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DISCUSSION

Cultural safety and maternity care for Aboriginal and Torres Strait Islander Australians

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Summary
Purpose: To discuss cultural safety and critique the provision of culturally appropriate maternity services to remote Aboriginal and Torres Strait Islander women in Australia.
Procedure: The literature and policies around 'culture' and 'cultural safety' are discussed and applied to the provision of maternity services to Aboriginal and Torres Strait Islander women in remote areas of Australia.
Findings: The current provision of maternity services to Aboriginal and Torres Strait Islander women, particularly those living in remote Australia, appears largely inadequate. The provision of culturally safe maternity care requires health system reform at all levels including: the individual practitioner response; the educational preparation of practitioners; the delivery of maternity services and the development of policy at local, state and national level. This paper considers the changes that can be made from the individual practitioner through to the design and implementation of maternity services.
Principal conclusions: Cultural safety provides a useful framework to improve the delivery of maternity services to remote Aboriginal and Torres Strait Islander women and their families.

Introduction

Midwives represent the largest numbers of workers providing maternity services in Australia.[1] The western health system in which they work was developed to meet the needs of the majority population which was white, middle class and predominantly Christian.[2] However, the cultural mix of Australian society is now very diverse. Despite this, western health systems remain directed towards the needs and beliefs of the majority group and in many cases are inappropriate for the smaller, less dominant population groups.[3] The situation is compounded by inadequate preparation of professionals to work cross culturally.

Much of the literature around cross-cultural care comes from the nursing discipline, including the concept of 'cultural safety'. The term 'cultural safety' originates from Maori nurses in New Zealand. Whilst there are many similarities to the historical and social situation between the Maori and Aboriginal and Torres Strait Islander peoples, there are fundamental differences when applying cultural safety in an Australian context. The purpose of this paper is to apply the concept of cultural safety to the provision of maternity services in Australia care to Aboriginal and Torres Strait Islander women.

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Culture

In 1952, Kroeber and Kluckhohn[4] identified 164 different definitions of 'culture'. The 'culture' concept has been challenged over recent years in academic circles.[5,6] While an acceptable contemporary notion of 'culture' involves the shared meanings, values attitudes and beliefs of a group,[7] it has to be acknowledged that individuals within a group vary in their knowledge or interpretation of these meanings and often hold different or even conflicting values and beliefs. In other words cultures are not rigid, homogeneous entities and should not be thought of as objects or things.[8] However, in everyday discourse this is often occurs with the concept of 'culture' being commonly connected to minority groups and frequently refers to the 'other' or 'outgroup'.[7] In other words, the dominant group assumes that only minority groups have cultures and cultural needs.[9] It is difficult for members of a dominant culture to recognise or accept that each individual is racially and ethnically constructed, because they perceive their own culture as the 'normal' and the non-dominant groups are the 'other'.[10] It is more often 'differentness' rather than 'culture' that influences the relationship between practitioner and client.[11]

Focusing on cultural components of a person may result in ignoring the differences within that group created by other power differentials including gender, age, economics, poverty and politics. Cultures, therefore, cannot be examined, explored or understood without consideration of the politics and history that influence them, including the power relations within the group.[12] Many health practitioners are constrained by their own cultural perspective with little understanding of institutional racism and discrimination inside the health service or in society in general.[13] This may lead to differences in care provision. This has been found in studies where nurses and midwives spent more time with patients of their own cultural group[14] and identified minority group clients as being 'difficult' or 'non-compliant'.[15]

Providing health care for people who are culturally 'different' requires more effort than doing so for people from one's own group.[11] Minority groups are often seen as inferior and midwives and nurses tend to negatively stereotype.[16] This may be due to the lack of education around these concepts. Midwives and nurses frequently report feeling ill equipped and poorly prepared to deal with culturally diverse groups.[3,17] It appears there is insufficient educational preparation for midwives or nurses to work effectively with other groups, and many of the educators themselves are inappropriately skilled to help others learn this.[18]

Cultural safety

In the late 1980s a Maori nurse, by the name of Irihapiti Ramsden, led the development of 'cultural safety' as a framework for more appropriate health services for Maori people in New Zealand.[10] Rather than an emphasis on midwives and nurses learning about diverse cultures (learning about *the other)*, cultural safety requires them to explore their own cultural make up.[19] Based on attitudinal change, cultural safety aims at educating the health practitioner to become open minded and non-judgmental.[20] It encourages health staff to understand, rather than blame, the victims of historical and social processes for their current situation.[10] Cultural safety also encourages health practitioners to have a thorough understanding of poverty and its impact on people.[20]

Another important tenet of cultural safety is that the midwife or nurse not only acknowledges her/his own personal culture, but the power of nursing or midwifery culture.[21] It requires health practitioners to question the consequences of the long standing ethic of 'treating everyone the same' regardless of age, ethnicity or gender.[22] A health practitioner cannot assume s/he provides culturally safe care, as only the recipient of care can assess the level of risk or safety they experience.[19]

A number of educators initially confused cultural safety with the field of Maori studies, which led to significant tensions in New Zealand.[23] Cultural safety leaders however, discouraged the promotion of traditional Maori culture[24] as this was seen as being harmful to the urbanised Maori who frequently have been denied knowledge of their own culture.[25] Like the Australian Aboriginal and Torres Strait Islander population, cultural practices range in the Maori people, from very traditional to those that are indistinguishable from the dominant culture.[20] For some urban Maori who have not been exposed to traditional practices and beliefs, having a non-Maori practitioner teach, or assume traditional knowledge, would further alienate them from the health service.[25]

In contrast to the international literature's focus on 'multiculturalism', cultural safety adopted the term 'biculturalism'.[26] For the developers of cultural safety, multiculturalism was seen as distracting attention away from the power differences involved between the health practitioner and receiver.[23] Earlier publications on cultural safety suggested biculturalism was related to the relationship between Maori, as the traditional occupants of New Zealand and all those who have come since.[27] Ramsden[20] claimed that because of the serious health status of the Maori people of Aotearoa/New Zealand, and the real possibility of the disappearance of their culture and language, cultural safety must begin with the Maori people. However, the Maori, as custodians of the concept of cultural safety, have extended its principles to include those of other cultures, who subsequently came to live in New Zealand.[20] Cultural safety was further developed to include an emphasis on the relationship between any health professional and consumer who differ by: age or generation; gender; sexual orientation; socioeconomic status; ethnic origin; religious or spiritual belief; disability.[21] These categories highlight the use of the term 'culture' in its broadest sense[28] rather than the concept of being only ethnic or race specific.

An alternative explanation of biculturalism is that all interactions between health practitioner and service user are 'bicultural' due to the culturally informed messages that are filtered between the giver of the message and the receiver of that message.[23] The convergence of two 'cultures' — the professional culture of the health practitioner and the culture of the consumer (regardless of ethnicity) — may result in a power imbalance which can cause the recipient of care to feel intimidated and powerless.[22]

Cultural safety in New Zealand has been linked to the Treaty of Waitangi[29] which was signed in 1840, and Maori people gave the Crown rights to govern and to develop British