Citation:

Social change and social justice: cultural safety as a vehicle for nurse activism

Abstract

Current circumstances demand that university graduates become change agents who pursue social justice by being knowledgeable critical thinkers, able to skillfully negotiate culture and diversity issues. These matters are core business in university cultures and curricula, and health systems embrace them too. Yet much of our work is blind to the assumptions and privilege underlying practice.

This paper extends a body of work which considers cultural safety’s potential to challenge culturalist responses to power imbalances, racisms and white dominance in educational, research and clinical practices. It advances three central arguments in advocating for the consistent uptake of the model as a philosophical foundation and practice by nursing’s regulatory bodies and university faculty.

Currently we have an opportunity to overcome the racist ghettoizing of cultural safety, which positions it as relevant only to Indigenous contexts or to those otherwise conceptualised as ‘diverse’. It is precisely this disavowal of culture and diversity on behalf of dominant cultures that the model sought to overcome. So firstly we argue that the model is applicable in any context.

Secondly we argue to better equip students for the real world, the conceptual confusion surrounding culture and diversity evident throughout faculty of health, in nursing standards and curricular, and in clinical and research practice, needs urgent resolution. A coherent approach can be achieved by abandoning attempts to learn others’ cultures and by sustained effort to come to grips with the impact of our own cultures and those of the systems and society we work within.

Thirdly we argue therefore, that the model’s potential to challenge established ways of doing business can be realised more fully. This outcome relies on nursing, a profession embodying white privilege, rising to the challenge to acknowledge and negotiate power imbalances to address racism, stigma and discrimination in society and our everyday lives. [300 words]
Introduction

The global situation and our local social climate rightly demand that university graduates become change agents who can contribute to social justice by being knowledgeable about and able to skillfully negotiate issues concerning culture, diversity, and Aboriginal and Torres Strait Islander issues. These concerns are now core business in university cultures and curricula (Queensland University of Technology 2014, p. 4) and health systems of necessity embrace the same issues (Queensland Health 2016, p. 2; p. 4). Yet much of our work in university and health systems is blind to the unacknowledged assumptions and privileges underlying our practice, not the least of which involves the mobilization of privilege in assumptions about the location and import of diversity and culture.

Cultural safety, a model underpinned by critical theory and social constructionism, was developed by Maori scholar Dr Irihapeti Ramsden and colleagues. Cultural safety is defined as effectively caring for a person/family from another culture which is determined by that person or family; unsafe cultural practice is ‘...any action, which diminishes, deems or disempowers the cultural identity and well-being of an individual’ (NCoNZ 1996, p. 9). Ramsden saw that nursing curricula ignored structural issues in health care being designed by and for those who did not share her cultural position or experience of colonisation. She challenged this cultural dominance and the way it shaped policy and developed nurses as mere biomedical technicians rather than agents of social change who could address inequity and racism (Ramsden 2002).
Ramsden saw cultural safety as a way for nurses to consider how their socialisation and cultural position impacted on their work. She emphasised links between ill-health and dispossession, economic status and political agendas, as against individualist biomedical notions that illnesses merely occur within bodies and that the practice of professions such as nursing and medicine are disinterested, value free activities. Cultural safety recognises that nursing care, education and research are not value neutral pursuits but reflect socio-political contexts and the values, assumptions and priorities of those involved (Ramsden 2002; Anderson et al. 2003; Reimer-Kirkham et al. 2002, 2009; Browne et al. 2009; Racine 2009; Cox & Simpson 2015).

**Cultural safety as vehicle for activism**

In the following paper three central arguments are advanced in advocating for a coherent and broad uptake of cultural safety by nursing’s regulation authorities and university faculty as a philosophical foundation to all aspects of nursing practice. Firstly the author’s decade of working with Ramsden’s (2002) model of cultural safety has crystalized its potential and aim to challenge culturalist responses to power imbalances, racisms and white dominance in nursing research, education and practice. Such an approach presents the exciting possibility of overcoming the frequent racist ghettoizing of cultural safety, which limits the model as only applicable to Indigenous contexts or to those who the mainstream conceptualise as ‘other’. A close reading of Ramsden (2002) shows of course, that it is precisely this disavowal of culture on behalf of the dominant culture that cultural safety sought to overcome. As Ramsden (2002, p. 5) said: ‘The consistent focus of Cultural Safety as originally envisaged was to be grounded in the Critical Theory approach constantly questioning power relations between nurse and the
person being nursed with the emphasis on the attitudes and behaviours of the nurse [my emphasis].’ It aimed for cultural change by exposing and addressing power imbalances to decrease the impact of cultural dominance and racism in health care, education and research (McCleland 2011). So while the model specifically seeks to address racism at personal, institutional and scientific levels, it also confronts ageism, sexism and others forms of dominance such as hetero-dominance for example.

Hence one of the models’ key concepts, biculturalism, signals that everyone has culture which further challenges common ideas that culture only belongs to so-called Culturally and Linguistically Diverse (CALD) ‘others’ (Tolich 2002; Cox and Taua 2013). This aspect considers the relationship of health inequity to white mainstream domains and implies that that the model is applicable in any context whatsoever. It considers the dominant culture as part of and not somehow outside of diversity concerns and it places the responsibility for change firmly with the dominant culture and professionals in positons of power in educational and health systems. Nevertheless we consistently see cultural safety being reduced in university curricular and in health services to an empty type of rhetoric which serves largely as a shallow panacea to institutional demands to address diversity and inequity and to embed Indigenous knowledges and/or perspectives in curricula. The worst example of this process is when the term ‘cultural safety’ is assumed to be mere words, rather than the name of a fully theorised model. The term is then used to incorrectly refer to what I call ‘business as usual approaches’ where culture is reduced to ethnicity, always belongs to ‘exotic’ others, and where privilege and racism remain unaddressed and unacknowledged.
These observations lead to the second point which is that there is an urgent need to resolve the conceptual confusion and sheer vagueness surrounding the culture concept that is evident throughout faculty of health, in nursing standards and curricular, and in clinical and research practice. For example in the new Registered Nurse Standards for Practice (Nursing and Midwifery Board of Australia [NMBA] 2016) there is a welcome and needed recognition that all registered nurses in Australia must be knowledgeable about colonisation and the impacts of history and social issues on health, however the term culture remains undefined. Further the statement that a nurse ‘respects all cultures and experiences, which includes responding to the role of family and community that underpin the health of Aboriginal and Torres Strait Islander peoples and people of other cultures’ implies that mainstream culture is the norm from which these ‘other cultures’ differ or deviate (NMBA 1026, p. 3). As Puzan (2003) reminds us, such an entrenched unexamined assumption is a hallmark of white privilege.

Further, in a 2015 Australian national workshop on the issue of teaching cultural safety, speakers used a plethora of terms as if they were interchangeable including cultural humility, cultural security, cultural awareness, cultural competence, cultural appropriateness, culturally specific and cultural safety. At a recent meeting to discuss curriculum development, the term ‘culturally conscious’ was used and was added to my list. The resolution of this conceptual confusion requires clarity around the very definition of culture as it is used in cultural safety. Ramsden was very clear that culture can neither be reduced to ethnicity nor to formal ritual and beliefs such as those relating to religion and custom. In cultural safety culture is
conceptualised as changeable, learned, strategic and socio-political and its significance is not differences in ethnicity, art, ritual or ceremony, but in how people are treated differently during everyday life.

Culture ‘...is used in its broadest sense to apply to any person or group of people who may differ from the nurse/midwife because of socio-economic status, age, gender, sexual orientation, ethnic origin, migrant/refugee status, religious belief or disability’ (Ramsden 2002, p. 114). In cultural safety these differences are respected as legitimate not as deficits to dominant norms. Ramsden argued that these aspects of culture are most relevant to our work along with our unexamined cultural assumptions, attitudes and values. Thus it is the interaction of worldviews and lifeworlds that is of interest in culturally safe practice, a perspective which speaks to all parameters of discrimination including those associated with age, class and gender as indicated earlier.

If this confusion about what we mean by the term culture and its significance could be eliminated, then the model’s potential to challenge the complacency of established ways of doing business, as envisioned by Ramsden (2002) and her colleagues, could be brought to fuller fruition by refocusing on the import diversity has in the model. Cultural safety provokes a crucial change of emphasis from locating the source of problems in the diversity amongst people, to locating it in how society and its institutions respond to diversity and to difference from the dominant culture; a change in focus from individualistic to systemic concerns.
As Puzan (2013) argued the nursing profession embodies white privilege and this argument is repeatedly born out in curricula processes where ‘diversity’ is frequently based on an ‘othering’ discourse which somehow leaves ‘us’ outside of diversity. Thus the possibilities inherent in cultural safety rely on all nurses genuinely engaging in and modelling deep self-reflection [individually and as a profession] as a form of conscious activism which can lead change and challenge the cultural dominance of systems and professions which so often limit socially just outcomes for those who use health services.

The forces that reduce culture to ethnicity, disavow racism and other imbalances of power, assume the existence of discrete human races and see mainstream systems and cultures as cultureless, natural, normal and right are strong; nurses can engage with, embed, practice and promote cultural safety as a form of activism to contribute to social change. A coherent approach to the issues outlined at the beginning of this paper can only be achieved by both the abandonment of attempts to learn the cultures of others and sustained effort to recognise ourselves as cultural beings and to come to grips with the impact of our own cultures and those of the systems and society we work within. In so doing nurses could rise to the challenge of addressing social responses to diversity in society and our everyday lives.

Cultural safety calls for nurses to accept that we are bearers of culture, are socially powerful, privileged and positioned and that our status is related to historical and political processes. The practice of cultural safety requires us to acknowledge how our own social experience, values, beliefs and assumptions inform power relations and structural inequalities. This negotiation of power and resource sharing establishes trust and strives for social justice.
provokes us to ask who holds the power to define what counts as knowledge, as health, as recovery or as evidence; challenging us to question the idea that ‘culture’ and ‘race’ determine outcomes and to resist blaming people for their social situation including their health (Browne et al. 2009; Racine 2009; McCleland 2011; McGibbon et al. 2013). Far from cultural safety being the sole province and responsibility of Aboriginal people and Torres Strait Islanders it is everybody’s business and responsibility to practice decolonisation and be part of the story of social change.

**Discussion points or questions to raise as issues/feedback/critique**

- Could cultural safety be a vehicle for activism and social change in health?
- How to safely challenge long and deeply held assumptions about culture; that it is just another word for ethnicity and that only people of colour ‘have culture’?
- How to safely challenge long and deeply held assumptions about ‘race’ that sees it as a biological fact rather than a social construction?
- Discussing white privilege as a dimension of racism feels like it is off limits at times. How to overcome barriers and facilitate the acknowledgment of privilege to promote power sharing and negotiation.
- What are the major limitations of cultural safety?
References


**Acknowledgements**

I acknowledge the support of the School of Nursing, QUT for funding to attend this event.