Cultural safety in health for Aboriginal people: will it work in Australia?

Rosemary van den Berg

I was happy in my retirement and living on the old-age pension with my husband when I had a call in early 2009 from Curtin University requesting a meeting to discuss cultural safety in Aboriginal health. You can imagine my surprise! Here I was, a 70-year-old retiree, content in the knowledge that I had worked and studied my way up from being a housewife and mother to being a respected Doctor of Philosophy, writer, and promoter of Aboriginal issues through my writing. I was full of curiosity to know the reason for this out-of-the-blue telephone call.

Arrangements were made to meet with Associate Professor (now Professor) Sandra Thompson to discuss her proposition. I was to work as an Associate Professor for Cultural Safety in the Faculty of Health Sciences at Curtin University's Centre for International Health, which had recently added Indigenous Health to its program. I started work there in April 2009.

The cultural safety for indigenous health movement began in New Zealand during the 1980s when a Maori student nurse, Irihapeti Ramsden, queried hospital policy on standard nursing practices by saying "You people talk about legal safety, ethical safety, and safety in clinical practices and a safe knowledge base, but what of cultural safety?"[1] Clearly, cultural safety was not on the nursing agenda. Irihapeti Ramsden instigated the cultural safety movement in New Zealand. Although the Treaty of Waitangi recognised the Maori as being the first people of their country, Maori nurses knew that the Treaty was not being honoured in the nursing fraternity.[1] Maori nurses and patients were being isolated from mainstream nursing practices and treated as second-class citizens because of their cultural differences. Maori nurses wanted to be acknowledged and treated as equals in the workplace. The Maori nurses and patients had strong cultural ties and began to question why they should maintain nursing practices that were contrary to their own cultural beliefs and customs. Gradually the concerns of Maori nursing staff and patients in hospitals were recognised, and cultural safety is now embedded in most schools of nursing in New Zealand. The Nursing Council of New Zealand has amended its standards for registration to include safe cultural practices.[1]

Now the concepts of cultural safety, including cultural awareness and cultural competence, are being introduced into the Australian nursing system through the universities. Unfortunately, it is taking longer to change the colonial mentality and inherent racist attitudes towards Aboriginal people in this country than in New Zealand. We have over 200 years of invisibility and exile to overcome before Aboriginal people can attain the ideal status of equality.

After joining the Centre for International Health at Curtin University, my interest in cultural safety grew and I realised that it was the solution to many health problems facing Aboriginal people. They needed to feel worthy as individuals and not be denigrated for being Aboriginal, with all the negative connotations that that image conjures up. If medical, nursing and other health organisations could forget the policies of the past and accept Aboriginal people as equals instead of patronising them and treating them as children, the health and hospital systems would have a better chance of reducing morbidity and mortality rates among Aboriginal people. As my own awareness of the cultural safety issues grew, I remembered the past and the government policies I had lived through over the years.

Before the 1967 referendum,[2] Aboriginal people were wards of the state governments and had no authority over their own lives. They were subject to laws and policies that enabled state governments to monitor their movements and enforce those laws if Aboriginal people dared to show initiative by making their own decisions. They were a subjugated people. However, due to the United Nations policy on indigenous rights, attitudes were slowly changing towards indigenous peoples worldwide. The Universal Declaration of Human Rights was adopted and proclaimed on 10 December 1948 at the General Assembly of the United Nations.[3] All countries were to give citizenship to their indigenous people, and Australia was no exception. But the Aboriginal people of Australia did not know about the Declaration, and it was not until almost 20 years later that they were made citizens of this country. The 1967 referendum, in which Australians voted 90.77% in favour of Aboriginal people becoming citizens in their own country,[2] was an important landmark for us because it meant we were no longer wards of state governments but were free citizens.

Improvements to the living conditions of Aboriginal people living on reserves in Western Australia began by providing the basic necessities of life, such as having easy access to tap water (instead of carrying water in buckets from public taps) and having ablutions blocks with laundry, bathing and toilet facilities. Two-bedroom wooden-slab housing was erected (with no electricity) to replace tin shacks, tents and bough sheds. But no one thought about Aboriginal health except Aboriginal people themselves, when they needed medical and nursing attention. The health and wellbeing of Aboriginal people were in a sorry state.

On the positive side, teenage Aboriginal children were being sent to Perth to further their education and obtain training in different careers. I was one of those children. However, it wasn't until March 1956, when I began training as a nursing aide at Royal Perth Hospital, that the issue of Aboriginal health was brought to my awareness. Training Aboriginal girls as nursing aides (a new program implemented by the state government of Western Australia) had only begun two months previously. But I found that while the hospital system accepted Aboriginal patients, the health personnel were indifferent to Aboriginal needs. In fact, at this time, native hospitals were situated in many country towns, and Aboriginal people with chronic illnesses were mainly admitted to these hospitals. The treatment they received was passable, but there was a definite paternalism that hindered quality patient care.

Being an Aboriginal nursing aide in the mainstream hospital system was difficult at times, and I experienced racism from staff and patients. For example, one time when I was working in a

country town after completing my training, I needed to have my appendix removed. On the morning of the operation, I had a shower and considered myself clean. But, according to the ward sister, I hadn't washed the navel area clean enough for her liking, so she sent me back to scrub myself again. What can I say? I was 18 years old and gauche, and arguing with the ward sister was out of the question. In retrospect, I realise that my personal hygiene was being called into question. I felt degraded, because I always showered every morning. Other examples of racism occurred with patients in other hospitals — some didn't want me to touch them when I had to bed-bathe them or see to their personal needs. When I told the ward sister, she berated these patients, but it was horrible to know that many of these people judged me by the colour of my skin and not my work ethic. These days, racist attitudes have become more covert, and are a subtle mixture of paternalism, arrogance and the assumption of white privilege.

But there is an even more serious lack of cultural safety for Aboriginal people when receiving nursing care (as patients) or giving care (as staff). My own cultural upbringing made it very hard for me to tend to the personal needs of Aboriginal men who were hospital patients. I felt uneasy when they needed assistance with their bed-baths or toilet needs. It was embarrassing for both parties because, as a woman, it was culturally taboo for me to be tending to a man's personal needs. It was a matter of cultural protocols gone awry. Knowing and understanding Aboriginal protocols would be a starting point for many who work in the hospital system.

Nevertheless there are many fair-minded Australians who want to improve Aboriginal health and the hospital system through introducing cultural safety to those who have the power to implement change. It needs to be widely recognised that achieving cultural safety in health programs for Aboriginal people will advance good health practices and boost positive health statistics through the acceptance of Aboriginal people for their differences from mainstream Australians. In other words, we are the first peoples in Australia — people in our own right, with our own cultures, customs and protocols.

At the Centre for International Health, we intend to implement programs in the curriculum that will include Aboriginal studies and protocols for cultural safety in all schools of health. Talking to Aboriginal students in high school is also on the agenda because it is important for students to think about training for a career in health. Knowing and understanding Aboriginal protocols would be a starting point for many who work in the hospital system. I remember when my father was sick just before he passed away in 1992. The staff at Sir Charles Gairdner Hospital, in Perth, let members of the family visit him regardless of the time limit on hospital visits or the number of family members present. This was at a time when cultural safety was unheard of, but the hospital staff had the common decency to realise that my father had a large family and we all wanted to say goodbye. The human kindness shown by the hospital staff is remembered with gratitude and proves that cultural safety for Aboriginal people can be attained. In this instance, the nursing staff chose to show respect for a grieving family rather than passing negative judgement on us because we were Aboriginal people.

The number of workshops and seminars teaching cultural awareness is increasing, but making people aware does not mean they are culturally competent or that they understand cultural safety as a health practice. People working in remote areas generally have more knowledge and acceptance of Aboriginal people than those who live in the cities and suburbs, although there are exceptions, as the above example of my family's experience shows. Urban and foreign medical and nursing staff working in city and country hospitals should take a crash course in Aboriginal studies and protocols, as many have had no contact with Aboriginal people, let alone experience with treating them as patients.

Aboriginal people themselves must change their attitudes to ill health, and understand the necessity of maintaining the treatment that medical and hospital personnel advise. For instance, diabetes sufferers should follow appropriate diets, have regular exercise and remember to take their medication. It is very important that Aboriginal people take responsibility for their own health, provided they are not too old, too young or too infirm to do so. They need to work with medical staff to find mutually acceptable solutions to combat their own or their family's health problems. Working with medical and nursing practitioners would enhance the practice of cultural safety.

Finally, to the question posed in the title of my essay: "Cultural safety in health for Aboriginal people: will it work in Australia?" — I believe it could work. Attitudinal changes of medical and nursing staff will change the status quo of Aboriginal health, and changing antiquated images of a past era is a step in the right direction. We can alter the negativity associated with Aboriginal people and their cultures by recognising their unique value to Australia's past, present and future. If implementing and maintaining cultural safety for Aboriginal people means improving their wellbeing and survival, then it should be compulsory in all spheres of health practice in this country.

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2 Bennett S. The 1967 referendum. *Aust Aborig Stud* 1985; (2): 26-31.
3 General Assembly, United Nations. Universal declaration of human rights. Geneva: United Nations, 1948.

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