Cultural Safety Modules 1 and 2 Handout

What is cultural safety?

"Cultural safety requires healthcare professionals and their associated healthcare organisations to examine themselves and the potential impact of their own culture on clinical interactions and healthcare service delivery. This requires individual healthcare professionals and healthcare organisations to acknowledge and address their own biases, attitudes, assumptions, stereotypes, prejudices, structures and characteristics that may affect the quality of care provided. In doing so, cultural safety encompasses a critical consciousness where healthcare professionals and healthcare organisations engage in ongoing self-reflection and self-awareness, and hold themselves accountable for providing culturally safe care, as defined by the patient and their communities, and as measured through progress towards achieving health equity. Cultural safety requires healthcare professionals and their associated healthcare organisations to influence healthcare to reduce bias and achieve equity within the workforce and working environment." (Curtis et al, 2019)

What cultural safety isn't

Sometimes it is helpful to say what cultural safety is not.

Not cultural safety	Reasons
Treating everyone the same	People are not all the same, even if they are all from the same culture. Treating everyone the same makes health inequities worse, not better.
A checklist	There is no predetermined list of things to do when you work with a person from a particular culture. You may offer to work in a particular way, or give people ideas to choose from, but you still need to be guided by the people and whānau you are working with.
Learning about other cultures	While it is helpful to know things about cultures, it is not sufficient for cultural safety as this can lead to assumptions about appropriate behaviour with other cultures. You still need to be guided by the people and whānau you are working with, rather than assume that culturally safe care will be based on their culture or ethnicity.
Coming from the same ethnic group	Working with people and whānau from the same culture as you is not a guarantee that you will provide culturally safe care as what you each value and believe may be different (and in any event people and whānau are from multiple cultures).

Speaking the same first language	This is similar to the point above. You and the people and whānau you are working might both be speaking English but that is no guarantee that you share the same values and beliefs, and will therefore provide culturally safe care.

What about cultural competence?

New Zealand's regulated health care staff have had to be trained to be culturally competent for nearly 40 years. The purpose of cultural competence training was to improve the health equity outcomes and experience for Māori. Equity recognises that different people have different levels of advantage in the health system. This means that healthcare services and staff need to use different approaches and resources to ensure that people with less advantage still achieve equitable health outcomes.

So, while cultural competence training may mean that more mainstream health care organisations use karakia to open and close meetings and sing waiata, and staff have learnt how to introduce themselves in te reo Māori, the health outcomes for Māori have not improved but have in fact worsened (Curtis et al, 2019).

Partly this has been because poor practices have become part of cultural competence e.g. suggesting health professionals can learn about other cultures and then use checklists to assist them when working with people from a particular culture. Activities such as these support negative perspectives (e.g. that all people from one culture have the same beliefs and needs) and increase health inequities.

History of cultural safety

Cultural safety is a term that was developed in New Zealand by the late Dr Irihapeti Ramsden. Dr Ramsden brought about a revolution in the way the health system considers the cultural contexts of the people the health system is meant to serve.

In the 1980s, Dr Ramsden developed *Kawa Whakaruruhau (Cultural Safety in Nursing Education)* which was ground-breaking and controversial.

Dr Ramsden "consistently argued for the need to address the ongoing impact of the historical, social and political processes on Māori health disparities" (Ramsden, 2003).

Medical Council's Statement on Cultural Safety

In October 2019, the Medical Council of New Zealand published a Statement on Cultural Safety to replace a previous requirement about cultural competence (Medical Council of New Zealand, 2019).

The Council's definition of cultural safety can be summarised in two key aspects. Doctors need to:

1. be aware of how their own culture and biases impacts on the quality of care that doctors provide
2. reflect on, and then change, what they do with the aim of improving the quality of care they provide.

The Statement acknowledges that becoming a culturally safe doctor takes time. While the Statement specifically refers to doctors, the principles and definition also applies to all staff working in healthcare in New Zealand.

The key points in the Statement of Cultural Safety:

1. Cultural safety focuses on the patient experience to define and improve the quality of care. It involves doctors reflecting on their own views and biases and how these could affect their decision-making and health outcomes for the patient.
2. The Medical Council has previously defined cultural competence as "a doctor having the attitudes, skills and knowledge needed to function effectively and respectfully when working with and treating people of different cultural backgrounds". While it is important, cultural competence is not enough to improve health outcomes, although it may contribute to delivering culturally safe care.
3. Evidence shows that a competence-based approach alone will not deliver improvements in health equity.
4. Doctors inherently hold the power in the doctor-patient relationship and should consider how this affects both the way they engage with the patient and the way the patient receives their care. This is part of culturally safe practice.
5. Cultural safety provides patients with the power to comment on practices, be involved in decision-making about their own care, and contribute to the achievement of positive health outcomes and experiences. This engages patients and whānau in their health care.
6. Developing cultural safety is expected to provide benefits for patients and communities across multiple cultural dimensions which may include indigenous status, age or generation, gender, sexual orientation, socio-economic status, ethnicity, religious or spiritual belief and disability (Papps and Ramsden, 1996). In Aotearoa/New Zealand, cultural safety is of particular importance in the attainment of equitable health outcomes for Māori.

1. Becoming aware of how biases impact on the quality of healthcare provided

This is the first aspect of the New Zealand Medical Council's definition of cultural safety.

What is a bias?

A bias is when we hold predetermined beliefs about a person or a group that show positive or negative prejudice. Biases are part of the way we view the world and often only change slowly over time.

From the time we are born, we learn and take on beliefs and values about the world. We get most of our beliefs and values from our family, friends and the media as well as our own lived experiences.

Every person has developed biases as part of their upbringing (and the messages in our environment, including the media). This may cause staff to act in a culturally unsafe way when someone from a particular group accesses health care.

We have biases and beliefs relating to many things such as age, gender identity, employment, culture, hobbies and interests, religion, family background, health conditions, political affiliations, behaviours and actions.

Your biases act like 'shortcuts' and affect your thinking and actions, especially in situations where you are under pressure or in a new or complex situation. Health care staff are likely to be in all those situations.

Our reactions are also affected by our immediate needs and feelings, for example:

- if we are having a good or bad day
- if we feel scared or confused or confident
- how much time we have
- how tired or hungry we are
- if we have something else we are worrying about
- how well we know the people involved
- previous experiences in a similar situation
- if we are at work in a professional environment.

Our biases and immediate needs and feelings can strongly influence our reactions and behaviours in a situation. These reactions and behaviours can create a barrier when trying to relate to someone, both because our reactions and behaviours **affect our interpretation of what is actually happening** and because our reactions and behaviour can **stop people from sharing with us**.

All people working in health care need to be aware of their biases and the distractions in their immediate environment. Trying to keep their biases and distractions out of their reactions and behaviours when listening to and talking with others can help them hear what others are really saying, and establish a relationship.

Understanding our biases is an essential part of cultural safety. It is our biases which make us feel uncomfortable in new or unfamiliar situations. If you understand your biases then you will be able to feel uncomfortable and not react badly.

Your language shows your biases

Health care staff can show their biases by the language they use. Using words such as non-compliant, non-adherent, morbidly obese, targeted and uncontrolled diabetes to describe people shows biases against people who do not do what health care services and staff expect them to do.

This language is used regularly in health care settings because it focuses on service definitions and treatments, but the language is not patient or whānau-centred. However, while all these terms are meaningful to health services, the terms show a bias and stereotype, and judge people.

The following is an article that appeared on the Stuff website (Broughton, 2021).

"It's been a huge journey: Urologist says racist comments have led to change

"A Christchurch urologist says racist comments he made at a conference in Queenstown diminished the mana of a Māori man who was present – but the incident resulted in a journey of reconciliation (Broughton, 2021).

Peter Davidson, 63, said he took part in a debate at an Urological Society of Australia and New Zealand (USANZ) conference in November 2020 about whether Māori men's reluctance to undergo a digital rectal examination prevented them from being screened for prostate cancer.

"I hugely regret those comments and if I could take back those five minutes, believe me I would."

Hamilton-based regional Māori health manager Rawiri Blundell was the only Māori person in the audience of about 200 people, and filed a complaint following Davidson's comments.

Blundell's complaint stated Davidson said many Māori were in prison and could not access screening – but this should not be a problem "as there is so much rectal probing, so 'they' could do their own examinations".

Blundell, who is a member of Māori cancer group Hei Āhuru Mōwai, was scheduled to present on his work supporting Māori men with prostate cancer and their whānau immediately after the debate.

Davidson said on Friday he realised his comments had been harmful as soon as Blundell got up to give his presentation.

"I don't set out to hurt or offend people. The reality of this is that I did, and I guess firstly I reduced the mana of a Māori man in the room and I didn't really understand concepts of mana. The bottom line is those comments were considered offensive and I think, correctly so, and I accept that."

Davidson said he apologised to conference attendees and Blundell but, realising this was not enough, he arranged to meet with him in Hamilton.

The pair met for an hour and Blundell explained how Davidson's comments were harmful. A restorative justice hui facilitated by Hei Āhuru Mōwai followed.

"From my perspective I think he was taking in what I had called out – in terms of racist comments," Blundell said of the meeting. Blundell said the conversation and hui was challenging but necessary, and he hoped they would lead to changes for Māori patients at an organisational level as well.

"Change happens with the movers and the shakers within the system and if it doesn't come from the top then we're going to struggle to influence change."

Davidson said he agreed at the hui to work on his unconscious bias over the next 12 months.

He had since signed up to a basic te reo Māori class and had started a course at Otago University aimed at improving the way health practitioners work with Māori.

The course involved readings and podcasts including the book *White Fragility: Why it's so hard for white people to talk about racism* by Robin DeAngelo, and had helped him understand links between individual and organisational bias, Davidson said.

"I've had a privileged life. I've never considered myself racist but actually with that privileged life ... there is ... bias and unconscious racism that's existing there. That is probably part and parcel of the institutional racism that we've talked about a lot with [Hei Āhuru Mōwai] about."

Davidson has agreed to present at the 2021 USANZ conference about his experience and learnings.

"It's been a huge journey."

He said his experience had already changed his practice as a urologist and particularly his approach with Māori patients. "You never, ever think of yourself as being racist but understanding the importance of a connection – particularly with Māori patients – at the start of a consultation is something that is already in place."

Davidson said he was extremely grateful to Hei Āhuru Mōwai for its constructive approach to the incident and praised its work to reduce stark inequities in cancer care and outcomes.

"This group have been trying to address that, and I have immense sympathy for the task ahead of them"."

Questions about Stuff article

- What bias did Dr Davison have about Māori men getting prostate checks?
- How do you think this bias might have affected Dr Davidson's previous treatment of Māori men with prostate cancer?
- What has Dr Davidson identified that contributed to his bias?
- How has this experience changed how Dr Davidson now works with Māori patients?

2. Reflecting and then changing what you do with the aim of improving the quality of care provided

This is the second aspect of the New Zealand Medical Council's definition of cultural safety.

Power relationships in health care

The New Zealand health care system is made up of multiple organisations, and is governed by both formal and informal regulations, clinical and administrative rules for the health care providers that the system funds and the health care staff who work in the system. Access to, and the health services provided, are strictly managed. When a person sees a health professional it is on the understanding that the health professional provides knowledge and expertise, which gives them more status (power) in the interaction. Receptionists also have power in health care environments because they manage access to the clinical team. Even though there have been shifts towards patient-centred and whānau-centred care, the power imbalance in interactions still persist.

Cultural safety means health care staff have to be actively aware of and work to manage the power imbalance, particularly in relation to ensuring timely access to care and navigation of the health system.

Practical guide to working in a culturally safe way

Working in a culturally safe way means identifying and respecting the values and beliefs of the people you are working with, and using these as the basis for working together.

From a practical point of view:

- ask people if they want to start their appointment in a particular way
- ask people if they would prefer to have whānau involved in health discussions
- pronounce people's names correctly - if you are not sure, ask how to pronounce their name and check you are getting it right.
- be prepared to work with people and their whānau if that is what is wanted e.g. respect that the person might nominate a whānau member to speak on their behalf
- greet people appropriately – kia ora
- respect that the person and whānau may see karakia as essential to their safety and wellbeing
- support a person to involve other people who are important to them.

Other things you can do:

- Stop using terms and phrases that reflect bias, (e.g. 'person not following their treatment plan' - we are not yet aware of those reasons).
- Address any barriers that might stop a person or whānau accessing another service that you refer them to "*You will get a phone call or a letter telling you about an appointment at the hospital. What could stop you going to that appointment?*"
- Understand that it can take a long time for a person or whānau to trust you because of their prior experiences with the health and other systems.
- Consider using the Hui Process as the basis for your appointments.

The Hui Process

The Hui Process contains four key elements:

- Mihi
- Whakawhānaungatanga
- Kaupapa
- Poroporoaki.

Mihi: Initial greeting and engagement

- Clearly introduce yourself, your role and the purpose of the meeting to the Māori patient and whānau.

Whakawhānaungatanga: making a connection

- Connect at a personal level with the person and any whānau present. Explain where you come from and where you live now, and then ask the person where they come from and where they live now.
- Keep connecting with the person and whānau throughout the meeting.

Kaupapa: attending to the main purpose of the meeting

- The point in the hui at which the focus moves to setting an agenda and then going through why the person is there and what needs to be done.

Poroporoaki: concluding the meeting

- Make sure you have understood what the person has said.
- Make sure you have been clear.
- Make sure the person is clear about the next steps (for example the date for a follow-up, details of any referrals and so on).

(Lacey et al, 2011)

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