NURS2003 | INDIGENOUS HEALTH | REFLECTIVE ESSAY SAMPLE

Indigenous Health Nursing Reflection: Cultural Safety, Unconscious Bias, and the Ongoing Impact of Colonisation

A 1,800-word distinction-level reflective essay using Gibbs' Reflective Cycle (1988), exploring a student nurse's encounter with an Aboriginal Elder and its implications for culturally safe, equitable nursing practice in Australia.

1,800 Words | Gibbs' Reflective Cycle | Harvard Referencing | Cultural Safety Framework | AHPRA Standards 2022 | Close the Gap

Acknowledgement of Country: AssignProSolution acknowledges the Traditional Custodians of Country throughout Australia and their continuing connection to land, waters, and community. We pay our respects to Aboriginal and Torres Strait Islander cultures, and to Elders past, present, and emerging. Aboriginal and Torres Strait Islander readers should be aware that this sample contains references to issues that may be distressing.

FIGURE 1 — GIBBS' REFLECTIVE CYCLE (1988) APPLIED IN THIS REFLECTION

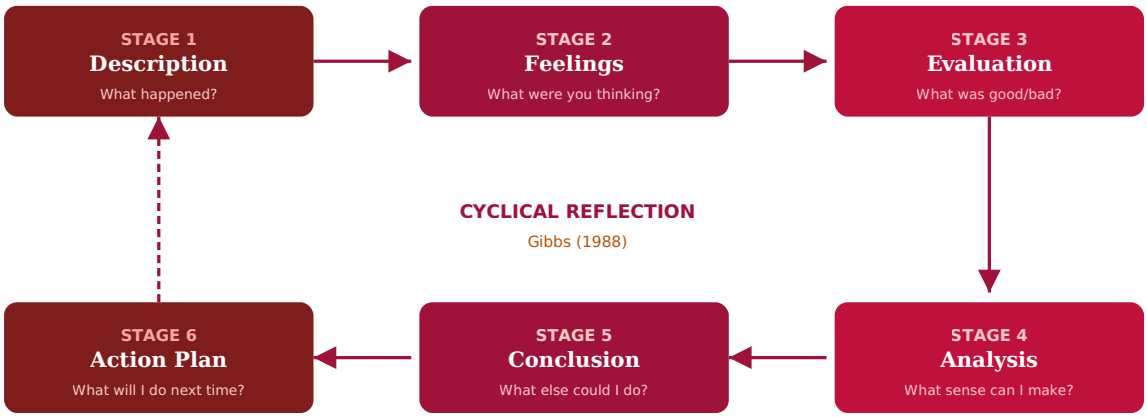

Figure 1: Gibbs' Reflective Cycle (1988) — the six stages applied in this nursing reflection. The dashed return arrow from Stage 6 (Action Plan) to Stage 1 (Description) indicates the cyclical, ongoing nature of reflective practice. This framework is one of the most widely used models of reflection in Australian undergraduate nursing programmes.

INTRODUCTION

Introduction

Reflective practice is not a luxury in nursing — it is a professional obligation. The Nursing and Midwifery Board of Australia (NMBA) Registered Nurse Standards for Practice (2016) explicitly require nurses to think critically and analytically, to examine their own assumptions and biases, and to commit to ongoing learning in response to clinical experience. Nowhere is this obligation more pressing than in the context of caring for Aboriginal and Torres Strait Islander peoples, whose health outcomes continue to be profoundly and unjustifiably shaped by the enduring consequences of colonisation, systemic racism, and institutional failure (AIHW, 2023).

This reflection uses Gibbs' Reflective Cycle (1988) — comprising six stages: description, feelings, evaluation, analysis, conclusion, and action plan — to critically examine an encounter I experienced during my third-year clinical placement on a general medical ward. The encounter involved providing nursing care to Aunty Doris Mitchell (fictitious), a 68-year-old Aboriginal Elder admitted with a diabetic foot infection and stage 3 chronic kidney disease (CKD). Through this reflection, I seek to honestly examine how my own unconscious biases and inadequate cultural knowledge undermined the quality of care I initially provided, and to articulate a substantive commitment to culturally safe practice informed by the AHPRA and National Boards Cultural Safety Framework (2022) and the National Aboriginal and Torres Strait Islander Health Plan 2021–2031 (Department of Health and Aged Care, 2021).

1 Description — What Happened?

During a morning shift, I was asked to conduct Aunty Doris's routine observations and assist with a wound dressing change on her right foot. When I entered the room, Aunty Doris was seated on the bed accompanied by her adult daughter, Sarah, and her son, James. The room felt quiet and the family were speaking to one another in a language I did not recognise. I was running behind schedule following a difficult handover, and I acknowledged the family briefly before directing my attention immediately to the observation equipment.

I introduced myself and explained I was there to take observations and change the wound dressing. I spoke at my normal pace, using clinical terminology — "wound debridement", "blood glucose monitoring", "CKD stage 3" — without pausing to check whether Aunty Doris understood. When she did not immediately respond to my questions, I instinctively turned to Sarah to repeat them, effectively bypassing Aunty Doris as the primary interlocutor. Sarah gently corrected me: *"Mum understands you. She just takes a moment to think before she speaks. Please talk to her."*

I completed the observations and began preparing for the wound dressing, but at no point did I ask Aunty Doris or her family whether there were any cultural considerations that should guide my approach to wound care, or whether any family members wished to be present during the procedure. The wound dressing was completed efficiently, but the interaction felt transactional rather than therapeutic.

2 Feelings — What Was I Thinking and Feeling?

In the moment, I was primarily preoccupied with the task at hand — completing observations efficiently within a busy shift. Sarah's correction produced an immediate flush of embarrassment, and my instinct was to apologise quickly and move on, minimising the discomfort of the moment. I felt flustered and self-conscious, aware that I had made a mistake but not yet understanding the full nature or significance of it.

Reflecting later in the shift, I became aware of a more troubling undercurrent in my initial assumptions. I realised I had subconsciously expected Aunty Doris to have difficulty understanding me because of her language background — an assumption for which I had no clinical basis, and which, I now recognise, reflected an unconscious racial bias. I had also assumed that because she was an older Aboriginal woman from a remote community, her daughter would be a more reliable communication partner — a paternalistic assumption that stripped Aunty Doris of her voice and agency in her own healthcare encounter. I felt genuinely ashamed when I sat with these reflections, and somewhat unsettled by the realisation that I had held these biases without awareness.

3 Evaluation — What Was Good and Bad?

A candid evaluation of this encounter reveals significant failures alongside a few positive elements. On the positive side, I did complete the clinical task competently and safely — observations were accurate, the dressing was changed aseptically, and I documented my findings correctly. I also responded to Sarah's correction without defensiveness, apologising directly to Aunty Doris and redirecting my communication appropriately for the remainder of the visit.

However, the failures were substantial and potentially harmful. I failed to address Aunty Doris as the primary agent in her own care. I used jargon without checking comprehension. I made no inquiry about cultural or family considerations for wound care — a significant omission, as body integrity and the involvement of family in care decisions carry deep cultural significance for many Aboriginal peoples (Dudgeon, Milroy and Walker, 2022). I did not introduce myself with an acknowledgement of Country or an expression of respect for Aunty Doris's Eldership — a meaningful cultural courtesy that requires no clinical training to enact. Most fundamentally, I allowed time pressure to override the person-centred, culturally safe relational practice that is both a professional standard and an ethical imperative (AHPRA, 2022).

4 Analysis — What Sense Can I Make of This?

Critically analysing this encounter requires engagement with the broader historical, structural, and theoretical context within which it occurred. The AHPRA and National Boards Cultural Safety Framework (2022) defines cultural safety as an outcome determined by Aboriginal and Torres Strait Islander peoples themselves — not a checklist to be completed by non-Indigenous practitioners. Cultural safety is achieved when the healthcare environment is one in which Aboriginal and Torres Strait Islander peoples feel respected, where their identity is affirmed, and where power imbalances are acknowledged and actively addressed. By this definition, my encounter with Aunty Doris was not culturally safe.

The concept of unconscious bias is essential to understanding what happened. Fitzgerald and Hurst (2017) define implicit bias as automatic, unintentional mental associations that influence judgement and behaviour without awareness. Research consistently demonstrates that implicit racial bias contributes to differential treatment of Aboriginal and Torres Strait Islander patients in Australian healthcare settings, including undertreatment of pain, shortened consultations, and reduced engagement with preventive care (Paradies et al., 2022). My assumption that Aunty Doris could not understand me, made without any clinical evidence, is precisely the kind of implicit racial bias that contributes to this pattern.

This encounter cannot be understood outside its historical context. The health disparities experienced by Aboriginal and Torres Strait Islander peoples are not a natural or inevitable outcome of difference — they are the direct and quantifiable consequence of colonisation: dispossession of land and culture, the forced removal of children through the Stolen Generations, destruction of language and kinship systems, and the deliberate exclusion of First Nations peoples from economic and civic participation (Dudgeon, Milroy and Walker, 2022). The AIHW (2023) reports that Aboriginal and Torres Strait Islander peoples have a life expectancy approximately 8.1 years shorter for males and 7.8 years shorter for females than non-Indigenous Australians — a gap that is not biological but social, political, and historical. My interaction with Aunty Doris was a microcosm of these broader structural dynamics: a rushed, task-focused non-Indigenous clinician bypassing the voice of an Aboriginal Elder in her own care.

The Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM, 2023) emphasises that cultural safety is not a static skill to be acquired but an ongoing, reflexive commitment that requires nurses to continuously examine the power they hold within clinical encounters and the ways in which institutional systems marginalise First Nations peoples. The National Aboriginal and Torres Strait Islander Health Plan 2021–2031 (Department of Health and Aged Care, 2021) similarly identifies racism — including the everyday, interpersonal racism enacted through assumptions and microaggressions — as a fundamental determinant of health outcomes for Aboriginal and Torres Strait Islander peoples. My behaviour, while not intentionally racist, reproduced these dynamics.

Close the Gap Context: The Close the Gap Campaign (2023) identifies that progress towards health equity for Aboriginal and Torres Strait Islander peoples requires transformation at both the structural and individual practitioner level. Cultural safety in nursing is not peripheral to clinical quality — it is inseparable from it. Patients who experience culturally unsafe care disengage from health services, resulting in delayed presentations, poorer disease management, and preventable mortality. My interaction with Aunty Doris, if it had discouraged her from engaging with the healthcare system, could have had real clinical consequences for the management of her diabetes and CKD.

5 Conclusion — What Else Could I Have Done?

With the benefit of critical reflection and engagement with the literature, I can identify several concrete actions I could have taken differently. Before entering the room, I could have reviewed Aunty Doris's care plan for documented cultural preferences, confirmed the role of her family members, and sought a brief consultation with the ward's Aboriginal Liaison Officer (ALO) — a resource I had not thought to utilise. Upon entering, I could have introduced myself, acknowledged Country, and addressed Aunty Doris directly and respectfully as an Elder, pausing adequately after each question to allow the reflection time that is culturally appropriate and communicatively respectful (Dudgeon, Milroy and Walker, 2022).

I could have explicitly asked: *"Are there any cultural or family considerations that are important to you in how we manage your wound care today?"* This question, costing seconds to ask, would have demonstrated respect, invited partnership, and potentially revealed clinically important information about Aunty Doris's preferences regarding who should be present, who should touch her, and whether any spiritual or cultural protocols applied to her wound or her body. I could have used plain language throughout, checked understanding through teach-back, and ensured that both Aunty Doris and her family felt genuinely heard, not merely administratively processed.

6 Action Plan — What Will I Do Differently?

This reflection compels me to commit to specific, measurable changes in my practice and my ongoing professional development. First, I will complete the online cultural safety training modules available through the Koori Curriculum (if within Victoria) and the AHPRA-endorsed cultural safety education resources, and I will document this completion in my professional portfolio as evidence of Standard 1 — Thinks Critically and Analyses Nursing Practice (NMBA, 2016). Second, I will develop a personal habit of consulting with the Aboriginal Liaison Officer at every facility where one is available, recognising this as a mandatory rather than optional element of preparing for the care of Aboriginal and Torres Strait Islander patients.

Third, I will practise cultural humility as a sustained orientation rather than a competence to be achieved and filed away. Cultural humility, as defined by Tervalon and Murray-Garcia (1998) and operationalised in the Australian context by AHPRA (2022), requires lifelong self-evaluation and self-critique, recognition of and challenge to power imbalances, and genuine, respectful partnership with communities. This is fundamentally different from cultural competence — the notion that cultural knowledge can be acquired, applied, and completed. Fourth, I will advocate at a practice level: if my ward does not have documented protocols for cultural assessment at admission for Aboriginal and Torres Strait Islander patients, I will raise this with my clinical supervisor as a patient safety issue, consistent with Standard 3 — Maintains the Capability for Practice (NMBA, 2016).

Finally, I commit to never again allowing time pressure to override the fundamental relational quality of nursing care. The therapeutic relationship — grounded in respect, authenticity, and the genuine valuing of each person — is not something that can be deferred when the shift is busy. For Aboriginal and Torres Strait Islander peoples, for whom historical encounters with health and government systems have so frequently meant disrespect and disempowerment, every interaction with a nurse is an opportunity either to reproduce or to interrupt that history. I intend to be the latter.

CONCLUSION

Overall Conclusion

This reflection, structured through Gibbs' Reflective Cycle (1988), has examined a clinical encounter that, on the surface, appeared uneventful but which, under critical scrutiny, revealed the operation of unconscious racial bias, insufficient cultural knowledge, and the reproduction of power dynamics that undermine culturally safe care for Aboriginal and Torres Strait Islander peoples. The health inequities that characterise the experience of Australia's First Nations peoples are not abstractions — they are the cumulative product of millions of individual clinical encounters, policy decisions, and institutional practices. Registered nurses have both the obligation and the capacity to interrupt this pattern, one encounter at a time, through critical reflection, sustained cultural humility, and unwavering commitment to person-centred, equitable care. This reflection has not made me a culturally safe practitioner — that is a lifelong journey, not a destination. But it has made me a more honest and more committed one.

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FAQS

Frequently Asked Questions — Indigenous Health Nursing Reflections

Q What is cultural safety in Australian nursing?

Cultural safety in Australian nursing refers to an environment that is spiritually, socially, emotionally, and physically safe for Aboriginal and Torres Strait Islander peoples — one where there is no assault, challenge, or denial of their identity, who they are, and what they need. It goes beyond cultural awareness or competence: it requires nurses to examine their own power, assumptions, and the structural inequities that produce differential health outcomes. The AHPRA and National Boards Cultural Safety Framework (2022) mandates cultural safety as a core obligation of all registered health practitioners in Australia.

Q What is Gibbs' Reflective Cycle and how is it used in nursing assignments?

Gibbs' Reflective Cycle (1988) is a six-stage structured framework used to reflect on professional experiences: (1) Description — what happened; (2) Feelings — what were you thinking and feeling; (3) Evaluation — what was good and bad; (4) Analysis — what sense can you make of it; (5) Conclusion — what else could you have done; (6) Action Plan — what will you do next time. In nursing, Gibbs' model is used to move beyond surface description to critical analysis of clinical practice, identification of learning needs, and professional growth. It directly supports NMBA Standard 1 — Thinks Critically and Analyses Nursing Practice (NMBA, 2016).

Q Why is there a health gap between Aboriginal and non-Aboriginal Australians?

The health gap between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians is the direct result of colonisation: dispossession of land, forced removal of

children (the Stolen Generations), destruction of culture and language, intergenerational trauma, and ongoing systemic racism in institutions including healthcare. The AIHW (2023) reports a life expectancy gap of approximately 8 years. This is not a biological difference but a social, political, and historical one. The social determinants of health — housing, education, employment, income, and cultural connection — are all profoundly shaped by Australia's colonial history. The Close the Gap campaign and the National Aboriginal and Torres Strait Islander Health Plan 2021–2031 are Australia's formal responses to this inequity.

Q What is unconscious bias and how does it affect Aboriginal patients?

Unconscious bias refers to automatic, unintentional attitudes or stereotypes that influence perception and behaviour without awareness (Fitzgerald and Hurst, 2017). In healthcare, unconscious bias against Aboriginal and Torres Strait Islander patients can manifest as assuming inability to understand clinical information, reducing the quality of communication, shorter consultations, and attributing symptoms to lifestyle without proper assessment. Paradies et al. (2022) demonstrate that healthcare provider racism — including implicit bias — is widespread and contributes to Aboriginal and Torres Strait Islander peoples avoiding health services, presenting later with illness, and experiencing poorer health outcomes. Nurses are obligated by the AHPRA Cultural Safety Framework (2022) to actively examine and challenge their own biases.

Q What is the difference between cultural competence and cultural humility?

Cultural competence frames cultural knowledge as a set of skills and information that can be acquired, applied, and completed — as if a practitioner can "become competent" and move on. Cultural humility, introduced by Tervalon and Murray-Garcia (1998), rejects this finite framing. It positions cultural learning as a lifelong process of self-evaluation, critical examination of power, and genuine partnership with communities. AHPRA (2022) explicitly adopts cultural humility as the appropriate orientation for Australian health practitioners, recognising that no amount of training makes a non-Indigenous practitioner an authority on Aboriginal and Torres Strait Islander culture. Cultural humility means

approaching every encounter with openness, respect, and a willingness to learn from the patient and community.

How do you write a distinction-level nursing reflection on Indigenous health?

A distinction-level Indigenous health nursing reflection requires critical self-examination, not just description of events. Key elements include: using a structured model such as Gibbs' (1988) or Johns' (2022); engaging with theoretical frameworks including cultural safety, cultural humility, and the social determinants of health; honestly examining your own unconscious biases; connecting your experience to Australia's colonial history and its measurable health consequences; using current peer-reviewed literature and national frameworks (AHPRA 2022, AIHW 2023, CATSINaM, National Health Plan 2021–2031); and producing a specific, actionable plan for changed future practice. Reflections that merely describe good intentions without critical analysis or theoretical engagement will not achieve distinction-level marks.