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Patients' Rights

WHY IS CULTURAL SAFETY ESSENTIAL IN HEALTH CARE?

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Abstract: The concept of cultural safety involves empowerment of the healthcare practitioner and the patient. The determinants of 'safe' care are defined by the recipient of care. Cultural safety is linked to the principles of New Zealand's founding document, the Treaty of Waitangi. These are participation, protection and partnership. Cultural safety was initially a response to the poor health status of indigenous New Zealanders but has since broadened to encompass a wide range of cultural determinants. Importance is placed on identifying and evaluating one's own beliefs and values and recognising the potential for these to impact on others. Dissemination of cultural safety knowledge and practice outside of New Zealand is growing. This concept provides recognition of the indices of power inherent in any interaction and the potential for disparity and inequality within any relationship. Acknowledgement by the healthcare practitioner that imposition of their own cultural beliefs may disadvantage the recipient of healthcare is fundamental to the delivery of culturally safe care.

Keywords: Cultural safety; New Zealand; nursing; power

INTRODUCTION

The concept of power, the role and influence of the decision maker and the archetype of the 'knowledgeable expert' in healthcare are increasingly open to debate. Questions arise about who really holds (or should hold) the power in a patient/clinician relationship, who is the 'expert' and how is this determined?

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Traditionally, health care providers have based their practice on their individual and professional definitions of 'appropriate' care. There is an entrenched view of the health care professional as being 'in charge', of being the acknowledged expert. While the rhetoric of autonomy, partnership and informed consent is common, there is less evidence of 'true' negotiation and effective or authentic collaboration. When the existing, traditional concepts are challenged, there may be associated difficulty with recognition and acknowledgement of the impact these have had. Despite the 'best of intentions', traditional approaches to healthcare can lead to care that is altruistically applied 'regardless' of difference in an effort to ensure equality. The underlying assumption is made that if all patients are treated as equals, then this will result in 'best care' for all. From this, the question arises, best from whose perspective? In assuming that all patients will benefit from the same standard and type of approach (usually based on that which the practitioner would themselves wish to receive) this ignores the uniqueness and difference of individuals. Failure to identify and value difference results in forced, although often unconscious, assimilation policies. Instead of everyone being treated as 'equals', individuals are effectively being defined and stereotyped into the ideals associated with the dominant culture. Recognition of the significance of this has given rise to the ideal of caring for patients 'regardful' of their differences, rather than 'regardless'. Cultural safety addresses some of these issues, providing an essential tool for patient care and allowing the movement beyond concept into practice.

Defining the core concept

Healthcare systems have always sought to ensure that a safe clinical environment is provided. Discussions have centred around a range of 'safety' concerns, including aspects of clinical care provision, physical environment, recognition of patients' legal rights and entitlements, the ethical issues surrounding patient choice, equity and equality of care. In 1988, concerns were expressed in New Zealand by a group of Maori nurses regarding their sense of 'safety' within a predominantly Pakeha, Westernised educational setting. This raised awareness of issues of cultural disparity in healthcare, poor health outcomes for Tangata Whenua (the indigenous peoples of New Zealand) and the difficulties faced by students in the health care system who did not identify with the 'mainstream' cultural identity and beliefs. If this was an issue for health system 'insiders', how much more challenging was interaction with the health system for those who lack specific health knowledge and who already felt marginalised within society? This in turn led to questioning whether this potential lack of

familiarity and confidence with the health system could be a contributing factor to poor uptake of health services and reduced levels of compliance amongst Maori people, directly impacting on continued poor health status. Raised awareness of these issues ultimately led to the cultural safety model being developed. The adoption of the term 'cultural safety' is reported to have arisen following a question posed by a nursing student at an education hui (meeting): "You people talk about legal safety, ethical safety, safety in clinical practice and a safe knowledge base, but what about Cultural Safety?"[1].

The well respected nurse and academic, Irihapeti Ramsden[1, 2], was instrumental in the development and implementation of the concept of cultural safety into nursing in New Zealand. This came to fruition largely due to the experience gained by Ramsden in her role as a public health nurse. In this role she was exposed to the 'realities of life'. These 'realities' aided in uncovering the differences that existed between the various inhabitants of New Zealand, in particular the differences experienced by the Maori population. Following on from this, the concept and terminology of cultural safety emerged, initially focussing on Maori health issues, but broadening over time to encompass a wider range of cultural elements.

Cultural safety was formally incorporated into the nursing curriculum assessment standards by the Nursing Council of New Zealand in 1990. The role of the Council is to monitor standards and competencies for registration and to ensure that the public of New Zealand receives safe and competent nursing care. In 1992 further guidelines were introduced which saw cultural safety established as an essential component in the attainment and maintenance of nursing registration[3]. Specific guidelines were developed by the Nursing Council of New Zealand regarding the related areas of cultural safety, application of the Treaty of Waitangi principles in healthcare and Maori health. As a result the following definition of cultural safety was published by regulatory body, this being:

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1. Ramsden, I. 2002. *Cultural safety and nursing education in Aotearoa and Te Waipounamu.* A thesis submitted to Victoria University, Wellington. New Zealand: Author.

2. Ramsden, I. (2000). Defining cultural safety and transcultural nursing. *Kai Tiaki, Nursing New Zealand 6*(8) 4-5.

3. Nursing Council of New Zealand. (2002). *Nursing Council of New Zealand.* Retrieved 1/5/06 from http://www.nursingcouncil.org.nz

> "The effective nursing or midwifery practice of a person or family from another culture, and is determined by that person or family. Culture includes, but is not restricted to, age or generation; gender; sexual orientation; occupation and socioeconomic status; ethnic origin or migrant experience; religious or spiritual belief; and disability…"[4]:

Background

While cultural safety offers a unique approach to healthcare, it has application within a wider scope. It developed within a nursing context, was subsequently integrated into nursing education and is now influential in the educational curricula of a number of professions.[5, 6, 7] This concept was based on New Zealand's founding document, the Treaty of Waitangi (Te Tiriti O Waitangi), which represented an agreement between the indigenous Maori population and the colonial settlers. This document, although subject to debate and misinterpretation at times, enshrines the concepts of participation, protection and partnership. Recognition and application of the Treaty is a basic element which continues to underpin government policies and processes. In 1987 the Standing Committee on Maori Health recommended that the Treaty be regarded as the foundation for good health[1].

Cultural safety focuses on recognising the uniqueness of the individual, acknowledging that each person carries their own cultural identity. McPherson, Harwood and McNaughton (2003) suggest that cultural safety "goes further than learning factual information regarding dietary or religious needs of different ethnic groups: it means engaging with the sociopolitical context of beliefs…" This incorporates recognition of the range of cultural influences including but not limited to ethnicity, gender, age, sexual orientation, life style choices, beliefs

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4. Nursing Council of New Zealand. (2002). *Guidelines for cultural safety, the Treaty of Waitangi, and Maori health in Nursing and Midwifery education and practice*. Wellington : Author. (p.7).

5. Gray, M., & McPherson, K. (2005). Cultural safety and professional practice in occupational therapy: a New Zealand perspective. *Australian Occupational Therapy Journal 52*(1) 34

6. Royal Australasian College of General Practitioners. (2004). Cultural Safety Training: Meeting the Needs of GPs Working in Aboriginal and Torres Strait Islander Communities. Media release. Retrieved 3/5/06 from : http://www.racgp.org.au/document.asp?id=12450

7. Crampton, P., Dowell, A., Parkin, C., & Thompson, P.C. (2003). Combating the effects of racism through a cultural immersion medical education programme. *Academic Medicine 78*(6) 595-598.

and values. Cultural safety has allowed for a more reflective, critical understanding of the actions of health care professionals. The integration of cultural safety into nursing practice provides for the formal recognition of power relations within health care interactions. By adopting cultural safety it becomes not only possible but inevitable that an exploration of the assumptions underlying practice, brought by both individuals and the profession will occur. This reflective model is effective at the individual, institutional and professional levels, and encourages identification of the assumptions and preconceptions that structure practice[8].

At the centre of this concept is acknowledgment that in any healthcare relationship two cultures are interacting – those of the practitioner and the individual seeking care. Cultural safety highlights the need for acceptance rather than assimilation of difference and provides a reflective model that allows for recognition of the power disparities that occur within healthcare. The term 'cultural safety' has been chosen as a means of emphasising the role of the consumer as arbitrator of the concept, the effectiveness or otherwise of cultural safety can only be assessed by the recipient of care. If the semantics were changed, for example to refer to cultural awareness or sensitivity, this would signal a shift in the locus of power away from the consumer and on to the practitioner. The term 'cultural safety' encompasses the idea that the recipients of care need to 'feel safe' in accessing health care services, and that these need to be provided in a non judgmental and non-threatening environment. Healthcare policy and service development currently acknowledge and uphold basic patient rights, including respect, informed consent and dignity. However, the individual's cultural safety must also be upheld. Failure to do so risks disempowerment, alienation from health services, and potentially places the patient at risk of a less than optimal outcome.

Impact and implications for practice

In order to assess the utility of a concept such as cultural safety it is necessary to identify the degree to which this model is applied in practice. While only the patient has the right to identify whether cultural safety was present in an interaction, it is ethically complex to approach patients in order to examine their perceptions. Richardson (2004) suggests that:

8. Richardson, S. (2004). Aotearoa / New Zealand Nursing: from eugenics to cultural safety… *Nursing Inquiry 11*(1) 35-42.

A number of ethical concerns underlie any attempt to gather this information directly from the patient. These include the potential of undue influence (either intentional or otherwise) on the part of the researcher, a desire to 'please' on the part of the participant due to fear of retribution or compromised care, and the ability to provide a 'safe' environment in which to express any concerns.

While approaching patients may be a necessary step, other preliminary research can be undertaken to examine the context and environment. One approach is to examine the perceptions and beliefs around cultural safety held by health care practitioners. To date only a limited number of studies have attempted to address the question of nurses responses to and use of cultural safety, with these focussing primarily on knowledge attainment and educational experiences.[9, 10, 11] There needs to be research regarding the application of the model in a clinical setting, and as a starting point for this, an audit of health professionals' responses to cultural safety is currently being undertaken in an acute hospital setting in Christchurch, New Zealand[12].

As NZ society becomes increasingly multicultural, so too does the health care workforce. Not only does the impact of the professional culture need to be taken into consideration but also that of the individual practitioner. A key aspect of cultural safety is an individual's capacity to recognise their own cultural assumptions. The practice of health care has its own unique culture, with associated expectations, world view and unspoken assumptions. In order to overcome this, there needs to be a deliberate and conscious movement away from the automatic ethnocentrism which sees the patient's culture as 'different' or 'exotic' to recognition that it is this culture that is in fact the 'norm' and the health care culture that is 'foreign'. Underpinning this concept, the question for many health professionals is 'do we feel safe in our own culture?' Failure to feel safe in one's own culture can lead to often unrecognised projection of negative cultural assumptions. The consequential imbalance of power between the provider and the recipient of healthcare that results is fraught with destructive

9. Jeffs, L. (2001). Teaching cultural safety the culturally safe way. Nursing praxis in New Zealand 17(3): 41-50.

10. Warren, S. (2003). How students understand cultural safety. Kai Tiaki Nursing New Zealand 9(5) 26-28.

11. Jeffs, l. (2001). Research in progress: the impact of cultural safety education on nursing and midwifery practice. *Nursing Praxis in New Zealand* 17(1):44.

12. Richardson, S. & Williams, T. (2006). Cultural safety audit. Unpublished data.

connotations. In the context of nursing, cultural safety requires a process of reflection to bring about the realisation of how the practitioner relates to other cultures. Rather than an ethnocentric approach, this process requires recognition that there is an identifiable nursing culture and that the requirements of the patient may be in conflict with those of the practitioner. The patient must be empowered so that they feel safe to participate in the health care relationship[13].

Traditional healthcare education around cultural issues has focussed on itemising aspects of the patient's culture. This implies that it is possible to identify a key set of cultural parameters or 'boxes' within which generalisations are the norm. The underlying assumption is that all people loosely associated with a particular culture will necessarily share these same characteristics.

Compartmentalising in this way is a pitfall that potentially leads to stereotyping and labelling of individuals. Cultural affiliations are often assumed based on physical appearance and characteristics. This fails to acknowledge the invisible cultural indices unique to the individual. An individual may present certain ethnic features, but this does not mean that they identify with any or all aspects typically ascribed to that ethnic group. The role of health professionals is to act as an advocate for the patient and their relatives by providing culturally congruent care that meets the cultural expectations of those concerned[14].

If the ability to identify their own cultural beliefs and values is lacking, health care professionals need to be aware that this will impact on the delivery of their care and influence their attitudes and conduct towards patients[15]. Insensitivity regarding cultural expectations can damage the status of health care professionals, as well as impact negatively on the patient's experience. Trust can be breached and this can damage the therapeutic relationship that exists between cultures in the health care setting. This can lead to patients experiencing anxiety and apprehension about accessing health care services and create doubt about the desire to utilise these services.

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13. Ellison-Loschman, L. (2001). Giving a voice to health consumers. *Kai Tiaki Nursing New Zealand 7*(1) 12-13.

14. Matzo, M.L.,Sherman, D.W.,Mazanec,P.,Barber, M.A.*et al.* (2002) Teaching cultural considerations at the end of life: end of life nursing education consortium program recommendations. *The Journal of Continuing Education in Nursing* 33(6) 270-279.

15. Thomas, N.D. (2001). the importance of culture throughout all of life and beyond. *Holistic Nursing Practice 15*(2) 40-46.

As with all healthcare interactions between the provider and the recipient, the role of the family/whanau or significant other is ignored at the provider's peril. The cultural beliefs of the patients' wider social group also have the potential to impact on their care. All too often this group is tacitly judged in terms of their behaviour and responses against the healthcare system definition of 'acceptable' and 'normal'. The significance of their influence requires consideration and has the potential to be an important factor in the dynamics of culturally safe health care.

Summary

Theoretical frameworks and models have traditionally been used to guide practice, and provide the tools for practitioners. Cultural safety is one such tool that has emerged within the NZ setting and which has now moved to become a more globally recognised practice. However, the risk of misconceptions around the concept of cultural safety remains and potentially forms a barrier to implementation into practice. Cultural naivety is often still expressed even when cultural safety is taught. Cultural assumptions continue to risk negative outcomes and provide an environment for misinterpretation. Continued failure to recognize the potential implications can negatively impact on delivery of patient care.

Despite these limitations, following cultural safety's beginnings in NZ it has developed into a key component of nursing practice and from there spread to influence the guiding principles and policies of other professions. The awareness and application of cultural safety has gone some way to address the sense of disequilibrium that results from cultural dissonance.

Glossary of terms:

Maori: the name of the indigenous people of New Zealand, and their language

Pakeha: Pakeha is a New Zealand English word for European New Zealanders, that is, New Zealanders of predominantly European descent

Whanau: Family. Whanau is a wider concept than just an immediate family made up of parents and siblings - it links people of one family to a common tipuna or ancestor.

Hui: Meeting, gathering, for purposes of discussion and/or celebration

Te Tiriti O Waitangi: The Treaty of Waitangi. This was signed on 6 February 1840 at Waitangi in the Bay of Islands, New Zealand. It was signed by representatives of the British Crown, the chiefs of the Confederation of the United Tribes of New Zealand, and other Maori tribal leaders.

The founding document of New Zealand as a nation, given legal effect in its incorporation into various statutes, particularly for environmental and resource management. By the Treaty, Maori ceded to the Crown the right to govern, and in return the Crown confirmed and guaranteed the rangatiratanga of tangata whenua.

Tangata Whenua : literally means ‘people of the land’ and is the common reference to the indigenous people of an area. Tangata whenua usually consist of tribes or iwi, which are further organised into sub-tribes or hapu.

Rangatiratanga : Rights of autonomous self-regulation, the authority of the iwi or hapu to make decisions and control resources