RECEIVING THE STRANGER

FOREWORD

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Ruth is Stream Leader: Research, Policy and Evaluation at the Centre for Culture, Ethnicity and Health (CEH) at North Richmond Community Health. She has held a wide range of academic, clinical and governance roles, including Senior Lecturer in Nursing at Monash University, Melbourne (2013–2015) and AUT University, Auckland (2005–2012) where she coordinated the Centre for Asian and Migrant Health Research. Ruth's mission is to develop research that translates to improved outcomes for marginalised groups, with a particular focus on cultural safety, consumer participation and health literacy.

"If one agrees that the manner in which a society receives refugees (the stranger) and upholds their rights is a fairly accurate barometer of the extent to which human rights are generally respected, it follows that an investment in promoting the rights of refugees is a an investment in a more just society for all." (Harrell-Bond, 2002, p.80).

This special issue on disaster health acknowledges the relational aspects of being a human. A disaster is "the widespread disruption and damage to a community that exceeds its ability to cope and overwhelms its resources" (Mayner & Arbon 2015, p. 24). At times of disaster, people need help, and nurses are often on the front line. This is because even outside of what we usually understand to be a disaster, nurses typically work with people and communities who have exhausted their own resources or who need infrastructural and systemic support to galvanise their resources and strength.

The call to care that we associate with nursing practice is often juxtaposed with an uncaring social and political context. This leads many nurses to experience moral distress, defined by Jameton (1984) as "aris(ing) when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action".

The lack of care in our border discourse reflects how devoid of context the issue of migration is in political debates. Fleeing bodies are objectified and dehumanised by politicians who trumpet xenophobic and alarmist discourses of fear. These discourses are oriented toward a mass media for distribution to people as a proxy for actual engagement with refugees and asylum seekers, underpinning cruel deterrence policies and for-profit detention of vulnerable people.

For the practitioner, even if one is concerned, the dominant economic order of neo-liberalism keeps us focused on outputs rather than relationships; we keep our heads down to keep up. Our working situations often pull up the drawbridges to our hearts and selves so we can survive.

The work of the three refugee health nurses and an arts practitioner working for refugee support organisation RISE provides important lessons for us, even if we do not work directly with former refugees. These profiles emphasise the relational aspects of nursing: skilled, empathetic, compassionate care that is tailored, solution-oriented, flexible and seen as safe by the recipient. Care that is delivered by providers who are skilled communicators who use interpreters as needed. Cultural competence is not about being of a particular culture but of knowing how to bring resources to a new cultural situation where one has limited expertise.

The practitioners profiled here continuously attempt to improve through evaluation and overcome resource constraints to work toward models of care that facilitate shared decision-making. And outside the clinical relationship, these practitioners articulate and demand strategic interventions to disrupt institutionalised discourses and practices that have a marginalising effect on vulnerable communities.

Paradoxically, this move from individual to collective and community responsibility – demanding in an individualist culture – can resource our weary hearts, minds and bodies. The critical perspectives foregrounded here draw on new understandings of intersectionality as a key issue in addressing health inequity.

They show how categories of difference such as race, gender and class intersect with broader social, economic, historical and political structures to shape experiences of health care. They allow us to look "upstream" (Clark et al 2015) and to critically evaluate the virulent anti-asylum seeker rhetoric made by politicians and media that refugees and asylum seekers are "trying to take over", are not "genuine", are not using the "proper channels". They surface the often overlooked truth that the Geneva Convention — to which Australia is a signatory — provides people in fear of their lives with a legitimate and legal right to seek asylum.

Intersectionality might allow us to engage in cultural safety, to see how our 'selves' intersect with the institutional, geopolitical and material aspects of our roles; to consider the investments and conditions that enable us to care and to interrogate the constraints and accountabilities that influence our practice.

Much of the history of critical nursing practice has focused on the "reflective practitioner" (Schön, 1983). However, in the real world there's rarely time to reflect and institutional demands often preclude reflective time. And reflecting by ourselves assumes we can be fully aware or conscious of ourselves and the social relations that we are a part of. This kind of deliberation cannot adequately address the messy unpredictable nature of nursing contexts.

We might need to start talking to each other again, working in partnership to take part in more socially engaged knowledge practices, where we recognise the limitations of our own knowledge so we are better able to work across difference. Nurses are already skilled at building relationships with clients. We need to extend our therapeutic alliances to families, communities, service providers and community resources.

The Australian College of Nursing and nursing's other professional organisations have taken up the challenge, speaking out against Australian policies and practices that impact on the health outcomes of detainees, asylum seekers and refugees — the secrecy provisions of the Australian Border Force Act of 2015 being a key example. What are our collective responsibilities now? As they have always been: to conduct ourselves with a duty of care.

However, in this increasingly complex world, effective care is no longer a matter of caring only for the individual, but requires partnerships that transcend the boundaries of clinical practice, research, education and political advocacy to work more collaboratively and improve the wellbeing of those marginalised by our nation's unhealthy policies.

References

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SANDY EAGAR FACN

Nurse Manager, NSW Refugee Health Service

"Refugee nurses place the patient in the centre of the care plan and work with trust, respect and time."

Tell us a little bit about your background and why you decided to work in refugee health?

I have been nursing for over 30 years, with a background in emergency nursing and education. In 1999, I was seconded to be the Nurse Manager for "Operation Safe Haven", which was the temporary shelter offered to 4,000 Kosovar Albanians. I managed the reception centre in Sydney and then stayed on to manage the reception and care for 1,200 East Timorese who had escaped the slaughter following the vote for an independent East Timor.

Following that work, I was nominated by ACN (then the Royal College of Nursing Australia) to represent them on the newly formed Detention Health Advisory Group, providing advice, policy frameworks and inspection capability in the immigration detention health networks across Australia, including Christmas Island. I am very proud of the work we achieved and saddened when the advisory body was disbanded by the incoming Immigration Minister in the Abbott government.

In 2012 I was appointed as the Nurse Manager at the NSW Refugee Health Service to introduce a nurse-led model of care called the Refugee Health Nurse Program.

Can you describe a typical day in your role?

I manage 11 nurse-led clinics across the Sydney metropolitan region. The program does early health assessments and care planning for newly arrived refugees in Sydney, ensuring that they are linked into services they require. So a typical day maybe reviewing offshore medical assessments (which enables me to triage for appointments), liaising with a myriad of stakeholders and/or representing the service at a variety of levels, including statewide and national meetings.

What are some important attributes a nurse should possess for working in refugee health?

Due to the vast range of health conditions that may present, refugee nurses need advanced clinical assessment skills; the ability to work in a cross-cultural context, including working with interpreters, and an understanding of the psychological trauma that their patients may have endured and how that trauma may manifest in day to day practice. Refugee nurses need to be keenly aware of the current political situations across the globe and must have an understanding of past world events that has led to this unprecedented movement of people across the globe.

Why is it important to have specialist nurse-led health services for refugees?

Refugees are particularly vulnerable and, when they arrive in a sophisticated first world country like Australia, they are often overwhelmed and bewildered. Nurses, with their holistic view of health, understand that settlement issues, such as housing, language, welfare and enrolment in education, are all competing priorities. Refugee nurses place the patient in the centre of the care plan and work with trust, respect and time. A 15-minute GP appointment is just not