



Clarifying Cultural Safety: its focus and intent in an Australian context

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Abstract

The nursing/midwifery professions are facing a sea change with the inclusion of cultural safety in the Code of Conduct for Registered Nurses (NMBA 2018a), the Code of Conduct for Midwives (NMBA 2018b), the Registered Nurse Accreditation Standards (Australian Nursing and Midwifery Accreditation Council [ANMAC] 2019) and the Midwife Accreditation Standards (ANMAC 2021). In this paper we focus on the theme of enabling cultural safety seeking to overcome the barrier of confusion surrounding it. The inclusion of cultural safety in codes and accreditation standards, highlights the pressing need for these professions to attain deep understanding of

cultural safety so that clinicians and educators can confidently practice and teach in this area. This need is underscored by the context of heightened awareness, that developed amongst mainstream Australians with Black Lives Matter in 2020, of inequity including health inequity.

Our concern as academics responsible for staff development, curriculum development and implementation in university Schools of Nursing/Midwifery is to enable and support the teaching and practice of cultural safety. Its focus on working in partnership, addressing power imbalances, racisms, and related systems of discrimination constitutes it as a vastly different model to cultural other-awareness and notions of cultural competency which have held sway on matters of culture in health service provision up to now. Our approach was to undertake a reflection on our combined decades of studying, leadership, teaching and practice of cultural safety, which consistently showed the confusion in Australia about the model overall and about the definition of culture underpinning it. This paper supports the profession by addressing the need to educate academics and clinicians on cultural safety itself and on the role of all nurses/midwives, Indigenous and non-Indigenous, in these endeavours. This paper encourages a coherent development and confident implementation of cultural safety curriculum and practice to meet current requirements.

Key Words: Cultural Safety, culture, racism, power relations, decolonisation, whiteness/ white privilege

Introduction

This paper by an Indigenous and a non-Indigenous author, on the unceded country of the Turrbal, Jagara, Wakka Wakka, Jinibara and Gubbi Gubbi Peoples acknowledges traditional owners. Culturally unsafe practices spanning decades at Australian hospitals are lethal for Indigenous people. In 2009 Doomadgee Hospital repeatedly turned away a four-year-old girl who died (Guest 2019), in 2014 Ms Dhu was declared fit by Hedland Health Campus Hospital and returned to custody and died (Fogliani, 2016; 2018), in 2016 Tumut Hospital sent Naomi Williams home 20 times before she died (Hayter and King 2019), and in 2017 Bamaga Hospital turned away six-year-old Charlie Gowa who

died (Smee 2020). Instances being examined by the National Justice Project (n.d.) and findings of Royal Commission into Aged Care (Commonwealth of Australia, 2019) show the urgent need for nurses/midwives to turn their gaze to cultural assumptions, racism, and power imbalance first identified by the Royal Commission into Aboriginal Deaths in Custody (Johnston, 1991).

Deaths and poor outcomes result from racism and systems of discrimination in health teams' and services' cultures which impact on clinical decision-making, demanding changes to clinical practice (Hayter and King 2019, National Justice Project n.d.). To this end, NMBA included cultural safety in its codes of conduct for registered nurses and for midwives (NMBA, 2018a; NMBA, 2018b) and Australia's Registered Nurse Accreditation Standards (ANMAC, 2019) and in Midwife Accreditation Standards (ANMAC 2021) mandated it in curricula.

This paper arises from our academic leadership on cultural safety including curriculum design/implementation, staff development, research, and publishing, embedding cultural safety in nursing programs at Bachelor and Master's level, and in a wide variety of health degrees. We engaged in incorporating cultural safety nationally being invited to a series of National Roundtables by Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM), between 2017-2019. We took a leading role in discussions and provided written material on cultural safety and whiteness, now evident in key documents (see NMBAb, 2018; CATSINaM 2017). The first author conducted invited cultural safety workshops at CATSINaM's national conference in 2017 and the NMBA national conference in 2018 (mandatory for all delegates).

In a climate of global disruptions to white power agendas evidenced by the Black Lives Matters movement (Geia et al., 2020) consolidating the professions' grasp of cultural safety is imperative for health care outcomes. The model recognises this goal depends on systemic change in health service provision and requires transforming the cultures of professions and services. Confronting white dominance and apathy and changing the lens used in clinical and collegial encounters between Indigenous and non-Indigenous people is essential. We propose that by

improving these relationships and working in partnership, interpersonal and systemic racism and intersectional discrimination can be confronted and addressed. However, a barrier to developing and implementing culturally safe practice and systems is the confusion in the professions about cultural safety. We frequently observe amongst colleagues (academics, clinicians, and researchers), and in grey and other literature, misunderstandings about the focus, intent, and practice of the model (Doran et al. 2019; Cox et al. 2020) and a limited grasp of the conceptualisation of culture that underpins it. These circumstances raise interesting questions about how Schools of Nursing/Midwifery and health services can meet cultural safety requirements.

To provoke thought and support the implementation of cultural safety, we commence by explaining the model clarifying whose culture is its focus. We then discuss the confusion that currently surrounds cultural safety and the conceptualisation of culture that underpins it. Finally, we discuss white privilege as a dimension of racism and conclude that all academics, clinicians, managers, and researchers have a role in and a responsibility for cultural safety.

CULTURAL SAFETY: WHAT DOES IT MEAN?

Developed in Aotearoa by nurse, scholar, and Māori woman Dr Irihapeti Ramsden (2002) and colleagues, cultural safety is an Indigenous knowledge and model of practice that is openly political. It is widely applicable in preparing nurses/midwives to take their place as leaders in social transformation (Ramsden, 2002), as evidenced by its spread to various contexts globally (see Curtis et al. 2019) and academically (Cox and Simpson 2015). However, our focus is considering the model as Ramsden developed it. Cultural safety has philosophical, epistemological, and practical aspects which confront cultural dominance in health systems and Australian society.

Philosophically it is humanistic as it seeks social justice and is underpinned by critical, feminist, and emancipatory theory (Ramsden 2002). Epistemologically it considers the power dynamics of knowledge creation and legitimacy since knowledge (such as nursing/midwifery knowledge) is influenced by cultural values and positions. In practice, cultural safety starts with an

analysis of power during critical reflection by nurses/midwives at all levels. Reflective focus is on personal and organisational cultures (power dynamics, values, priorities, beliefs, traditions) and their impact on clinical encounters. Ramsden said: 'structural influences which have a significant impact on health status, cannot be ignored' (2002, p. 112), so critical reflection is not an individualistic naval-gazing exercise. Rather its practice clarifies matters of power and privilege and how these operate systemically, bringing to light the socially constructed nature of health, race, age, class, ability, and gender and how these inform health itself and nursing/midwifery practice (Ramsden 2002).

Cultural safety provides direction in thinking about and understanding these complex social processes. Nurses/midwives collectively develop an appreciation of the social determinants of clients' health including how the attitudes and preconceptions of nurses/midwives, teams and systems can be fatal, reproduce social exclusion and consolidate social inequity for Indigenous people. Engaging in the process of cultural safety clarifies a practitioner's stance on current social issues, as they contemplate their own privileges and opportunities, how they came about and who was disadvantaged as a result, leading to shared grasp of the need for social justice. Since cultural safety requires historical literacy, it inspires understanding of health disparity's relationship to dispossession and ongoing colonisation, and of how Indigenous people's trust in nurses/midwives and health services is continually undermined. Notions that the nursing/midwifery professions and health systems are value neutral are challenged, by highlighting relationships between their cultural values, assumptions, and histories (Cox 2007; Forsyth 2007) and peoples' experiences of racism and stigma (Cox et al., 2020; Best, 2021; Cox & Simpson, 2015; Molloy & Grootjans, 2014; Wilson, 2014).

Culturally safe nurses/midwives and services, engaging in the ongoing practice of critical self-reflection, develop confidence and compassion with greater self and social awareness. This growth allows negotiation of complex, ambiguous matters about culture and power, focussing on

systems of privilege and intersectional discrimination in nursing/midwifery education, practice and health systems (Best 2021; Browne et al. 2009; Ramsden 2002; Reimer-Kirkham 2009; Wilson 2014). That is, cultural safety raises awareness of the cumulative impacts of discrimination experienced by reactions to a person's ethnicity, gender, sexuality, age and health issues (Sambrano & Cox 2013). Cultural safety builds relationships between people and services based on trust, sharing power, knowledge, and partnership. It responds to needs as defined by a person/family and in ways that inspire trust, so people feel heard, supported, respected, and safe. Ongoing cultural self-reflection by **all** nurses/midwives and systemic critical reflection by leaders in the organisations in which they work, must be structurally supported by professions and health systems (NMBA 2018 a, b, c, and d), by providing resources, space, time and clearly documented protocols and processes to undertake it. These practices would maintain ongoing analysis of and accountability for unreflective culturally unsafe habits, their consequences such as the deaths of Ms Dhu, Naomi Williams and others, and the development of preventative strategies supporting culturally safe practice. We concentrate next on key documents and experiences arguing that there is conceptual confusion about the model and its focus in Australia, tied up with the conceptualisation of culture, which we then unpack. These matters impact on how it is taught and practiced.

Cultural safety: Whose culture?

The consistent focus of Cultural Safety as originally envisaged was to be grounded in the Critical Theory approach constantly questioning power relations between nurse and the person being nursed with the emphasis on the attitudes and behaviours of the nurse' (Ramsden 2002, p. 5).

Contrary to Ramsden's intent, we encounter misguided assumptions that cultural safety is the newest buzzword for cultural competency and business as usual (Cox 2016, p.5). Usual business in nursing/midwifery and throughout the health care system, reduces culture to ethnicity, and by extension, conceives of cultural safety as focussing on the cultures of Indigenous

people and so-called 'ethnic' others and being only relevant for that work (NMBA, 2018d). In a change of emphasis in efforts to address social inequity, cultural safety '...is about the analysis of power and not the customs and habits of anybody' (Ramsden 2002, p. 181). There is no question that discrimination and health inequity impact more on Indigenous Australians than others (Best, 2015; Best & Gorman, 2016; Best & Bunda, 2020; Cox, 2007; Forsyth, 2007). But Indigenous outcomes and experiences, are not because of Indigenous people's culture but because of non-Indigenous people's personal and institutional cultures. Misunderstanding these matters and concentrating the gaze on Indigenous cultures, promotes unhelpful nursing/ midwifery practices, including guesses and homogenising assumptions about Indigenous people, culture and needs, judgments about authenticity and moralising about health (Cox et al. 2020; Best 2021). These practices directly oppose cultural safety's focus which is *not* the ethnicity of service users but the dominant colonising culture and its expression in interpersonal clinical encounters through personal and institutional cultures. After all it was mainstream culture's claim to value free acultural innocence in reproducing itself to the detriment of others, that inspired the model in the first place (Ramsden 2002).

Ramsden's focus can be demonstrated by looking at biculturalism a key aspect of cultural safety. An interviewee of Ramsden's (2002, p. 114) explains it: 'Yes, we live in a society that to some extent is a bi-cultural society... let's recognise that even if I was a nurse or a doctor dealing with a fellow Pakeha patient that had many of the same characteristics as me... that would still be a bi-cultural situation ... you have two parts to a dynamic which can be bicultural because of issues of class, gender, professional identity'.

These ideas confront the notion amongst white people that only 'people of colour' are 'ethnic' and therefore cultural beings (Cox & Simpson, 2015; Cox et al., 2020; Van Herk et al., 2011)

and suggest that cultural safety can improve all clinical encounters even when the nurse/midwife and the service user seem to share a culture. Biculturalism naturally leads to a recognition that social inequity in the form of poor health outcomes is related to mainstream cultures who are part of diversity. These moves locate the possibility for transformation within dominant cultures and those who hold power and benefit from the status quo in educational and health systems, but conceptual clarity is needed.

Conceptual confusion

In a series of Australian national workshops in 2015 and 2016 (McDermott and Sjoberg, 2015) on teaching cultural safety attended by the first author, an assortment of terms was used interchangeably with cultural safety, such as 'culturally specific' and 'culturally conscious'. Various others, as reflected in grey and other literature, include culturally responsive (Department of Health, 2018), cultural humility (Foronda et al., 2016), cultural security (Milroy, 2013), cultural competence (Brown et al., 2014; Davidson & Hickman, 2017; Queensland University of Technology, 2016) and cultural appropriateness (Barcelona De Mendoza & Damio, 2018; Deek et al., 2016; NMBA, 2016; Department of Health, 2018). Examples of a mixture of approaches contributing to the confusion of health professionals and educators, include the Australian Commission on Safety and Quality in Health Care Standards (2017), Universities Australia (2017), Migrant and Refugee Woman's Health Partnerships (2018) and Queensland Health (2018). At a meeting in 2018 to discuss curriculum development attended by the first author, the term 'culturally comfortable' was used and cultural fluency appeared and adds to the mix (Leitch 2017). Further confusion is presented by Shepherd et al., (2019) who advocate for cultural other-awareness, cultural safety, AND cultural competence. None define culture and nor grasp the profound differences between cultural safety and cultural competence.

In our combined 30 plus years' experience in the tertiary sector and with professional bodies, we see cultural safety exploited as a tick box exercise claiming action on diversity targets and inequity. In these cases, 'cultural safety' is used with no grasp of it as a model, no grasp of the theories underpinning it and no grasp of what it means in practice. As a result, '... privilege, power and racism remain unaddressed and unacknowledged' (Cox, 2016, p. 5). The confusion that arises from the misguided focus already discussed, enables spurious claims that cultural safety is fulfilling needs to properly embed and resource Indigenous knowledges and/or perspectives in curricula. The latter are different bodies of work to that of cultural safety.

These various approaches to culture and inclusivity result in profound misunderstandings of cultural safety, a lack of clarity around which version of the contested culture concept is being used and the practice of referring to quite different models as if they are the same. These problems are apparent in clinical and research practice, university documents and curricular, and in society generally (Bonson, 2018). Similar issues were raised by Papps: 'Is Cultural Safety, then the same as the notion of Transcultural Nursing . . . or the same as cultural sensitivity . . . or the same as cultural competence . . . or the same as culturally competent nursing' (Papps, 2002, p. 101 cited in Ramsden 2002, p. 117)? As Ramsden goes on to note, she and many others she cites, say they are not the same (also see Curtis et al. 2019).

The term 'cultural competence', a transcultural notion suggesting that competence can be gained in another's culture (Ryder et al., 2011; Curtis et al. 2019), remains a deep source of confusion. This term persists even though it does **not** appear in the Australian and Nursing and Midwifery Accreditation Council Standards (ANMAC, 2019), the Midwife Standards of Practice (NMBA, 2018a), the Registered Nurse Standards for Practice (NMBA, 2016), the Code of Conduct for Nurses (NMBA, 2018b), the Code of Conduct for Midwives (NMBA, 2018c) nor in the Cultural Respect Framework for Aboriginal and Torres Strait Islander Health (Australian Health Ministers

Advisory Council, 2016). Resolving this conceptual confusion requires clarity around the definition of culture as it is used in cultural safety (Cox & Best, 2019).

The culture concept in cultural safety

Culture is far from self-evident. As Katan put it 'the task of defining culture...can move from difficult to extremely political' (2018, p. 17). Cultural safety calls for nurses/midwives to take a critically informed, historical view of themselves as persons, to acknowledge privilege, and to accept and know themselves as cultural beings (Best, 2021; Cox & Simpson, 2015; Cox et al., 2020). In cultural safety the concept of personal culture '...is used in its broadest sense to apply to any person or group of people who may differ from the nurse/midwife because of socio-economic status, age, gender, sexual orientation, ethnic origin, migrant/refugee status, religious belief, or disability' (Ramsden, 2002, p. 114). Ramsden (2002) was clear that culture can neither be reduced to ethnicity nor to formal ritual and beliefs (religion and custom). Rather culture is dynamic, and its social and political significance as learned and strategic are emphasised.

Individuals' cultures are informed by, reflected by, expressed in, and reproduce professional, institutional, and societal cultures. It is to be expected then, that students bring to university unexamined common-sense ideas about culture, that conflate it to ethnicity and align it with skin colour, an obvious, significant, yet superficial physical variation from the dominant white culture. There is a lack of appreciation of culture's contested nature and its significance for outcomes, which misguides practice. When teaching cultural safety and questioning what culture means to tertiary students, responses are overwhelmingly based on assuming culture equates to ethnicity and that whiteness is 'natural', neither an ethnicity nor a culture. When asked to consider their culture by specific reflection on culture as it is defined in cultural safety, white Australian undergraduate nursing students frequently make statements such as '*oh but I'm just Australian*' (Cox

et al. 2020). Reflecting an impoverished and yet privileged notion of culture which fails to include gender, gender identity, class, ethnicity, age, profession, spirituality, religion, sexuality, or social experience, students disavow that we are all culture bearers and cannot be placed outside the realm of concerns about culture and its impacts on practice (Cox et al., 2020). As Best (2021, p. 65) argues these circumstances show 'an imagined sense of being acultural –without culture' and yet clearly non-Indigenous Australians have many and varied cultures.

The significance of culture in nursing/midwifery practice lies in the interplay between nurses'/midwives' worldviews [values, beliefs, attitudes], the lifeworlds nurses/midwives inhabit [ethnicity, age, sexuality, class, ability, gender, gender identity, privilege, status, experience, context] and the ways of doing business of health systems. Cultural safety considers how professionals and health systems treat and respond to differences in worldviews and lifeworlds between them and service users, since culture influences relationships with people during nursing/midwifery practice and impacts clinical decision-making. These processes reproduce [or could transform] patterned structural privilege and disadvantage (Cox et al. 2020). We argue that the confusion surrounding culture needs resolution to realise cultural safety's capacity to challenge established ways of doing business, as Ramsden envisioned (2002). When there are entrenched health disparities, discrimination, racism and health care access issues, cultural safety looks to how professionals, professions and institutions conduct themselves; it does not locate problems in the cultural identity of people seeking help or using services. It urges practitioners and systems to grasp and respond to the social determinants of health including their own contribution to maintaining the status quo. It aims to stop blaming people for the difficulties they face while being 'regardful' of each persons' unique needs and context (Ramsden 2002, p. 119). These arguments bring us to a consideration of white privilege and whiteness in nursing/midwifery and the role of those located in the white domain in the implementation of cultural safety.

White privilege and nursing/midwifery: Realising the potential of cultural safety

'One of the reasons there has been so much fear and opposition to ... Cultural Safety is because it requires consideration of issues of power. And not just the imbalance of power between a patient and a medical professional but the wider origins of that power beyond the hospital' (Mona Jackson, interviewee in Ramsden 2002, p. 176).

Understanding, acknowledging and critically reflecting on whiteness and white privilege are central to implementing cultural safety, consequently the NMBA included it in the Code of Conduct (NMBA 2018, p. 15). Our experiences impressed on us that many in the white domain experience talk of white privilege as an accusation that they are racist. Ramsden (2002, p. 145-147) describes the media frenzy in 1993-1994 in Aotearoa when culture safety was introduced into state nursing examinations, citing headlines such as 'rampant apartheid'. In 2018 Australia there was a similar furore about 'white privilege'. The ABC's Media Watch covered the 'white privilege outrage' manufactured by Graeme Haycroft (Australian Broadcasting Corporation [ABC] 2018). As outlined there, the 'outrage' started with Cory Bernardi calling the Code (NMBA 2018) 'medical Marxism' (Weekly Dose of Common Sense, 31 January 2018 cited in ABC 2018). Haycroft called it 'an insidious form of racism ... it's going to end up with a form of apartheid in the health system' (Classic Hits 4CA, Mornings with John MacKenzie, 7 March, 2018 cited in ABC 2018).

He claimed that the Code (NMBA 2018) would lead to job losses: 'If you've got an Aboriginal or Indigenous patient and they don't like the bedside manner of the nurse because the nurse is not acknowledging her white privilege... then a complaint can be lodged and there's no defence' (2GB, Overnight with Michael McLaren, 13 March, 2018 cited in ABC 2018). Peta Credlin said the Code 'requires obviously white nurses to announce they've got white privilege...' (Sky News, 21 March, 2018 cited in ABC 2018). The risible claims reached new heights when Andrew Bolt said: 'What about if they're just within seconds of dying...but they have to stop... while they just announce their white privilege' (2GB, The Chris Smith Show, 22 March, 2018 cited in ABC 2018). The NMBA and

professional organisations issued a joint statement refuting these claims (NMBA 2018c), however our recent staff development and tertiary teaching works tells us these ideas still resonate.

In these contexts, many confuse white privilege with class privilege when they cite low socio-economic status or other personal struggles. Looking at white privilege in terms of what one does not have materially instead of what one does not have socially misses the point, which is that being born into the white domain means **not** having the constant experience of being racialised and inferiorised based on ethnicity and/or skin colour. As Van Herk et al. (2011, p. 31) argued, people socially constructed as white have an 'unearned privilege that does not require them to self-identify as any racial or ethnic identity'. It is precisely because of these parameters of white privilege, the breadth and depth of its practice, its impacts in the form of systemic and everyday mundane racism, and its direct relevance to nursing/midwifery work, that requires white people, white nurses/midwives, who are most often in positions of power in health systems, to be directly involved in the teaching and practice of cultural safety, true to the partnership model outlined by Ramsden (2002).

Cultural safety challenges the notion that white Australians should have a 'hands-off' approach to cultural safety. The idea that there is no place in Indigenous health for those in white domains, arose as a reaction against enduring white interference in every aspect of Indigenous people's lives since invasion and subsequent colonisation (Cox 2007). We strongly support self-determination and advocate for a culturally safe partnership model rather than the irresponsible idea, masked as cultural respect, that white domains have no role in Indigenous health or in cultural safety. This idea only serves to relieve white people and institutions of the need to engage in critical cultural reflection, acknowledge power and privilege, confront systemic racism, and be accountable for changing structures and systems of discrimination. In the current situation where racisms, cultural dominance and power inequity are the bedrock of poor health outcomes and experiences by

Indigenous people (Fogliani 2016, 2018; Hayter and King 2019; Shaw 2016) and other sectors of society, (Cox et al. 2021; Marmot 2016) we argue it is imperative that white people shoulder this responsibility. We cannot see how confronting discrimination in all its forms and contexts, addressing power imbalance and implementing cultural safety education can proceed without those who both predominate in the nursing/midwifery workforce and share cultural assumptions with white systems.

Conclusion:

It could not be clearer that people die from decisions based on racist and other assumptions on the part of staff in the context of the cultural logic of services. Therefore, preventable deaths and health system avoidance, cannot be seen as merely due to the actions of a few ill-intentioned individuals imagined as abhorrent from most well-intentioned others. This paper reflects on the glaring necessity to improve how nurses/midwives and health systems treat Indigenous peoples and argues that cultural safety can confront these concerns if it is properly understood and coherently implemented. We emphasise that cultural safety clarifies the connection between interpersonal racism and institutionalised systems of privilege/ discrimination. That is, the cultures of health professionals, professions and services interact to effect clinical decision-making producing tragic outcomes and **that** process must be the focus of scrutiny and change.

We argue that the model provides a framework to nurses/midwives that is deeply relevant for addressing inequity experienced by Indigenous people promoting a strengths-based sociological approach to understanding health. The paper provides clarity around the culture concept and the Indigenous knowledge of cultural safety, as a model for nurses and health systems to manage the complexity and ambiguity of socio-cultural matters including power imbalances, racisms, and white cultural dominance. We argue that cultural safety, in aiming to address inequity, is the business of

white domains in partnership with those whose daily lives are impacted by such practices. We propose that to realise the promise of cultural safety deeper conversations about its philosophy and practice can assuage the evident misunderstandings of it. This outcome involves resolving conceptual confusion and moving away from the notion that cultural safety is a new name for cultural competency in Indigenous Peoples' cultures, and therefore that it only concerns Indigenous people and contexts (NMBA, 2018d), a fundamental and profound misreading of Ramsden's model and its purpose.

Nurses/midwives as the largest professions in the workforce, as systems leaders and managers and as players on national and international stages for regulatory and policy development, can engage with, embed, teach, practice, and promote cultural safety to contribute to social change (World Health Organisation, 2020). Transformation of the Australian health system will be hard to achieve unless all stakeholders have a shared understanding of cultural safety, its theoretical basis, its definition, its focus, and its practice. Like Ramsden (2002) we want to reinvigorate a form of nursing/midwifery grounded in the art of human relationships, communication, and trust to bring about the change needed to improve how our professions and systems works with Indigenous people.

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