

# CORRESPONDENCE

issue, which reported that chewing gum increased pain and that resumption of a normal diet was delayed.<sup>7</sup>

**Postoperative diet.** This created the most debate in the survey. Thirty per cent of surgeons prescribed a 'normal' diet, and the remainder advised diets ranging around chips, Nik Naks-type snacks, avocados, pawpaws (Natal graduates) and biltong (particularly Gauteng graduates); others advised patients to avoid 'acidic' foods, bananas and fruit juices. Reasons for prescribing the particular diets included 'experience'; 'patients must eat to prevent bleeding'; 'hard things get stuck in the tonsil bed'; and 'acid burns the tonsil bed'. No publications could be found relating to dietary advice.

Tonsillectomy is a commonly performed operation, and has significant morbidity relating to pain, yet peri- and postoperative pain management practices vary considerably, with little evidence to support some of these practices. Cold steel dissection and intraoperative steroids can be recommended, based on our literature review.

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## Cultural safety and family medicine in Africa

**To the Editor:** It took 3 continents and 11 years post-qualification for me to realise that Western medicine's approach to improving health care in Africa may be flawed. The realisation occurred as a result of reading Belfrage's experiences of working within the Aboriginal community in *terra nullius* (Australia's vast inhabited interior) and seeing how, as a doctor of European descent, she and her culture, and the local Aboriginals (*Alyawarr*) and their culture, perceived the world in fundamentally different ways.<sup>1</sup>

I was born in Europe, raised in southern Africa where I studied and worked, decided to further my education abroad, and now reside in Melbourne, Australia. My aim has always been to return to Africa and implement the skills I now have.

Family medicine in Africa differs from that in Europe in that it is generally regarded as not the first point of care, usually takes place in

a district or teaching hospital, and often requires considerable surgical expertise in a resource-poor environment. However, both approaches aim to provide comprehensive and compassionate generalist services within a community context.

Western-trained doctors believe in the scientific approach and disbelieve the supernatural or the anecdotal. We believe in the **germ theory** of many diseases. A doctor's work is linear – history, examination, investigation, diagnosis, treatment. Doctors expect patients to believe and share their world view and act on their advice.

'Cultural safety' is quite different for each approach. This concept was developed in the 1980s in New Zealand in response to the indigenous Maori people's discontent with nursing care. Maori nursing students and the work of I M Ramsden supported 'cultural safety', which upheld political ideas of self-determination and de-colonisation of Maori people;<sup>2</sup> it goes beyond ethnocultural practices, political views or being culturally aware or sensitive. Ramsden and others view these latter terms as a learning process continuum: **cultural awareness** is the starting point involving the understanding of differences; **cultural sensitivity** is intermediate where self-exploration begins; and **cultural safety** is the final outcome.

Rather than emphasising learning about other peoples' diverse cultures, cultural safety requires practitioners to identify their own values, beliefs and assumptions that guide their thinking and actions, and then to engage in practice that reflects an understanding and respect for what the patient and family believe is important to healing, health and well-being.<sup>3</sup> Health practitioners cannot assume that they provide culturally safe care, as only the recipient of care can assess the level of risk or safety that they experience. Cultural safety questions the dictum of 'treating everyone the same' regardless of age, ethnicity or gender. A central tenet of cultural safety is that people receiving the care decide what is culturally safe or unsafe, enabling them to believe that the health care is connected to their lives. They are involved and have choices that are not primarily part of someone else's agenda. Cultural safety is often more concerned with not disempowering people than with empowering them.

Whether family medicine in Africa should adopt this concept in clinical care and teaching needs to be explored. Culturally safe, or appropriate, programmes enhance personal empowerment, so promoting more effective health care service delivery for African people.

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