Volume 8, No. 2
August, 2025

e-ISSN : 2685-1997
p-ISSN : 2685-9068

REAL in Nursing Journal (RNJ)

Research of Education and Art Link in Nursing Journal

https://ojs.fdk.ac.id/index.php/Nursing/index

Concept Analysis: "Cultural Disruption" in Indigenous Cardiac Patients and Its Implications for Nursing Practice

Aria Wahyuni, Rola Oktorina & Yenni

UNIVERSITAS FORT DE KOCK BUKITTINGGI

Nursing Study Program
Universitas Fort de Kock Bukittinggi, Indonesia

Concept Analysis: "Cultural Disruption" in Indigenous Cardiac Patients and Its Implications for Nursing Practice

REAL in Nursing Journal (RNJ)

https://ojs.fdk.ac.id/index.php/Nursing/index

Aria Wahyuni[1], Rola Oktorina[2], Yenni[2]

ABSTRACT

Background: *Indigenous populations experience disproportionately high rates of cardiovascular disease (CVD), yet their encounters with healthcare systems often involve cultural disconnection and marginalization. Despite increasing use of terms such as cultural safety and competence, the specific phenomenon of cultural disruption—particularly in hospital-based cardiac care—remains underexplored and poorly defined in nursing literature.*

Purpose: *This concept analysis aims to explore and clarify the meaning of cultural disruption as it relates to Indigenous patients undergoing cardiovascular care, with a focus on implications for nursing practice.*

Methods: *Walker and Avant's eight-step method of concept analysis was employed to identify the defining attributes, antecedents, consequences, and empirical referents of cultural disruption. Data were synthesized from peer-reviewed articles published within the last 10 years, including qualitative studies and Indigenous health frameworks relevant to cardiac care.*

Results: *Cultural disruption is characterized by disconnection from cultural identity and practices, invalidation of Indigenous knowledge systems, breakdown in relational and community support, spiritual alienation, and erosion of trust in healthcare systems. Antecedents include colonization, systemic racism, and biomedical dominance, while consequences include treatment non-adherence, patient disengagement, and poor health outcomes. Empirical referents include patient-reported cultural safety assessments, narrative interviews, and clinical documentation audits.*

Conclusion: *Cultural disruption is a distinct and critical concept in understanding health inequities experienced by Indigenous cardiac patients. Recognizing this phenomenon enables nurses to implement culturally responsive strategies that uphold spiritual, relational, and community-based dimensions of care. Future research is needed to validate tools that assess cultural disruption and evaluate outcomes of culturally grounded interventions in cardiovascular nursing.*

Keywords:
Cultural disruption; Indigenous health; cardiovascular nursing; cultural safety; concept analysis.

Corresponding author:
Aria Wahyuni
Email:
ariawahyuni@gmail.com

[1]*Department of Nursing, Faculty of Health, Universitas Muhammadiyah Sumatera Barat, Indonesia*
[2]*Department of Nursing, Faculty of Health, Universitas Sumatera Barat, Indonesia*

Introduction

Cardiovascular diseases (CVDs) remain the leading cause of death globally, and their burden is particularly pronounced among Indigenous populations. Despite significant advances in the diagnosis and management of cardiac conditions such as coronary artery disease and heart failure, these benefits are not equitably shared. Indigenous peoples—including Aboriginal and Torres Strait Islander peoples in Australia, First

Nations and Inuit communities in Canada, Native American and Alaska Native populations in the United States, and various Indigenous groups across Southeast Asia—continue to experience disproportionately higher rates of CVD morbidity and mortality compared to non-Indigenous populations. For instance, in Australia, cardiovascular disease is the second leading cause of death among Aboriginal and Torres Strait Islander peoples and contributes significantly to the mortality gap between Indigenous and non-Indigenous Australians (Australian Indigenous HealthInfoNet, 2023). Similarly, in the United States, American Indian and Alaska Native populations exhibit higher prevalence and earlier onset of coronary heart disease and stroke, with CVD identified as the leading cause of death in these groups (Goerger et al., 2025). While this paper references Indigenous populations globally, the supporting literature is predominantly drawn from settler-colonial nations such as Australia, Canada, and the United States. Thus, the scope of this concept analysis is shaped by these contexts and may not fully reflect the experiences of Indigenous communities in Southeast Asia, such as those in Indonesia and Malaysia.

These disparities are frequently compounded by systemic inequities such as limited access to healthcare, socioeconomic disadvantage, racism in health institutions, and geographic remoteness. In particular, Indigenous patients may face multiple layers of disadvantage during hospitalization, especially for specialized and invasive cardiovascular procedures like percutaneous coronary intervention (PCI) or coronary artery bypass grafting (CABG). While the focus in such settings is often on rapid biomedical interventions, the broader psychosocial, cultural, and spiritual needs of patients are often overlooked—despite evidence that culturally informed models of care can improve outcomes and patient experiences (Harrop et al., 2024; Ralph et al., 2023).

Beyond these structural determinants, an equally important but frequently overlooked factor is the cultural disruption experienced by Indigenous patients when engaging with mainstream healthcare systems. Cultural disruption refers to the erosion or breakdown of one's ability to maintain cultural identity, practices, and values—especially in times of illness, dependency, and institutionalized care. In the context of cardiovascular care, this disruption can occur when patients are hospitalized far from their communities, prevented from observing cultural rituals, encounter language and communication barriers, or receive treatment that contradicts or disregards their traditional beliefs regarding illness and healing. These experiences highlight a critical gap in clinical environments where Indigenous-defined cultural safety and patient-centered care are often secondary to biomedical protocols (Josewski et al., 2023; Tremblay et al., 2023).

Indigenous patients undergoing cardiovascular interventions, such as percutaneous coronary intervention (PCI) or coronary artery bypass grafting (CABG), are frequently immersed in highly biomedical and technologically oriented healthcare settings that emphasize procedural efficiency and standardization. Hospital environments characterized by rigid routines, clinical jargon, unfamiliar dietary regimens,

and minimal family involvement can unintentionally foster a sense of alienation, disempowerment, and spiritual fragmentation. In many Indigenous worldviews, healing is understood as a holistic and relational process, integrating body, mind, spirit, kinship, community, and land. When these dimensions are disregarded or actively disrupted, a patient's sense of coherence and engagement in their own healing journey may be profoundly compromised—often resulting in reduced treatment adherence, reluctance to seek follow-up care, and ultimately, poorer health outcomes (Mbuzi et al., 2017; Ralph et al., 2023; Tane et al., 2024; Verbunt et al., 2021; Vervoort et al., 2022).

Although terms like cultural safety, cultural competence, and cultural humility are increasingly emphasized in nursing and public health discourse, the specific phenomenon of cultural disruption—especially in relation to cardiovascular care among Indigenous populations—remains poorly defined and underexplored. Cultural disruption is often referenced implicitly in qualitative studies as "feeling culturally unsafe," "disconnected," or "dehumanized," but it lacks the conceptual clarity that would allow for structured assessment, intervention development, or policy implementation. Without a clearly articulated understanding of this phenomenon, healthcare systems and nursing education risk continuing practices that inadvertently reinforce cultural exclusion and inequality (Burchill & Dos Santos, 2024; MacLean et al., 2023; Pirhofer et al., 2022; Powell-Wiley et al., 2022).

A growing body of Indigenous health scholarship and community-led initiatives has emphasized the need for strengths-based, culturally grounded approaches that restore cultural continuity, support land-based practices, and center Indigenous knowledge within healing frameworks. These approaches are critical not only to enhance well-being but also to challenge the dominance of Eurocentric medical models that often marginalize Indigenous worldviews. However, the absence of a clearly defined concept of cultural disruption within clinical settings remains a significant gap. Without conceptual clarity, this phenomenon cannot be adequately identified, measured, or addressed. Understanding cultural disruption is therefore essential for nursing professionals striving to deliver equitable, trauma-informed, and culturally responsive cardiovascular care that honors Indigenous identities and ways of knowing (Absolon, 2023; Kim, 2019).

Therefore, the aim of this concept analysis is to explore and clarify the meaning of cultural disruption in the context of Indigenous cardiac patients. Using Walker and Avant's method of concept analysis, this paper will identify the defining attributes, antecedents, consequences, and empirical referents of the concept (Walker & Avant, 2014). Through this analysis, we seek to provide a theoretical foundation that can support the integration of culturally responsive care into cardiovascular nursing practice, education, and research—ultimately contributing to the reduction of health disparities and the promotion of cultural justice in clinical settings.

Methods

This concept analysis employs the Walker & Avant, (2014) method, a widely used framework in nursing theory to develop conceptual clarity around phenomena that lack standardized definitions. The method consists of eight systematic steps, each designed to distill the essence of the concept, uncover its key dimensions, and contextualize it within real-world applications. The eight steps are: 1) Select a concept: Cultural Disruption in Indigenous Cardiovascular Care is selected due to its relevance, under-definition, and significance in advancing culturally safe nursing practice; 2) Determine the aims or purpose of analysis: To clarify and operationalize the concept so that it can inform culturally sensitive nursing interventions and policy; 3) Identify all uses of the concept: A broad literature search across databases such as PubMed, Scopus, and Google Scholar will be conducted to identify definitions and uses of "cultural disruption" in health, sociology, Indigenous studies, and psychology; 4) Determine the defining attributes: Through thematic synthesis, the essential characteristics of the concept will be identified; 5) Construct a model case: A case that clearly illustrates all defining attributes of cultural disruption in an Indigenous cardiovascular patient; 6) Construct additional cases (borderline, related, contrary): These cases will help differentiate cultural disruption from similar but distinct phenomena (e.g., cultural misunderstanding, institutional racism); 7) Identify antecedents and consequences: Antecedents might include hospitalization in unfamiliar settings or institutional neglect of spiritual needs. Consequences may include treatment non-adherence, emotional distress, or worsened health outcomes; 8) Define empirical referents: Indicators or tools that can help identify cultural disruption in practice, such as patient-reported experiences of disconnection or exclusion. By following this structured approach, the concept of cultural disruption can be translated into a usable and measurable construct within nursing practice and policy—enhancing culturally safe care and health equity for Indigenous cardiac patients.

Results

This concept analysis followed Walker and Avant's eight-step method to clarify and define the meaning of cultural disruption in the context of Indigenous cardiovascular care. The steps enabled a systematic exploration of the term's usage across disciplines, its defining characteristics, related constructs, and implications for nursing. The analysis draws upon peer-reviewed literature from nursing, Indigenous health, sociology, and public health published within the last decade. Each step is presented below with supporting evidence to provide conceptual clarity and practical relevance for integrating this concept into culturally responsive nursing care.

Select a concept

The concept of cultural disruption was chosen to better capture the specific barriers Indigenous patients face in biomedical cardiovascular settings. While terms like cultural safety and competence are well established, they may not fully encompass the disconnection, invalidation, and relational breakdowns that patients experience. Research shows that even trained health professionals often struggle to apply cultural principles effectively in fast-

paced hospital environments(Wilson et al., 2022). Moreover, Indigenous perspectives on health emphasize holistic and relational dimensions—family, land, and spiritual practices—which are frequently disrupted in clinical care (Verbunt et al., 2021). This disruption leads to alienation and worsened healthcare outcomes. Therefore, cultural disruption emerges as a distinct and under-theorized concept that requires closer analysis to inform nursing practice and policy more effectively.

Determine the aims or purpose of analysis

The purpose of this concept analysis is to explore, clarify, and define the construct of cultural disruption within the context of cardiovascular care among Indigenous populations. Despite increasing recognition of the importance of cultural safety and cultural competence in nursing, the specific phenomenon of cultural disruption—especially in technologically intensive settings such as cardiac care—remains poorly articulated and under-theorized. This lack of conceptual clarity hinders the development of culturally responsive nursing practices, limits the design of relevant assessment tools, and weakens the foundation for equitable health policy implementation. By systematically analyzing this concept, the study aims to establish a clear definition, identify defining attributes, antecedents, consequences, and empirical referents, and ultimately provide a theoretical foundation that can guide nursing practice, education, and research in Indigenous cardiovascular care.

Identify all uses of the concept

The concept of **cultural disruption** has been used across a range of disciplines, including anthropology, Indigenous studies, education, public health, and nursing. Although it is not always explicitly defined in healthcare literature, its usage can be traced through various terms, narratives, and phenomena that describe the **interruption or severing of cultural continuity**, particularly among Indigenous populations in colonized settings.

Cultural disruption broadly refers to the breakdown of cultural traditions, languages, beliefs, and social structures, often resulting from colonization, forced assimilation, and systemic marginalization. In Indigenous communities, this is tied to historical trauma caused by colonial policies—such as residential schools, land dispossession, and bans on spiritual practices—which have disrupted knowledge transmission, weakened intergenerational bonds, and undermined cultural identity and resilience. (McGiffin, 2022; O'Neill et al., 2018).

In education and community development, cultural disruption refers to the disconnection of youth and families from Indigenous languages, ceremonies, and knowledge systems, often leading to identity confusion and disengagement from formal institutions. Studies in Alaska show that cultural identity is strengthened through local language use, storytelling, and land-based learning—while the absence of these practices undermines youth engagement and well-being. (Lunda et al., 2024).

In public and Indigenous health, cultural disruption is used to explain health disparities beyond standard social determinants. It reflects the

systemic disregard for Indigenous values and healing practices in clinical settings—such as restricting ceremonies or access to Elders—which leads to cultural rupture, loss of trust, and disengagement. This highlights a broader failure to recognize culture as a key determinant of health, deeply tied to identity, land, community, and self-determination. (Redvers et al., 2019; Roher et al., 2023; Verbunt et al., 2021)

In nursing, although the term "cultural disruption" itself is rarely operationalized, its essence is reflected in patient narratives describing feelings of being "unheard," "disconnected," or "culturally unsafe." These experiences often surface during invasive procedures, prolonged hospitalization, or interactions with healthcare providers who lack cultural awareness or sensitivity (Josewski et al., 2023; Tremblay et al., 2023). The term is thus closely related to—but distinct from—concepts such as cultural competence, cultural safety, cultural loss, and identity fragmentation.

In summary, the uses of the concept suggest that cultural disruption is not merely the absence of cultural support, but a disempowering experience in which individuals are cut off from the cultural foundations that give meaning to health, healing, and identity. Within Indigenous cardiovascular care, this may have profound implications for emotional well-being, treatment adherence, and patient-provider relationships.

Defining Attributes

Defining attributes are those characteristics that appear repeatedly in the literature and help to differentiate the concept of cultural disruption from related concepts. Through a review of empirical and theoretical sources across nursing, Indigenous health, public health, and sociology, the following core defining attributes of cultural disruption—especially as experienced by Indigenous patients during cardiovascular care—have been identified, disconnection from cultural identity and practices: a consistent feature of cultural disruption is the loss or suppression of the patient's ability to engage in cultural practices, such as ceremonies, spiritual rituals, or language use, especially during hospitalization. This disconnection leads to a feeling of estrangement from self and community, particularly in environments where Indigenous ways of knowing and healing are excluded or devalued (Anderson & Migwans, 2021; Tootell et al., 2024); invalidation or dismissal of indigenous knowledge Systems: Cultural disruption occurs when predominantly biomedical frameworks dominate clinical encounters, effectivelyov marginalizing or dismissing Indigenous epistemologies, spiritual practices, and holistic health paradigms. When patients' cultural meanings of illness, healing rituals, and community-based understandings are overlooked or labeled as *'non-scientific'* within dominant biomedical frameworks, they experience symbolic invalidation and loss of agency. This contributes to diminished trust, increased alienation, and reduced engagement in care (Anderson & Migwans, 2021; Carrie et al., 2015); breakdown in relational and community support: In many Indigenous cultures, healing is inherently **relational**, involving close connection with **family, Elders, community**, and **land**. A critical aspect of cultural disruption occurs when **healthcare institutions establish barriers that sever these essential connections**,

negatively affecting holistic healing (Askew et al., 2021; Ralph et al., 2023); 4) **Erosion of Trust and Engagement with the Healthcare System:** When cultural disruption occurs, it undermines trust and the therapeutic alliance, resulting in reduced treatment adherence, avoidance of follow-up care, and long-term disengagement from the health system (B. Jones et al., 2020; Ralph et al., 2023; Tane et al., 2024).

Construct a model case

Mary is a 62-year-old Indigenous woman from a remote community who is admitted to an urban cardiac center for urgent coronary artery bypass grafting (CABG). She speaks limited English and is deeply connected to her cultural traditions, which include daily prayer rituals, consultation with community Elders, and eating traditional foods that hold spiritual significance. Upon admission, Mary is placed in a ward with strict clinical routines, unfamiliar hospital food, and minimal allowance for family visits due to COVID-19 restrictions. No cultural liaison officer or interpreter is assigned. Her spiritual practices are dismissed as *'irrelevant to her recovery'* by the care team, reflecting a biomedical perspective that excludes cultural healing practices, and a nurse asks her to "save that for later." She is unable to contact her community Elder, and the hospital does not accommodate traditional healing practices. As a result, Mary becomes withdrawn, refuses physiotherapy, and expresses a desire to leave. She later misses follow-up appointments and reports feeling "alone and invisible" during her hospitalization.

Construct additional cases

Borderline cases

Thomas is a 58-year-old Indigenous man from a coastal community who is admitted to a regional hospital after experiencing chest pain. He is diagnosed with unstable angina and scheduled for percutaneous coronary intervention (PCI). The hospital employs a cultural liaison officer, but they are unavailable during his first few days. Nurses provide medically appropriate care and allow limited family visitation, but no efforts are made to understand or incorporate his spiritual beliefs. Thomas requests to speak with a community Elder before surgery, but the care team postpones the request due to scheduling constraints. He is able to eat familiar food brought by his niece, but "his prayer items are stored away due to infection control policies, which implicitly signal that such practices are considered *'non-essential'* within the biomedical routine. Some staff are respectful but clearly unfamiliar with Indigenous health perspectives. Thomas follows medical advice but expresses dissatisfaction afterward, stating, "They were kind, but they didn't really understand what I needed".

Related case

Mr. Antonius, a 61-year-old man from the Dayak Ngaju community in Central Kalimantan, was referred to a cardiac centre in Banjarmasin for emergency percutaneous coronary intervention (PCI) following acute myocardial infarction. Traditionally, his community conducts a *Balai ritual* (healing prayer) and receives spiritual support from a *basir* (traditional healer) before undergoing major health interventions. Upon admission, the cardiology unit lacked specific cultural services, but a nurse with knowledge of

local customs engaged Mr. Antonius and his family in conversation. She acknowledged the importance of the ritual and facilitated a video call with the *basir*, allowing a remote prayer to take place before the procedure. The nurse also allowed his wife to remain longer during visiting hours to provide emotional and spiritual support. Although the hospital did not fully incorporate Dayak healing practices into its formal care model, the efforts to accommodate his beliefs led Mr. Antonius to feel more at ease. He complied with all pre- and post-procedure protocols and expressed trust in the care team, stating, "They respected my way, even if it's not their way".

Contrary case

Mr. John Carter, a 65-year-old retired engineer from suburban New Jersey, is admitted to a well-equipped cardiac hospital for coronary artery bypass grafting (CABG). He speaks the same language as the medical staff, shares similar cultural norms, and fully understands the biomedical explanations provided about his condition and the procedure. He expresses no spiritual or cultural needs beyond clinical care. He is comfortable with the hospital routine, food, and environment. His family visits regularly, and he actively engages with the healthcare team. He reports feeling supported and confident in the care he receives. He complies with all post-operative instructions and attends cardiac rehabilitation without hesitation.

Identify antecedents and consequences

Antecedents (Conditions that lead to cultural disruption)

Biomedical-dominant hospital settings without cultural alignment, health systems structured around Western models often neglect Indigenous holistic health frameworks, setting the stage for cultural disruption (Curtis et al., 2025). Weak or absent cultural safety practices, even though cultural safety training exists, definitions and implementations vary widely, and systems often fail to fully incorporate Indigenous perspectives in care. Disconnection from cultural determinants of health, indigenous wellbeing is closely tied to culture—elements like family, land, language, and self-determination are central. When these cultural determinants are disrupted in clinical contexts, cultural disruption may follow (Verbunt et al., 2021). Limited Indigenous participation in healthcare design and research, exclusion of Indigenous voices—from policy-making to clinical design—reinforces systemic mismatches between care environments and Indigenous health values.(Tait & de Leeuw, 2025).

Consequences (Outcomes following cultural disruption)

Erosion of trust and engagement, when cultural needs are ignored, patients may disengage from treatment, follow-up, or entirely withdraw from healthcare systems. Decreased healthcare efficacy and poorer outcomes, cultural continuity supports resilience. Disruption weakens relational supports and resilience that otherwise buffer against health stresses (Verbunt et al., 2021; Wali et al., 2024). Barrier to equitable health strategies, without recognition of cultural determinants and voices, programs and care models risk perpetuating inequities (Hiyare-Hewage et al., 2024).

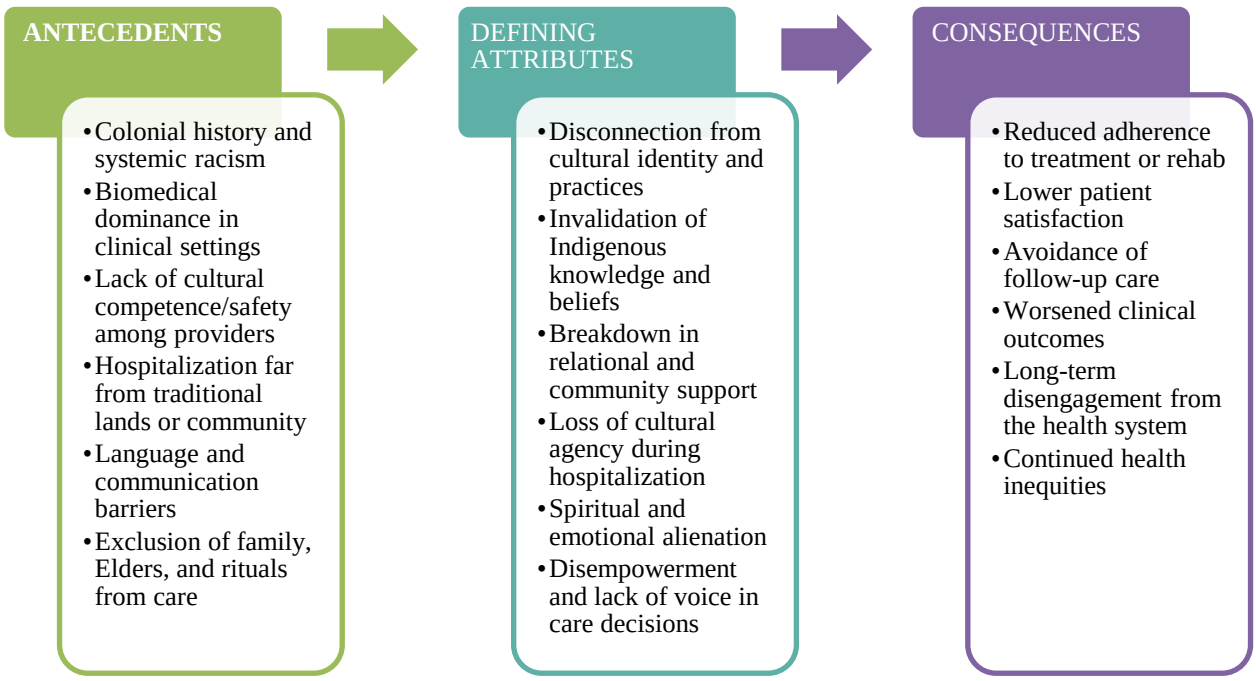

Figure 1. Cultural Disruption Pathway in PCI/CABG among Indigenous Populations

Figure 1. illustrates the conceptual pathway of cultural disruption experienced by Indigenous patients undergoing cardiovascular procedures such as PCI or CABG. It outlines the antecedents (e.g., colonization, lack of cultural representation), defining attributes (e.g., cultural disconnection, invalidation of Indigenous knowledge), and consequences (e.g., poor treatment adherence, disengagement from care). This model highlights the need for culturally responsive nursing practices in cardiac settings.

Empirical Referents

Empirical referents of cultural disruption are measurable signs that reflect how Indigenous patients experience care. These include: 1) Patient-reported experiences, such as feeling culturally unsupported, which can be assessed using tools like the Cultural Safety Assessment Tool (CSAT) (Curtis et al., 2025; R. Jones et al., 2019); 2) Clinical observations and documentation, such as missing notes on spiritual needs or signs of patient withdrawal during procedures. (West et al., 2010); 3) Post-discharge behaviors, like low adherence to treatment and reduced satisfaction, often linked to cultural disconnection during hospitalization. (Mbuzi et al., 2018).

Discussion

The concept of cultural disruption highlights a critical barrier in cardiovascular care for Indigenous patients—especially those undergoing invasive procedures like PCI or CABG. While nursing discourse often centers on cultural safety, competence, and humility, cultural disruption adds nuance by drawing attention to the breakdown of cultural continuity, identity, and relational healing in clinical settings. This analysis is reinforced by recent findings in Indigenous health scholarship. For

example, cultural determinants of health—such as connection to family/community, land (Country), cultural identity, and self-determination—are strongly linked to resilience and wellbeing among First Nations peoples; their disruption is associated with poorer outcomes and diminished cultural coherence (Moloney et al., 2023). Moreover, commentary in The Lancet Global Health underscores ongoing deficits in cultural safety within cardiovascular care, pointing to institutional biases and a lack of Indigenous-informed models that potentially exacerbate health disparities. Additionally, literature examining continued colonial impacts on Indigenous heart health demonstrates that the erosion of cultural practices, spiritual connections, and community rituals—resulting from colonization—has tangible physiological and psychosocial consequences that harm cardiovascular outcomes (Schultz et al., 2021). Together, these sources support the premise that Indigenous cardiac patients frequently experience care environments that prioritize biomedical efficiency at the expense of cultural and spiritual integrity—driving alienation, disengagement, and diminished health outcomes.

Nursing is inherently holistic and patient-centered, positioning nurses to recognize and mitigate cultural disruption through continuous engagement across the care trajectory. Their close interaction with patients during procedures like PCI or CABG provides a unique vantage point to detect and address cultural disconnections. However, the lack of a clearly defined framework for cultural disruption undermines nurses' ability to systematically identify or respond to its manifestations. The defining attributes of cultural disruption—such as disconnection from cultural identity, invalidation of traditional knowledge systems, and erosion of trust—are not just psychosocial issues but tangible barriers to recovery, adherence, and long-term wellness. This aligns with findings from a qualitative study of Advanced Practice Nurses in Europe, which revealed that nurses often face communication challenges, insufficient knowledge, and institutional barriers that inhibit the translation of cultural safety concepts into practice (Pirhofer et al., 2022). Similarly, literature on Indigenous strengths-based healthcare approaches emphasizes how acknowledging and integrating cultural beliefs enhances engagement and outcomes, suggesting that when these are omitted, cultural disruption is facilitated (Kennedy et al., 2022). Furthermore, comprehensive reviews of cultural determinants of health among Aboriginal and Torres Strait Islander peoples underscore the importance of connection to family, land, identity, and self-determination for resilience and well-being. These determinants are foundational to Indigenous health paradigms and their disruption by standard biomedical care can directly lead to diminished trust and disengagement. In sum, nursing's holistic philosophy, combined with empirical recognition of the relational and structural roots of cultural disruption, makes the profession both ideally situated to observe and responsible for responding to these care failures. Yet, without a shared conceptual framework, these critical disruptions often remain invisible or unaddressed in cardiac care settings, to the detriment of Indigenous patients.

This concept also complements and extends established nursing theories such as Leininger's Culture Care Theory

and Ramsden's Cultural Safety Model. Leininger's theory emphasizes culturally congruent care that aligns with patients' values and beliefs; cultural disruption highlights what occurs when these values are neglected or dismissed. Similarly, Ramsden's model of cultural safety calls attention to the power dynamics within healthcare encounters, which cultural disruption makes visible through its focus on relational and epistemological breakdowns. Together, these theories offer a foundation for understanding how cultural disruption not only represents a failure to respect cultural needs, but also signals systemic inequities that nurses are uniquely positioned to recognize and remediate in practice (Leininger, 2002)

Nurses play a pivotal role in mitigating cultural disruption among Indigenous cardiac patients through their proximity to patients, holistic care orientation, and position within care teams. Interventions such as including Indigenous Elders or cultural liaisons, arranging language interpretation, facilitating spiritual practices, and offering culturally appropriate dietary options represent concrete strategies to counteract the entrenched antecedents of cultural disruption—colonization, systemic racism, and biomedical dominance.(Poitras et al., 2022). These culturally grounded interventions directly target the defining attributes of cultural disruption, such as disconnection from identity, invalidated knowledge systems, breakdown of relational support, and erosion of trust. When nurses facilitate cultural inclusion, they help restore patient agency, trust, and engagement, which are essential for recovery and adherence (Poitras et al., 2022; Tane et al., 2024).

This concept analysis contributes to nursing theory by offering a context-specific and operational definition of cultural disruption, particularly within cardiovascular care for Indigenous populations. By delineating the concept's defining attributes, antecedents, consequences, and empirical referents, this analysis provides a theoretical foundation to inform both clinical practice and nursing education. Tools such as the Cultural Safety Assessment Tool (CSAT), clinical documentation audits, and narrative patient interviews are identified as practical approaches to recognizing and addressing cultural disruption in care settings. Their use can enable nurses to translate cultural awareness into actionable interventions, especially in high-intensity environments such as PCI or CABG units. Importantly, this analysis underscores the need for future empirical validation of these instruments across diverse Indigenous contexts, including those in Southeast Asia, Oceania, and North America. Research should also explore the long-term effects of culturally responsive nursing care on patient outcomes such as adherence, satisfaction, and trust in the healthcare system. By advancing the conceptual clarity of cultural disruption, this work supports the integration of equity-focused, relational models of care in cardiovascular nursing, contributing to both improved practice and health justice.

Ultimately, this analysis reinforces that addressing cultural disruption is not a peripheral concern, but a central obligation in ethical, equitable, and patient-centered nursing practice. Recognizing and operationalizing this concept equips nurses with the insight and tools necessary to advocate for

culturally responsive care, particularly in high-stakes environments like cardiovascular treatment. By doing so, nursing professionals can play a transformative role in reducing health disparities and advancing cultural justice within healthcare systems that have historically marginalized Indigenous worldviews and healing traditions.

Ultimately, this analysis reinforces that addressing cultural disruption is not a peripheral concern, but a central obligation in ethical, equitable, and patient-centered nursing practice. Recognizing and operationalizing this concept equips nurses with the insight and tools necessary to advocate for

culturally responsive care, particularly in high-stakes environments like cardiovascular treatment. By doing so, nursing professionals can play a transformative role in reducing health disparities and advancing cultural justice within healthcare systems that have historically marginalized Indigenous worldviews and healing traditions.

To further guide clinical application, Table 1 summarizes how the defining attributes of cultural disruption can be mapped to specific nursing interventions that promote cultural responsiveness and mitigate harm.

Table 1. Mapping Defining Attributes of Cultural Disruption to Nursing Interventions

Defining Attribute	Example of Nursing Intervention
Disconnection from cultural identity and practices	Encourage use of cultural attire, language, or rituals; provide space for cultural expression
Invalidation of Indigenous knowledge and beliefs	Acknowledge traditional beliefs; integrate patient's explanatory model into care discussions
Breakdown in relational and community support	Facilitate visits or calls with family, Elders, and community members; engage Indigenous liaison
Loss of cultural agency during hospitalization	Support patient autonomy through shared decision-making; explain procedures in culturally safe terms
Spiritual and emotional alienation	Offer spiritual support; accommodate rituals or prayer practices when possible
Disempowerment and lack of voice in care decisions	Validate patient perspectives; involve them in care planning and respect their preferences

These interventions represent practical steps that nurses can implement across cardiac care settings to minimize cultural disruption and strengthen therapeutic engagement with Indigenous patients.

Implication and limitations

Implications for Nursing Practice and Research: This concept analysis provides a foundational understanding of cultural disruption as it pertains to Indigenous patients receiving cardiovascular care, especially in settings involving invasive procedures like PCI and CABG. For nursing practice, it emphasizes the need to integrate cultural safety assessments, involve Indigenous liaison officers, and adapt care protocols to include relational, spiritual, and land-based dimensions of healing. These efforts can enhance patient trust, improve adherence, and support more holistic recovery processes. In nursing education, the clarified attributes and empirical referents of cultural disruption can inform curricula on cultural humility,

trauma-informed care, and Indigenous health. For researchers, this analysis suggests a pathway for developing and validating tools to measure cultural disruption and its impact on health outcomes. It also highlights the need for longitudinal studies that examine how culturally responsive nursing interventions affect engagement and long-term cardiac rehabilitation.

Despite its theoretical contributions, this analysis is limited by the relative scarcity of peer-reviewed literature that explicitly defines or measures cultural disruption—especially within Indigenous cardiovascular care. Much of the supporting evidence is derived from qualitative and contextual studies, which, while rich in narrative, may lack generalizability. Additionally, the empirical referents proposed have not yet been universally validated across different Indigenous populations, and cultural experiences vary widely between regions and nations. Furthermore, this concept analysis employed Walker and Avant's eight-step method, which, while systematic and widely used in nursing theory, is rooted in Western epistemological traditions. As such, it may not fully capture or honor Indigenous ways of knowing, relational worldviews, or community-led definitions of health and disruption. Future concept analyses should consider integrating decolonial, participatory, or Indigenous-led methodologies that more authentically reflect the values, voices, and cultural paradigms of the communities being studied. Moreover, the literature base informing this analysis is predominantly drawn from settler-colonial contexts—namely Australia, Canada, and the United States—which may limit the transferability of findings to Indigenous populations in Southeast Asia or other regions with distinct historical, cultural, and colonial trajectories. Therefore, caution must be taken not to oversimplify or universalize Indigenous experiences. Future work should focus on co-designing research and interventions with Indigenous communities to ensure contextual relevance, ethical alignment, and cultural authority.

Conclusion

This concept analysis offers a clarified and context-specific understanding of cultural disruption within Indigenous cardiovascular care, particularly in relation to nursing practice. By identifying its defining attributes—such as disconnection from cultural identity, invalidation of traditional knowledge systems, and erosion of trust—this analysis distinguishes cultural disruption from broader concepts like cultural safety or competence. It highlights how cultural disruption functions as both a social determinant and a clinical barrier, particularly for Indigenous patients undergoing invasive procedures such as PCI or CABG. Through the development of empirical referents and model cases, this analysis provides a framework that nurses, educators, and researchers can use to identify, measure, and address cultural disruption in care settings. Integrating culturally grounded practices into cardiovascular nursing can promote trust, improve health outcomes, and contribute to more equitable systems of care. Ultimately, this concept underscores the need for nursing to move beyond cultural awareness toward structurally and relationally informed models that uphold cultural continuity and justice for Indigenous peoples.

Acknowledgments

The author wishes to acknowledge the insights of Indigenous communities and the existing body of Indigenous scholarship that inspired the development of this concept analysis. Gratitude is also extended to fellow nursing colleagues and academic peers for their informal input and discussions that enriched the clarity of this work. This study was conducted independently without external funding.

Author contribution

AW conceptualized the study, conducted the literature review, and drafted the initial manuscript. RO contributed to the refinement of the concept analysis framework, provided critical revisions, and supported reference validation. YY assisted in data organization, formatting, and manuscript editing for journal submission. All authors read and approved the final version of the manuscript.

Conflict of interest

The authors declare no conflict of interest in the development and publication of this manuscript.

References

Absolon, K. (2023). Decolonizing Education and Educators' Decolonizing. *Journal of Indigenous Social Development*, *12*(1). https://journalhosting.ucalgary.ca/index.php/jisd/article/view/75815

Anderson, M., & Migwans, A. (2021). Supporting and enabling indigenous ceremonial practices within healthcare institutions: A wise practices guideline. In *Toronto Central Regional Cancer Program*. https://www.trcp.ca/en/indigenous-cancer-program/Documents/CWP_Guideline.pdf

Askew, D. A., Foley, W., Kirk, C., & Williamson, D. (2021). "I'm outta here!": a qualitative investigation into why Aboriginal and non-Aboriginal people self-discharge from hospital. *BMC Health Services Research*, *21*(1), 1–10. https://doi.org/10.1186/s12913-021-06880-9

Australian Indigenous HealthInfoNet. (2023). *Cardiovascular disease - Measure 1.05*. Australian Indigenous Health Performance Framework. https://www.indigenoushpf.gov.au/measures/1-05-cardiovascular-disease

Burchill, L., & Dos Santos, A. (2024). Progress towards cultural safety in Indigenous cardiovascular health care and research. *The Lancet. Global Health*, *12*(4), e541–e542. https://doi.org/10.1016/S2214-109X(24)00080-9

Carrie, H., Mackey, T. K., & Laird, S. N. (2015). Integrating traditional indigenous medicine and western biomedicine into health systems: a review of Nicaraguan health policies and miskitu health services. *International Journal for Equity in Health*, *14*, 129. https://doi.org/10.1186/s12939-015-0260-1

Curtis, E., Loring, B., Jones, R., Tipene-Leach, D., Walker, C., Paine, S. J., & Reid, P. (2025). Refining the definitions of cultural safety, cultural competency and Indigenous health: lessons from Aotearoa New Zealand. *International Journal for Equity in Health*, *24*(1). https://doi.org/10.1186/s12939-025-02478-3

Goerger, K., Abbott, K., Larson, M. K., & Holinstat, M. (2025). Cardiovascular Disease Risk Factors in the Native American Population. *Journal of Cardiovascular Development and Disease*, *12*(1), 1–16. https://doi.org/10.3390/jcdd12010027

Harrop, D. L., Bryce, V., Kitchener, T., Grugan, S., Renouf, S., Mitchell, S.,

Hasking, G., Pauza, D., Richards, G., Ng, A. C. T., & Wang, W. Y. S. (2024). Effects of a culturally informed model of care for Aboriginal and Torres Strait Islander patients with acute coronary syndrome in a tertiary hospital in Australia: a pre-post, quasi-experimental, interventional study. *The Lancet. Global Health*, *12*(4), e623–e630. https://doi.org/10.1016/S2214-109X(23)00601-0

Hiyare-Hewage, A., Sinka, V., Grande, E. D., Kerr, M., Kim, S., Mallitt, K.-A., Dickson, M., Jaure, A., Wilson, R., Craig, J. C., & Stephens, J. H. (2024). The cultural safety of research reports on primary healthcare use by Indigenous Peoples: a systematic review. *BMC Health Services Research*, *24*(1), 873. https://doi.org/10.1186/s12913-024-11314-3

Jones, B., Heslop, D., & Harrison, R. (2020). Seldom heard voices: a meta-narrative systematic review of Aboriginal and Torres Strait Islander peoples healthcare experiences. *International Journal for Equity in Health*, *19*(1), 1–11. https://doi.org/10.1186/s12939-020-01334-w

Jones, R., Crowshoe, L., Reid, P., Calam, B., Curtis, E., Green, M., Huria, T., Jacklin, K., Kamaka, M., Lacey, C., Milroy, J., Paul, D., Pitama, S., Walker, L., Webb, G., & Ewen, S. (2019). Educating for Indigenous Health Equity: An International Consensus Statement. *Academic Medicine : Journal of the Association of American Medical Colleges.*., *94*(4), 512–519. https://doi.org/10.1097/ACM.0000000000002476

Josewski, V., de Leeuw, S., & Greenwood, M. (2023). Grounding Wellness: Coloniality, Placeism, Land, and a Critique of "Social" Determinants of Indigenous Mental Health in the Canadian Context. *International Journal of Environmental Research and Public Health*, *20*(5). https://doi.org/10.3390/ijerph20054319

Kennedy, A., Sehgal, A., Szabo, J., McGowan, K., Lindstrom, G., Roach, P., Crowshoe, L. L., & Barnabe, C. (2022). Indigenous strengths-based approaches to healthcare and health professions education - Recognising the value of Elders' teachings. *Health Education Journal*, *81*(4), 423–438. https://doi.org/10.1177/00178969221088921

Kim, P. J. (2019). Social Determinants of Health Inequities in Indigenous Canadians Through a Life Course Approach to Colonialism and the Residential School System. *Health Equity*, *3*(1), 378–381. https://doi.org/10.1089/heq.2019.0041

Leininger, M. (2002). Culture Care Theory: A Major Contribution to Advance Transcultural Nursing Knowledge and Practices. *Journal of Transcultural Nursing*, *13*(3), 189–192. https://doi.org/10.1177/10459602013003005

Lunda, A., Frommherz, A., Bolton, W. G., Cook, C., Dude, B., Leask, N., Littlefield, R., McCarty, J., Puustinen, S., & Vaska, N. (2024). Supporting the Cultural Identity Development of Indigenous Youth: Findings from an Indigenous Educators' Community-Of-Practice. *Education Sciences*, *14*(12). https://doi.org/10.3390/educsci14121272

MacLean, T. L., Qiang, J. R., Henderson, L., Bowra, A., Howard, L., Pringle, V., Butsang, T., Rice, E., Di Ruggiero, E., & Mashford-Pringle, A. (2023). Indigenous Cultural Safety Training for Applied Health, Social Work, and Education Professionals: A PRISMA Scoping Review. *International Journal of Environmental Research and Public Health*, *20*(6). https://doi.org/10.3390/ijerph20065217

Mbuzi, V., Fulbrook, P., & Jessup, M. (2017). Indigenous cardiac patients'

and relatives' experiences of hospitalisation: A narrative inquiry. *Journal of Clinical Nursing*, *26*(23–24), 5052–5064. https://doi.org/10.1111/jocn.14005

Mbuzi, V., Fulbrook, P., & Jessup, M. (2018). Effectiveness of programs to promote cardiovascular health of Indigenous Australians: A systematic review. *International Journal for Equity in Health*, *17*(1), 1–17. https://doi.org/10.1186/s12939-018-0867-0

McGiffin, E. (2022). Raced and Erased: Settler Colonialism and Environmental Violence in the Poetry of Jordan Abel. *ISLE: Interdisciplinary Studies in Literature and Environment*, *31*(1), 4–25. https://doi.org/10.1093/isle/isac023

Moloney, A., Stuart, L., Chen, Y., & Lin, F. (2023). Healthcare professionals' cultural safety practices for indigenous peoples in the acute care setting–a scoping review. *Contemporary Nurse*, *59*(4–5), 272–293. https://doi.org/10.1080/10376178.2023.2271576

O'Neill, L., Fraser, T., Kitchenham, A., & McDonald, V. (2018). Hidden Burdens: a Review of Intergenerational, Historical and Complex Trauma, Implications for Indigenous Families. *Journal of Child & Adolescent Trauma*, *11*(2), 173–186. https://doi.org/10.1007/s40653-016-0117-9

Pirhofer, J., Bükki, J., Vaismoradi, M., Glarcher, M., & Paal, P. (2022). A qualitative exploration of cultural safety in nursing from the perspectives of Advanced Practice Nurses: meaning, barriers, and prospects. *BMC Nursing*, *21*(1), 178. https://doi.org/10.1186/s12912-022-00960-9

Poitras, M.-E., T Vaillancourt, V., Canapé, A., Boudreault, A., Bacon, K., & Hatcher, S. (2022). Culturally safe interventions in primary care for the management of chronic diseases of urban Indigenous People: a scoping review. *Family Medicine and Community Health*, *10*(Suppl 1). https://doi.org/10.1136/fmch-2022-001606

Powell-Wiley, T. M., Baumer, Y., Baah, F. O., Baez, A. S., Farmer, N., Mahlobo, C. T., Pita, M. A., Potharaju, K. A., Tamura, K., & Wallen, G. R. (2022). Social Determinants of Cardiovascular Disease. *Circulation Research*, *130*(5), 782–799. https://doi.org/10.1161/CIRCRESAHA.121.319811

Ralph, A. P., McGrath, S. Y., Armstrong, E., Herdman, R. M., Ginnivan, L., Lowell, A., Lee, B., Gorham, G., Taylor, S., Hefler, M., & Kerrigan, V. (2023). Improving outcomes for hospitalised First Nations peoples though greater cultural safety and better communication: the Communicate Study Partnership study protocol. *Implementation Science : IS*, *18*(1), 23. https://doi.org/10.1186/s13012-023-01276-1

Redvers, N., Marianayagam, J., & Blondin, B. (2019). Improving access to Indigenous medicine for patients in hospital-based settings: a challenge for health systems in northern Canada. *International Journal of Circumpolar Health*, *78*(2), 1589208. https://doi.org/10.1080/22423982.2019.1589208

Roher, S. I. G., Andrew, P., Chatwood, S., Fairman, K., Galloway, T., Mashford-Pringle, A., & Gibson, J. L. (2023). Envisioning Indigenous and biomedical healthcare collaboration at Stanton Territorial Hospital, Northwest Territories. *International Journal of Circumpolar Health*, *82*(1). https://doi.org/10.1080/22423982.2023.2253603

Schultz, A., Nguyen, T., Sinclaire, M., Fransoo, R., & McGibbon, E. (2021). Historical and Continued Colonial Impacts on Heart Health of Indigenous Peoples in Canada: What's Reconciliation Got to Do With It? *CJC*

Open, *3*(12, Supplement), S149–S164. https://doi.org/https://doi.org/10.1016/j.cjco.2021.09.010

Tait, A. W., & de Leeuw, J. S. (2025). Building Culturally Responsive Health Systems for Indigenous Peoples: A Global Scoping Review. *Co-Designing a Chatbot for Culturally Competent Clinical Communication: Experience and Reflections*. http://arxiv.org/abs/2506.11393

Tane, T., Selak, V., Eggleton, K., & Harwood, M. (2024). Drivers of access to cardivascular health care for rural Indigenous Peoples a scoping review. *Rural and Remote Health*, *24*(2). https://doi.org/10.22605/RRH8674

Tootell, N., McGaw, J., Patten, U. H., & Vance, A. (2024). 'Doing culture' in contemporary south-eastern Australia: how Indigenous people are creating and maintaining strong cultural identities for improved health and wellbeing. *BMC Public Health*, *24*(1), 1–15. https://doi.org/10.1186/s12889-024-19146-w

Tremblay, M.-C., Olivier-D'Avignon, G., Garceau, L., Échaquan, S., Fletcher, C., Leclerc, A.-M., Poitras, M.-E., Neashish, E., Maillet, L., & Paquette, J.-S. (2023). Cultural safety involves new professional roles: a rapid review of interventions in Australia, the United States, Canada and New Zealand. *AlterNative: An International Journal of Indigenous Peoples*, *19*(1), 166–175. https://doi.org/10.1177/11771801221146787

Verbunt, E., Luke, J., Paradies, Y., Bamblett, M., Salamone, C., Jones, A., & Kelaher, M. (2021). Cultural determinants of health for Aboriginal and Torres Strait Islander people – a narrative overview of reviews. *International Journal for Equity in Health*, *20*(1), 1–9. https://doi.org/10.1186/s12939-021-01514-2

Vervoort, D., Kimmaliardjuk, D. M., Ross, H. J., Fremes, S. E., Ouzounian, M., & Mashford-Pringle, A. (2022). Access to Cardiovascular Care for Indigenous Peoples in Canada: A Rapid Review. *CJC Open*, *4*(9), 782–791. https://doi.org/10.1016/j.cjco.2022.05.010

Wali, S., Hiscock, E. C., Simard, A., Fung, N., Ross, H., & Mashford-Pringle, A. (2024). Learning From Our Strengths: Exploring Strategies to Support Heart Health in Indigenous Communities. *CJC Open*, *6*(7), 849–856. https://doi.org/10.1016/j.cjco.2023.06.005

Walker, L. O., & Avant, K. C. (2014). *Strategies for Theory Construction in Nursing* (5th ed.). Pearson Education Limited.

West, R., Usher, K., & Foster, K. (2010). Increased numbers of Australian Indigenous nurses would make a significant contribution to 'closing the gap' in Indigenous health: What is getting in the way? *Contemporary Nurse*, *36*(1–2), 121–130. https://doi.org/10.5172/conu.2010.36.1-2.121

Wilson, L., Wilkinson, A., & Tikao, K. (2022). Health professional perspectives on translation of cultural safety concepts into practice: A scoping study. *Frontiers in Rehabilitation Sciences*, *3*, 891571. https://doi.org/10.3389/fresc.2022.891571