Progress towards cultural safety in Indigenous cardiovascular health care and research

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Aboriginal and Torres Strait Islander Indigenous Australians are not adequately screened or treated for cardiovascular disease,[1,2] and Indigenous Australians are less likely to receive guideline-recommended treatment after being hospitalised for a severe heart attack than non-Indigenous Australians. Although cardiovascular-disease mortality has improved, it is still substantially higher than for non-Indigenous Australians.[3] If we define health equity as everyone having a fair and just opportunity to attain their highest quality of health,[4] then much work is needed to advance Indigenous cardiovascular health equity in Australia.

Integral to this work will be research that changes the focus from deficit narratives to solutions that consider Indigenous culture as a strength of Indigenous people and the most effective way to advance our health, as well as that privileges (ie, gives a special right or honour to) Indigenous worldviews by co-creating care pathways with Indigenous people that consider not only each person's cardiovascular-disease risk profile but also the social, political, historical, and cultural realities in which we experience cardiovascular disease. Recognising that cardiovascular treatment is not delivered in isolation, we also need research teams that are willing to confront and challenge culturally unsafe health-care systems that continue to have a major effect in sustaining generational injustices for Indigenous Australians.

By assessing the effects of a culturally informed model of care for Indigenous Australians who had been admitted to a tertiary hospital in Australia with acute coronary syndrome, Harrop and colleagues[5] challenged the status quo of mainstream Indigenous cardiovascular-disease research by creating and allowing space for diverse Indigenous voices, knowledge, and leadership from study design to implementation. In addition to a reference group and steering committee that involved Aboriginal and Torres Strait Islander community groups and Indigenous community health stakeholders, the research team engaged with Elders in the Cherbourg Aboriginal community, the Inala Community Jury for Aboriginal and Torres Strait Islander Health Research, the Queensland Health Aboriginal and Torres Strait Islander Health Division, and the Queensland Aboriginal and Islander Health Council. Together they created a model of care that involved Indigenous people being greeted in hospital by artwork made by local Aboriginal artists, being cared for by staff that have completed mandatory cultural-capability training, and receiving flexible and culturally sensitive support with the welcome participation of family members. The culturally informed care pathway also referred participants at hospital discharge to specialist care delivered in partnership with local Aboriginal and Torres Strait Islander community-controlled health services. The authors observed a significant decrease in the primary composite outcome of death, acute myocardial infarction, unplanned revascularisation, and cardiac readmission at 90 days after index admission (hazard ratio 0·60, 95% CI 0·40–0·90; p=0·012), motivated by a reduction in unplanned cardiac readmissions.

The authors were careful to distinguish between culturally informed and culturally safe care. Proposed by Irihapeti Ramsden and Māori nurses in the 1990s,[6] cultural safety is intended to emancipate and empower Indigenous people to say whether the health care we receive is safe or not. A crucial difference between cultural safety and other concepts, such as cultural competency, humility, and respect, is that cultural safety attends directly to the power imbalance that exists between patient and provider. Rather than a focus on becoming competent in the cultures of others, cultural safety requires health-care providers to understand their own culture and its effect on patient care.[7] This understanding includes a willingness to critique the existing social, political, and cultural hierarchies they take for granted and to hold themselves accountable for challenging the biases, assumptions, prejudices, and stereotypes they have as a reflection of having been born into and educated within these structures and systems. Through a process of unlearning and learning, health-care providers and organisations can achieve critical consciousness[7] and recognise that gaps in Indigenous versus non-Indigenous cardiovascular-disease outcomes are largely due to systemic inequities across the patient journey from their first report of

chest pain, to the diagnosis of myocardial infarction, to the decision to revascularise, and through to their follow-up care once home. We need to overcome the effects of systemic inequities and the ways in which we are seen or unseen, heard or unheard, and cared for or uncared for if we are to provide culturally safe care, as defined by the patient and their community and as measured through progress towards achieving health equity.[8]

Future research is needed to establish whether this culturally informed pathway delivers culturally safe care for Aboriginal and Torres Strait Islander people. In the interim, the research deserves attention because it shows a much-needed development in Indigenous cardiovascular research—an important change in power from the researcher to the researched, which upholds culture itself as a strength and an indispensable factor of Aboriginal and Torres Strait Islander health and wellbeing.

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