms and the physical environment and its political and economic antecedents, and encourages the researcher to build abstractions from the data toward the macrosociological theory that best explains the environment. Thus, Carspecken does allude at times to social determinants of health but tends to focus on traditional elements (i.e., norms, beliefs, and values) throughout most of his book.

On the other hand, although ethnography is often described as the outsider's attempt to gain an insider's view of certain cultural realities, Carspecken (1996) suggests that one can never attain such a view of another's reality. This viewpoint indicates his awareness of the dynamic nature of culture, that it is more than a list of behaviors and objects. In this, he is supported by Ogilvie et al. (2008), who asserted that the insider-outsider debate represents a false dichotomy and that researchers and participants can simultaneously occupy various points along the continuum of belongingness. Indeed, in the current project, the first author was clearly an outsider due to her status as a Canadian citizen working in Uganda. However, as a registered nurse working with other registered nurses she shared aspects of the culture associated with the nursing profession. She was able to connect with the participants on the level of joint interest in nursing concerns yet at the same time recognized the need to ask questions about aspects of their lives of which she had no knowledge. Similarly, she found other ties, such as motherhood and gender roles, that afforded additional opportunities for exploring common experiences. In this way, the dance of developing rapport with participants was initiated.

This observation is significant because it indicates the importance of context and relationship to the making and interpretation of data. The researcher must pay attention to shifting conditions and influences as well as the potential to misinterpret information or introduce bias. The researcher from a high-income country who works in an LMIC must realize that trust and humility are key components of the process, and should endeavor to create collaborative, respectful relationships with participants. Even in situations where the researcher and participant share a common language, the researcher must be sensitive to the possibility of misunderstanding that occurs when local nuances and expressions are unfamiliar. Such awareness is necessary for

the conduct of critical methodology, and it is also relevant to the creation of a culturally safe environment for participants and researchers alike, regardless of setting and degree of "difference" between researcher and participant.

Aspects and components of the research process

Carspecken's (1996) assertion that critical ethnographers must begin by examining their biases and values to articulate the relationship among power, thought, and truth claims is congruent both with the principles of cultural safety and with nursing's code of ethics. Cultural safety is about exposing the antecedents and outcomes of power inequities in order to amplify the voices of those who are marginalized by historical, political, economic, and social events. Researchers and practitioners must acknowledge their own beliefs to gain insight into and understanding of the beliefs of others. Although Carspecken (1996) does not address cultural safety in those words, he notes that the researcher must be aware of the potential impact of his or her perspectives on the data-making and interpretation process. Likewise, Polaschek (1998) acknowledged that culturally safe nursing practice is broader than the practice behaviors of the individual nurse; however, there is a component of self-examination by the practitioner in order to better recognize his/her impact on the health care interaction (Nursing Council of New Zealand, 2005). It is up to the individual or community to ascertain the safety of a particular health care approach or intervention, and what is found to be safe in one situation might not be so in another. Therefore, it becomes the responsibility of the researcher and the nurse to deliberately create opportunities to ensure safety rather than make assumptions that might be inaccurate.

Integration of cultural safety into a critical ethnographic nursing study is facilitated by purposeful consideration of the context in which potential participants live. Sampling and recruitment strategies can present particular obstacles. In some settings, it might be important to conduct community consultations prior to contacting individual participants to ensure relevance of the proposed research questions and process and to gain the appropriate consents and access (Ogilvie et al., 2008). In the current study, we worked with the nursing administrator at the Ugandan hospital to determine the research question, and the ethics committee of both the university medical school and the hospital reviewed and approved the protocol. The first author was assigned a physician to be her Ugandan supervisor. Although this is not typical procedure in the Canadian context, her compliance was expected in Uganda. By doing so, she was able to ensure the relevance of the project, demonstrate respect and collegiality, learn from local experts, and gain the access she required to conduct the study. In addition, the principles of both critical ethnography and cultural safety were appropriately maintained.

The researcher must be explicit about whose voices are being heard and whose are not, and must choose recruitment approaches that neither coerce nor exploit. This can be difficult as the very act of categorizing people can marginalize them. Anderson et al. (2003) cautioned that the researcher must be prepared for the participants to disrupt the "predetermined subject positions" (p. 204) as they exert agency. Multiple strategies may be required. In the current study, participants were selected by virtue of their involvement in the education program prior to the initiation of data collection; we did not recruit them in the usual sense, other than to explain the project and obtain consent. This process created its own challenges as the nurse administrator who implemented the program chose the nurses who would be offered the opportunity to join. Because of the lack of anonymity and the potential for coercion, we had to be particularly attentive to the need for strict confidentiality and the process of informed and ongoing consent with participants over the two years of the study.

The consent process itself stimulated further reflection about our assumptions. It was the typical one used in most research studies in North America, in which participants read a carefully prepared form and sign it to indicate their understanding and agreement. The first author was questioned by the participants in this study regarding the need to sign such an official document; the process did not seem to make sense to them. On further inquiry, we discovered that they felt that we could trust each other with a verbal explanation and commitment, and did not see the reason for signatures and records. In observance of the approved protocol, the first author did collect signed forms from participants after careful discussion of the reasons behind the process. In addition, for the remainder of the study, she obtained ongoing consent from participants at each interaction, by reviewing their rights and recording their verbal agreement to continue. For future studies, we would explore the possibility of explaining and recording consent differently to better meet the needs and expectations of participants, while still protecting them adequately. The obligation to create a formal paper trail must be balanced with the duty to avoid imposing discomfort through an unfamiliar and off-putting process.

Careful attention to language and the need for translation and interpretation are critical to ensuring cultural safety. In practice and in research, language prejudice may be indicative of cultural racism (Johnstone & Kanitsaki, 2008; Ogilvie et al., 2008). Interpretation is complex and multilayered, and often involves a third party, with the attendant implications for the relationship between researcher and participant. Researchers might not be knowledgeable or skilled in the use of interpreters, and this situation can negatively affect the quality and accuracy of the data and its meanings. Because inequitable social structures and power relations are often reflected in communication modalities (Carspecken, 1996), it is essential that the researcher be particularly conscious of the potential threats to cultural safety in the process of data-making. Such threats must be carefully managed to prevent harmful outcomes to participants. In the current study, participants all spoke excellent English and appreciated the first author's attempts to learn their local language. Nevertheless, there were times when she had to clarify subtle nuances associated with words and phrases that were used in ways that were vague or unfamiliar to her.

One final concern to be addressed is that of the vulnerability of participants once the study is completed and findings disseminated. Exposure of inequities and power differentials may occur in the confidential setting of the research interview, but when those same issues are released into the public domain, they take on a life of their own and the researcher loses control over their interpretation and use. Participants should be made aware of the potential risks, to the extent that the researcher can anticipate them, at the outset of the study to minimize later distress and possible withdrawal of data from the study. Although Carspecken (1996) does not address this vulnerability concern specifically, he does advocate the "democratization" (p. 155) of the research process by the taking on of a facilitator role by the researcher. The researcher is then responsible for creating a safe environment in which participants explore issues using their own vocabulary and ideas and power relations are equalized as much as possible. Carspecken also warns the researcher to "be prepared to be threatened" (p. 169) in the process of honoring the experiences and truth claims of participants that might conflict with those of the researchers, particularly if his or her background differs markedly from that of the participants. This approach is compatible with Lather's (1986) notion of cathartic validity, which refers to the extent to which researchers allows themselves to change and grow in ways that challenge oppressive cultural forms. Thus the researchers' efforts to be open and humble and to enhance the environment for the participant may be seen as consistent with the principles of cultural safety. The researchers are then in a position to negotiate the interpretation and dissemination of data with the participants to diminish the risk of repercussions to the participant.

In the current study, the first author attempted to develop a strong rapport with participants through prolonged engagement (the project extended over a 24-month period with 18 weeks in the field and ongoing electronic contact when she was not in the country) as well as frequent consultations regarding her understanding of the data and the documentation of findings. During these discussions she was able to ask participants if they had concerns about what might be published following the study, and they were able to negotiate what was said and how it was articulated. Final drafts of manuscripts were shared with those participants who were available, and their feedback was incorporated. Although it is difficult to ensure absolute and complete cultural safety in all situations, it is important for the researcher to make clear and deliberate efforts to demonstrate attention to the process throughout the life of the study.

Conclusion

Globally, nurses are committed to the provision of safe, competent, compassionate, and ethical care to all clients. Identification and application of the concept of cultural safety as a unique aspect of that care has been confined until recently to nursing education and practice in the New Zealand context where it originated. In the past decade, a number of authors have argued for broader application, asserting that cultural safety is an essential component of postcolonial nursing discourse. Extending the definition of *care* to include the treatment of those who consent to engage in research studies, this principle can be interpreted as embracing sensitivity to and awareness of those aspects of the participants' culture that they deem important in the process of conducting that research. However, consideration of cultural safety as an essential aspect of research protocols has not been discussed widely in the nursing literature. In particular, implications for researchers from high-income countries working in the unfamiliar cultural context of LMIC have not been articulated or addressed to date. In this paper, congruence between Carspecken's (1996) approach to critical ethnography and cultural safety was explored and linkages established, using the example of a research project in Uganda conducted by Canadian investigators. Carspecken does not fully address all of the issues that might be of concern to nurse researchers; therefore, care and attention must be directed at ensuring participants are not harmed by the cultural dangers to which they might be exposed in the process of conducting the study.

To protect research participants and to represent them fairly, it is essential that researchers deliberately create the "caring spaces" advocated by Dion Stout and Downey (2006, p. 327) in which cultural safety is likely to occur. To do otherwise is to violate the ethical standards on which research involving human subjects is based. Nevertheless, the complexities of the issue and the contexts in which international health research is conducted demand that further debate and dialogue occur in order to broaden the discussion and examine in greater detail the utility of cultural safety as a component of research design.

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