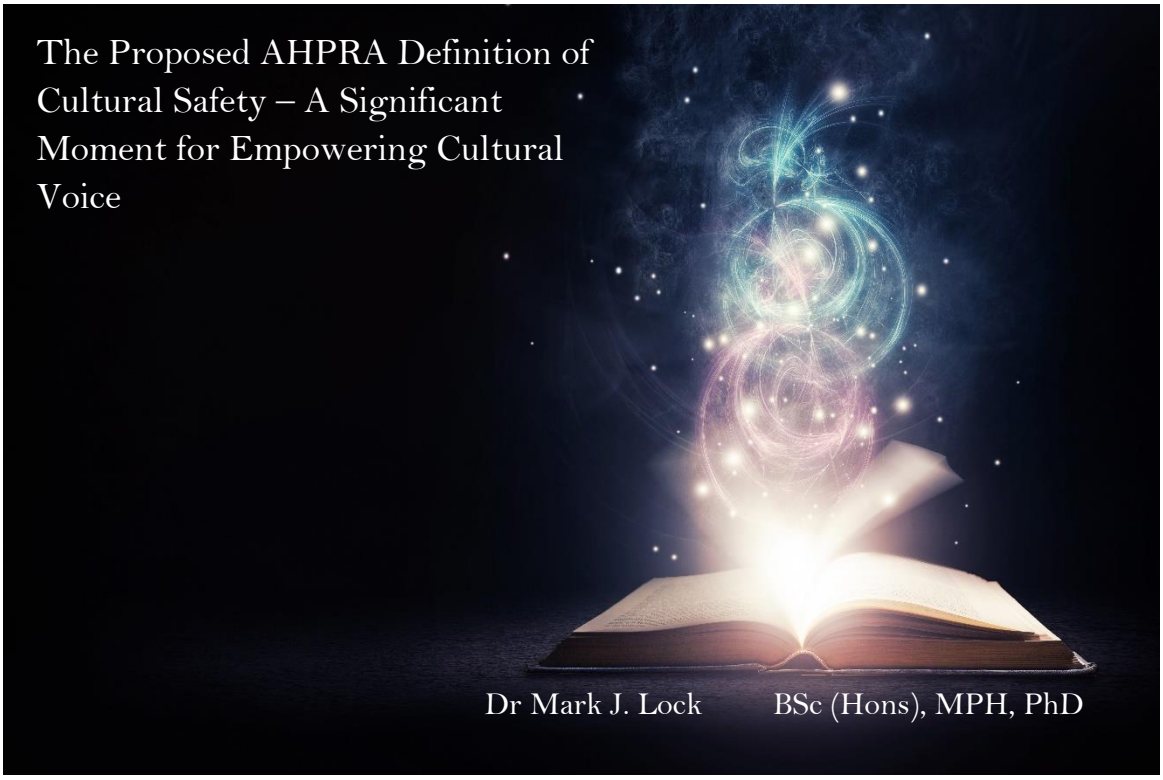

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Committix respects Australia's First Peoples as the traditional owners of Australia

Contents

Introduction

On 3rd April 2019, the Australian Health Practitioner Regulation Agency announced a public consultation process on a definition of cultural safety (hereafter referred to as the proposed AHPRA definition of cultural safety). The aim of this paper is to provide a critique of Australian usage of the phrase 'cultural safety', to consider the philosophical implications of a definition of cultural safety for health practitioner regulation, to explain the reason why an agreed definition of cultural safety is important for Australian health practitioners, to ascertain the principles of cultural safety that could be relevant for health practitioners, and to outline the potential unintended consequences of the use of cultural safety in the National Registration and Accreditation Scheme.

The terms of reference for the public consultation process stated that 'The National Scheme and NHLF [National Health Leadership Forum] have agreed on a draft definition of cultural safety to be used in the context of the National Scheme and for the purposes of the NHLF and their members. Please note, we are not seeking feedback on a national definition of cultural safety for all governments/jurisdictions and purposes across Australia. Rather, we seek feedback for the purpose of the National Scheme's and NHLF's core business. And that the 'The intention is for the new, agreed definition to provide a consistent baseline definition for use in the National Scheme.'[1]

This is the proposed definition we are seeking your feedback on:

> Cultural safety is the individual and institutional knowledge, skills, attitudes and competencies needed to deliver optimal health care for Aboriginal and Torres Strait Islander Peoples as determined by Aboriginal and Torres Strait Islander individuals, families and communities.

The consultation process represents a significant moment in the evolution of Australian cultural safety and the AHPRA and the NHLF are to be commended for undertaking a public and transparent process on the proposed definition. The opinions are my own and represent the current development of my knowledge base in the area and my biases.

Statement of Reflexivity

Bias is an integral part of writing and critique and so it is necessary to situate this paper as part of my socio-political enterprise to understand the meaning and nature of cultural safety and how it could be leveraged into enabling healthcare governance to value the cultural voice of Australia's First Peoples. This is partly due to discriminatory attitudes preventing my voice from being heard: I am too fair skinned to be a real Aborigine, too educated but not a medical doctor or professor, not in a position of seniority, not published enough in A class journals, not raised on a mission, not an idealised poster image of an Aboriginal person, not a nurse (or dietitian, or health professional), not living in Melbourne or Sydney or Canberra, not a member of any Aboriginal community due to being multiply displaced, not an 'ordinary' Aboriginal patient or fitting the notion of the 'common man on the street'

Aborigine. Cutting through all this 'not good enough' noise is the voice of my Nan, Marjorie Woodrow, who encouraged me to become educated and "make changes for our mob", and the strength of her voice drives me onward.

Another part of my enterprise as a health policy analyst is that I recognise the power of definitions – like that of 'identity' or 'Aboriginal' or 'Indigenous' – and my academic trajectory has been to examine definitions of 'holistic',[2, 3] 'participation',[4, 5] and 'engagement and voice'[6] – and this paper is about a definition built on the ethic that unsafe (nursing or midwifery) practice is seen as 'actions or omissions that endangers the wellbeing, demeans the person, or disempowers the cultural identity of a person'.[7] In my professional and academic experience, I experienced unsafe actions in committee meetings to the selection of words were used in a briefings to ministers. Therefore, cultural safety appeared intuitively relevant outside nurse and patient interactions to include governance contexts (e.g. committees in Australian Open Disclosure Policy)[8] to knowledge production processes behind academic journal articles.[9] To me, definitions serve to rule-in or rule-out the potential for transformative change and I hope that the proposed AHPRA definition rules-in cultural voice and rules-out different forms of discrimination.

Cultural Validity

I have followed the governance of the cultural safety agenda through AHPRA because of my interest in the transparency of cultural voice in Australian mainstream health governance processes. Could the cultural perspectives of Australia's First Peoples be truly embedded throughout a healthcare system that has systematically excluded them from the intellectual development of healthcare governance? Does the AHPRA process demonstrate cultural validity?

The **cultural validity** of the proposed AHPRA definition is rooted in the membership of the Aboriginal and Torres Strait Islander Health Strategy Group[10] who have worked through a genuine process of engagement to develop the AHPRA Statement of Intent,[11] lead the development of the AHPRA Reconciliation Action Plan,[12] and conducted a tender process for cultural safety training. It is noted that one of the values of the Statement of Intent states 'Aboriginal and Torres Strait Islander leadership and voices in the National Scheme'[11] and this is visible in the membership of the Strategy Group and the processes endorsed by AHPRA to develop a cultural safety agenda in the National Scheme. The AHPRA demonstrates genuine organisational co-design process coupled with public transparency and accountability in the development of activities to improve the health outcomes of Australia's First Peoples. Therefore, I feel that this proposed definition comes from genuine value and respect for Australia's First Peoples, as transparently stated:

> 'Our intent is to have a national and consistent baseline definition that has been led by Aboriginal and Torres Strait Islander health leaders, which can be used as a foundation for embedding cultural safety across all functions in the National Scheme and members of the NHLF. All entities represented in the Strategy Group

> have committed to supporting health equity for Aboriginal and Torres Strait Islander Peoples. The Strategy Group has identified two important goals: embed cultural safety in how registered health practitioners work, and increase access to culturally safe health services for Aboriginal and Torres Strait Islander Peoples.'[1]

This **intent** aligns with the development of Williams's (1999) definition of cultural safety, as quoted by Bin-Sallik (2003): Cultural safety is an 'environment that is spiritually, socially and emotionally safe, as well as physically safe for people; where there is no assault, challenge or denial of their identity, of who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience of learning together.'[13, 14] In this paper, I will refer to Williams's definition of cultural safety as the general **default definition** that should be used because it: refers explicitly to Australia's First Peoples, was develop in discussion with Aboriginal colleagues, comes from an ethic of deep engagement in the education system with Aboriginal students, and represents a defining moment that 'Critical reflection on experiential knowledge and defining or framing a debate on cultural safety is essential'.[13] That is, Williams's definition reflects Australian cultural provenance that the **New Zealand definition** of cultural safety does not.

Understanding the 'National Scheme'

This refers to Australia's National Registration and Accreditation Scheme : 'The Council of Australian Governments (COAG) decided in 2008 to establish a single National Registration and Accreditation Scheme (National Scheme) for registered health practitioners with the national regulation of: chiropractors, dental practitioners (including dentists, dental hygienists, dental prosthetists & dental therapists), medical practitioners, nurses and midwives, optometrists, osteopaths, pharmacists, physiotherapists, podiatrists, psychologists, Aboriginal and Torres Strait Islander health practitioners, Chinese medicine practitioners (including acupuncturists, Chinese herbal medicine practitioners and Chinese herbal dispensers), medical radiation practitioners (including diagnostic radiographers, radiation therapists and nuclear medicine technologists), and occupational therapists'.

The National Scheme 'ensures that all regulated health professionals are registered against consistent, high quality, national professional standards and can practice across state and territory borders without having to re-register in each jurisdiction'[11] and this means having a consistent definition to refer to because the current confusing situation is culturally dangerous, as I outlined in the responses to question 1 and question 2.

Australian Cultural Safety Ecosystem

The basic elements of the Australian cultural safety ecosystem are mapped so that a clear line of sight is evident for the proposed AHPRA definition of cultural safety to fit within (figure 1).

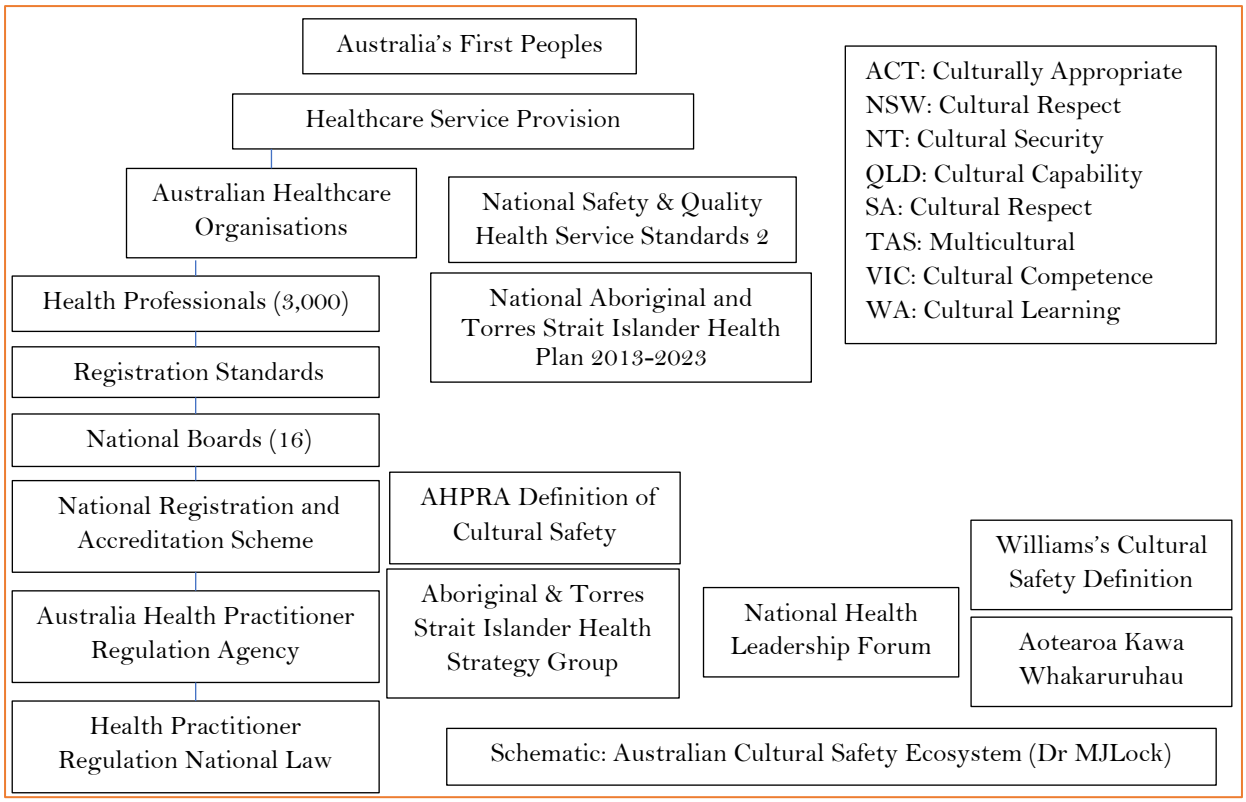


Figure 1: Australian Cultural Safety Ecosystem (Dr MJLock)

The Australia Health Practitioner Regulation Agency's (AHPRA) 'operations are governed by the Health Practitioner Regulation National Law, as in force in each state and territory (the National Law), which came into effect on 1 July 2010. This law means that for the first time in Australia, 16 health professions are regulated by nationally consistent legislation under the National Registration and Accreditation Scheme.' The objectives of the National Scheme, which are to:

- Objective 1 - help keep the public safe by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered
- Objective 2 - facilitate workforce mobility for health practitioners
- Objective 3 - facilitate provision of high quality education and training for practitioners
- Objective 4 - facilitate the assessment of overseas qualified practitioners
- Objective 5 - facilitate access to services provided by health practitioners, and
- Objective 6 - enable the continuous development of a flexible Australian health workforce.'

'The National Boards set the registration standards that practitioners must meet in order to register. Once registered, practitioners must continue to meet the standards and renew their registration yearly with the National Board.'

The National Health Leadership Forum is…'the national representative body for Aboriginal and Torres Strait Islander peak organisations who provide advice on health. Since its

establishment in 2011, the NHLF brings together senior Aboriginal and Torres Strait Islander health leaders to consider and consult on the health policies for Australia's First Peoples.' [1]

Cultural safety is now embedded in the codes of conduct of Australian Health Professional Boards: Aboriginal and Torres Strait Islander Health Practice, Chiropractic, Dental, Chinese Medicine, Medical, Medical Radiation Practice, Nursing and Midwifery, Occupational Therapy, Optometry, Osteopathy, Paramedicine, Pharmacy, Physiotherapy, and Podiatry. The Psychology Board refers to the Australian Psychological Society Code of Ethics (2007, as amended in 2003) which does not specifically refer to Aboriginal and Torres Strait Islander People in the body text and only using the phrase 'culturally appropriate services' and then referring to 'Ethical guidelines for the provision of psychological services for, and the conduct of psychological research with, Aboriginal and Torres Strait Islander peoples' which is not accessible to the public.

The Australian cultural safety ecosystem shows many points and pathways where cultural safety could be enabled and constrained and a theory of change helps to understand the value of the proposed AHPRA definition.

Theory of Change

The proposed AHPRA definition needs to be placed within a theory of change so that health professionals can see how different elements of the definition refer to the ecosystem of health professional regulation. The theory of change helps to understand why the AHPRA definition is needed and how to apply it. Anthony Giddens' Structuration Theory (AGST)[15] is used because it highly values the knowledgeability of people as being in control of their lives; sees the concept of 'structure' not as a physical apparatus within which people have no choice about their lives, but as 'rules and resources' which are open interpretation and change through our decisions; focusses on the notion of 'routines' as the transformation sites of simultaneous enablement and constraint; explicitly places the concept of 'power' as central to the analysis of interactions; and accepts the incredible complexity of diversity of human social life. These aspects of AGST will be developed further throughout this critique.

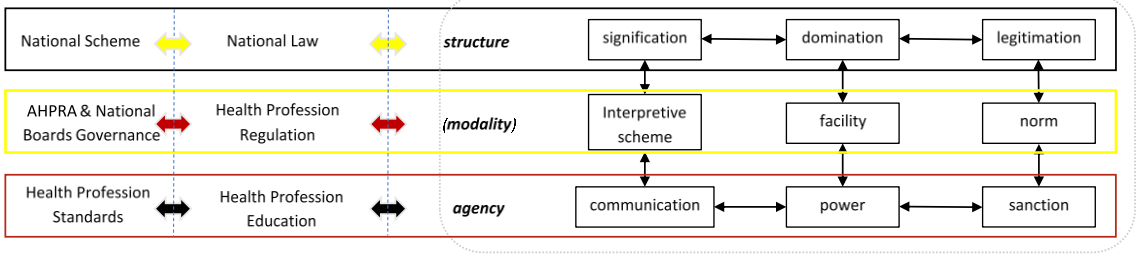


Figure (©2019 MJ Lock): Transformation of Structuration Theory (Giddens 1984:29) into Dimensions for the AHPRA Definition of Cultural Safety

Figure 2: Structuration Theory for the AHPRA Definition of Cultural Safety

Structuration theory is defined as the 'structuring of social relations through space and time in virtue of the duality of structure' (Figure 2).[15] In the following paragraphs, I develop a structuration statement for the AHPRA definition. The AHPRA definition is directed at restructuring health professional regulation so that Australia's First Peoples feel culturally safe in health service access and use - which is the 'structuring of social relations'. The notions of space and time refer to social relations occurring in the 'space' of health professional standards, and 'time' referring to layers of time: each time an interaction occurs between a clinician and patient, each time health professional standards are modified, and the larger time of the operation of the National Standard. Therefore, the **first half** of the structuration statement is 'the structuring of health professional standards through health regulations and multilayered time'.

The duality of structure (Figure 2) is more complex but is the key concept in AGST. The term 'duality' represents a dynamic sense of social relations and overcomes the tendency for dualism thinking – are we a product of society, or do we as individuals determine our own lives? This structure and agency dualism is reformulated by Giddens to be one of mutually interacting duality, where structure and agency interplay and coexist. We decide (agency) to see a health professional, whose education is determined by Acts, legislation and regulations of the health system (structure), but we can influence the structure to frame the provisions of better services. Of course, this simple description belies our health system's complexity of differences in health conditions, services provided and organisational types.[16] Nevertheless, the principle cutting through the complexity is of a dynamic interaction between patient decisions (agency) and the National Registration and Accreditation Scheme (structure).

For the AHPRA definition, Giddens's definition of structuration can be recast as the 'the structuring of health professional standards through health regulations and multilayered time in virtue of the duality of cultural voice influencing the National Registration and Accreditation Scheme.' Cultural voice denotes the human cultural perspectives of Australia's First Peoples, which – as shown in Figure 2 – could be embedded in every point and pathway of health professional education – the 'points' are the blocks of text, and the 'pathways' are the coloured lines and coloured arrows connecting and surrounding those boxes.

Feedback questions

1. Will having a single definition for the National Scheme and NHLF be helpful? Why or why not? Are there unintended consequences of a single definition?

An unambiguous definition is needed for health profession training and regulation.

In general usage the concept of cultural safety is difficult to define[17-19] and incorrect perceptions of this concept may result in cultural risk.'[20] The examples of Australian usage of cultural safety (Table 1, below) show the differences in the source, definition, and interpretation of it. How are health professionals supposed to enable a culturally safe

environment when different stakeholders, leaders, and their organisations offer varying interpretations?

I propose that a single definition will be helpful as a conceptual keystone in a textscape where the various interpretations of cultural safety serve to confuse health professionals. In my thinking, the proposed AHPRA definition of cultural safety sits in the 'facility' box of structuration theory (Figure 2) because 'facility' means the mechanisms used to convey power, like language is a facility/mechanism of communication or a curriculum is a facility for education. A definition is a conceptual facility that spreads across and through multiple facets of the National Scheme – it can be a vehicle both for enabling and constraining the meaning and understanding of cultural safety for health professionals. A single definition would enable a consistent reference point for discussions and interpretations into health profession regulations.

Currently, the 'norm' (see box in Figure 2) is for multiple reference points to be used where academic authors gather literature from different countries and construct their own meaning of cultural safety biased towards supporting their research, article or point of view – in effect practicing a form of cultural appropriation that ignores the cultural provenance of concepts.[9] If the proposed AHPRA definition becomes the 'norm' in the National Scheme it could mean that when a health professional talks about cultural safety in whatever diverse practice context, they carry with them a single frame of reference rather than having to negotiate the 'labyrinthine learning' currently required.[21] This would also help workforce mobility for health professionals when moving through different jurisdictions (Objective 2 of the National Scheme).

An **unintended consequence** is that critics will imply that the AHPRA proposed definition is 'impoverished' that 'will be its death' (of cultural safety) and will be 'some other model' of cultural safety.[22] These arguments are not the case proposed by AHPRA (see 'cultural validity' section, above) as is clear to read in the terms of reference of the consultation process. Therefore, AHPRA needs to market and communicate as 'the AHPRA definition of cultural safety' or 'AHPRA Cultural Safety'. This is in-line with Objective 1 of the National Scheme, to where 'to help keep the public safe' also includes culturally safe.'

Alongside of that, AHPRA and the NHLF could take the position to adopt Williams's (1999)[13] Australian definition of cultural safety as stated by Bin-Sallik (2003)[14]:

> Cultural safety is an environment that is spiritually, socially and emotionally safe, as well as physically safe for people; where there is no assault, challenge or denial of their identity, of who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience of learning together.

This would signal (see the 'signification' box, Figure 2) within the Australian cultural safety ecosystem (Figure 1) that 'AHPRA cultural safety' does not replace Williams's cultural safety or Ramsden's cultural safety. Furthermore, it would signal the philosophical shift away from reliance on appropriating New Zealand's cultural safety to a position where Australia's First Peoples self-determine our own interpretation. Thus, legitimising (see

'legitimation' box, Figure 2) Williams's cultural safety as the official position of AHPRA and the NHLF in the National Scheme and showing that AHPRA cultural safety and Williams's cultural safety are co-existing and complementary.

Vital cultures and amorphous attitudes allow for redefinition

The dynamic nature of 'culture' leaves the door open for redefinition depending the specific cultural context.[7] In Ramsden's (1990) report 'Kawa whakaruruhau : cultural safety in nursing education in Aotearoa' it was concluded 'that there is no rigid definition of cultural safety' and that 'Because cultural safety is based on the less measurable dimension of attitude, it cannot be defined against physical or legal safety'.[23] Therefore, the AHPRA process of seeking a definition relevant for the 'culture' of health profession regulation is a justifiable exercise.

Other definitions of cultural safety exist. For example, in the poster 'Is Canada's Post-Graduate Medical Education Curricula Producing Physicians who can provide Culturally Safe Care?', Canada's National Aboriginal Health Organization defined 'culturally safe care is when a healthcare provider can: 'communicate competently with a patient in that patient's social, political, linguistic, economic, and spiritual realm'.[24] Gregory Phillips (2005) in his *Applied Model of Aboriginal Health and Cultural Safety in Australia*, states 'cultural safety is defined as the internal work an institution should undertake in order to provide a safe enabling environment for the practice of Aboriginal health. This safe enabling environment includes action at the individual and institutional level, is transparent and accountable, and is concerned with continuous quality improvement.'[25]

The point is that in general discourse cultural safety can be fluidly defined due to vital cultures and amorphous attitudes. However, in the sphere of health profession training and regulation, a tighter definition could mean a better 'awareness' level engagement with cultural safety as the beginning of the journey towards being culturally competent health professionals. However, this may result in another **unintended consequence** that the AHPRA cultural safety definition is seen as superior or better to other interpretations of cultural safety. Therefore, a caveat should be attached to the resulting AHPRA definition of cultural safety that it reflects current context and should be reviewed periodically and revised appropriately. Perhaps, even, allowing each health profession to develop a profession-specific version of cultural safety.

2. Does this definition capture the elements of what cultural safety is? If not, what would you change?

Below I outline the case that it is currently it is difficult to say what are the elements of cultural safety and if they are captured in the proposed AHPRA definition:

> Cultural safety is the individual and institutional knowledge, skills, attitudes and competencies needed to deliver optimal health care for Aboriginal and Torres Strait Islander Peoples as determined by Aboriginal and Torres Strait Islander individuals, families and communities.

The ethic of cultural safety is about power and culture

In answering this question I reference my favourite grounding quote from the late Ms Hinerangi Mohi, the Māori nurse who said, 'You people talk about legal safety, ethical safety, and safety in clinical practices and a safe knowledge base, but what of cultural safety?'[26]

I suggest that it is important to ensure that the proposed AHPRA definition reflects the *ethic* of cultural safety which is fundamentally about two things – power and culture. Power as seen in colonisation, forms of racism, whiteness and privilege, control over rules and resources, decision-making or non-decision making, ideological, mobilisation of bias, authority and coercion, bureaucracy and hierarchy, domination and repression, and transformative capacity to make a difference. The proposed AHPRA definition of cultural safety is a powerful cultural exercise because of the potential influence on Australian health professionals in their journey to become culturally competent. Over time, it would allow a cultural shift in health professions where 'culture' becomes a routine consideration in their practice.

Clearly emphasising culture as human interactions

The word 'culture' is ambiguous as to meaning and nature in Australian healthcare policy. It appears in the phrases: organisational culture, workforce culture, safety culture, workplace culture, learning culture, profession culture, 'just culture', corporate culture, medical cultures, culture of quality, service culture, feedback culture, a culture of continuous measurement, culture of continuous improvement, culture of openness and constructive challenge, culture of collaboration, management culture, culture of good governance, ethical culture, risk-aware culture, disciplined culture, and cultures of blame, defensiveness, and forgiveness.[27-35] Without any clarity, the phrase 'cultural safety' could easily be confused with the safety of the workforce or the organisation or the workplace.

For example, the Australian Commission on Safety and Health Care published the report *Safety Culture Assessment in Health Care: A review of the literature on safety culture assessment modes* (2017).[36] Additionally, the National Safety and Quality Health Service Standards (Second edition) adopts the phrase 'a culture of safety and quality'[30] which refers to organisational culture. This confusing use of 'culture' in general health policy writing is a constraining factor in the proposed AHPRA definition, and this needs to be addressed.

Perhaps a suitable term could be sourced from a language of Australia's First Peoples as done for the Fifth National Mental Health and Suicide Prevention Plan (2017) where it is stated that, 'Governments also recognise the importance of Aboriginal and Torres Strait Islander leadership in building better mental health services, underpinned by the Gayaa Dhuwi (Proud Spirit) Declaration'.[159] This would show the power of language in text because there would be no similar English language word to confuse with. For example, the Maori term Kawa Whakaruruhau is widely used and searches for that term in journal articles and policy documents yield highly specific results, whereas searching for 'cultural safety' produces millions of variations. In short, a term from Australia's First Peoples languages is a cultural declaration of power in language which is fundamental to cultural belief systems.

Cultural voice – human cultural perspectives of Australia's First Peoples

One the problems with the word 'culture' as currently used in Australian health policy is the dumbing-down of the complexity of human cultures. For example, the Australian National Model Clinical Governance Framework (2017) contains a conceptualisation of culture as 'the values, beliefs and assumptions of occupational groups' (p.8). It appears to be an edited version of definitions of 'culture' but 'occupational groups' replaces 'people', for example the Nursing Council of New Zealand's (2011) narrow definition of culture as 'the beliefs and practices common to any particular group of people'.[37] Cultures are incredibly complex and the proposed AHPRA definition could be accompanied with a statement the culture means the human cultural perspectives of Australia's First Peoples.

I introduce the phrase 'cultural voice' to denote the human cultural values of Australia's First Peoples. It demarcates space in Australian health policy analysis, so that "human" culture becomes visible in a policy landscape crowded with the use of the term 'culture' but devoid of any sense of humanity. My assessment of governance policy documents shows that the 'human culture' of Australia's First Peoples is ruled-out of the intellectual history of healthcare governance. For example, in Meredith Edward's (2002) discussion of Australian public sector governance,[22] in Donald Philippon and Jeffrey Braithwaite's (2008) comparative review of Australian and Canadian systems of healthcare governance,[23] in Lynne Bennington's (2010) Australian review of corporate governance and healthcare literature,[24] and in Barbazza and Tello's (2014) international review of health governance[25] which referenced Braithwaite, Healy and Dwan's (2005) Australian discussion paper about the governance of health safety and quality.[26] This represents an institutional cultural blindness where there is no 'human culture' explicitly considered in healthcare governance, in a multicultural country, whose First Australians have suffered most in the evolution of healthcare.

Therefore, the proposed AHPRA definition, supported by the NHLF, has the potential to reorient how the intellectual development of governance for health professions could explicitly consider the cultural voice of Australia's First Peoples. A nuanced definition of culture could be supported by AHPRA and the NHLF. In the context of cultural

competency, Cross et al. (1989) state that human culture 'implies the integrated pattern of human behaviour that includes thoughts, communication, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social group'.[38] While it is difficult to define and measure culture, as noted by one review of the concept.[39] It needs to be clearly stated that the word 'cultural' in AHPRA cultural safety is about the human cultures of Australia's First Peoples.

A strife of principles

I outline below the problem that principles of cultural safety are yet to be convincingly articulated because there is an ongoing intellectual debate about just what are cultural safety principles.

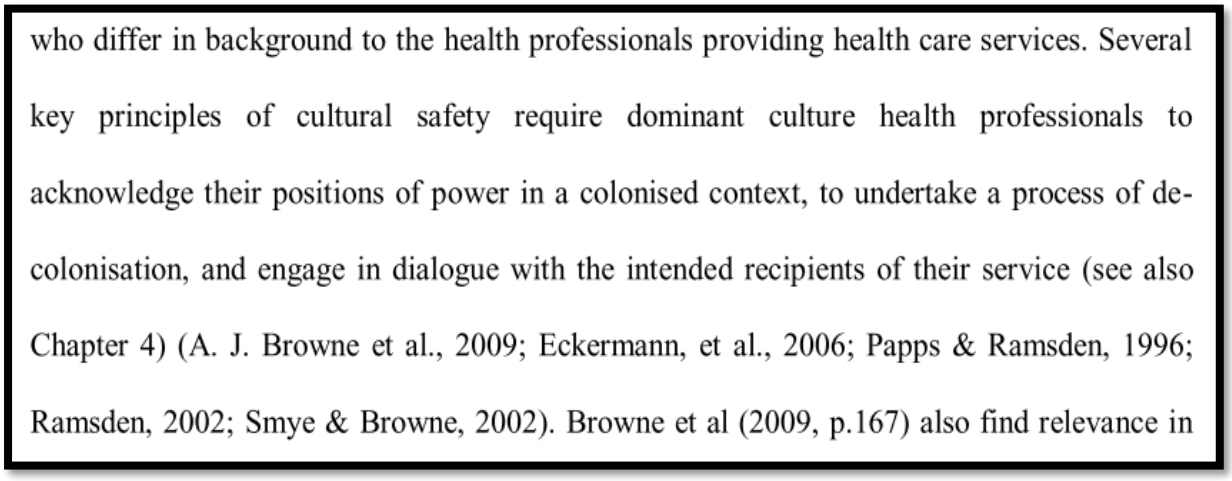
Ramsden (2002), citing Mason Durie (1989) notes that extracting principles and applying them to contemporary health situations assists people to translate treaty (of Waitangi) guarantees into possibilities for action.[40] This translational process is where the translators biases are carried into the resulting principles. Therefore, any literature cited about 'principles' needs to be viewed through a colonial lens where professional power (e.g. such as researchers) can manipulate the philosophical basis of the principles – even unwittingly.

Phillips (2005) offers 'applied cultural safety principles' developed without any empirical foundation, logical argumentation to theories of power, reference to cultural safety literature, or cultural validation to the broader community of Australia's First Peoples.[25] His principles include a constellation of concepts – difference, reflexivity, systemic racism, privilege, whiteness, structural violence, respect, sensitivity, competence, habitus, institutional, white benevolence, power sharing, and cultures. Thus, highlighting a central problem that individual academics attach their own biases to the concept of 'cultural safety' and thus devalue its power because of the ad-hoc nature of this practice, as highlighted briefly below.

Kruske et al. (2006) state 'Another important tenet of cultural safety is that the midwife or nurse not only acknowledge her/his own personal culture, but the power of nursing or midwifery culture'.[41] Again, 'tenet' is not a word used either by Ramsden (2002) or the New Zealand Nursing Council (2015) and power is limited to personal and nursing or midwifery culture which misses the power of service providers, organisations, institutions, and the State within which people and professions are embedded.

Seaton (2010) states that the 'The central principle of cultural safety is an exploration of professional knowledge and position and the power that this infers, which has an impact at both a personal and an interpersonal level'[18] but the phrase 'central principle' is not stated by the Nursing Council of New Zealand (2011) which implies a tri-fold platform in the sentence 'Cultural safety is underpinned by communication, recognition of the diversity in worldviews (both within and between cultural groups), and the impact of colonisation processes on minority groups'.[37]

Taylor & Geurin's (2010) approach (Figure 3), begins with the phrase 'several key principles…' which are derived from a mish-mash of sources from different countries (Canada, Australia, and New Zealand), implying a universality of principles from Indigenous peoples with vastly different colonial experiences and traditional cultural heritages. In taking this approach, Taylor & Geurin reproduce the colonial practice of assuming that all Aboriginal or Indigenous peoples are the same, which runs afowl of the notion of responding to cultural diversity.[37]



who differ in background to the health professionals providing health care services. Several key principles of cultural safety require dominant culture health professionals to acknowledge their positions of power in a colonised context, to undertake a process of de-colonisation, and engage in dialogue with the intended recipients of their service (see also Chapter 4) (A. J. Browne et al., 2009; Eckermann, et al., 2006; Papps & Ramsden, 1996; Ramsden, 2002; Smye & Browne, 2002). Browne et al (2009, p.167) also find relevance in

Figure 3: Taylor's (2010) inferal of cultural safety principles

The Australasian College of Emergency Medicine (2015), in citing Ramsden's work on cultural safety, state 'The fundamental premise that cultural safety actively addresses power imbalances and non-Indigenous privilege remains a cornerstone of the concept',[42] however, actively addressing white privilege is not explicitly articulated by either Ramsden (2002) or the New Zealand Nursing Council (2015) and 'privilege' is only used in Ramsden's (2002) thesis to reference the socio-political context of Maori/Pakeha relations.

Ryder et al. (2017) proposed five key principles of for their cultural safety framework: reflective practice, power differential minimisation, engagement and discourse, decolonisation, and regardful care.[43] However, 'profession power' appears to be central in them where the locus of actions are firmly located with the competent health professional to determine and administer to the patient. There appears to be no scope for Australia's First Peoples to challenge health profession power in the formulation of them. Furthermore, there was no external validation of the principles with reference to Aboriginal community groups or Aboriginal communities more generally.

Then, Fleming et al. (2018a)[44] propose 'three key principles of cultural safety' as 'partnership, participation, and protection' based on Ramsden's (2002) thesis as the '3 Ps framework for development of cultural safety by health professionals'. However, Ramsden (2002) simply referred to 'partnership, participation and protection' (see Ramsden 2002, p. 75) as an example of various attempts at converting the Treaty of Waitangi into everyday principles – not as principles of cultural safety. The use of these principles in Australia is an example of academic policy naiveite because partnerships with Australia's First Peoples are

not legislated in Australia[45] compared to Māori people and the Crown in New Zealand,[46] participation is more complex in Australia's federal system,[5, 47] the term 'protection' raises the spectre of protectionist policies[48-51] which have a devastating impact on Australia's First Peoples (e.g. Stolen Generations).[52]

Additionally, in a second paper, Fleming et al. (2018b)[53] propose three principles of 'respect, relationships and responsibility provide a framework for culturally safe midwifery practice' but these principles are not explicitly stated as 'principles of cultural safety' in various reports.[37, 54-56] They are certainly keywords used in the cultural safety literature, but not 'principles' as described by Ramsden (2002) or the Nursing Council of New Zealand (2011). Again, this highlights the theme of policy naivety by academics because the history of 'principles' in Australian healthcare is extremely contentious with Sydney Sax stating health politics was 'a strife of interests masquerading as a conflict of principles'.[57]

The strife of principles constrains health professionals in contributing to the objectives of the National Scheme. For example, objective 4 (facilitate the assessment of overseas qualified practitioners) – when cultural safety is variously interpreted in Australia and Internationally, then what Australian principles would be the baseline for assessment? Answers to that question need to be discussed through engaging with health professionals and Australia's First Peoples.

What is evident in the literature is that all the statements of principles occur without cultural voice.[9] For example, Taylor & Geurin's cultural safety principles are unvalidated by the recipients of care – Aboriginal people in Central Australia. Their book thus enters the health professional education system as an authoritative source on cultural safety without cultural validity. In effect, this continues an Australian norm of discursive disempowerment of the voices of Australia's First Peoples in the knowledge production economy, which I have sought to address in my work.[8, 9]

3. Do you support the proposed draft definition? Why or why not?

I offer my thoughts now with the caveat that more working, thinking, yarning, and writing need to occur before arriving at a definitive set of principles. I would not support the definition in its current form for the reasons listed below.

> Cultural safety is the individual and institutional knowledge, skills, attitudes and competencies needed to deliver optimal health care for Aboriginal and Torres Strait Islander Peoples as determined by Aboriginal and Torres Strait Islander individuals, families and communities.

At this stage, I offer the following points for consideration:

1) I need to be clear that the term 'institutional' refers to the 'rules and resources' of societies and not 'organisations'. Phillips (2005) states that 'a feature of bio-power is that institutional arrangements, including buildings, professionalization, systems and structures all reinforce the power of the state (Rabinow 1991)'.[25] However, Giddens (1984) sees institutions as the 'rules and resources' most deeply embedded in social relationships. For example, the institutions of democracy, religion, health, sport, liberalism and conservatism, and racism and sexism are examples of institutions. They are characterised by deeply held values and norms that are often beyond our ability to put into words. Ask yourself, what are the values and norms of the institution of health? Phillips, as do many authors, conflate 'organisation' with 'institution' and this needs to be amended in the proposed definition or eliminated completely.
2) Furthermore, the reification of 'institution' is also problematic, where 'institution' is personified with personal 'skills, attitudes and competencies'. Giddens (1984) makes it clear that if society is without any citizens then 'institutions' have no physical presence outside of the people whose relationships constitute it. That is, our relational interactions simultaneously draw-on and re-create institutions, which is Giddens's Duality of Structure. Therefore, I suggest the separation of individual and institutional to be redundant and could be better reflected with the term 'relational' and so the proposed definition could be 'Cultural safety is the relational knowledge, skills, attitudes…'
3) On the definition of 'knowledge' I think of know-why, know-how, know-who, and know-what and so 'knowledge' intrinsically includes skills, attitudes, and competencies (and behaviours and actions). Therefore, the phrase 'relational knowledge' means putting 'relationships' first in knowledge so that finding the know-why (theoretical understanding affecting attitudes) depends on relations with Australia's First Peoples (instead of the reliance on literature reviews). Relations also come first with know-how (skills), know-who (collaboration, engagement, and participation), and know-what (competencies). In this construction the phrase 'relational knowledge' privileges the human cultural relationships needed with Australia's First Peoples in enabling cultural safety (see the 'interpretive scheme' box in Figure 2).
4) Aboriginal and Torres Strait Islander Peoples could be replaced with Australia's First Peoples because 'Aboriginal' and 'Torres' are terms of colonisation whereas, in using my tribal name Ngiyampaa, I am signalling to the State that I determine my identity. It says that I am not an 'Aboriginal' product of Western ideology described by an archaic Latin language – so this is about the power of language, discourse and knowledge construction (after Foucault) – where the State continually controls the discourse using the trope of Aboriginal, but I want to control the discourse by asserting my intellectual sovereignty.
5) At a philosophical level, I disagree with the phrase 'deliver optimal care' because I advocate for a strict separation between cultural competence and cultural safety. I see cultural competence as retaining the dominance of profession power whereas cultural safety is about more power in the hands of the citizen to determine if an action is culturally unsafe. Currently, the wording reads as 'health professionals can

deliver culturally safe care' as though 'cultural safety' is an off-the shelf product dispensed like a medicine. Perhaps, this could be reoriented so that it reads 'health professionals can enable cultural safety' by altering the words to 'needed to enable holistic health care'.

6) The whole phrase 'for Aboriginal and Torres Strait Islander Peoples as determined by Aboriginal and Torres Strait Islander individuals, families and communities.' Is just a bit confusing and wording and could be restructured to 'with Australia's First Peoples.'
7) In my construction, wording like 'Cultural safety is the relational knowledge needed by health professionals to enable holistic health care with Australia's First Peoples.' Captures the elements of power, human cultures, and cultural voice.

The proposed AHPRA definition needs to more technically concise, easily remembered, simple to explain, clear in its application to every aspect of health professional practice and reflect the cultural voice of Australia's First Peoples.

4. What other definitions, frameworks or policies should NRAS and NHLF's definition of cultural safety support?

Referring to the Australian cultural safety ecosystem (Figure 1), the AHPRA and the NHLF definition would be inserted into a very confusing strategic context – just look at the different brands of cultural policy in different Australian States. But if marketed, communicated, and branded appropriately, an AHPRA definition could act as a communication keystone (see 'communication' box, Figure 2) for health professionals throughout Australia, and support objective 3 of the National Scheme (facilitate provision of high quality education and training for practitioners). I see 'high quality education and training' to be based on a consistently applied definition that can be measured, monitored, and evaluated. The current ecosystem sees confusing concept soup (competence, safety, humility, inclusion, capability, etc.), multiple interpretations of cultural safety (Table 1), and many points (the boxes in Figure 1) and pathways (between the boxes in Figure 1) where the influence of cultural safety could be diminished.

I propose that to empower the cultural safety agenda in the National Scheme, that AHPRA cultural safety be endorsed by the NHLF whose members could also endorse Williams's (1999)[13] Australian cultural safety definition as stated by Bin-Sallik (2003):[14]

> Cultural safety is an environment that is spiritually, socially and emotionally safe, as well as physically safe for people; where there is no assault, challenge or denial of their identity, of who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience of learning together.

Williams's (1999) definition was constructed in the context of health professional education at the Northern Territory University and that is a thematic thread to the AHPRA definition within its context of health professional education. In fact, most usage of cultural safety focusses on education (Table 1). Thus, the alignment between the AHPRA definition and

Williams's definition would be a powerful message that says enabling culturally safe health services means health professionals ascribe to the AHPRA definition which supports Williams's definition. Therefore, in the power of communication (see 'power' box, Figure 2) there would be clearly defined terms for health professionals to refer to as a baseline for education and training.

This has implications for many policies and strategies (see Table 1). For example, the National Aboriginal and Torres Strait Islander Health Plan 2013-2023 states 'Implement cultural safety and quality of care agendas for Aboriginal and Torres Strait Islander people across the entire health system'[58] which is a 'key strategy' within the overarching goal of 'health system effectiveness and clinically appropriate care'. The definition of cultural safety is derived from the National Aboriginal Community Controlled Health Organisation's (2011) Creating the NACCHO Cultural Safety Training Standards and Assessment Process, which references Ramsden's cultural safety and not Williams's (1999) cultural safety. This confusing situation needs to be addressed and the dual support of the AHPRA and the NHLF for both the AHPRA definition of cultural safety for health professionals and Williams's cultural safety for Australian Aboriginal and Torres Strait Islander health policy promotes consistency for policy and strategy.

However, the proposed AHPRA definition of cultural safety should support (not supplant) Williams's Australian definition of cultural safety. For example, 'optimal health care' seems to be about 'physical safety' so that is the link between the two definitions, but the AHPRA definition does not claim the whole ground of holistic health as stated by Williams (an environment that is spiritually, socially, and emotionally safe…) which needs addressing through other social policy areas. Therefore, the AHPRA definition would support and not supplant Williams's definition. This kind of strategy could be pursued further but lack of time and resources prevents a more detailed analysis.

> Cultural safety is the individual and institutional knowledge, skills, attitudes and competencies needed to deliver optimal health care for Aboriginal and Torres Strait Islander Peoples as determined by Aboriginal and Torres Strait Islander individuals, families and communities.

5. Is there anything else you'd like to tell us about the draft definition?

I will raise the issue of the importance of cultural provenance, which I define as the culturally based philosophical roots of concepts and definitions. 'While one might expect the concept of cultural safety to have similar utility with other indigenous peoples as it does in New Zealand, the question as to whether it could be transported to other contexts has been pursued by different scholars.'[17] The information in Table 1 shows that different sources of cultural safety inform the definitions used in different documents. It seems that policy writers are happy to appropriate the intellectual work of authors from different countries in ignorance of the concepts of self-determination and empowerment intrinsic to the 'local' policy principle in Aboriginal and Torres Strait Islander health policy. That is, with

hundreds of First Nations it is required to develop policy, strategy, and programs with local Aboriginal and Torres Strait Islander communities. In my review of Australian academic literature of cultural safety,[9] it seemed normal for academics to decide that the cultural fit between Australia's First Peoples and other colonised peoples was good enough to assume that cultural safety was a universal 'given' between all colonised Indigenous peoples!

There are no 'validation' studies to test if Australia's First Peoples see cultural safety the way other Indigenous peoples see cultural safety, or how non-Indigenous people see cultural safety, or how different cultures see cultural safety. Unfortunately, I think the proposed AHPRA definition carries with it this assumption of cultural uniformity because it is constructed based on the intellectual mish-mash shown in Table 1 and as I have found in the academic literature. This implied cultural uniformity is evident in the copy and paste proforma (Figure 4) to cultural safety where the AHPRA has provided a generic 'code of conduct' template for the 14 Boards wherein section 3 (working with patients and clients) contains a subsection 'culturally safe and sensitive practice':

Good practice involves an awareness of the cultural needs and contexts of all patients and clients, to obtain good health outcomes. This includes:

a. having knowledge of, respect for and sensitivity towards the cultural needs and background of the community practitioners serve, including those of Aboriginal and/or Torres Strait Islander Australians and those from culturally and linguistically diverse backgrounds. For example, better and safer outcomes may be achieved for some patients if they are able to be consulted or treated by a practitioner of the same gender
b. acknowledging the social, economic, cultural, historic and behavioural factors influencing health, both at individual and population levels
c. understanding that a practitioner's own culture and beliefs influence their interactions with patients or clients, and
d. adapting practice to improve engagement with patients or clients and healthcare outcomes.

Figure 4: AHPRA Proforma for Cultural Safety

This proforma looks like a set of principles that could be about cultural awareness, cultural appropriateness, or cultural competence, so it seems disingenuous to the ethic of cultural safety (power and culture, see question 2). More work is needed to move beyond the copy and paste approach to cultural safety by undertaking a rigours audit of each health profession[8] so that profession specific principles (and definitions) are determined, rather than assuming that one-size-fits-all proforma.

Conclusion

The proposed AHPRA definition of cultural safety for the National Registration and Accreditation Scheme represents a key moment in the evolution of cultural safety in Australia. I sought to argue the importance of definitions in terms of structuration theory, in the context of the broader cultural safety ecosystem, considering current usage of cultural safety in policies and strategies, and how cultural safety is used in academic journal articles. This revealed a troubling trajectory leading up to this consultation point where there is a high degree of variation in the use of cultural safety and a very confusing situation facing health professionals when they seek to enable cultural safety in their practices. Therefore, the AHPRA and NHLF should continue to refine the proposed definition so that the energy of this moment is not lost in policy rhetoric but empowers the cultural voice of Australia's First Peoples into health professional education, training, and regulation.

Table 1: Australian Usage of Cultural Safety

Source	Definition	Cultural Provenance	Cultural Voice
RACP and AIDA (2004) – An introduction to cultural competency	Cultural safety is based on the experience of the recipient of care, rather than from the perspective of the medical practitioner. It involves the effective care of a person or family from another culture by a medical practitioner who has undertaken a process of reflection on their own cultural identity and recognises the impact their culture has on their own medical practice. Cultural safety aims to enhance the delivery of health services by identifying the power relationship between the medical practitioner and the patient, and empowering the patient to take full advantage of the health care service offered. Unsafe cultural practice is any action that diminishes, demeans or disempowers the cultural identity and wellbeing of an individual. Patients who feel unsafe and who are unable to express degrees of felt risk may subsequently require expensive and often dramatic medical treatment. Cultural safety gives Aboriginal people the power to comment on the care provided, leading to reinforcement of positive experiences. It also enables them to be involved in changes in any service experienced as negative. Cultural safety recognises that inequalities within health care interactions represent in microcosm the inequalities in health that have prevailed through history and within our nation more generally. It accepts the legitimacy of difference and diversity in human behaviour and social structure. It recognises that the attitudes and beliefs, policies and practices of medical practitioners can act as barriers to service access, and is concerned with quality improvement in service delivery and consumer rights.	Nursing Council of New Zealand, 'Cultural Safety, the Treaty of Waitangi, and Maori Health in Nursing and Midwifery, Education and Practice', March 2002	Unstated developmental process and no explicitly methodology of development that stipulates how Australia's First Peoples were involved.
Phillips, G. (2004). CDAMS Indigenous Health Curriculum Framework. Melbourne.	Ensuring that those individuals and systems delivering health care are aware of the impact of their own culture and cultural values on the delivery of services, and that they have some knowledge of, respect for and sensitivity towards the cultural needs of others. There is much written about slightly different but related terms, such as 'cultural security', 'culturally appropriate', 'culturally aware', 'culturally valid', and 'culturally competent'.	For more on Cultural Safety see: J. Campinha-Bacote 2003 (US), 'Many Faces: Addressing diversity in health care'. ; I. Dyck & R. Kearns 1995 (Canada), 'Transforming the	Individually defined based on synthesis from multiple sources of information.

		Relations of Research: Towards culturally safe geographies of health and healing'; I. Ramsden 2000, 'Cultural Safety/ Kawa Whakaruruhau Ten Years on: A personal overview', Nursing Praxis in New Zealand, vol. 15, no. 1, pp. 4–12; M. Tervalon 2003, 'Components of culture in health for medical students' education' (US). Williams [1999], Cultural Safety—What Does it Mean for our Work Practice.	
Thomson, N. (2005). "Cultural respect and related concepts: a brief summary of the literature." Australian Indigenous Health Bulletin 5(4): 1-11.	The effective nursing practice of a person or family from another culture, and is determined by that person or family. Culture includes, but is not restricted to, age or generation; gender; sexual orientation; occupation and socioeconomic status; ethnic origin or migrant experience; religious or spiritual belief; and disability. This definition is accompanied by the comment that 'the nurse delivering the nursing service will have undertaken a process of reflection on his or her own cultural identity and will recognise the impact that his or her personal culture has on his or her professional practice. Unsafe cultural practice comprises any action which diminishes, demeans or disempowers the cultural identity and wellbeing of an individual'.	Nursing Council of New Zealand (2005) Guidelines for cultural safety, the Treaty of Waitangi and Maori health in nursing education and practice.	Individual research without any explicitly sociological methodology or attempt to refer to the cultural perspectives of Australia's First Peoples.
Hospital and Health Service Performance Division (2010). Improving the patient experience for Aboriginal people in the emergency department.	Cultural safety, as it applies to health care, is the need to be recognised within the health care system and be assured that the system reflects something of your culture, language, customs, attitudes, beliefs and preferred ways of doing things.	Eckermann, A., Dowd, T., Martin, M., Dixon, L., Gray, R., & Chong, E., 1992, Binan Goonj: Bridging cultures in Aboriginal health, Armidale, Department	Community consultation processes

Melbourne, Victorian Government.[59]		of Aboriginal and Multicultural Studies, University of New England.	
Taylor, K. and Guerin, P. (2010). Health Care and Indigenous Australians: Cultural safety in practice. Palgrave MacMillan, Victoria, Australia	The effective nursing practice of a person or family from another culture, and is determined by that person or family. Culture includes, but is not restricted to, age or generation; gender; sexual orientation; occupation and socioeconomic status; ethnic origin or migrant experience; religious or spiritual belief; and disability. The nurse delivering the nursing service will have undertaken a process of reflection on his or her own cultural identity and will recognise the impact that his or her personal culture has on his or her professional practice. Unsafe cultural practice comprises any action which diminishes, demeans or disempowers the cultural identity and wellbeing of an individual'	Nursing Council of New Zealand (2011) Guidelines for cultural safety, the Treaty of Waitangi and Maori health in nursing education and practice.	Individual thesis[60]
National Aboriginal Community Controlled Health Organisation (2011). Creating the NACCHO Cultural Safety Training Standards and Assessment Process. A Background Paper. Canberra.	Definitions of cultural respect and cultural safety, particularly those from the perspective of Aboriginal Peoples, emphasise that the presence of cultural safety can only be defined by those who receive health care; they will determine if their cultural identity and meanings are being respected, and they are not being subjected to discrimination. Therefore, a discussion of power and power imbalances between consumers and health care providers that includes the place of culture is needed within cultural respect/safety training. This means approaching health care services and outcomes in a political context, not just a social, scientific, ethical or legal context.	Ramsden (2002)	Aboriginal Health Council of South Australia, Aboriginal Health Council of Western Australia, Aboriginal Health & Medical Research Council of NSW, Aboriginal Medical Services Alliance Northern Territory, Queensland Aboriginal and Islander Health Council, Victorian Aboriginal Community Controlled Health Organisation, Winnunga Nimmityjah

			Aboriginal Health Service, and the National Aboriginal Community Controlled Health
The Royal Australian College of General Practitioners (2011). Cultural awareness and cultural safety training.	Cultural safety is defined as 'an outcome of health practice and education that enables safe service to be defined by those who receive the service'.3 Strategies aim to create an environment that is 'safe for people: where there is no assault, challenge or denial of their identity, of who they are and what they need', where there is 'shared respect, shared meaning, shared knowledge and experience, of learning, living and working together with dignity and truly listening'.4	Eckermann AK, et al. Binan Goonj: Bridging Cultures in Aboriginal Health. 2nd edn. Churchill Livingstone, 2006. Williams R. Cultural safety – What does it mean for our work practice? Australian and New Zealand Journal of Public Health 1999;23:213–4.	Consultation process
Victorian Department of Health (2012), Koolin Balit Victorian Government strategic directions for Aboriginal health 2012–2022	cultural safety, which is where people feel safe and secure, in an environment due to shared respect, meaning, knowledge and experience, ensuring dignity and truly listening (Williams 2008)	Australia – Williams (1999)	Consultation processes
National Aboriginal and Torres Strait Islander Health Worker Association (2013). Cultural Safety Framework: National Aboriginal and Torres Strait Islander Health Workers Association. Canberra.	Cultural safety is the 'outcome of education that enables safe services to be defined by those who receive the service' and 'Unsafe cultural practice is any action which diminishes, demeans or disempowers the cultural identity and wellbeing of an individual'	Nursing Council of New Zealand (2002), Guidelines for cultural safety in nursing and midwifery. Wellington: NCNZ.	Australian Aboriginal and Torres Strait Islander Health Workers – but no explicit process or methodology explained for gaining opinions about cultural safety.

Australian Indigenous Doctors' Association (2013). Cultural Safety Factsheet. Manuka, ACT.	Cultural safety refers to the accumulation and application of knowledge of Aboriginal and Torres Strait Islander values, principles and norms. It is about overcoming the cultural power imbalances of places, people and policies to contribute to improvements in Aboriginal and Torres Strait Islander health and increasing numbers within, and support for, the Aboriginal and Torres Strait Islander medical workforce. As outlined in our Cultural Safety for Aboriginal and Torres Strait Islander Doctors, Medical Students and Patients position paper, AIDA views cultural safety on a continuum of care with cultural awareness being the first step in the learning process and cultural safety being the final outcome. This is a dynamic and multi-dimensional process where an individual's place in the continuum of care can change depending on the setting. For example, Aboriginal and Torres Strait Islander community-controlled health services, hospitals or communities.	Unstated	No consultation or development process documented.
Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (2014). Cultural Safety Position Statement. Canberra.	Cultural safety is viewed by CATSINaM as the final step on a continuum of nursing and/or midwifery care that includes cultural awareness, cultural sensitivity, cultural knowledge, cultural respect and cultural competence. Cultural safety is the recipient's own experience and cannot be defined by the caregiver. CATSINaM advocates on behalf of Aboriginal and Torres Strait Islander peoples by promoting a framework of cultural safety to inform attitudes and behaviours in the provision of care by health professionals to Aboriginal and Torres Strait Islander individuals and communities, so individuals and their families feel culturally secure, safe and respected. To achieve this state, cultural safety must be embedded in every aspect of nursing and midwifery practice.	Unstated	No consultation or development process documented.
Australian Government Department of Health (2014). Aboriginal and Torres Strait Islander Health Curriculum Framework. Canberra.	The concept of cultural safety in health service delivery focuses on the subjective experience of the health service user, whereby they experience an environment that does not challenge, assault or deny their cultural identity. Cultural safety is enabled if the people who work there show respect and sensitivity for the different cultural needs of Aboriginal and Torres Strait Islander peoples, and are aware of how their own cultural values may have an impact (Phillips 2004). A culturally safe setting allows for shared learning, shared meaning and genuine listening with full acceptance of Aboriginal and Torres Strait Islander diversity (Eckermann et al. 2010).	Phillips, G 2004 , CDAMS Indigenous Health Curriculum Framework, The Project Steering Committee of Deans of Australian Medical Schools, CDAMS, University of NSW, Sydney.	Consultation process.

		Eckermann, A-K, Toni D, Chong, E, Nixon, L, Gray, RL & Johnson, SM 2010, Binan gooniji: bridging cultures in Aboriginal health, (3rd edition), Elsevier, Chatswood.	
Indigenous Allied Health Australia (2015). Cultural Responsiveness in Action: An IAHA Framework. Deakin West, ACT.	Cultural safety is about experiencing environments, e.g. family, workplace, service provider and community, in which people feel safe and secure in their identity; where there is no assault, challenge or denial of their identity, who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience of learning, living and working together with dignity.	Williams R. Cultural safety – What does it mean for our work practice? Australian and New Zealand Journal of Public Health 1999;23:213–4.	No consultation or development process documented.
Phillips, G. (2015). Dancing with Power: Aboriginal Health, Cultural Safety and Medical Education. Social Sciences and Health Research Unit, School of Psychological Sciences, Faculty of Medicine, Nursing and Health Sciences. Unpublished PhD thesis. **Doctoral**.	At the heart of ideas of cultural safety were notions of: strengthening and validating Maori cultural identity in an essentially western, biomedical and alienating health care system (Te Kaunihera Tapuhi o Aotearoa Nursing Council of New Zealand 2005); identifying how otherness and white privilege worked in a systemic way (Moreton-Robinson 2000, Ramsden 2002); promoting understanding of reflexivity such that the myth of monoculturalism as 'normal' was exposed (Richardson 2004), and empowering and giving voice to Maori worldviews, beliefs and customs (Ramsden 2000).	Ramsden (2002)	Individual thesis.
Australian Government Department of Health (2015). Implementation Plan for the National Aboriginal and Torres	Provide care in a manner that is respectful of a person's culture and beliefs, and that is free from discrimination.	National Aboriginal Community Controlled Health Organisation, 'Cultural Safety', NACCHO, n.d.	Consultation process

Strait Islander Health Plan 2013-2023. Canberra.		Accessed 12 July 2015 <http://www.naccho.org.au/promote-health/cultural-safety/>. Link Broken	
ACEM (2015) 'Statement on Culturally-Competent Care and Cultural Safety in Emergency Medicine'	Cultural safety can be defined as patient care in an environment "that is spiritually, socially and emotionally safe, as well as physically safe for people; where there is no assault challenge or denial of their identity, of who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience of learning together."	Bin-Sallik, M. (2003) citing Williams (1999).	No consultation or development process documented.
ACEM 'Quality Standards for Emergency Departments and other Hospital-based Emergency Care Services', 1st Edition, 2015	The effective care of a person or family from another culture by a medical practitioner who has undertaken a process of reflection on their own cultural identity and recognises the impact their culture has on their own medical practice. Cultural safety aims to enhance the delivery of health services by identifying the power relationship between the medical practitioner and the patient, and empowering the patient to take full advantage of the health care service offered.	RACP, An Introduction to Cultural Competency. 2004, Royal Australasian College of Physicians (Nursing Council of New Zealand, 'Cultural Safety, the Treaty of Waitangi, and Maori Health in Nursing and Midwifery, Education and Practice', March 2002)	Consultation process
Sibthorpe, B., et al. (2015). National CQI Framework for Aboriginal and Torres Strait Islander Primary Health Care 2015-2025. Prepared for the Commonwealth Department of Health, November 2015. Melbourne.	[A]n environment that is safe for people: where there is no assault, challenge or denial of their identity, of who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience of learning, living and working together with dignity and truly listening.	Robyn Williams (1999) as cited by Maryann Bin-Salik (2003)	Consultation process

Australian Health Ministers' Advisory Council (2016). Cultural Respect Framework for Aboriginal and Torres Strait Islander Health, 2016-2026. Canberra.	Identifies that health consumers are safest when health professionals have considered power relations, cultural differences and patients' rights. Part of this process requires health professionals to examine their own realities, beliefs and attitudes. Cultural safety is not defined by the health professional, but is defined by the health consumer's experience—the individual's experience of care they are given, ability to access services and to raise concerns. The essential features of cultural safety are: a) An understanding of one's culture, b) An acknowledgment of difference, and a requirement that caregivers are actively mindful and respectful of difference(s), c) It is informed by the theory of power relations; any attempt to depoliticise cultural safety is to miss the point, d) An appreciation of the historical context of colonisation, the practices of racism at individual and institutional levels, and their impact on First Nations people's living and wellbeing, both in the present and past, & e) Its presence or absence is determined by the experience of the recipient of care and not defined by the caregiver.	New Zealand - Papps, E, & Ramsden, I 1996, 'Cultural Safety in Nursing: the New Zealand Experience', International Journal for Quality in Health Care, vol. 8, no. 5, pp. 491-497.	No consultation or development process documented.
Australian College of Rural and Remote Medicine (2016). Advanced Specialised Training Aboriginal and Torres Strait Islander Health Curriculum. Brisbane.	Cultural safety training requires health professionals to undertake a process of personal reflection of their own cultural identity to be able to recognise the impact that their own culture has upon health care practice. It also involves acknowledging the consequence of colonisation as a major factor in the poor health status of Aboriginal and Torres Strait Islander people, the denial of which has been at the heart of conflict between Aboriginal and Torres Strait Islander and Western world views.	Nursing Council of New Zealand (2002), and Ramsden (2002). Australia's Rural and Remote Health: A Social Justice Perspective (2004))	Consultation process
Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (2017). The Nursing and Midwifery Aboriginal and Torres Strait Islander Health Curriculum Framework. Canberra.	Cultural safety is a philosophy of practice that is about how a health professional does something, not what they do, in order to not engage in unsafe cultural practice that '… diminishes, demeans or disempowers the cultural identity and wellbeing of an individual' (Nursing Council of New Zealand 2011, p 7). It is about how people are treated in society, not about their diversity as such, so its focus is on systemic and structural issues and on the social determinants of health. Cultural safety represents a key philosophical shift from providing care regardless of difference to care that takes account of peoples' unique needs. It requires nurses and midwives to undertake an ongoing process of self-reflection and cultural self-awareness,	Ramsden (2002) & Nursing Council of New Zealand (2011)	No consultation or development process documented.

	and an acknowledgement of how a nurse's/midwife's personal culture impacts on care. Cultural safety uses a broad definition of culture that does not reduce it to ethnicity, but includes age/generation, sexual orientation, socio-economic status, religious or spiritual belief, ethnic origin, gender and ability. It also recognises that professions and work places have cultures, and cultural safety is as applicable to working with colleagues in providing health care as it is to working with health service users. In relation to Aboriginal and Torres Strait Islander health, cultural safety provides a decolonising model of practice based on dialogue, communication, power sharing and negotiation, and the acknowledgment of white privilege. These actions are a means to challenge racism at personal and institutional levels, and to establish trust in health care encounters.		
The Wardliparingga Aboriginal Research Unit of the South Australian Health and Medical Research Institute (2017). National Safety and Quality Health Service Standards user guide for Aboriginal and Torres Strait Islander Health. Sydney.	cultural safety: identifies that health consumers are safest when clinicians have considered power relations, cultural differences and patients' rights. Part of this process requires clinicians to examine their own realities, beliefs and attitudes. Cultural safety is defined not by the clinician but by the health consumer's experience – the individual's experience of the care they are given, and their ability to access services and to raise concerns. The essential features of cultural safety are: • An understanding of one's culture, • An acknowledgement of difference, and a requirement that caregivers are actively mindful and respectful of difference(s), • Informed by the theory of power relations; any attempt to depoliticise cultural safety is to miss the point, • An appreciation of the historical context of colonisation, the practices of racism at individual and institutional levels, and their impact on First Nations people's living and wellbeing, in both the present and the past, • That its presence or absence is determined by the experience of the recipient of care and not defined by the caregiver.	National Aboriginal and Torres Strait Islander Health Standing Committee of the Australian Health Ministers' Advisory Council. Cultural respect framework 2016–2026 for Aboriginal and Torres Strait Islander health. Canberra: AHMAC; 2016. – From New Zealand	Consultation process
Nursing and Midwifery Board of Australia (2018). Code of Conduct for Nurses. Melbourne.	Cultural safety concept was developed in a First Nations' context and is the preferred term for nursing and midwifery. Cultural safety is endorsed by the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM), who emphasise that cultural safety is as important to quality care as clinical safety. However, the "presence or absence of cultural safety is determined by the recipient of care; it is not defined by the caregiver" (CATSINaM, 2014, p. 94). Cultural safety is a philosophy of practice that is about how a health professional does something, not [just] what they do. It is	Ramsden (2002) & Nursing Council of New Zealand (2011)	Consultation process

	about how people are treated in society, not about their diversity as such, so its focus is on systemic and structural issues and on the social determinants of health. Cultural safety represents a key philosophical shift from providing care regardless of difference, to care that takes account of peoples' unique needs. It requires nurses and midwives to undertake an ongoing process of self-reflection and cultural self-awareness, and an acknowledgement of how a nurse's/midwife's personal culture impacts on care. In relation to Aboriginal and Torres Strait Islander health, cultural safety provides a de-colonising model of practice based on dialogue, communication, power sharing and negotiation, and the acknowledgment of white privilege. These actions are a means to challenge racism at personal and institutional levels, and to establish trust in healthcare encounters (CATSINaM, 2017b, p. 115). In focusing on clinical interactions, particularly power inequity between patient and health professional, cultural safety calls for a genuine partnership where power is shared between the individuals and cultural groups involved in healthcare. Cultural safety is also relevant to Aboriginal and Torres Strait Islander health professionals. Non-Indigenous nurses and midwives must address how they create a culturally safe work environment that is free of racism for their Aboriginal and Torres Strait Islander colleagues (CATSINaM, 2017a)		

References

1. Australian Health Practitioner Regulation Agency, (2019). Public Consultation. Have Your Say: Consultation on the Definition of 'Cultural Safety': AHPRA. Available: https://www.ahpra.gov.au/News/Consultations.aspx. Accessed: 29 April 2019.

2. Lock M.J., (2007). Aboriginal Holistic Health: A Critical Review. Darwin: CRCAH. Available: https://www.lowitja.org.au/lowitja-publishing/C002. Accessed: 15 October 2018.

3. Lutschini M., (2005). Engaging with Holism in Australian Aboriginal Health Policy – a Review. *Aust New Zealand Health Policy*. Vol.2(1):15. Available: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1187865/. Accessed: 3 August 2018.

4. Lock M.J., (2008). The Participation of Indigenous People in National Indigenous Health Policy Processes. Melbourne: Publisher. Available: https://minerva-access.unimelb.edu.au/handle/11343/35282.

5. Lock M.J., Thomas D.P., Anderson I.P., Pattison P., (2011). Indigenous Participation in an Informal National Indigenous Health Policy Network. *Australian Health Review*. Vol.35(3):309-315. Available: http://www.publish.csiro.au/AH/AH09812. Accessed: 30 November 2018.

6. Lock M.J., Stephenson A.L., Branford J., Roche J., Edwards M.S., Ryan K., (2017). Voice of the Clinician: The Case of an Australian Health System. *Journal of health organization and management*. Vol.31(6):665-678. Available: https://doi.org/10.1108/JHOM-05-2017-0113. Accessed: 2017/11/13.

7. Papps E., Ramsden I., (1996). Cultural Safety in Nursing: The New Zealand Experience. *International Journal for Quality in Health Care*. Vol.8(5):491-497. Available: https://www.researchgate.net/profile/Elaine_Papps3/publication/14101522_Cultural_Safety_in_Nursing_the_New_Zealand_Experience/links/5403bf800cf2c48563b03069/Cultural-Safety-in-Nursing-the-New-Zealand-Experience.pdf. Accessed: 20 March 2018.

8. Lock M.J., (2018). Australian Open Disclosure Governance - Closed to Cultural Voice. Critique of Australian Open Disclosure Governance and the Cultural Voice of Australia's First Peoples. Newcastle: Committix Pty Ltd. Available: https://committix.com/projects/cultural-voice-and-open-disclosure/. Accessed 14 May 2019.

9. Lock M., (2018). Australian Healthcare Governance and the Cultural Safety and Security of Australia's First Peoples: An Annual Critique. No.1: Focussing on Knowledge Governance. Newcastle: Committix Pty Ltd. Available: https://committix.com/projects/the-cultural-safety-project/. Accesses 14 May 2019

10. Australian Health Practitioner Regulation Agency. (2018). Ahpra Aboriginal and Torres Strait Islander Health Strategy Group. Available: http://www.ahpra.gov.au/About-AHPRA/Aboriginal-and-Torres-Strait-Islander-Health-Strategy.aspx. Accessed: 10 July.

11. Australian Health Practitioner Regulation Agency. (2018). Aboriginal and Torres Strait Islander Health Strategy - Statement of Intent. Available: http://www.ahpra.gov.au/About-AHPRA/Aboriginal-and-Torres-Strait-Islander-Health-Strategy/Statement-of-intent.aspx. Accessed: 10 July 2018.

12. Australian Health Practitioner Regulation Agency, (2018). Ahpra 'Reflect' Reconciliation Action Plan 2018-2019. Available: http://www.ahpra.gov.au/About-AHPRA/Aboriginal-and-Torres-Strait-Islander-Health-Strategy.aspx#statement-of-intent. Accessed: 10 July 2018.

13. Williams R., (1999). Cultural Safety – What Does It Mean for Our Work Practice? *Aust N Z J Public Health.* Vol.23(2):213-214. Available: http://onlinelibrary.wiley.com/doi/10.1111/j.1467-842X.1999.tb01240.x/abstract. Accessed: 23 March 2016.

14. Bin-Sallik M., (2003). Cultural Safety: Let's Name It! *The Australian Journal of Indigenous Education.* Vol.32:21-28. Available: https://www.cambridge.org/core/journals/australian-journal-of-indigenous-education/article/cultural-safety-lets-name-it/C36DE4A99C22B3AC482E01694276C61D. Accessed: 23 August 2018.

15. Giddens A. (1984). The Constitution of Society: Outline of the Theory of Structuration. Berkeley: University of California Press. Available: https://www.ucpress.edu/book/9780520057289/the-constitution-of-society. Accessed: 11 July 2018.

16. Piña l.L., Cohen P.D., Larson D.B., Marion L.N., Sills M.R., Solberg L.I., Zerzan J., (2015). A Framework for Describing Health Care Delivery Organizations and Systems. *Am J Public Health.* Vol.105(4):670-679. Available: https://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2014.301926. Accessed: 11 July 2018.

17. Anderson J., Perry J., Blue C., Browne A., Henderson A., Khan K.B., Kirkham S.R., Lynam J., Semeniuk P., Smye V., (2003). "Rewriting" Cultural Safety within the Postcolonial and Postnational Feminist Project: Toward New Epistemologies of Healing. *Advances in Nursing Science.* Vol.26(3):196-214.

18. Seaton L.P., (2010). Cultural Care in Nursing: A Critical Analysis. Unpublished Doctoral Thesis,: Publisher. Available: https://opus.lib.uts.edu.au/bitstream/10453/20316/4/02Whole.pdf. Accessed: 10 April 2019.

19. Polaschek, (1998). Cultural Safety: A New Concept in Nursing People of Different Ethnicities. *J Adv Nurs.* Vol.27(3):452-457. Available: http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=5278016&site=ehost-live.

20. Bozorgzad P., Negarandeh R., Raiesifar A., Poortaghi S., (2016). Cultural Safety: An Evolutionary Concept Analysis. *Holistic nursing practice.* Vol.30(1):33-38. Available: https://journals.lww.com/hnpjournal/Abstract/2016/01000/Cultural_Safety__An_Evolutionary_Concept_Analysis.6.aspx. Accessed: 8 August 2018.

21. McGough S., Wynaden D., Wright M., (2018). Experience of Providing Cultural Safety in Mental Health to Aboriginal Patients: A Grounded Theory Study. *Int J Ment Health Nurs.* Vol.27:204-2013. Available: http://onlinelibrary.wiley.com/doi/10.1111/inm.12310/abstract. Accessed: 15 October 2018.

22. Cox L., Best O. (2019). "Cultural Safety History Repeats: Why Are We Taking the Redefinition Road?". Available: https://croakey.org/cultural-safety-history-repeats-why-are-we-taking-the-redefinition-road/. Accessed: 6 May 2019.

23. Ramsden I., (1990). Kawa Whakaruruhau : Cultural Safety in Nursing Education in Aotearoa. TBD: I.M.Ramsden. Available: http://www.moh.govt.nz/NoteBook/nbbooks.nsf/0/707224BC1D4953C14C2565D700190AD9?opendocument. Accessed: 6 May 2019.

24. Iobst W.F., Sherbino J., Cate O.T., Richardson D.L., Dath D., Swing S.R., Harris P., Mungroo R., Holmboe E.S., Frank J.R., (2010). Competency-Based Medical Education in Postgraduate Medical Education. *Med Teach.* Vol.32(8):651-656. Available:

https://ojs.library.queensu.ca/index.php/inquiryatqueens/article/view/13260. Accessed: 6 May 2019.

25. Phillips G., (2015). Dancing with Power: Aboriginal Health, Cultural Safety and Medical Education. Unpublished PhD thesis: Monash University. Available: https://figshare.com/articles/Dancing_with_power_Aboriginal_health_cultural_safety_and_medical_education/4711894. Accessed: 7 December 2017.

26. Ghys L., (2008). Just Journalism or Just Journalism: Practising Safe Text. Adelaide: CSAA. Available: http://www.kooriweb.org/foley/resources/media/journalism%20or%20just%20journalism.pdf. Accessed: 30 May 2018.

27. Davies H.T.O., Nutley S.M., Mannion R., (2000). Organisational Culture and Quality of Health Care. *Quality in Health Care.* Vol.9(2):111-119. Available: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1743521/pdf/v009p00111.pdf. Accessed: 10 August 2108.

28. NSW Department of Health, (2011). Workplace Culture Framework. Making a Positive Difference to Workplace Culture. Sydney: Workforce Development and Innovation, NSW Department of Health. Available: http://www.health.nsw.gov.au/workforce/pages/workplace-culture-framework.aspx. Accessed: 10 August 2018.

29. Hart B., Cavanagh M., Douglas D., (2015). The "Strengthening Nursing Culture Project" - an Exploratory Evaluation Study of Nursing Students' Placements within Aboriginal Medical Services. *Contemp Nurse.* Vol.51(2-3):245-256. Available: http://www.ncbi.nlm.nih.gov/pubmed/26850674. Accessed: 10 August 2018.

30. Australian Commission on Safety and Quality in Health Care, (2017). National Safety and Quality Health Service Standards (Second Edition). Sydney: ACSQHC. Available: http://www.nationalstandards.safetyandquality.gov.au/. Accessed: 12 October 2018.

31. Braithwaite J., Healy J., Dwan K., (2005). The Governance of Health Safety and Quality. Available: https://safetyandquality.gov.au/wp-content/uploads/2012/01/governance0705.pdf. Accessed: 15 October 2018.

32. ACT Government Health, (2015). Act Health Quality and Clinical Governance Framework 2015-2018. Canberra: Australian Capital Territory Government.

33. ASX Corporate Governance Council, (2014). Corporate Governance Principles and Recommendations (3rd Edition). Sydney: Australian Securities Exchange. Available: http://www.asx.com.au/documents/asx-compliance/cgc-principles-and-recommendations-3rd-edn.pdf. Accessed: 2 May 2016.

34. Australian Government Department of Prime Minister and Cabinet, (2013). Cabinet Implementation Unit Toolkit - Governance. Canberra: Commonwealth of Australia. Available: https://www.pmc.gov.au/government/policy-implementation. Accessed: 13 August 2018.

35. Australian National Audit Office, (2014). Public Sector Governance - Strengthening Performance through Good Governance. Better Practice Guide. Barton: ANAO. Available: http://webarchive.nla.gov.au/gov/20170421043523/https://www.anao.gov.au/pubs/better-practice-guides. Accessed: 13 August 2018.

36. Australian Commission on Safety and Quality in Health Care, (2017). Safety Culture Assessment in Health Care: A Review of the Literature on Safety Culture Assessment Methods. Sydney: ACSQHC. Available: https://www.safetyandquality.gov.au/wp-

content/uploads/2017/10/Safety-Culture-Assessment-in-Health-Care-A-review-of-the-literature-on-safety-culture-assessment-modes.pdf. Accessed: 23 February 2018.

37. Nursing Council of New Zealand, (2011). Guidelines for Cultural Safety, the Treaty of Waitangi, and Maori Health in Nursing Education and Practice. Wellington: Nursing Council of New Zealand. Available: http://www.nursingcouncil.org.nz/Publications/Standards-and-guidelines-for-nurses. Accessed: 12 October 2018.

38. Cross T.L., Bazron B.J., Dennis K.W., Isaacs M.R., (1989). Towards a Culturally Competent System of Care: A Monograph on Effective Services for Minority Children Who Are Severely Emotionally Disturbed. Washington, DC: National Institute of Mental Health. Available: http://files.eric.ed.gov/fulltext/ED330171.pdf. Accessed: 31 July 2018.

39. Taras V., Rowney J., Steel P., (2009). Half a Century of Measuring Culture: Review of Approaches, Challenges, and Limitations Based on the Analysis of 121 Instruments for Quantifying Culture. *Journal of International Management.* Vol.15(4):357-373. Available: http://www.sciencedirect.com/science/article/pii/S1075425309000672. Accessed: 5 November 2018.

40. Ramsden I.M., (2002). Cultural Safety and Nursing Education in Aotearoa and Te Waipounamu. Wellington: Unpublished PhD thesis. Available: http://www.nzno.org.nz/Portals/0/Files/Documents/Services/Library/2002%20RAMSDEN%20I%20Cultural%20Safety_Full.pdf. Accessed: 15 August 2008.

41. Kruske S., Kildea S., Barclay L., (2006). Cultural Safety and Maternity Care for Aboriginal and Torres Strait Islander Australians. *Women and Birth.* Vol.19(3):73-77. Available: http://www.ncbi.nlm.nih.gov/pubmed/16911880. Accessed: 18 September 2017.

42. Australasian College for Emergency Medicine, (2015). Statement on Culturally-Competent Care and Cultural Safety in Emergency Medicine. Online: ACEM. Available: https://acem.org.au/getmedia/bc703912-38e8-47ec-86e5-7117439535ca/S63_culturally_competent_care_in_EM_02_Mar_15.aspx. Accessed: 10 April 2019.

43. Ryder C., Mackean T., Ullah S., Burton H., Halls H., McDermott D., Edmondson W., (2017). Development and Validation of a Questionnaire to Measure Attitude Change in Health Professionals after Completion of an Aboriginal Health and Cultural Safety Training Programme. *The Australian Journal of Indigenous Education.*1-15. Available: https://www.cambridge.org/core/article/development-and-validation-of-a-questionnaire-to-measure-attitude-change-in-health-professionals-after-completion-of-an-aboriginal-health-and-cultural-safety-training-programme/E6CFF0C801A5EA30747BCB84D13B693E. Accessed: 28 November 2018.

44. Fleming T., Creedy D.K., West R., (2018a). Cultural Safety Continuing Professional Development for Midwifery Academics: An Integrative Literature Review. *Women Birth.* Available: https://www.ncbi.nlm.nih.gov/pubmed/30341005. Accessed: 22 October 2018.

45. Howse G., Dwyer J., (2016). Legally Invisible: Stewardship for Aboriginal and Torres Strait Islander Health. *Aust N Z J Public Health.* Vol.40 Suppl 1:S14-20. Available: http://www.ncbi.nlm.nih.gov/pubmed/25903648. Accessed: 5 November 2018.

46. Anderson I., Crengle S., Leialoha Kamaka M., Chen T.-H., Palafox N., Jackson-Pulver L., (2006). Indigenous Health in Australia, New Zealand, and the Pacific. *The Lancet.* Vol.367(9524):1775-1785. Available: https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(06)68773-4/fulltext. Accessed: 30 November 2018.

47. Anderson I., Sanders W. (1996). Aboriginal Health and Institutional Reform within Australian Federalism: Australian National University, Centre for Aboriginal Ecomonic Policy Research. Available: http://caepr.cass.anu.edu.au/research/publications/aboriginal-health-and-institutional-reform-within-australian-federalism. Accessed: 15 October 2018.

48. Doukakis A. (2006). The Aboriginal People, Parliament and "Protection" in New South Wales, 1856-1916. Annandale, N.S.W.: The Federation Press. Available: http://www.federationpress.com.au/bookstore/book.asp?isbn=9781862876064. Accessed: 30 November 2018.

49. Gardiner-Garden J., (1999). From Dispossession to Reconciliation. Canberra: Deparment of the Parliamentary Library, Information and Research Services. Available: http://www.aph.gov.au/binaries/library/pubs/rp/1998-99/99rp27.pdf. Accessed: 15 October 2018.

50. Cox L., (2007). Fear, Trust and Aborigines: The Historical Experience of State Institutions and Current Encounters in the Health System. *Health and History*. Vol.9(2):70-92. Available: http://www.jstor.org/stable/40111576. Accessed: 30 November 2018.

51. Greer S., McNicholas P., (2017). Accounting for "Moral Betterment": Pastoral Power and Indentured Aboriginal Apprenticeship Programs in New South Wales. *Accounting, Auditing & Accountability Journal*. Vol.30(8):1843-1866. Available: https://www.emeraldinsight.com/doi/abs/10.1108/AAAJ-05-2013-1363. Accessed: 11 April 2019.

52. Australian Human Rights and Equal Opportunity Commission. (1997). Bringing Them Home : Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families. Sydney: Commonwealth of Australia,. Available: https://www.humanrights.gov.au/publications/bringing-them-home-report-1997. Accessed: 30 November 2018.

53. Fleming T., Creedy D.K., West R., (2018b). Evaluating Awareness of Cultural Safety in the Australian Midwifery Workforce: A Snapshot. *Women and Birth*. Available: https://doi.org/10.1016/j.wombi.2018.11.001. Accessed: 19 November 2018.

54. Australian Nursing and Midwifery Accreditation Council, (2014). Midwife Accreditation Standards 2014. Canberra: ANMAC. Available: https://www.anmac.org.au/document/midwife-accreditation-standards-2014. Accessed: 24 October 2018.

55. Congress of Aboriginal and Torres Strait Islander Nurses and Midwives, (2017). The Nursing and Midwifery Aboriginal and Torres Strait Islander Health Curriculum Framework. Canberra: CATSINaM. Available: http://catsinam.org.au/static/uploads/files/nursing-midwifery-health-curriculum-framework-final-version-1-0-wfxusnoufjil.pdf. Accessed: 11 October 2017.

56. National Aboriginal Community Controlled Health Organisation, (2011). Creating the Naccho Cultural Safety Training Standards and Assessment Process. A Background Paper. Canberra: NACCHO. Available: http://www.csheitc.org.au/wp-content/uploads/2015/11/CSTStandardsBackgroundPaper-NACCHO.pdf. Accessed: 15 October 2018.

57. Sax S. (1984). A Strife of Interests : Politics and Policies in Australian Health Services. Sydney: George Allen & Unwin. Available: https://catalogue.nla.gov.au/Record/2755925. Accessed: 28 November 2018.

58. Australian Government, (2013). National Aboriginal and Torres Strait Islander Health Plan 2013-2023. Canberra: Commonwealth of Australia. Available: http://www.health.gov.au/natsihp. Accessed: 21 August 2018.

59. Hospital and Health Service Performance Division, (2010). Improving the Patient Experience for Aboriginal People in the Emergency Department. Melbourne: Victorian Government. Available: https://www2.health.vic.gov.au/about/publications/researchandreports/Improving-the-patient-experience-for-aboriginal-people-in-the-emergency-department.

60. Taylor K.A., (2010). Intercultural Communication in Central Australian Indigenous Health Care: A Critical Ethnography. Unpublished: Publisher. Available: https://theses.flinders.edu.au/view/10c54637-5400-4e1c-9f0f-102ba7c262ce/1. Accessed: 12 October 2017.

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