Why “culturally safe” health care?

Mary Belfrage

People need to feel like themselves and believe that the health care is connected to their lives

As a medical student in 1989, I did my final year elective in Alice Springs and at an Indigenous community on the Pitjantjatjara Lands. In the depressed and squalid town camps of Alice Springs I came to understand that, even if a swab from a discharging ear grew *Haemophilus*, the patient didn’t have middle ear disease because of a bacterium. It triggered an ongoing interest in the determinants of health and disease — socioeconomic, personal and political.

I discovered that Indigenous Australia is like Europe. There are different ethnic and language groups. Many people speak several languages and may speak English as their second, third, or fourth language. I understood that Australia’s interior is inhabited, not empty. I started to understand the magnitude of insult embedded in *terra nullius*. I had my first adult glimpse into Indigenous cultures and came away fascinated and respectful, knowing that we — me and my culture and they and their cultures — had fundamentally different ways of experiencing the world.

I finished my degree, did the early years, travelled overseas, worked in general practice in community health settings, did a couple of brief stints in urban Aboriginal health services and a 4-month locum in the Pilbara, had two children, and quietly waited until I could get back to Central Australia.

The time came, and I accepted a job-share position with my partner Niall in a remote Indigenous community about 300 km north-east of Alice Springs in Alyawarr country. Between 250 and 400 people live in the community, but we tracked the health business of around 700 people from the area.

Life as a doctor in a remote Indigenous community is rich and fraught. People are so sick and die so young. It is deeply shocking. As I grew to understand more powerfully that these are real lives, and to grasp the amount of grief that people live with, and to comprehend how much time is lost to sickness and death, I was able to better appreciate the context in which I was providing medical care. In this setting you must be medically meticulous but also, to access the population, you need to offer services in a way that people recognise and want. People need to feel like *themselves* and believe that the health care is connected to *their* lives, that they are involved and have choices, that it’s not primarily someone else’s agenda. It’s often not so much about empowering people as not disempowering. This is what I think of as cultural safety.

The clinic had a nurse and an administrator, but we knew that we also needed health and cultural liaison workers from the community. We needed language support and translation and a way to find out who and where people were, but also a way of checking understandings and beliefs about health and disease. People slowly began to feel comfortable and trust us, and within 6 months we had several health and cultural liaison workers. Only then could we start providing effective primary health care, including effective acute health care.

Under guidance from the community-based Health Council and with other community members, we steadily built the clinic as a culturally safe place. We discussed, listened, made suggestions, checked and tried always to do things in a transparent and inclusive way. The look of the clinic transformed. The women chose the colour for the outside of the clinic and all the clinic doors were painted with bush tucker and local stories. We employed community members to collect and prepare a topical bush medicine that was given out as liniment and for various skin conditions. As well as being particularly effective for burns, this bush medicine gave the whole clinic a smell that was deeply familiar to the community and strongly associated with health care.

I was struck at some stage by the fact that the local people never or rarely saw themselves reflected in positive ways on television or in books. I wondered how you can value and acquire literacy if you cannot relate to anything you read, and so had the idea of building a mini-library in the clinic. People loved it. We obtained a book depicting local artists and their batik work, and other books about snakes, spiders, bush foods, and plants. We got maps of the surrounding areas and an aerial photograph of the community, allowing many — some of them for the first time — the experience of seeing their world and their lives depicted in books. It was very powerful.

At some point I expanded on the usual letter of referral and made a much fuller letter of introduction. This had so much impact on staff in Alice Springs and in Adelaide hospitals that I wondered that I hadn’t thought of it earlier. I really understood this as part of building safety in how Indigenous people accessed health services outside culturally familiar territory.

People came to the clinic in droves. It became easier and easier to establish robust primary health care programs:

- We increased and maintained vaccination rates to more than 95% cover.
- We provided antenatal care for all women from the first trimester. Most of the 12 or so women per year had their babies in Alice Springs by choice — ours and theirs.
- Children younger than 5 years were all mapped on a wall chart, recording when they were due for vaccination, weights, haemoglobin, developmental checks and so on. The community accepted this degree of visibility for the children’s health business. More than that, I would say this was consistent with the sense of collective responsibility for the welfare of the kids.
- By the time we left, most of the women had had a Pap smear.
- Most adults had had chronic disease screening and a large proportion came to the clinic for regular checkups and monitoring. (Our audits showed that around 30% of adults had diabetes and around 25% had impaired renal function.)
- Regular screening for and treatment of sexually transmitted infections was in place.
- A healthy dogs program included an annual visit from a vet backed up by Niall and health workers who would spay dogs, put down sick dogs, etc.
- We conducted annual school screening.
- The community had access to the industrial washing machine that had been installed in the clinic for washing blankets. Our predecessor had initiated this — a simple, powerful public health measure that resulted in a dramatic and sustained fall in scabies infestation and related skin infections.

- We provided palliative care for several people, including extensive family consultation and support.

As well as these programs, we tried to visit the elderly people in their camps each week. Many of them never came to the clinic, so this was the only way they accessed health care. We were also providing acute care day to day in the clinic, which was busy in itself. We were on-call all the time, second on call to the nurse half the time. We did a weekly 150 km round-trip visit to three satellite communities. And lurking in the background were the could-happen-at-any-moment medical emergencies, which of course did happen. Together with the nurse we treated a gunshot wound to the chest (and I put in my second-ever chest tube), a ruptured ectopic pregnancy, births, cardiac emergencies, and road and various other traumas.

Although work was full-on, there was also a simplicity about our lives. I got enough sleep for the first time in years. We were absorbed by life within the community. I felt like I had time to think. I read and thought and reflected a lot. Niall and I had time to talk and didn't have to have conversations about shopping, who'd pick up the kids, babysitting and other domestic arrangements. It was sparse and refreshing.

Under the vast sky in that uncluttered country, I connected to seasons, phases of the moon, movement of the stars. I got the kids up one night to see the Leonids, which is a meteor shower that happens to a greater or lesser extent every year in November. By luck, that year was the greatest shower in years. We lay on the trampoline and saw maybe 200 shooting stars in half an hour. It was exhilarating.

I went hunting many times with the women. As well as the time with people and experience of culture, my way of seeing the country transformed. I saw it was fecund, fertile, providing. I saw and learned how to find and collect seasonal foods — beans, potatoes, all sorts of fruits, wild honey. I ate kangaroo, turkey, echidna, witchetty grubs, the honey sac of honey ants, and goanna. I also understood that the land was knowable. That people were at home in their country, the land was steeped in the events and stories of their lives. That *nomad* didn't mean moving willy-nilly around, but was actually travelling within country that was all home. That, in comparison, non-Indigenous Australians move to places we have no connection to — country, city, suburb. I learned to see things, but not everything. A close friend and I went out one day tracking goanna and I couldn't see the tracks. I asked her to show me and she laughed and pointed. We squatted down on the ground and she pointed exactly to the tracks. I still couldn't see anything. We just both ended up laughing and laughing — she truly disbelieving that I couldn't see anything . . . and I thinking about how you can never really know what you're not seeing.

I know we can't change history. We can change our knowledge and understanding of it. My understanding is that many Indigenous people are sick because of the accumulated losses and trauma and now the burden of sickness and early death and the grief that comes with that. They are sick because of not having access to or not being able to or not knowing how to or not believing in the value of making life-affirming choices. I don't believe there has yet been real political will to change the health of Indigenous people, despite there being substantial knowledge about what makes a difference. People (we) need to have a sense of power in their (our) lives, and the principle of cultural safety is fundamental to the design of services that support this. I think we understood this well enough to have been able to go to this community and provide medical and health care in a way that people found useful. It was certainly a most enriching experience for me and my family.

Competing interests

This article is based on a presentation given at an Annual Women GPs Dinner, for which I received an honorarium.

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Artist: Walankura Napanangka
(from the Shalom Gamarada art exhibition — see page 551).