Review

Providing culturally appropriate care: A literature review

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ABSTRACT

Objectives: As part of a study that explored how midwives incorporate cultural sensitivity, into their practice, the literature was reviewed to ascertain how the concept of culture has been, defined and what recommendations have been made as to how to provide culturally appropriate care, to individuals from Indigenous and/or ethnic minority backgrounds.

Design: A systematic review of the literature was undertaken.

Data sources: Electronic databases including Medline, Cinahl, Socio-file and Expanded Academic Index, were accessed.

Review methods: Several key search terms were used for example, midwife, midwives, midwifery, nurse, nurses, nursing, culture or cultural, diversity, sensitivity, competency and empowerment. The results relating to midwifery were few; therefore ‘nursing’ was included which increased the amount of material. References that were deemed useful from bibliographies of relevant texts and journal articles were included. The inclusion criteria were articles that provided information about culture, and/or the culturally appropriate care of individuals from Indigenous and/or ethnically, culturally, and linguistically diverse backgrounds.

Materials reviewed for this paper satisfied the inclusion criteria.

Results: There are two main approaches to culture; the first focuses on the cognitive aspects of culture, the ‘values, beliefs and traditions’ of a particular group, identified by language or location such as, ‘Chinese women’ or ‘Arabic speaking women’. This approach views culture as static and unchanging, and fails to account for diversity within groups. The second approach incorporates culture within a wider, structural framework, focusing on social position to explain health status rather than on individual behaviours and beliefs. It includes perspectives on the impact of the colonial process on the ongoing relationships of Indigenous and non-Indigenous people and how this affects health and health care.

Conclusion: Most of the literature focuses on the cognitive aspects of culture and recommends learning about the culture of specific groups which is presumed to apply to everyone. This generic approach can, lead to stereotyping and a failure to identify the needs of the individual receiving care. The concept of, cultural safety derived from the second approach to culture and practice has potential but evidence to show how it is being incorporated into practice is lacking and health professionals appear to be unclear about its meaning.

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• This is important for all recipients of care, but especially so for Indigenous peoples who have higher rates of adverse outcomes compared to non-Indigenous peoples and who may have experienced discrimination in health care settings.
• However, little is known about how the literature informs health professionals about culture, diversity and culturally appropriate care.

What this paper adds

• A review of the nursing and midwifery literature identified two approaches for defining culture and providing appropriate care.
• The first is a cognitive approach focusing on customs and traditions. A criticism is that this approach fails to take into account broader social, political and economic factors which affect health and access to health care. Stereotyping of individuals may result.
• The second approach is broader and focuses on the social position of individuals rather than behaviours and beliefs to explain health status. Derived from the work of postcolonial scholars, this approach has recently gained acceptance under the rubric of cultural safety.
• However there is limited evidence in the literature on how this approach has been, or may be, incorporated into practice and health professionals appear confused by its meaning.

1. Introduction

Most nurses and midwives routinely care for people from diverse ethnic and linguistic backgrounds (Burnard and Naiyapatana, 2004). Globalisation and migrations past and present have contributed to this diversity and some countries also have Indigenous populations with their own cultural identity. Professional bodies such as the International Council of Nurses (2007) and the International Confederation of Midwives (2005), as well as many professional bodies in individual countries, expect that nurses and midwives will provide culturally appropriate care. However it is not always clear how this may be achieved. To begin to answer this question, this paper reviews the nursing and midwifery literature in relation to culture and practice, focussing in particular on how culture has been defined and the implications of this for practice.

The paper argues that two distinct approaches to culture and nursing and midwifery practice may be discerned in the literature. One tends to focus on the cognitive aspects of culture, discussing ‘traditions’, ‘values’ and ‘beliefs’, assumed to be shared by all with the same cultural background. Those working in this perspective support learning about other (specific) cultural groups, in particular about their health beliefs and (apparently) traditional behaviours, which will sensitise the nurse or midwife and allow him/her to provide appropriate care to people from ethnically diverse backgrounds. Scholars also often refer to the need for nurses and midwives to be aware of their own culture (again, seen as values and beliefs) in order to facilitate their understanding and acceptance of ‘difference’ (Duffy, 2001; Benkert et al., 2005).

There are a number of criticisms which may be made about this perspective and the assumptions that it makes. One is it assumes culture is static and unchanging but, even within the same culture, the experience of the individual changes over time and with it their practices, beliefs and views (Burnard and Naiyapatana, 2004). It also fails to take into account diversity within groups and between generations. This may lead to stereotypical images of particular groups, with the assumptions regarding their nursing and midwifery needs being made by care providers based on these stereotypical images. This approach has led to the development of generic care plans for people from particular cultural or ethnic backgrounds and the use of these care plans have been labelled as a ‘cookbook’ approach to care (Duffy, 2001).

The other perspective incorporates culture within a wider, structural framework, focusing on social position, education and socioeconomic status to explain health status rather than on individual behaviours and beliefs. Within this latter perspective is included a small group of postcolonial scholars who are interested in the impact of colonial processes on the ongoing relationships of Indigenous and non-Indigenous people and how this affects health and health care. This approach has been particularly evident in New Zealand (Ramsden, 2002) and Canada (Kirkham et al., 2002; Anderson et al., 2003) and is growing within Australia (Kruske et al., 2006). These countries all have Indigenous populations which continue to experience poorer health outcomes than their non-Indigenous counterparts, though the gap in health status indicators is most starkly seen in Australia (ABS & AIHW 2008).

The paper begins with a review of transcultural nursing, the oldest approach, followed by the other types of literature which aims to describe other ways of providing culturally appropriate care. The paper then discusses the influence that power has on providing appropriate cultural care. In particular the concept of cultural safety will be addressed.

2. Transcultural nursing

The growing interest in culture and health care can be directly related to the concept of transcultural nursing as first depicted by Leininger (1988) in the United States. However, although transcultural nursing has been endorsed by many in the nursing and midwifery profession, it has also been criticised. This criticism is based on the view that transcultural nursing provides a vehicle that allows individuals to be stereotyped and also fails to look at the effect of structural factors such as colonisation on individual behaviours (Bruni, 1988; Smye and Browne, 2002). None the less, transcultural nursing has been extremely influential and hence this paper begins with a discussion of Leininger’s work.

Leininger states that in the 1950s she became aware that ‘care is the essence of nursing and the central, dominant, and unifying feature of nursing’ (Leininger, 1988, p. 152). She believed that people from a different cultural background to the care giver had different
expectations; therefore nursing required a theoretical framework in which to provide suitable care. Leininger explains how the aspect of culture was not considered at this time. The main focus of nursing was on clinical procedures and so she completed a doctorate in anthropology to develop a theory to address this issue (Leininger, 1988). This research led her to introduce transcultural and cultural care nursing theory into nursing curricula, particularly in the United States.

Leininger states that her:

...theory of Culture Care is not static, but rather a dynamic theory that is being used worldwide by many knowledgeable nurses as the most meaningful, timely and relevant theory in nursing (Leininger, 2001, p. 37).

Leininger argues that transcultural nursing is:

...a formal area of study and practice focused on comparative holistic cultural care, health, and illness patterns of people with respect to differences and similarities in their cultural values, beliefs, and lifeways with the goal to provide culturally congruent, competent, and compassionate care [original in italics] (Leininger, 1997, p. 342).

Leininger (1997, p. 342) states that to provide appropriate transcultural nursing care, nurses must have an understanding of other cultures and look for culture specific ‘symbols, expressions, and meaning of specific and diverse cultures’. It is evident from the literature that there are many nurses internationally who support the theory of transcultural nursing (see Luna and Miller, 2008) and are concerned with its application to practice (Papadopoulos and Omeri, 2008).

Leininger is explicit in her belief that the concept of cultural care focuses on the views of the patients. These views, according to Leininger, provide the ‘meanings, symbols, patterns and expressions of cultural care and nursing from a holistic perspective’ (Leininger, 1988, p. 153). This view of culture espouses its cognitive aspects without taking into consideration the individual patient’s life experiences, such as their status within their social environment, socioeconomic factors and education level, which are known to affect an individual’s well-being (Hart et al., 2003).

Leininger has been publishing on the topic of culture care for over 40 years and she has provided different interpretations or definitions of the concept of culture during that time. In her earlier publications Leininger defined culture as:

...the learned and transmitted knowledge about a particular culture with its values, beliefs, rules and behavior, and lifestyle practices that guides a designated group in their thinking and actions in patterned ways (Leininger, 1978, p. 491).

Subsequently, she has not defined culture per se but she has instead focused on what ‘culture care’ is:

The theory is a holistic, culturally based care theory that incorporates broad humanistic dimensions about people in their cultural life context. It is also unique in its incorporation of social structure factors, such as religion, politics, economics, cultural history, life span values, kinship, and philosophy of living; and geo-environmental factors, as potential influencers of culture care phenomena (Leininger, 2007, p. 9).

The first definition is one which appears to view culture as static and unchanging (Price and Cortis, 2000). It does not address the issue of agency in relation to how people choose to act, as some individuals choose not to follow their ascribed cultural customs. This interpretation of culture does not allow for diversity (difference) within labelled ‘cultural groups’ to be recognised and it also fails to take into account the effect of migration on individuals and the subsequent merging or loss of different practices. Indeed, Campesino (2006, p. 300) has pointed out that this criticism of transcultural theory has focussed on the ‘essentialist conceptualization’ of culture.

As identified in the second quote Leininger is now incorporating social structural factors into care provision, such as the individual’s economic position and their social environment, although Campesino (2006, p. 300) still contends that transcultural theory is ‘reluctant’ to address structures of power in health care contexts and between the providers of care and its recipients. However, Leininger’s emphasis is still on the nurse being able to recognise the cognitive aspects of culture by using an ‘ethnonursing research’ approach to care;

...that enables the researcher to enter the world of the participant and tease out the largely unknown and covert care beliefs, values, and lifeways. The method includes five enabler guides to facilitate discoveries of specific care phenomena. These enablers have been extremely relevant and most helpful to enter the cultural world of informants and discover their covert culture care beliefs, values, and practices (Leininger, 2007 p. 11).

Since Leininger began her work, the increasing changes brought about by globalisation and the growing migration of people (Duffy, 2001) have influenced the continuing interest of the nursing and midwifery professions in providing care that is ‘culturally appropriate’. The vocabulary used has also increased, including terms such as ‘cultural diversity’, ‘cultural sensitivity’, ‘cultural competency’, ‘cultural safety’ and ‘empowerment’. The literature using these terms is now discussed.

3. Being culturally appropriate

‘Cultural diversity’ is the term used by several authors (Henkle and Kennerly, 1990; Erlen, 1998; Kirkham, 1998; Homer, 2000; Callister, 2001) to describe the changing population of the world through migration. These authors are referring to the United States, Canada and Australia, however many other countries are experiencing or have experienced changes to their population through immigration. Callister (2001, p.209) refers to the world becoming a ‘global village’. Erlen (1998) and Henkle and Kennerly (1990) expand on the concept of cultural diversity to include those people who were born in the
same country but who have different values or approaches to life to that of their health care provider.

According to Homer (2000), writing from an Australian perspective, cultural diversity refers to the recognition of different cultural groups and their needs. Homer is particularly concerned with the lack of representation within midwifery research studies of non-Anglophone women and she argues that many Australian studies in the past have excluded women whose first language is not English. Different cultural groups, from this perspective, are those whose first language is other than the dominant language of the country in which they live.

A definition of culture is not provided by Homer (2000), however, she seems to mean ‘tradition and custom’. She points out that traditional practice may be important for some women and not for others and she states that this may be because the women choose not to follow ‘their customs’ because of the effect of their new living and social conditions (Homer, 2000, p. 253). Homer refers to the cognitive aspects of culture, such as traditions and customs but does not provide examples. This term ‘traditional’ is problematic. It appears to assume that there is set of distinct unchanging practices which are, or should be, performed by all people from the same cultural backgrounds.

The emphasis in a large proportion of the literature is on the recognition of a consistent set of values exhibited by individuals who are labelled as belonging to specific cultural or linguistic groupings, such as ‘Asian women’ (Matthey et al., 2002; Liamputtong and Naksook, 2003). When health care professionals attempt to broaden their awareness of ‘difference’ by attending cultural training sessions that discuss cultural difference and subsequently adjust their practice to meet the needs of these individuals, they are said to be ‘culturally sensitive’ as they appreciate ‘the richness and the complexity that diversity brings to a situation’ (Erlen, 1998, p. 3).

It is argued by Erlen (1998) that to respect other cultures, the health professional must first recognise their own culture and any biases that may impact on their practice. As the literature on cultural sensitivity increases (Henkle and Kennerly, 1990; Erlen, 1998; Yearwood, 1998; Scholes and Moore, 2000; Omeri and Malcolm, 2004; Benkert et al., 2005) there is a growing consensus that health care professionals need to be aware of their own ‘cultural beliefs, attitudes and feelings’ (Duffy, 2001, p. 498) to facilitate their understanding of people who may be from a different background. There are numerous methods/teaching strategies, according to these scholars, to assist health professionals to recognise their own values, for example, ‘value clarification exercises’ (Erlen, 1998, p. 3), ‘self assessment tool’ (Benkert et al., 2005, p. 225) and ‘continuing education’ including ‘case conferences’ (Omeri and Malcolm, 2004, p. 187). However there is little evidence to show if these are effective.

It has been argued that when the focus of education is on cultural diversity, there is a danger of reinforcing an ethnocentric approach to care and, in some cases, a paternalistic approach to health care provision (Bruni, 1988; Blackford, 2003). Blackford (2003) even asserts that, in Australia, a cultural difference approach has allowed non-English speaking and non-white populations to be seen as ‘deviant’ compared to the health professional ‘norm’ (p. 239) and in some cases to be ‘invisible’ in health care policy and the provision of care (p. 242).

Endorsement of their ‘culturally sensitive’ practice is achieved for the nurse or midwife when they are rewarded by health care organisations or professional bodies by being called ‘culturally competent’. Robinson defines cultural competence as:

...a sensitivity to issues of culture, race, gender, sexual orientation, social class and economics. Cultural competence involves more than knowledge acquisition: it involves skills, awareness, encounters, desire and knowledge (Robinson, 2000, p. 131).

This definition goes beyond Leininger and transcultural nursing to include attributes such as awareness, skills and knowledge. However there is no mention of how these attributes are measured in the context of the nurse or midwife’s workplace.

4. The generic approach to care

Duffy (2001, p. 489) argues that nursing education continues to espouse ‘distinct cultural components (local particularities)’ without taking into account the interaction of the individual with global influences such as media and the increasing use of technology. The individual gets lost in an education that, focusing on cultural characteristics and customs, provides a ‘cookbook’ approach to care (Duffy, 2001, p. 498).

This ‘cookbook’ approach refers to generalised information that has been formulated about different specific groups. As argued by Duffy (2001), transcultural literature and texts are full of these generic ‘cookbook’ approaches. An example is the text, ‘Culture Care Diversity and Universality, A Worldwide Nursing Theory’ edited by Leininger and McFarland (2006). The text endorses ‘culture specific clinical nursing care’ which is a care plan that has been formulated specifically ‘to make nursing care decisions and take actions that are culturally congruent with the beliefs, practices, values and life-ways of people’ (McFarland and Zehnder, 2006, p. 199).

This approach in the majority of cases is used to provide generic information about people from specific culturally and linguistically diverse backgrounds. Some authors do warn the readers that this approach can lead to ‘stereotyping’ as it is impossible to cover the diversity within culturally and linguistically diverse groups such as those from South Asia (St. Hill et al., 2003). However despite the advice to not stereotype, generic cultural information is often provided for individuals from specific backgrounds, who are labelled as belonging to, or having the same characteristics as, a particular ethnic or linguistic group.

We respectfully ask you to avoid using this book as a cookbook or to stereotype the women described in each chapter. Please use it as a starting point from which to think about and ask whether this particular family, client, or student is similar to or different from what the chapter describes on the topic of interest (St. Hill et al., 2003, p. xviii).
The problem is that although the warning has been provided in the preface by St. Hill et al. (2003), it may not be read by those health care providers or students who are seeking to enhance their knowledge of people from specific ethnic or linguistic groups. It is likely that individuals seeking information will turn to the chapter that provides their required information. For example, in St. Hill et al. (2003) text entitled ‘Caring for Women Cross-Culturally’, chapters are labelled to provide generic information such as Chapter 4 ‘Arab Americans’, Chapter Six ‘Cambodians’ and Chapter 7 ‘Chinese’ women.

Educational strategies tend to focus on learning about particular ‘cultures’, as indicated above. Students may do this, according to the literature, by spending time overseas or by interviewing other nurses who are from diverse backgrounds (Henkle and Kennerly, 1990; Robinson, 2000; Scholes and Moore, 2000). This practice is believed to enhance cultural competency. However these approaches to cultural competency have rarely been critically evaluated (Suh, 2004). They suggest that an individual can ‘embody’ culture in some way or that individuals from similar backgrounds, either similar linguistic backgrounds, for example ‘Chinese speaking’, or similar national backgrounds, for example ‘Greeks’ are all alike in some way. Lock (1990) suggests that this approach ignores differences such as age, gender, class, education and sexual orientation which shape each person’s perspectives. As a result, health professionals may be unsympathetic to health care recipients whom they perceive as adhering to outdated traditional beliefs, despite the apparent sharing of a similar cultural background.

A final criticism of the approach to practice that focuses on the cognitive aspects of culture, traditions, customs and values, is that it fails to take into account broader social, political and economic factors which affect health and access to health care. As a result, health professionals may be unsympathetic to health care recipients whom they perceive as adhering to outdated traditional beliefs, despite the apparent sharing of a similar cultural background.

Although cultural safety originated in New Zealand (Jeffs, 2001), it has been taken up by scholars in other countries such as Canada (Kirkham et al., 2002). Not all agree that it is transportable. As it is concerned with ‘biculturalism’ in New Zealand (the Maori and Pakeha), some suggest that there are difficulties in utilising the concept of cultural safety in countries where there are multiple Indigenous groups (for example many different First Nation peoples, Inuit etc), and many different migrant groups, as is the case in Canada (Kirkham et al., 2002; Smye and Browne, 2002). However, these same authors (Kirkham et al., 2002; Smye and Browne, 2002) argue that by using the concept of cultural safety, (even though it is recognised to be a bicultural approach), the benefits outweigh the negatives, and there are many similarities between New Zealand and Canada in the way colonisation affected their respective Indigenous populations.

When discussing the concept of cultural safety, Kirkham et al. (2002, p. 227) describe it as requiring ‘a reconsideration of the disparate power relations within and beyond health care and the historical and social processes that organise these relationships’. These Canadian authors state that by taking a postcolonial viewpoint of the concept of cultural safety as developed in New Zealand, they are able to examine the extended history of the role of economic, political and social subordination of Indigenous groups and other ethnic minorities in Canada, and the direct negative impact this has had on their health outcomes.

5. Culture and power

The idea that learning about the customs and beliefs of particular groups is beneficial for the appropriate care of the individual and their families from ethnic minority groups, ignores more critical analyses of the culture concept. In particular, how it may be used in power relationships, which are usually detrimental to minority groups, including Indigenous populations. This critical analysis leads to an approach which is more explicitly theoretical, utilising the insights from postcolonial discourse theory. Proponents of ‘cultural safety’ tend to come from this perspective.

Cultural safety was initially developed in New Zealand by Irihapeti Ramsden, who stated that:

Cultural Safety has been developed almost entirely from the interactive experience of the indigenous [Maori] people with a nursing and midwifery service largely derived from a migrant ethic group thus making it unique to this country [New Zealand] although there are elements of international comparison (Ramsden, 2002, p. 180).

Ramsden (2002) explained in her thesis that the concept was derived from the need for the impact of colonisation to be acknowledged and for an understanding of the effect of colonisation on the Maori population to be taken into account when providing health care for this population. The concept of cultural safety according to Anderson et al. (2003) can be written within a critical postcolonial discourse.

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Kirkham et al. (2002) argue that it is important to understand that the concept of culture, defined by some health care professionals as being a balanced system of communal practices, beliefs and meanings, does not exist. On the contrary, when viewing culture from a postcolonial discourse perspective, it is seen as not being unitary or neutral. Kirkham et al. (2002, p. 224) argue:

...the concept of culture must be interrogated to unmask the relations of the ruling and domination that have shaped the constructions of the "other", even as attempts are made to bridge the gap between the Western self and the "colonised other" in the appeal to ideas such as cultural sensitivity.

Ramsden defined cultural safety as 'an outcome of nursing and midwifery education that enables safe service to be defined by those that receive the service' (Ramsden, 2002, p. 117). She stated that the process of cultural safety requires 'a critical analysis of existing social, political, and cultural structures and the physical, mental, spiritual and social outcomes for people who are different' (Ramsden, 2002, p. 180).

Ramsden stated that the non-Indigenous population of New Zealand did not consider the impact of colonisation on the Maori population. She argued that:

For patients to be considered in terms of their political status and historical circumstances requires an understanding and knowledge of history which continues to be uncommon in New Zealand currently (Ramsden, 2002, p. 180).

Using the concept of cultural safety, nurses and midwives are encouraged to reflect and analyse how power relationships and history have impacted on the health of individuals (Spence, 2003; Kruske et al., 2006). Part of this reflection includes how 'personal and institutional cultures impact on the delivery of health care' (Spence, 2003, p. 224). The goal of cultural safety is to provide care that is 'effective' and 'determined' by the individual (Spence, 2003, p. 224).

Cultural safety has also been endorsed by the Nursing Council of New Zealand, and their definition of the concept of cultural safety is:

The effective nursing 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 beliefs; and disability.

The nurse delivering the nursing service will have undertaken a process of reflection on his or her own cultural identity and will recognise the impact that his or her personal culture has on his or her professional practice. Unsafe cultural practice comprises any action which diminishes, devalues or disempowers the cultural identity and well-being of an individual (Nursing Council of New Zealand, 2005, p. 7).

In Australia, different approaches are apparent with regard to the Indigenous population. Some of the health, nursing and midwifery literature focuses on the 'empowerment' of Indigenous people and their participation in health care in direct response to unsatisfactory morbidity and mortality rates (Williams, 1999; Pyett, 2002; NSW Department of Health, 2003; Dahlen, 2006; Eckermann et al., 2006). Alongside this empowerment literature, however, is another literature which continues to focus on traditional practice (Gaff-Smith, 2001; Sarzin, 2003). For example, there is sometimes an assumption that all Indigenous women continue to follow the same 'traditional' birthing practices (Carter et al., 1987; Gaff-Smith, 2001; Sarzin, 2003), when this is not the case. Brady (1995, p. 1490) has critiqued this emphasis on notions of static 'traditional culture', which fails to recognise that contemporary Indigenous cultural forms are extraordinarily diverse.

Williams (1999) cautions that for cultural safety to be utilised (as intended by Ramsden and by the New Zealand Council of Nursing) within an Australian context, the Indigenous population need to be empowered to be able to direct appropriate care. Although there are similarities in the history of colonisation of Australia and New Zealand, there are also primary differences in the way in which colonisation was enacted (Kruske et al., 2006). Under the Treaty of Waitangi enacted in 1840, the Maori people were guaranteed to have their way of life protected and, at the same time, they were granted full citizenship rights (New Zealand Government, 2005). In Australia the Indigenous population were not treated in the same manner and full citizenship rights were not granted until the 1967 Referendum (Hemming, 1998), 179 years after Australia was colonised by the British. Excluded and marginalised, the Indigenous population's role in determining their well-being has been quite different to that of the Maori population in New Zealand. That is why Williams (1999) recommends that the Indigenous population in Australia needs to be empowered to direct the care that they wish to receive under the banner of cultural safety.

However, as argued by Hunt (2006), the present Australian health care system is not conducive to allowing Indigenous women to be empowered, as health care providers control pregnancy care. Hunt (2006) argues that many Indigenous women experience increased surveillance, as more assessments, tests or increased hospitalisation takes place to monitor the health of the woman and her foetus. Indigenous women will not be empowered until health professionals and the health system recognise and relinquish 'some of the control they currently exert over women' (Hunt, 2006, p. 53). This is reiterated by Kildea (2006) who argues that Indigenous women's voices need to be heard for cultural safety to be truly enacted and that the current dominant Western medical system needs to be challenged to improve the health outcomes for Indigenous women and children. Indigenous women from remote and rural communities are required to birth in hospitals in city or major town centres with little thought given to the impact this has on their and their families' social well-being. This removal of women from their communities has not improved their birth outcomes (Kildea, 2006).

There has been little education about Indigenous health issues so it is difficult to envisage how all nurses and
midwives can have a full comprehension of what cultural safety encompasses. An audit by the Congress of Aboriginal and Torres Strait Island Nurses of Australian nursing programs found that only 22 out of 33 provided a distinct subject on Indigenous Health (Australian Nursing and Midwifery Council, 2007). The Australian Nursing and Midwifery Council is now calling on all providers of nursing and midwifery programs leading to registration or enrolment to include a distinct subject/module on Indigenous health, culture and history (Australian Nursing and Midwifery Council, 2007).

However, there is limited evaluation of how the concept of ‘cultural safety’ and the inclusion of this concept in nursing and midwifery curricula have worked in reality (Richardson, 2004). Johnstone and Kanitsaki (2007) argue that although cultural safety is a part of all nursing and midwifery curricula in New Zealand, there is limited evidence (if any) on how this concept has impacted on the health outcomes of the Maori population. These authors undertook an Australian study to determine how the concept of cultural safety was understood and applied in an Australian context. They interviewed a total of 145 participants, including patients and their families. Their results showed that the concept of cultural safety is not readily understood by health professionals and therefore it is not applied as intended in the clinical setting (Johnstone and Kanitsaki, 2007).

Despite not being familiar with the term, health service provider participants had a sense that cultural safety was a complex process primarily concerned with health care providers “doing things safely” and ensuring that patients from diverse racial, ethnocentric, and language backgrounds got “safe care” and did not suffer mishaps and harms because “communication was not effective” or because “staff lacked cultural knowledge and awareness” (Johnstone and Kanitsaki, 2007, p. 251).

When cultural safety is viewed in this way there is no recognition of the social determinants that may affect an individual’s well-being. The focus of the health professionals in this study was on providing safe clinical practice. The meaning of cultural safety has been totally misinterpreted.

Most importantly Johnstone and Kanitsaki (2007) research identifies that consumers (patients) of health care were unable to define cultural safety or to express what they thought it may be. It should be noted that although consumers were included in the study, it is not clearly identified by the authors the exact number of participants who were Indigenous. This study undertook a broader approach to the concept of cultural safety by seeking to ascertain whether it was suitable in a multicultural context. This was not the original intention of the concept of cultural safety as defined by Ramsden. The use of the concept for the provision of care to all individuals subverts the original concept of recognising the impact of colonisation on Indigenous populations. Immigration is a different issue. Although immigrants face many challenges, they have not experienced the oppression or injustices that many Indigenous populations have faced and continue to face.

It can be argued, however, that the concept of cultural safety has at least provided a focus for nursing and midwifery education that has moved beyond providing a ‘cookbook’ approach to care.

The purpose of cultural safety in nursing education extends beyond the description of practices, beliefs and values of ethnic groups. Confining learning to rituals, customs and practices of a group assumes that by learning about one aspect gives insight into the complexity of human behaviours and social realities. This assumption that cultures are simplistic in nature can lead to a checklist approach by service providers, which negates diversity and individual consideration (Nursing Council of New Zealand, 2005, p. 7).

6. Conclusion

This paper has argued that there are two main approaches to defining culture in the nursing and midwifery literature. The first focuses on the cognitive aspects of culture (beliefs and values). This approach tends to provide generic information about different groups of ethnically and linguistically diverse people, which is then used to develop a ‘cookbook’ or ‘recipes of care’. This approach on the whole does not take into account other factors which may impinge on the individual such as their socioeconomic status or educational level. Illness or prevention of illnesses may then be seen as the individual’s responsibility regardless of their position within society.

The second approach to culture is broader and includes a structural framework that focuses on the individual’s social position and how this has impacted on their health and well-being. Derived from the work of postcolonial scholars, this approach has recently gained acceptance under the rubric of cultural safety which has been adopted by various professional bodies. While the concept of cultural safety has merit, there is little available evidence in the literature to show how it is being, or may be, incorporated into practice. It is in danger of becoming rhetoric only and health care professionals appear to be confused by its exact meaning. On the other hand, for Indigenous populations, any approach to culture and practice which incorporates the history of contact provides a more meaningful insight into the reasons for their poor health status than can be achieved with a focus on traditional beliefs and values.

The concept of culture is difficult both to define and operationalise. How this is done potentially has consequences for practice. None of the available approaches has been shown to overcome the problem of stereotyping the individual whose background differs from that of the health care provider or provides a clear way to provide culturally appropriate care.

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None declared.

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