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# EXEMPLAR

# Knowledge for practice: Challenges in culturally safe nursing practice

**RENEE BLACKMAN**
Nurse Practitioner Candidate, CNC Chronic Disease, Mount Isa Hospital and Community Services, Mount Isa, QLD, Australia; BIRC Scholar, School of Public Health Tropical Medicine and Rehabilitation Sciences & Indigenous Health Unit, Mount Isa, QLD, Australia; Australian Rural Leadership Fellow, Mount Isa, QLD, Australia

## ABSTRACT

*Aboriginal people currently remain the most vulnerable and sickest population within Australian society and therefore are frequent users of the Australian health system. In this paper I will discuss the importance of the role of Aboriginal and non-Aboriginal nurses in diminishing the negative ramifications of perceived racism that can be felt by patients. This exemplar will explore an example of perceived racism through the eyes of an Aboriginal nurse. Intrinsic to this exemplar is the role Aboriginal nurses can play as experienced, culturally safe clinicians and educators to their peers; and facilitators of the patient's ability to adequately access and consent to care.*

**KEYWORDS:** Aboriginal nurse; Aboriginal patient; perceived racism; cultural safety; learning; patient journey

## BACKGROUND

It is well established in Australia that the gap between Aboriginal peoples' health and their non-Aboriginal counterparts is worsening (Ring & Brown, 2002). Health services are continually looking for solutions to address the burgeoning gap in health status. This paper presents an exemplar of an Aboriginal nurse's perspective of an Aboriginal patient experiencing perceived racism. It will also briefly discuss how non-Aboriginal health professional staff contributed to, and also learned from the experience.

Aboriginal patients often present to health facilities with chronic co-morbidities and social issues that require intensive interventions. Clinicians expect patients to comply with a set of clinical instructions with the aim of improving their health. For an Aboriginal patient, in addition to those clinical expectations, superimpose a plethora of social issues like overcrowding, isolation, homelessness, racism, language barriers, cultural obligations, unfamiliar and non-committed health professionals, under resourced Aboriginal health services and limited numbers of skilled Aboriginal health professionals. The medical and social welfare picture for an individual becomes very confusing and these commitments, obligations and realities can become one overwhelming complex web (McMurray, 2008).

This maze for the Aboriginal patient alone in the hospital can be intimidating and the chances of total compliance become an illusive pipe dream reserved

for only those who can handle the pace. Enter the limited number of skilled Aboriginal health staff, who while still committed to their patients, are charged with assisting Aboriginal patients and their families to navigate through this labyrinth. In partnership, the Aboriginal health professional and the patient commence a difficult journey for better health that becomes like a 4WD trek through some of Australia's roughest bush trails.

## The journey begins...

A 45-year-old Aboriginal male patient (Mr M) is transferred to a medical ward after a suspected case of infective tuberculosis. He has a past medical history of continual respiratory infection, skin infections, type 2 diabetes mellitus and has disclosed a potentially harmful pattern of alcohol use. He is, according to the notes, being admitted after a history of presenting to the emergency department and not waiting to see a doctor on several occasions prior to this admission. He is very annoyed with his present admission. First impressions with nursing and medical staff are not good and he does not forge a good relationship at the emergency department or on the ward. He is known to the staff from past admissions related to infective exacerbations. The patient has been on the ward for a total of 3 h and has just completed a review with the medical team. This exchange was not valuable and the patient and doctor exchanged insults and threats about complications in relation to tuberculosis. The patient threatens to discharge himself and walk out of the ward.

## The Aboriginal nurse ...

The admitting nursing staff quickly contacts an Aboriginal nurse working in the community to intervene as they recognise the threat to public health if a diagnosis of tuberculosis is confirmed and the patient leaves without a management plan. After receiving the phone referral the Aboriginal community nurse makes a prompt visit to the ward. She meets the patient for the first time, who is being nursed in isolation. The patient is angry and the nurse is met with hostility. It takes a little time to break through the anger to discover that the patient is perceiving a racist attitude due to his delay in admission, his being placed in isolation and the use of barrier method of nursing. He does not wish to see any non-Aboriginal staff at this point.

Through honest communication and 'small talk' the nurse establishes her place in his community so a trusting connection is able to be created. The nurse is able to gain the patient's agreement to stay on the ward until a plan can be negotiated in relation to treatment. A plan is formulated in which the patient can be actively managed in the community with intensive support and education from the Aboriginal nurse and the Aboriginal community controlled health service. In terms of time, the plan has taken 1 h to formulate and all parties (doctors, public health nurses, community services and the patient) are satisfied that a workable plan has been developed.

## The learning opportunity...

Aboriginal nurses can provide the sense of safety an Aboriginal patient needs to feel comfortable in accepting the care that will lead to an optimal health outcome. The perceived racism Mr M felt remained a factor when an Aboriginal nurse first entered the room, in that Mr M remained distressed. However, all concern related to racism became irrelevant once that threat had been removed through the empathetic presence of an Aboriginal nurse (Sanderson, 2000). The Aboriginal nurse was able to feel Mr M's hurt and frustration, she also identified his vulnerability, and recognised Mr M was feeling very ill and stressed. The nurse knew that Mr M was a leader within his family and was distressed because of the loss of control and decision-making power associated with a hospital admission (Wenitong, 2006). Prior to the Aboriginal nurse involvement and intervention there was no evidence that anyone had been consciously aware of the influential factors in Mr M's life that could affect his consent to treatment and his willingness to remain in hospital.

Many Aboriginal people have lost their trust in the 'white system'. The historical mistrust of

services has bred anger, suspicion and hostility toward non-Aboriginal staff, albeit misplaced. In the case of Mr M, this was complicated because he also perceived health interventions, waiting times and isolation as being related to his Aboriginality and not hospital policy in relation to the treatment of tuberculosis (Henry, Houston, & Mooney, 2004).

The practitioners who were involved with Mr M were not overtly racist. However, the outcome was that Mr M had perceived a racist experience. Perceived racism is a factor that can cripple the opportunity for honest and valuable communication between a health care provider and patient. It can mark the beginning of a dishonest and misunderstood relationship that will foster suspicion, contempt and disrespect in future interventions thereby negatively influencing health outcomes for the patient (Chakraborty, McKenzie, Leavey, & King, 2009). The health practitioners at this point must consider the impact of perceived racism on the patient's readiness to receive information and consent to treatment. In the case of Mr M, the decision of the nurses to call an Aboriginal health professional was the principal priority and consequently resulted in the right referral and a successful outcome.

As nurses it is important we can reflect and recognise aspects in the practice of nursing that are unfamiliar. Nursing practice is a life long learning experience and failing to recognise a learning opportunity that could enhance knowledge and skill does nursing a great disservice. Non-Aboriginal nursing staff must recognise instances (like this one) that permit learning from an Aboriginal nurse. In Australia national and state level policies recommend that a workforce that is more inclusive of Aboriginal (Indigenous) Australians would increase opportunities for non-Aboriginal staff to learn about how to improve health delivery to Aboriginal patients and communities (Health, 1999). It is questionable that the nurses in this instance were driven by a desire to alleviate a culturally unsafe situation for the patient. However, when faced with a culturally unfamiliar circumstance, the nurse admitting Mr M utilised her knowledge of a local Aboriginal health support network. She knew that such a network could provide adequate clinical support to hospital staff and community follow-up and support to Mr M in a non-threatening and culturally safe manner.

## Conclusion

The aim of this exemplar is that the reader will be able to reflect on Mr M's hospital admission and those aspects of this case that were successful and those aspects that require more consideration. A number of questions are raised: could a non-Aboriginal nurse alone have made these inroads in building trust with Mr M in the absence of an Aboriginal nurse? Could a non-Aboriginal nurse recognise the cultural misunderstanding, and formulate a plan where everyone was happy? The answer to those questions heavily depends on a number of factors such as nurse readiness to be culturally safe, ability to listen and communicate appropriately. Nurses must also consider how well they know local Aboriginal health support systems and their level of acceptance by the local Aboriginal community. How is this knowledge acquired? There firstly has to be a willingness to learn and seek understanding in becoming more culturally competent (Meyst, 2005). Nurses must also recognise the value of familiarising themselves with local Aboriginal health networks or community members, who can assist in culturally confronting situations, and help nursing contribute to better outcomes for Aboriginal patients.

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