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Cultural Safety: Beyond the Rhetoric

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We acknowledge the sovereignty of Indigenous Peoples across the Earth as the traditional custodians of Country, and their timeless and embodied relationships with cultures, communities, lands, waters, and sky. We pay our respects to Elders, past and present, particularly those who led the way, allowing us to realise our own calling to be healers.

In this second iteration of a two-part special issue on Cultural Safety, we the Australian and Aotearoa New Zealand members of the guest editorial team would like to take this opportunity to draw attention to two contemporary examples of institutional racism in nursing and midwifery care in our respective countries. Despite decades of Indigenous activism, antiracism educational initiatives, and regulatory reforms, racism continues to be an endemic oppressive element in nursing and midwifery, and health systems. Despite Indigenous knowledges, anti-racism and cultural safety mandates being embedded in our professional standards and codes of conduct (Nursing and Midwifery Board of Australia, 2018; Nursing Council of New Zealand, 2011), we are forced to continue to interrogate the ongoing practice of culturally unsafe nursing and midwifery care.

As a guest editorial team, we are also members of our Indigenous communities. We share the lived experience of family and community, of marginalisation, intergenerational trauma, and the profound bereavement of deaths from preventable health conditions. Statistics tell a narrative of deficit, of inequitable determinants of health and disproportion in our Indigenous health status compared to the mainstream population. As Indigenous nurses and midwives, we are also members of an international body of health care professionals where we have seen and experienced racism in our respective national health care systems. We bring witness to its complicit role in enacting direct and indirect

trauma upon the Indigenous peoples and their community from culturally unsafe, and negligent nursing and midwifery practices.

The examples of unsafe practices we share in this paper are to highlight our argument that systemic racism continues to go unchecked and reforms at leadership and policy levels are not addressing the issue with expedience.

Australian Example

In a remote Australian Indigenous community in 2019 an 18-year-old Aboriginal woman died of complications from rheumatic heart disease (RHD) (Stevenson, 2022), her death attracting widespread attention in the media and raising questions of the health care system. Because in Australia RHD is eradicated in the broader population.

Following her diagnosis of RHD, this young Aboriginal woman presented to the hospital emergency department twelve times in a two-month period with symptoms of breathlessness, tachycardia, fever, and haemoptysis. Basic observations of vital signs were often omitted, and several times, the young woman was sent away from the hospital without being assessed but given the drug Paracetamol which was dispensed through a locked security grill. Paracetamol or Panadol is colloquially referred to as 'the shut-up pill' in Indigenous communities and is reported to be given out by health staff to avoid examining a patient. The young woman was accompanied by her concerned family members on her final presentation for health care. She was admitted into the hospital; however, her family was not allowed to enter and were made to wait outside. A non-urgent aerial medical evacuation was organised to transport the young woman to a larger hospital. However, two hours before the plane arrived, the young woman died (Stevenson, 2022). This young woman died despite having recently seen a specialist who sent detailed instructions to several staff members at the hospital including the Director of Nursing, that she was to be reviewed weekly and booked for an urgent surgical procedure. This young Aboriginal woman is one of many, with a coroner's inquest scheduled to begin in July 2022 investigating her, and two other recent deaths. The young woman's community have been protesting racist treatment by the hospital since the death of a four-year-old in 2009 (Stevenson, 2022).

Aotearoa Example

In Aotearoa New Zealand, a Māori man in his 50s was admitted to a single room in the medical unit with a history of diarrhoea after eating shellfish he bought of a roadside vendor. He lived rurally, one hour away from the hospital, and the only way his wife could visit was after their son finished work at 6 pm. He arrived with his wife, son, and two mokopuna (grandchildren) who were 2 years old and 3 years old. The admitting nurse rudely told him that the children were to get out of the room with no explanation. He was given a bedpan that was placed on the side cabinet and told to use this when he next wanted to go to the toilet. He asked if his wife could visit him at 7.30 pm and was promptly told that visiting hours finished at 8 pm. As expected, he needed to defaecate except his only privacy was a thin curtain and an open door with people going backwards and forwards. He remained in hospital for several days but was shifted to a room with an ensuite. However, tied to an IV pole and no one answering his bell (because the nurse disconnected it) left him with the dilemma of defaecating on the floor or on the bed because he could not get to the ensuite. The whānau (extended family network) laid a complaint about the quality of treatment their father received. While the nurses explained their behaviours as his communication problem, it became apparent that there was no understanding of the importance of his whānau. The presence of his mokopuna (grandchildren, nieces and nephews) made him feel at peace, visits from his wife and son brought a sense of calmness for his wairua (spirit), and the presence of body waste where food was served (where it was placed on his

side cupboard) was culturally offensive. The profound humiliation and spiritual distress he recounted during his hospital stay left him with shame and tears – obviously an experience that should have been healing was instead traumatic. The complaints meeting highlighted the culturally unsafe practice of the nurses, despite nurses being required to demonstrate cultural safety to practice. This is not an isolated occurrence as Mbuzi et al. (2017) reported in their metasynthesis of Indigenous Peoples experiences of hospitalisation where they felt isolated from family, discriminated against and stereotyped by staff, embarrassed, ashamed and powerless. Likewise, Graham and Masters-Awatere (2020, p. 199) in a systematic review of Māori peoples' experiences of public health reported 'coldness, micro-aggressions, discriminatory behaviour and shaming' from health care staff.

These contemporary examples of systemic racism in nursing and midwifery and Western health settings persist despite a long history of activism from Indigenous nurses and midwives. Australian Indigenous nurses and midwives have long been transforming the delivery of care and calling out the racist treatment of Indigenous Australians (Best & Bunda, 2020). As early as the 1950s, Aboriginal midwife Muriel Stanley in an interview for the Aboriginal publication Dawn Magazine stated that 'I do think it's time the White Australian realised what they owe the Australian Aborigine' (Rowe, 1955, p. 18). Best, argued that 'it is possible that Stanley's words in New Dawn represents the first health activist voice for Aboriginal health coming from an Aboriginal midwife' (Best & Gorman, 2016, p. 159). The 1960s saw a collective of Indigenous nurse activism (Flower, 2017) in the lead up to the 1967 referendum (Thomas, 2017). Isabel Ferguson and Dulcie Flower both Indigenous registered nurses collected many signatures for the referendum over years. Both would talk at nursing homes to residents expressing the importance of the referendum and the need for it to happen (Flower, 2017). The 1970s saw the development and rise of the Aboriginal Medical Services (AMS) beginning in Sydney and eventually spanning across Australia. The very first Registered Nurse and midwife to work in an AMS was Dulcie Flower. The rise of the AMS movement would see the establishment of Indigenous nurses and midwives working in community control health organisations (Best, 2005, 2011). The activism continues for Indigenous nurses and midwives within the Aboriginal Community Controlled Health Organisation sector and was clearly demonstrated throughout the COVID-19 Pandemic with Indigenous nurses leading testing and vaccination of Indigenous communities (Clark et al., 2021).

The establishment of the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives, CATSINaM (originally CATSIN, the Congress of Aboriginal and Torres Strait Islander Nurses) in 1997 by 32 Aboriginal and Torres Strait Islander Nurses was another significant demonstration of collective activism against racism in nursing and midwifery within the Australian health system (CATSINaM, 2021, 2022). CATSINaM was instrumental in ensuring that all accredited, pre-registration nursing and midwifery courses contain a discrete Indigenous health subject to provide future nurses and midwives with knowledge about Indigenous Peoples' health (ANMAC, 2019; CATSINaM, 2022). CATSINaM's political activities have seen them partner with peak mainstream healthcare bodies in Australia, including the Nursing and Midwifery Board of Australia (NMBA), inviting them to collaborate in determining culturally safe codes of conduct for all Australian nurses and midwives (NMBA & CATSINaM, 2018).

More recently, Geia et al.s' (2020) clarion call to action in response to the global Black Lives Matter movement, saw over one hundred Indigenous and non-Indigenous nursing and midwifery leaders commit to addressing racism in the professions through transformative nursing and midwifery education. However, to date we have no evidence that the study of Indigenous health and inclusion of Cultural Safety in curriculum, or that the resounding commitment from nursing and midwifery leaders two years ago are translating to graduating more culturally safe nurses and midwives (Geia et al., 2020; Power et al., 2016).

It is beyond dispute, that Aotearoa New Zealand is the birthplace of Cultural Safety on the background of a long history of Māori nurse and midwifery activism. Dr Irihapeti Ramsden's (2002, p. 110) thesis on 'Cultural Safety originated from the Māori response to difficulties experienced in interaction with the western based nursing service'. Dr Ramsden's thesis was in response to a first year, Maori nursing student stating, 'you people talk about legal safety, ethical safety, safety in clinical practice and a safe knowledge base, but what about cultural safety?' (Ramsden, 2002, p. 1). Thirty years later, Cultural Safety is still on the agenda and is being increasingly adapted in health care contexts globally. However, cultural safety remains contentious in New Zealand, with many nurses and midwives continuing to provide culturally unsafe care and upholding the systems that support institutional racism (Wilson et al., 2022).

Unlike Australia, where the doctrine of Terra Nullius (land belonging to no-one) saw Australia colonised with no treaty, the *Te Tiriti o Waitangi,* a treaty between the Māori and the British, affirmed Māori sovereignty and made guarantees about protecting Māori health (Wilson & Haretuka, 2015). Despite this treaty, like other colonised Indigenous peoples globally, Māori still experience major health disparities compared to other New Zealanders (Reid et al., 2019). This failure to honour the tenets of the treaty, has resulted in an ongoing investigation and the establishment of the Waitangi Tribunal in 1975 to investigate alleged breaches of the agreement and hold the Crown accountable. Utilising the Waitangi Tribunal, has been used as a significant form of activism for Māori (Baker et al., 2019; Catalinac, 2017). The Tribunal released a major report in 2019 that included testimony from 11 Māori nurses that has resulted in the 'Tribunal's recommendation for a complete redesign of New Zealand's primary health system to better serve Māori' (Nuku, 2019). This recommendation is testament to a long history of agitation and disruption by Māori nurses that involved 'lodging complaints with the Human Rights Commission and the United Nations Permanent Forum on Indigenous Issues' (Nuku, 2019). Also addressed is the wage disparity with Māori nurses working in Māori health care and primary care providers being paid 25% less than their non-Māori counterparts (Nuku, 2019).

Given the long history of activism and commitment to Cultural Safety in nursing and midwifery in both of our countries, it is paradoxical that our people are still experiencing racism and culturally unsafe health care with poor health outcomes. In this special issue, Cox and Best (2022, p. #) assert that one of the barriers in producing culturally safe nurses and midwives is that nursing and midwifery academics 'misunderstand … the focus, intent and practice of [Cultural Safety]'. They state that Cultural Safety teaching in Australia, is mistakenly focused on teaching about ethnicity and Indigenous culture instead of challenging students to understand their role in not perpetuating interpersonal and institutional racism, being value neutral in the care they provide, and understanding how their own cultures can perpetuate interpersonal and institutional racism and stigmas (Cox & Best, 2019, 2022).

In line with the examples provided above, publications in this special issue acknowledge the reality of lived experience of Indigenous Peoples, and the growing evidence that racism in our health care systems traumatise and kill Indigenous peoples. We cannot be silent on this matter, and we raise our voices to reiterate the urgent need for reform in our nursing and midwifery curriculum. We call for a re-grounding of what Cultural Safety is and how it is taught and enacted in the nursing and midwifery profession, and indeed the wider health care system (Cox & Best, 2022).

In conclusion, as the guest editorial team we have aimed for several things in this special issue. While it highlights the efforts and actions of Indigenous and non-Indigenous nursing and midwifery academics to enact Cultural Safety, some of these publications also problematise the current understandings of culturally safe care and challenge our professions 'to move beyond the aspirational rhetoric of Cultural Safety and put anti-racist knowledge into action' (Kelly & Chakanyuka, 2021, p. #).

Our Indigenous activism is increasing, and this is encouraging for those of us who are nearing the end of our careers and for those of us who are just stepping out in their nursing and midwifery career. We are seeing new fires being lit in our peak bodies as they work with us and commit to enact change through legislation, standards, accreditation, and codes of practice, but we cannot grow complacent, we need to keep fanning the flames (Sherwood et al., 2021).

It is not enough to say we are teaching Cultural Safety, we have to continue to return to Irihapeti Ramsden's (2002) model and ensure its intent is not bastardised by misunderstanding what Cultural Safety actually is. We need to combine the tenets of Cultural Safety with an unflinching focus on antiracist and decolonising approaches (Kelly & Chakanyuka, 2021). We need to equip pre-registration nurses and midwives with practical knowledge and skills to confront the profoundly racist systems they will enter. While Indigenous nurses and midwives need to oversee the process (Power et al., 2021), it is incumbent on all nurses and midwives to engage with the practice. We need to move beyond the rhetoric and take affirmative action in nursing and midwifery to embed Cultural Safety in education, research, and practice. We want to see the change and feel the change and share the change as a profession and practice what we preach.

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