

Cultural Safety: An Overview

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for the
First Nations, Inuit and Métis Advisory Committee
Mental Health Commission of Canada

06 April 2010

ABSTRACT

This report provides a critical exploration of the notion of ‘cultural safety’ as it pertains to health care and Indigenous health. The notion of “cultural safety” is a relatively new concept that has its origins within the Maori nursing education context of New Zealand. Over the last decade, this concept has transcended national boundaries and increasingly gained international influence across a variety of professional and political organizations and associations concerned with redressing health inequities and achieving social justice. Firmly positioned within the paradigm of critical theory, the concept of cultural safety is used here as an interpretive lens to focus attention on social, structural and power inequities that underpin health inequalities/disparities – it prompts a moral and political discourse/dialogue. Cultural safety is, therefore, not about ethnocultural practices, rather it highlights the need for the development of critical consciousness toward the power differentials inherent in the health care system as well as the broader socio-historical and political factors that shape health care and Indigenous health. Guided by the lessons learned from the New Zealand experience in implementing cultural safety into nursing education and critical- oriented knowledge derived from recent research on cultural safety outside its original context, this report critically discusses how to bring this agenda into relief in all areas of practice – clinical, education, research and policy.

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DRAFT

1: INTRODUCTION

The notion of “cultural safety” is a relatively new concept that has its origins within the Maori nursing education context of New Zealand. Over the last decade, this concept has transcended national boundaries and increasingly gained international influence across a variety of professional and political organizations and associations concerned with redressing health inequities and achieving social justice. But why its popularity, and what is it that cultural safety promises us?

This document provides a critical exploration of the notion of cultural safety as it pertains to health care and Indigenous¹ health. We begin the report with an overview of cultural safety, its origin and evolution and it how has been used outside its original context. We then describe its theoretical foundations and defining features as well as its implications for clinical practice, education, policy and research by drawing on the lessons learned from the New Zealand experience and critical-oriented knowledge derived from recent research.

¹ In this document, we use the designation *Indigenous* interchangeably with *Aboriginal*. We use these designations as consistent with the terminology used by the Royal Commission on Aboriginal Peoples (1996). The term Aboriginal peoples refers generally to the Indigenous inhabitants of Canada, including First Nations, Inuit and Métis peoples without regard to their separate origins and identities. The Commission stresses that the term Aboriginal people “refers to organic political and cultural entities that stem historically from the original peoples of North America, rather than collections of individuals united by so called ‘racial’ characteristics. The term includes the Indian, Inuit and Métis peoples of Canada (see section 35(2) of the Constitution Act, 1982)” (p. xii). Specifically, the term “First Nation” replaces the term “Indian” and “Inuit” replaces the term “Eskimo”. The terms Indian and Eskimo, however, continue to be used in federal legislation and policy, for example, the *Indian Act*, and in government reports and statistical data, particularly those generated by the federal department of Indian and Northern Affairs Canada (INAC). INAC retains the terms “status” or “registered Indian” to refer to people who have been registered by INAC as members of a First Nations under the terms of the Indian Act. When distinctions between Aboriginal groups are needed, specific nomenclature is used.

2: BACKGROUND

The concept of cultural safety emerged out of concern with structural inequities by Indigenous Maori nurse leaders within the postcolonial context of Aotearoa/New Zealand in the late 1980s (Anderson et al., 2003; National Aboriginal Health Organization (NAHO), 2008; Papps & Ramsden, 1996; Ramsden, 1990; 2000). Linking the poor health outcomes of Maori people, in part, to the cultural inappropriateness and insensitivity of health services, Ramsden (1990; 2000) developed cultural safety as a critical lens through which to examine health care interactions between the Maori and service providers (primarily descendants of European settlers) (Anderson et al., 2003). This reasoning stemmed from experiences and observations by Maori and non-Maori providers and researchers that, similar to Canada's Indigenous population, Tangata Whenua (the Indigenous peoples of New Zealand) tend to not use mainstream health care services, present at advanced stages of disease progression, show "non-compliance" and often drop out before the end of treatment (Browne & Fiske, 2001; McCormick, 1996; 1998; McGrath & Phillips, 2008; Nguyen, 2008; O'Neil, 1993; Smye & Mussell, 2001; Smye, 2004; Wilson, 2008). Cultural safety was designed to draw attention to the power imbalances between Maori and the dominant health care culture, which historically disregarded the illness and health belief systems of Maori and instead privileged those of the Pakeha or White culture (Ramsden, 1990; 1992; 1993; 2000). Under the premise that cultural safety in clinical practice would improve health outcomes for Maori, the Nursing Council of New Zealand formally adopted cultural safety into nursing curricula and state examinations for nurses and midwives in 1992 (Nursing Council of New Zealand, 2005).

Since then, cultural safety has continued to be a powerful nursing concept (e.g., Anderson, Perry, Blue, Browne, Henderson, Khan, et al., 2003; Smye & Browne, 2002; Wepa, 2005) but scholarly contributions from other fields, such as medicine (e.g., Crampton, Dowell, Parkin, & Thompson, 2003; Indigenous Physicians Association of Canada & the Association of Faculties of Medicine of Canada (AFMC), 2009; Kearns, 1997; Nguyen, 2008); occupational therapy (e.g., Gray & McPherson, 2005; Jeffery, 2005; Nelson, 2007); physiotherapy (e.g., Haswell, 2002; Main, McCallin, & Smith, 2006); social work (e.g., Fulcher, 2001; 2002); sociology and anthropology (e.g., Brascoupe and Waters, 2009); education (e.g., Koptie, 2009); and, pharmacy (e.g., Stoneman & Taylor, 2007), demonstrate that cultural safety has permeated a spectrum of health and social disciplines.

Although cultural safety as originally conceptualized by Ramsden (1990) is based on the notion of biculturalism (Maori and non-Maori), several authors convincingly assert that the concept of cultural safety also retains significance for multicultural contexts because the experience and effects of colonization on health transcend geographical and political boundaries (Anderson et al., 2003; Reimer Kirkham, Smye, Tang et al., 2002; Smye, 2004). A few scholars have explored its applicability to the health care contexts in the United States (McCubbin, 2006) and the United Kingdom (Cortis, 2008; De & Richardson, 2008; Hart, Hall, & Henwood, 2003). However, the majority of international scholarly contributions originate from Australia and Canada.

While cultural safety is gaining influence among Australian regulatory authorities and educational institutions in nursing (Australian Nursing & Midwifery Council, 2009; Morgan, 2006; Nelson, 2007; Sherwood & Edwards, 2006), there is still considerable

divergence in opinions within the Australian health care context as to whether or not cultural safety is compatible with Australia's multiculturalism (Edwards & Taylor, 2008; Ganguly, 1999; Johnstone & Kanitsaki, 2007a; Johnstone & Kanitsaki, 2007b; Johnstone & Kanitsaki, 2008; McGrath & Phillips, 2008; Morgan, 2006; Nash, Meiklejohn, & Sacre, 2006; Nguyen, 2008; Raymond, 2008).

In contrast, within Canada, cultural safety has been taken up in various ways in health discourses affirming the transportability of cultural safety to a multicultural policy context. However, while cultural safety has been applied across diverse populations and social groups (Anderson et al., 2003; Baker, 2007; Ogilvie, Burgess-Pinto, & Caufield, 2008), the primary focus in Canada has been on cultural safety in relation to First Nations health care (Barkwell, 2000; Browne, 2003; Browne & Smye, 2002; Browne & Varcoe, 2006; Dion Stout & Downey, 2006; Jensen-Ross, 2006; MacLeod, Browne, & Leipert, 1998; Smye, 2004; Smye & Browne, 2002; Smye et al., 2006).

Advocacy for the implementation of cultural safety into health education and clinical practice reaches from national Aboriginal health and political organizations across professional associations to government. For example, in Canada, both the Assembly of First Nations (AFN) and the National Aboriginal Health Organization (NAHO) officially endorse the practice of cultural safety by health care professionals as a means to improve the health status of First Nations, Inuit and Métis (AFN & NAHO, 2008).

In addition, Canada has undertaken critical steps toward moving cultural safety into education. For example, in 2008, NAHO released a guide for health care administrators, providers and educators, which provides a working definition of culturally

safe practice and programming. Likewise, in partnership with the Association of Faculties of Medicine of Canada (AFMC), the Canadian Association of Schools of Nursing (CASN), the Canadian Nurses Association (CNA), and the Indigenous Physicians Association of Canada (IPAC), the Aboriginal Nurses Association of Canada (ANAC) have generated frameworks for medical and nursing curricula to teach students and faculty how to build competency in cultural safety (ANAC et al., 2009; IPAC & AFMC, 2009). These efforts are supported by Health Canada through a five year Aboriginal Health Human Resources Initiative (AHHRI) (2005/06-2009/10), which provides funding to increase, and retain, the number of post-secondary educational institutions with cultural safety curricula (ANAC et al., 2009; Chiefs of Ontario Office (COO), 2008).

However, deriving from experientially-grounded reflection by nurses, rather than from academic theorizing (Polaschek, 1998), cultural safety has been subject to ongoing theoretical and methodological criticism (Ramsden, 2000; Johnstone & Kanitsaki, 2007a; Johnstone & Kanitsaki, 2007b; Johnstone & Kanitsaki, 2008). As a result, proponents of cultural safety have continued to redefine cultural safety and, at the same time, maintain, the overall significance of cultural safety for moving toward transformative change and social justice (Anderson et al., 2003; Browne, Varcoe, Smye, Reimer-Kirkham, Lynam, et al., 2009; Kirkham et al., 2002; Papps & Ramsden, 1996). Therefore, the concept of cultural safety presented in this report is a synopsis of the evolution of cultural safety since its inception in 1989.

3: INTERPRETING & READING CULTURAL SAFETY

3.1 Theoretical Foundations

Because cultural safety challenges the ways in which the culture of the dominant group has redefined local meanings and dictated race relations within the context of New Zealand's health care delivery system, cultural safety has been linked to postcolonial theorizing (Anderson et al., 2003; Papps & Ramsden, 1996). Central to post-colonial scholarship are the deconstruction of current socio-historical and political conceptions of 'race' and 'culture' to unmask colonizing practices and neocolonial relations. Both the notion of race and culture are deeply enmeshed in contemporary health discourses. Anderson (2003), for example, critically discusses how dominant culturalist² frameworks in the domain of health care conflate culture with racial markers, such as physical characteristics and visible appearances of certain ethnic groups. Simplistic representations of culture reinforce negative stereotypical conceptualizations of the "Other" and divert attention from the structural inequities that disadvantage certain groups of people based upon their culture (Browne & Smye, 2002; Browne & Varcoe, 2006; Nguyen, 2008).

Examining issues of health and health care within the context of culture from a post-colonial vantage point requires culture to be understood as "a complex network of meanings enmeshed within historical, social, economic and political processes" (Anderson & Reimer Kirkham, 1999, p. 45, as cited in Smye and Browne, 2002). Cultural safety

² Culturalism refers to the process of viewing people through the lens of culture, defined narrowly as shared values, beliefs and practices (Browne, Varcoe, Smye, Reimer-Kirkham, Lynam et al., 2009). In the case of Aboriginal people, 'culture' thus defined operates as the primary explanation for why groups experience various health, social or economic problems such as, for example, poverty, substance use, low birth weight. This is problematic because the issues of social determinants of health, or the root causes of health inequalities/disparities, are viewed as necessarily linked to peoples' culture, when in fact, they are part of the colonial history of Canada, and ongoing inequitable social relations.

draws on this latter notion of culture. In doing so, cultural safety moves beyond traditional notions of cultural awareness, sensitivity and competence (ANAC et al., 2009; Carberry, 1998; IPAC & AFMC, 2009; Papps & Ramsden, 1996; Polaschek, 1998; Smye et al., 2006). Although awareness of cultural beliefs, values and practices by health care providers and researchers can promote cultural sensitivity (Smye & Browne,, concerned with understanding health beliefs and practices of different ethnocultural groups, cultural sensitive or competent care approaches tend to omit a critical analysis of the influential social structures within which all health care interactions take place (Cooney, 1994; Coup, 1996; Polaschek). In fact, some have argued that Western notions of culturally sensitive or congruent care associated with the U.S. transcultural nursing movement are not only inadequate but “may well reinforce the very problem of paternalistic and ethnocentric care...[they] seek to redress” (Bruni, 1988, p.31). Pointing to the intra-cultural differences among Maori, Ramsden (1990) explains the objective of nursing schools to create experts in Maori culture would be “an extension of the colonial process” since a legacy of colonialism is that many Maori themselves lack knowledge of their own cultural identity and traditions (p.19).

As a progression of this argument, that culture cannot be narrowly defined in terms of static and essentialized categories (Coup, 1996; Varcoe, 2004), cultural safety has been further developed to extend the notion of culture to include intersections of gender, class, race, age and other social relations (Papps & Ramsden, 1996). Informed by critical feminist theoretical perspectives, proponents of cultural safety have proposed “the rewriting of cultural safety within a postcolonial-postnationalist feminist scholarship that transcends the boundaries of race and nationalism, to emphasize realignments that expose our common

humanity and vulnerabilities” (Anderson et al., 2003, p. 198). The authors conclude that the concept of cultural safety when refracted through the lens of a critical postcolonial-postnational feminist discourse opens up a new window for dialogue by creating hybrid, cultural spaces that speak to all cultures.

3.2 Defining Cultural Safety

A central tenet of cultural safety is that those people who receive the care decide what is culturally safe or unsafe (Papps & Ramsden, 1996) – shifting power from providers to consumers of health care (Kearns & Dyck, 1996; 1997). In line with this view, culturally safe practice has been defined as those actions that “recognize, respect and nurture the unique cultural identity of tangata whenua and safely meet their needs, expectations and rights” (Whanau Kawa Whakaruruhau, 1991, p.7). On the other hand, cultural risk or unsafe practice occurs when actions “diminish, demean and disempower the cultural identity and well being of an individual” (ibid).

To achieve cultural safety when working with Aboriginal peoples, several core competencies have been identified. First, there is strong agreement that culturally safe practice necessitates an *understanding of colonization and post-colonial forces* and their affect on the lives of Aboriginal peoples (Smye, 2004; Smye & Browne, 2002; Smye et al., 2006; Kirmayer et al., 2009). In particular, this would involve recognizing the role of social determinants of Aboriginal health and the relationship between residential school experience and historic trauma transmission and their resultant intergenerational health outcomes (ANAC et al., 2009; Smye; Smye & Browne). It also includes knowledge of how historical and current government practices towards Aboriginal peoples have mediated and perpetuated health disparities and inequities among First Nations, Métis and Inuit (IPAC &

AFMC, 2009). Second, cultural safety requires commitment to the key principles that are driving the Indigenous health movement, such as reciprocity, inclusivity, respect, collaboration, community development and self-determination (Dion Stout & Downey, 2006; IPAC & AFMC; Wilson, 2006). This means a focus on *relationship-building* and *collaboration* with Aboriginal community contacts and support structures *inclusive* of elders, families and health care professionals (traditional/medicine peoples/ healers) (NAHO, 2008). In the Canadian context, it also includes *respect* for the unique histories, cultures, languages and social circumstances manifest in the diversity of First Nation, Inuit and Métis communities and peoples (ANAC et al., 2009). Third, central to cultural safety is the concept of *culturally safe communication and language* (ANAC; De & Richardson, 2008). As Willis, Rameka and Smye (2006) remind us, like ‘culture’, ‘language’ is a fluid and dynamic concept that is enacted relationally through a number of contextual features, such as history and social position, “with similar potential for negative consequences for Indigenous peoples” (p.142). For example, names used for Aboriginal peoples (e.g. First Nations; Indigenous etc.) can be understood as an act of identity, a political act or racism depending on the identity of the speaker (e.g., Indigenous vs. non-Indigenous) and the context (e.g., Canada vs. Australia). Language can be perceived as symbolic for power differentials between people (Smye et al., 2006). For example, the use of technical jargon by health care professionals increases the social distance between provider and client undermining a trust and safety (NAHO, 2008). And lastly, culturally safe practice involves the recognition of *Indigenous knowledges and practices* with respect to health and wellness of First Nations, Inuit and Métis and their inclusion as legitimate intervention options (ANAC et al., 2009; IPAC & AFMC, 2009; Smye & Browne, 2002; Wilson, 2008).

4: PRACTISING CULTURAL SAFETY

Cultural safety reminds us that it is incumbent on all of us involved in health care including practitioners, educators, researchers and policy makers to critically self-reflect_ to consider if our attitudes and actions may place others at risk for cultural harm (Smye et al., 2006). However, as Dion Stout and Downey (2006) warn, “too much can be taken for granted when a perceived panacea like cultural safety emerges” (p.327). If cultural safety is to live up to its promises, strategies to rectify our approaches will have to be taken across several dimensions of health care– education, clinical, research and policy (Smye et al.).

4.1 Education

Cultural safety is predicated on the idea that the education of service providers can redress health inequities by shifting provider attention from the individual to the power differentials inherent in the health care system and in the educational structures (Nursing Council of New Zealand, 2005; Ramsden, 2000; Spence, 2001; 2005; Wood & Schwass, 1993). According to Ramsden (1990), a crucial factor in the emergence of the concept of cultural safety was the experience of Maori nursing students who perceived the process of moving through nursing education as a very real and potentially dangerous assault on their Maori identity. Similarly, pedagogical approaches and curricula content of Canada’s educational institutions have been dominated by Western and bio-medical approaches, placing Aboriginal nursing and medical students and teachers and, by extension, Aboriginal people who will seek their services, at cultural risk. These ideological underpinnings are, in part, manifested in the observed need to increase and

retain an increased number of First Nation, Inuit and Metis people in nursing and medical programs in Canada (Gregory & Barsky, 2007; NAHO, 2008).

Thus, cultural safety calls for educational institutions to commit to the creation of culturally safe learning environments and curricula changes that will foster the attainment of core competencies for cultural safe practice by Aboriginal and non-Aboriginal graduates and faculty (ANAC et al. 2009; IPAC & AFMC, 2009). Ensuring safe passage through nursing, medical and other health care professional programs entails the academic and personal mentoring and support of students, and an environment of equal engagement between different ways of knowing, including mechanisms for safe feedback of students' experience in moving towards degree completion (ANAC). Students and faculty alike are more likely to experience satisfaction when classrooms provide safe spaces for dialogue and respectful learning encounters (ANAC; NAHO, 2008). Such an environment requires curricula changes to contemporize the concept of 'culture' as it is currently taught (ANAC) and to assist Aboriginal and non-Aboriginal students to develop a relational understanding of culture, which acknowledges that we are all "bearers of culture" (Varcoe, 2004). A *best-practice* curriculum would raise critical consciousness regarding the dominance of the bio-medical paradigm in health by exposing students to the failures of current health policy and practice to meet the most pressing needs of Indigenous peoples.

In nursing schools in New Zealand, some of these changes included the incorporation of racism awareness training and Maori rights for educators and students, a broad base of courses that draw from different disciplines, such as sociology, politics and history as well as a opportunities to visit and interact with Indigenous communities

(Ramsden, 1993). On this point, several authors have discussed the concept of cultural immersion programs as a creative and innovative teaching-learning project (Arnold, Appleby, & Heaton, 2008; Crampton et al., 2003; Human Capital Strategies, 2005; Jones, Bond, & Mancini, 1998; Kavanagh, 1998). However, while engagement and collaboration with First Nation, Inuit and Métis communities can present a very rich learning experience for both students and communities (Kavanagh) and may also contribute to the presence and retention of Aboriginal students (Human Capital Strategies, 2005; Newson, 2009; Thomas, 2008), more critical voices caution that some immersion programs do not necessarily foster cultural safety (Meyst, 2005) and in fact might place Aboriginal communities, which are hosting the students, at risk for cultural harm (Crampton et al., 2003).

Instead, changing underlying attitudes toward an ethical commitment to cultural safety, means for many students, a complex and challenging process of self-exploration that requires a critical analysis of the student's value system (Wood & Schwass, 1993) along with an understanding of the historical and contemporary contexts of Aboriginal peoples lives (ANAC et al. 2009; IPAC & AFMC, 2009). Recognizing the need for a pedagogical framework that can guide educators' choice of teaching strategies when dealing with a diverse class of students, Wood and Schwass developed a three-stage teaching model for promoting attitude change. This framework suggests a combination of teaching strategies with an initial emphasis on support to encourage the value clarification towards a gradual process of challenging existing attitudes or values (Wood & Schwass) by exposing students to alternative epistemological and ontological foundations, such as Indigenous worldviews (ANAC). From a cultural safety perspective,

exposure to this knowledge is seen as imperative to develop the competency of students to engage in culturally safe health care interactions with First Nation, Inuit and Métis communities, and adopt a role as advocates *with* Aboriginal people for transformative change.

Within practice settings, the use of cultural safety for drawing attention to and prompting critical reflection on current racializing practices and discourses adds another layer of complexity. Browne et al. (2009), for example, discovered that without an adequate framework for engaging with practising nurses in critical dialogue as part of knowledge-translation, there is considerable risk that ‘cultural safety’ is read in ways that align with conventional understandings of ‘culture’ and ‘patient safety,’ reproducing the very culturalist discourses that are supposed to be at the centre of critique. Drawing on their realization that translating critically-oriented knowledge first requires fostering an understanding of the critical conceptualization of culture that is foundational to cultural safety, the authors propose a social justice curriculum in which cultural safety could serve as a conceptual entry point for discussion (Browne).

4.2 Clinical

As an outcome of nursing education, cultural safety is intended to foster the development of a workforce that is self-reflective, open-minded and non-judgmental (Ramsden, 1992). Critical self-reflective practice means that the practitioner is able to identify the values, beliefs and assumptions guiding the practitioner’s thinking and actions and that the practitioner is able to then engage in practice that reflects an understanding and respect for what the patient and family believe is important to healing, health and well-being (Smye, Rameca & Willis, 2006). Given the stark contrast between

the Western biomedically-centered understandings of health and many Indigenous worldviews, which support holistic concepts of health and illness, health care providers who are only attending to the physical aspects of the illness without exploring the socio-cultural dimensions that impact health and well-being, run the risk of hindering positive health experiences and outcomes (Wilson, 2006). Barkwell (2000), for example, found that the disjuncture between bio-medical understandings of cancer and pain by health care providers and Ojibway conceptualizations undermined the cultural integrity of Ojibway peoples.

In addition, in a slightly different vein, Browne and Fiske (2001) found that Aboriginal women often experienced racialized and gendered stereotyping and discriminatory attitudes when accessing routine health care, with the unfortunate result that many Aboriginal people waited until their health conditions were severe before accessing primary care. For many Aboriginal people who live with mental health and addictions issues, these experiences are heightened through the layering of persistent stigma toward mental illness and the widespread stereotype of what Furniss (1999) identified in her research as, the “drunken Indian.” This is particularly problematic as many Aboriginal mental health issues are a direct or indirect manifestation of residential school trauma or historic trauma transmission which has often resulted in severe trust issues, feelings of social alienation and loss of identity (Kirmayer, Tait, & Simpson, 2009). Interventions and institutions designed according to Western bio-medical models of care, often risk re-traumatizing people and thus present extremely unsafe conditions for many Aboriginal peoples (Josewski, 2009; Smye, 2004; Smye & Browne, 2002; Smye & Mussell, 2001).

The ability of the health care provider to deconstruct power imbalances inherent in mainstream professional-client relationships is essential for establishing therapeutic relationships that are characterized by understanding, trust, respect, honesty and empathy (Kearns, 1997; Ramsden, 1992). Thus, excellence in relational practice is key to cultural safe practice (Smye et al., 2006) and includes a willingness to negotiate and share decision-making power with patients and their families by attending to issues of difference without giving way to essentializing and stereotyping (Kearns; Ramsden; Smye et al.). Notably, for redressing health inequities, cultural safe practitioners have to move beyond the critical self-reflective to engage in actions that address the broader sociopolitical and economic determinants of Indigenous health and challenge the taken-for-granted processes and practices that continue to marginalize Indigenous voices and needs (Smye et al.). This demands not only demonstrated knowledge about how contemporary lives of Indigenous peoples have been affected by colonialism and recognition of traditional healing knowledge but also advocacy and the creation of multiple clinical pathways for clients that extend beyond biomedical models of treatment.

Being built upon the premise that it is the recipient of care who determines what is culturally safe practice (Ramsden, 1992), evaluation of clinical practices and cultural safety would, by definition, include the those perspectives. However, while there is a body of literature and research demonstrating the adverse effects on health secondary to ethnocentrism and racism (British Columbia Royal Commission on Health Care and Costs., 1991, Royal Commission on Aboriginal Peoples (RCAP), 1995; 1996) there is a paucity of research into the efficacy of cultural safety (Wilson, 2008) and limited evidence that focuses on facets of cultural safety in nursing (Wepa, 2003; Simon, 2004).

This is particularly concerning in the light of one recent study from New Zealand that found that after 15 years of cultural safety education in nursing schools, the experience of cultural risk of Maori women when accessing mainstream health services is still pervasive (Wilson).

4.3 Policy

Cultural safety also provides us with a much needed critical cultural lens for examining health policy (Smye et al., 2006). For example, Smye and Browne (2002) used cultural safety as an interpretative lens for analyzing how “taken-for granted” processes and practices related to mental health policy continue to marginalize Aboriginal voices and needs. In Smye’s (2004) dissertation study, she explores this theme in-depth concluding that an embedded assimilationist ethos and the predominance of psychiatry in the mental health system continue to perpetuate and reinforce mental health policies that place Aboriginal people at risk of not having their needs addressed. Other studies used cultural safety as a framework to show how current policies and practices are failing to respond to the intergenerational trauma of residential school experiences and related histories of violence, placing many Aboriginal peoples at continued risk for cultural harm (Smith, Varcoe, & Edwards, 2005; Smith, Edwards, Martens, & Varcoe, 2007). Together these studies and others highlight the opportunity to promote social justice and health equity by the adoption of a cultural safety lens in addressing health policy and service delivery (Lynam & Young, 2000; Smye et al., 2006).

While there seems to be a broad base of support for the integration of cultural safety into health care planning and delivery among Canada’s leaders in Aboriginal health, very few health authorities have, in fact, adopted a cultural safety framework, and

little is known about how the health reform is perceived by Aboriginal peoples. In Josewski's (2009) master's thesis, cultural safety served as a tool for analyzing Aboriginal mental health reform within the context of one of British Columbia's health authorities. This analysis revealed how neo-liberal-infused funding schemes and a corporate decision-making hierarchy have in fact fostered the disintegration of community-based Aboriginal mental health and addictions services and continue to marginalize Aboriginal voices within mental health policy and programming. Drawing on insights gained from their own research, Fiske and Browne (2008) concluded in much the same way that unless "[health policy reform] is accompanied by a significant shift in socio-economic power structures, critical awareness of the power discourse, and consciousness of the colonial legacy that underpins notions of reform and consultation ... many Aboriginal women, discredited as medical subjects, will find policy itself a barrier to their well-being" (p.2).

To foster critical consciousness regarding the failure of current health policy to meet the most pressing health concerns of Indigenous peoples and to raise accountability, Smye et al. (2006) advocate for recruiting policy decision-makers as collaborators into research projects and inviting them to health forums and discussion where there may be implications for policy as part of knowledge translation strategies.

4.4 Research

Querying what is moral and just also includes interrogating the assumptions and consequences of our research. Reflecting colonial values and beliefs of Western superiority, the large majority of health research has, for example, been done *on* instead of *with* Aboriginal peoples resulting in either inaction or poorly designed policy or

programs (First Nations Centre, 2007). Tuhiwai Smith (1999) suggests that the cultural formations of Western research draw on ideas that classify Aboriginal peoples as the “Others” and marginalize Aboriginal ways of knowing. Coloured by predominant Western disciplines and scientific paradigms, research often has been used to ‘prove’ the cultural deficiency or inferiority of the Aboriginal ‘race’ relative to the standards set by the dominant Western society. By and large, Aboriginal peoples only participated in so far that they were the ‘objects’ of Western research, while non-Aboriginal researchers decided on what information was relevant and how to collect and interpret it. In the absence of Aboriginal input, poor scoring of Aboriginal peoples on such variables as health, economic and social well-being, has directly fed into existing stereotypes and racist ideas of the inferior “other” (Fiske & Browne, 2008; O’Neil, Reading, & Leader, 1998; Smye & Browne, 2002; Wall, 1997). Thus, in research with Indigenous peoples, we need to be vigilant of the ways in which research might be colonizing rather than decolonizing (Tuhiwai Smith, 1999). Such vigilance requires the researcher to engage into an ongoing process of reflexivity and critical reflection related to whose agenda is being served in research, whose voices are included in the data and in which ways Indigenous people will be affected by the research, i.e., will they benefit? (Reimer Kirkham et al., 2002; Schnarch, 2004; Smandych, Lincoln, & Wilson, 1993). Reimer Kirkham et al. (2002), for example, point out that “research, however well intended, can foster feelings of being cultural unsafe if marginalized groups see themselves as targeted for research and constructed as ‘different’” (p.229). Thus, even when the research is firmly positioned within the paradigm of critical inquiry, addressing issues of culture remains a double-edged sword in that the researchers run the risk of engaging in the same

categorizing processes of which we are critical (Razack, 1998; Varcoe, Browne, Wong, & Smye, 2009) Anderson et al., 2003; Browne et al., 2009). To avoid unwittingly replicating culturalist discourses, cultural safety is used to direct researchers to draw attention to both shared experiences of histories of oppression and marginalization as well as to variations in individual experiences by examining expressions of culture in relation to individual's social location (e.g., class, "race", sexuality, or gender) (Dyck & Kearns, 1995; Kearns, 1997; Reimer Kirkham et al., 2002) within the broader socio-historical and political context (Anderson et al., 2003; Lynam & Young, 2000). For example, in a recent study on the intersecting risks of HIV and violence for Aboriginal women, Varcoe and Dick (2008) used a cultural safety framework to navigate the risks of reinforcing culturalist stereotypes by highlighting both the specific impact of colonization and racism on the experience of Aboriginal women as well as the similarities in experiences among rural women regardless of ethnicity.

In keeping with the notion of relational practice within clinical care, culturally safe research demands researchers to acknowledge the power differentials inherent in researcher-participant relationships and to seek ways to redress these through building ongoing partnerships with Indigenous researchers and communities (Battiste, 2000; Duran & Duran, 2000; Tuhiwai Smith, 1999).

5: SUMMARY

The concept of cultural safety has to be understood as both “process and outcome” (Ramsden, 1993 p.6). As a reflexive and interpretative lens (Anderson et al., 2003; Browne & Fiske, 2001) or a moral and political discourse (Smye, 2004; et al., 2006; Smye & Browne, 2002; Browne & Smye, 2002), cultural safety reminds us, in much the same way as Foucault (1973), that health discourses are shaped by political, social, cultural and economic structures, which have historically subjugated certain knowledges and privileged others. By raising a set of ethical questions about how these dominant discourses shape the health care and illness experience and permeate research, institutions, policies and everyday practice, cultural safety “becomes a vehicle for translating postcolonial concerns into praxis” (Smye et al., 2006, p.38) including clinical practice, education, policy and research. Given the historical context of Indigenous health and health care, and relations within the political economy, cultural safety is particularly useful in the area of Indigenous health. However, as Anderson (2004) cautions in relation to research, despite its potential to mitigate social inequities and to promote social justice, if cultural safety is not applied as an inclusive framework and turned into a methodology “for the marginalized, by the marginalized, rather than [a] scholarship that informs both margin and ‘center’” it will be rendered impotent as a tool for social change (Anderson 2004, p. 245).

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