

Australian Healthcare Governance
and the Cultural Safety and Security
of Australia's First Peoples: An
Annual Critique. No.1: Focussing on
Knowledge Governance.

Dr Mark J. Lock

BSc (Hons), MPH, PhD

Dedicated to 30 years of cultural safety from 1988-2018, in memoriam of
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?'

Committix Pty Ltd
ABN:786 146 747 34
ACN: 614 674734



Australian Healthcare Governance and the Cultural Safety and Security of Australia's First Peoples: An Annual Critique. No.1: Focussing on Knowledge Governance. Committix Pty Ltd, Newcastle.

Dr Mark J Lock, BSc (Hons), MPH, PhD

Keywords: Cultural Voice, Healthcare Governance, Australia's First Peoples, Cultural Safety, Cultural Security, Knowledge Governance

ISBN: 978-0-6483077-3-0 (pdf)

©2018 Committix Pty Ltd

Email: marklock@committix.com.au



This copyright work is licensed under a Creative Commons Attribution 4.0 International (CC BY 4.0) licence. You may share (copy and redistribute the material in any medium or format), adapt (remix, transform, and build upon the material) for any purpose, even commercially. For attribution, you must give appropriate credit, provide a link to the license, and indicate if changes were made. To view a copy of this licence, visit <https://creativecommons.org/licenses/by/4.0/>

Citation: Lock, M.J. (2018), Australian Healthcare Governance and the Cultural Safety and Security of Australia's First Peoples: An Annual Critique. No.1: Focussing on Knowledge Governance. Committix Pty Ltd, Newcastle. Available at: <https://committix.com/projects/the-cultural-safety-project/>, DOI: 10.13140/RG.2.2.26818.63688



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

Contents

Foreword.....	1
Executive Summary	2
Introduction	4
Australian Healthcare Governance is Devoid of Humanity.....	4
Why Cultural Safety and Security?	5
The Stormy Sea of Australian Cultural Policy.....	5
A Focus on Knowledge Production Governance	6
The Ambiguity of the ‘Culture’ Word.....	7
Culturally Unsafe and Insecure by Design.....	8
Methodology of the Critique	10
Results – Australian Journal Articles in the Health Domain.....	11
An Australian Critique of Cultural Safety & Security.....	14
Williams’s Cultural Safety	14
Criterion 1 – Culturally Safe Knowledge Governance.....	15
Houston’s Cultural Security	16
Criterion 2 – Culturally Secure Knowledge Governance.....	17
Consider Moral Obligations	18
Criterion 3 – Consider the Moral Obligations of Knowledge Governance	20
Culturally Safe Research Methodology.....	20
Criterion 4 – Include Australia’s First Peoples in Knowledge Services	21
Unsafe Literature Reviews	22
Criterion 5 – Culturally Safe Literature Reviews.....	23
Coffin’s Cultural Security Scale	24
Criterion 6 – Assess Progress using Coffin’s Cultural Security Scale	26
Academic Political Appropriation.....	27
Criterion 7 - Examine the Potential for Cultural Appropriation.....	29
Ignoring Cultural Provenance.....	30
Criterion 8 – Value Local Cultural Provenance	31
Promoting Exotic Immersion.....	32
Criterion 9 – Critically Evaluate Exotic Experiences	32
Culturally Unsafe Writing Practice	33
Criterion 10 – Critically Reflexive Writing Practice	34
Reflexive Publishing	35

Criterion 11 – Practice Critical Reflexivity in Publication Practice.....	36
White Knowledge Privilege	37
Criterion 12 – Address White Privilege in Knowledge Governance.....	38
Culturally Safe Textmarks.....	38
Criterion 13 – Promote Culturally Safe Textmarks.....	39
Flattening Power Hierarchies	40
Criterion 14 – Peer Review Commissioned Articles	41
Decolonise Knowledge Governance	42
Criterion 15 – Decolonise Knowledge Governance	43
Double ‘Othering’ and Cultural Security.....	43
Criterion 16 – Critically reflect on ‘othering’ exotic cultures	44
Culturally Unsafe Methodology	45
Criterion 17 – Promote Culturally Rigorous Research Methodology	46
An Archetype of Culturally Unsafe Research	47
Criterion 18 – Organisational Responsibility for Culturally Safe Knowledge Governance.....	48
White Anti-Racist Empowerment.....	48
Criterion 19 – Consider White Anti-Racist Privilege.....	50
Decolonisation Lens.....	50
Criterion 20 – Engage with Decolonisation Theorists	52
Lax Quality	53
Criterion 21 – Identify Junk Research.....	53
Erasing the Copy and Paste approach to ‘Cultural Safety’	54
Criterion 22 – Detect Tokenism in the use of Cultural Concepts.....	55
Curriculum Power.....	56
Criterion 23 – Consider the Power Imbalance in Health Curriculum Governance	57
Cherry Picking Norm	58
Criterion 24 – Uncover Cherry Picking Bias	60
Culturally Unsafe Research Governance.....	61
Criterion 25 – Ensure Culturally Rigorous Research Governance Process	61
Language Power Imbalance.....	62
Criterion 26 – External Evaluation of Academic Programs	63
Assumptions of Cultural Fit	64
Criterion 27 – Assess the Cultural Fit of Knowledge	66
Absence of Theoretical Merit	66
Principle 28 – Include a Theory of Change.....	67

Narrow Focus on Health Professional/Patient Communication.....	68
Criteria 29 – Assess the Relevance of the Research Focus	69
Unsubstantial Political Rhetoric.....	70
Criterion 30 – Connect with Healthcare Leader and Stewards	71
High Standard Intervention Study.....	72
Criterion 31 – Aim for High Quality Knowledge.....	74
Unsafe Research Profession Governance	75
Criterion 32 – Develop Researcher Accreditation Standards	77
Labyrinthine Learning.....	78
Criterion 33 – Aim for Clear Pathways	79
Privileging Indigenous Voices.....	80
Criterion 34 – Highlight Cultural Voice	80
Privileging Literature Reviews	81
Criterion 35 – Strategic Awareness in Knowledge Production	83
Cultural Safety Measurement.....	84
Criterion 36 – Measure Cultural Safety and Security	86
Conclusion – Dizzy with Conceptual Confusion	87
Discussion – Governance, Cultural Policy, and Knowledge.....	89
Criteria for Culturally Safe and Secure Knowledge Governance.....	90
References	94

Foreword

The phrase ‘cultural safety and security’ is a new aspect of health policy for Australia’s First Peoples. It asks healthcare leaders and stewards to consider cultural safety not only when health professionals communicate with patients, but throughout every point and pathway of the healthcare system which, in so doing, could become culturally secure for Australia’s First Peoples. The question that stimulated this critique was: how are healthcare stewards meant to restructure their corporate governance so that their healthcare services are more culturally safe and secure for Australia’s First Peoples?

The policy context is Australia (a Western Democratic nation) and the audience is Australian policy writers who are anonymously responsible with the difficult task of converting values and opinions to text. The topic is about Australia’s Aboriginal and Torres Strait Islander Peoples, which I refer to as Australia’s First Peoples. The setting is the phrase ‘cultural safety and security’ and the data is published Australian journal articles from the health domain. This critique is the first performed by a descendent of Australia’s First Peoples and is significant because our voices have been deliberately and systematically excluded from intellectual developments in Australian healthcare governance. Through this critique I plant a flag in the moon of Australian healthcare governance and declare “this ground includes the cultural voice of Australia’s First Peoples.”

The methodology of this critique combines an interest about the outcomes of committees as key mechanisms of corporate governance with the notion of ‘institution’ as conveying a long period of time. I begin with a policy topic (in this case, cultural safety and security) and examine its developmental trajectory by using published documents which contain some information on those people involved in its making. Why committees? They are the way an organisation operationalises its corporate governance processes. The two governance principles that drive my research are transparency and accountability. After all, if I am to trust the architects of the health system then I want to see how they built its foundations and know who is responsible for ongoing oversight of the process. And it begins with committee analysis and that is why Committix Pty Ltd takes committees... *seriously*.

Executive Summary

1. Australian healthcare executives are encouraged to consider the cultural needs of Australia's First Peoples for their health services, but they are faced with a primordial policy soup where concepts like 'security', 'competence', 'capability', 'respect', and 'inclusion' circulate in policy eddies to leave them dizzy with confusion.
2. I established a link between healthcare governance, cultural policy, and knowledge production and found that evidence-based governance and evidence based cultural policy do not exist. Specifically, that formal published knowledge produced by academics and researchers have no relevance for either healthcare governance or cultural policy.
3. This critique began with the question: how are healthcare stewards meant to restructure their corporate governance so that their healthcare services are more culturally safe and secure for Australia's First Peoples? Method: A critique of Australian only publications in the health domain. Results: 36 journal articles (32 on cultural safety, 4 on cultural security).
4. Robyn Williams's definition of cultural safety should be the Australian standard: 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.
5. Shane Houston's definition of cultural security should also be an Australian standard: Cultural security is a commitment that the construct and provision of services offered by the health system will not compromise the legitimate cultural rights, views, values and expectations of Aboriginal people. It is a recognition, appreciation and response to the impact of cultural diversity on the utilisation and provision of effective clinical care, public health and health systems administration.
6. My current proposition is that when cultural safety is evident at every point and pathway of the Australian healthcare system then Australia's First Peoples can trust that it is culturally secure for them, their families, and their communities.
7. 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.
8. My assessment of healthcare governance literature shows that Australia's First Peoples' cultural meanings of governance are invisible. Therefore, if the institutional ethos of Australian healthcare governance is to exclude cultural voice then the safety of healthcare organisations is compromised at its philosophical roots.
9. It became apparent during the critique that the leading theme is 'culturally unsafe and insecure knowledge production governance' because the antecedent knowledge base for healthcare governance excludes cultural voice. Therefore, the objective of this critique is to provide criteria for policy makers to use when they select evidence for developing a course for their organisation's journey towards designing culturally safe and security healthcare governance for Australia's First Peoples.

10. Based on the thirty-six journal articles reviewed here, policy makers to health service managers to health professionals would have a very difficult time converting the information in the articles into any useable basis to steer their organisations on a course towards culturally safe and secure healthcare governance.
11. Australian journal articles from within the health sector and focussed on cultural safety and security provide a confusing textscape of themes that undermine the development of a high-quality knowledge base from which healthcare executives could develop evidence-based healthcare governance. I describe 36 themes and propose 36 criteria to use for the assessment and production of knowledge.
12. The themes underscore the **main finding** that examining the Australian cultural safety and security literature would leave any healthcare steward confounded as to how to translate the ideas from them into meaningful points for integration and diffusion into healthcare governance.
13. Therefore, the 36 criteria are meant to push the knowledge user (healthcare leaders and stewards) and the knowledge producer (academics and researchers) into a co-design space to produced shared knowledge. A key barrier is that neither healthcare governance policy nor cultural policy consider formal published knowledge in their formulations.
14. The **ultimate message** is that Australian healthcare governance lacks standards about formal knowledge governance. The contradiction is healthcare leaders and stewards require health professionals to deliver care based on best evidence, but healthcare governance does not reflect that standard.
15. Ms Mohi's words of humanity beat against the culturally blind minds of Australian healthcare governance intellectuals who need to genuinely engage with Australia's First Peoples. Australian researchers need to privilege more our cultural voices and look inwards towards the richness of cultures of Australia's First Peoples, rather than focus on literature, definitions, and intellectuals from foreign cultures.
16. The greatest challenge is for researchers and academics (knowledge producers) to develop culturally safe and secure knowledge governance with healthcare leaders and stewards (knowledge users), and for them to build a high-quality knowledge base relevant for culturally safe and secure Australian healthcare governance.



Introduction

This critique is in honour of Ms Hinerangi Mohi. The concept of cultural safety was raised in 1988 in New Zealand when Ms Hinerangi Mohi stated, 'You people talk about legal safety, ethical safety, safety in clinical practice and a safe knowledge base, but what about cultural safety?'¹ Irihapeti Ramsden (2002), moved by Ms Mohi's words, subsequently had an enormous influence on nursing practice and cultural safety in Aotearoa/New Zealand. And cultural safety is now an accepted policy concept in other parts of the world including Australia and Canada. It began with Ms Mohi's words and I hope that this critique echoes the emotion, feeling, and humanity of her appeal.

Australian Healthcare Governance is Devoid of Humanity

My assessment of healthcare governance literature shows that Australia's First Peoples' cultural meanings of governance are invisible. For example, in Meredith Edward's (2002) discussion of Australian public sector governance,² in Donald Philippon and Jeffrey Braithwaite's (2008) comparative review of Australian and Canadian systems of healthcare governance,³ in Lynne Bennington's (2010) Australian review of corporate governance and healthcare literature,⁴ and in Barbazza and Tello's (2014) international review of health governance⁵ which referenced Braithwaite, Healy and Dwan's (2005) Australian discussion paper about the governance of health safety and quality.⁶ 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, if the institutional ethos of Australian healthcare governance is to exclude cultural voice then the safety of healthcare organisations is compromised at its philosophical roots. And that is a governance norm because those publications (by different authors) about governance cover a period of 16 years (2002 to 2018) during which the social fabric of Australia has responded to improve the health outcomes of its First Peoples. If humanity is absent in healthcare governance, how can Australia's First Peoples trust the Australian State to provide healthcare services that are culturally safe and secure?

As Brigg and Curth-Bibb (2017) point out in an article about intercultural governance in Australian Indigenous organisations, 'Australian governments operate through a European-derived mode of state governance typically conceived, in the dynamics of settler-colonialism, as if it were a form of natural order – a benign and a-cultural framework as opposed to a deeply held set of cultural beliefs.'⁷ The Australian **Indigenous Community Governance Project** (2004-2008) stated that 'governance is not culture-neutral'⁸ and the **Institute of Internal Auditors Research Foundation in the United States** state that 'We also recognize that effective governance approaches may be applied in different ways across different cultures'.⁹ Therefore, a key task is to elucidate how cultural voice affects Australian healthcare governance.

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.

Why Cultural Safety and Security?

Answering the ‘why?’ of cultural safety and security is the topic for a future critique when I have analysed more source material other than journal articles: blogs, speeches, media releases, book chapters, books, and doctoral dissertations. As a policy analyst, my interest is not to justify the use of different cultural concepts, but to understand their nature and meaning and implications for Australian healthcare. It started with a question: what is cultural safety and security and how can it be applied through healthcare governance?

The emphasis on cultural safety is prominent in Aboriginal and Torres Strait Islander Nursing and Midwifery,¹⁰ for mainstream nurses and midwives,¹¹ into the accreditation of all health professions,^{12, 13} for cultural safety training,¹⁴ the Australian health system,¹⁵ for healthcare organisation accreditation,¹⁶ and healthcare legislation.¹⁷ Many organisations have taken up the call for cultural safety – lead by the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM)^{10, 11, 18–24} and its Chief Executive Officer, *Narrunga Kaurna* woman Ms Janine Mohamed.²⁵ An *organisational* review of cultural safety and security is the topic of a future critique. At this stage the key point I have observed is that cultural safety is pitched to be most relevant at the point of communication between a health professional and a patient as per Ramsden’s (2002) emphasis.

Even though many policy protagonists argue that cultural safety is relevant for all aspects of the healthcare system, the policy documents and literature maintain the locus and focus of cultural safety at the interaction between a health professional and a patient. How is the ethic and principles of cultural safety transformed throughout every point and pathway of the healthcare system where there is no interaction between a health professional and a patient? The answer appears to be understanding the concept of ‘cultural security’ that is prominent in the state of Western Australia. In my current interpretation of the literature on cultural security (discussed more fully below), when cultural safety is evident at every point and pathway of the Australian healthcare system, then Australia’s First Peoples can trust that it is culturally secure for them, their families, and their communities.

The Stormy Sea of Australian Cultural Policy

That cultural safety and security is a contentious undertaking is evident in Australian cultural policy documents. When reviewing the policy documents, below, it was rare for evidence to be provided to justify the suggestions and actions, neither evidence in the form of literature reviews of published journal articles nor in the form of community engagement processes of Australia’s First Peoples and their representative community organisations. I

recognised a gap between the producers of knowledge (researchers and Australia's First Peoples) and the users of knowledge (policy makers).

1. [Cultural Respect Framework 2016–2026 for Aboriginal and Torres Strait Islander Health](#) (Australian Health Ministers' Advisory Council, [2016](#))¹⁵
2. [Aboriginal Cultural Security Framework 2016–2026](#) (Northern Territory, [2016](#))²⁶
3. [Aboriginal and Torres Strait Islander Cultural Capability: A Framework for Commonwealth Agencies](#) (Australian Public Service Commission, [2015](#))²⁷
4. [Towards Culturally Appropriate and Inclusive Services 2014–2018](#) (Australian Capital Territory, [2014](#))²⁸
5. [WA Health Aboriginal Cultural Learning Framework 2012–2016](#) (Western Australia, [2012](#))²⁹
6. [Respecting the Difference – An Aboriginal Cultural Training Framework for NSW Health](#) (NSW Health, [2011](#))³⁰
7. [Queensland Health Aboriginal and Torres Strait Islander Cultural Capability Framework 2010–2033](#) (Queensland Health, [2010](#))³¹
8. [Aboriginal Cultural Competence Framework, and Matrix](#) (Victoria, [2008](#))^{32, 33}
9. [Victorian Government Aboriginal Inclusion Framework](#) ([2009](#))³⁴
10. [Aboriginal Cultural Respect Framework 2007–2012](#) (South Australia, [2007](#))³⁵

When reading the cultural policy documents, the knowledge used to inform them may be seen in the 'reference list' or 'bibliography' (if they are provided) and how statements of ideas in the body text cite academic research. However, the policy makers formulating Australian cultural policy did not cite (or only rarely cited) published research. Knowing the complexity of policy making processes with political timeframes, numerous stakeholders, and a complex healthcare system, the published academic journal literature offers one piece of the information jigsaw on Australian cultural safety and security. Therefore, I propose that academics and researchers need to work harder to ensure that their products (journal articles) are directly and explicitly relevant to the needs healthcare governance policy makers (such a healthcare leaders and stewards)

A Focus on Knowledge Production Governance

It became apparent during the critique that the leading theme is 'culturally unsafe and insecure knowledge production governance' because the antecedent knowledge base for healthcare governance excludes cultural voice. Therefore, restructuring healthcare governance is about the stewardship and leadership of what knowledge is gathered, how it is massaged into creating meaning, and how it is applied throughout an organisation. Knowledge production processes, therefore, need to be systematically restructured to include the human cultural values of Australia's First Peoples – their cultural voice.

In [2008](#), Professor Ian Anderson said that 'a fundamental step in the process of addressing health and social disadvantage is the production and exchange of knowledge'.³⁶ This was in the context of the role of Universities and in formal research knowledge production, but in

his talk, Anderson missed a crucial point of the responsibility of researchers to lead changes to their research practice that may unintentionally perpetuate the production of knowledge that is irrelevant to the lives of Australia's First Peoples.

Therefore, the objective of this critique is to provide criteria for policy makers to use when they select evidence for developing a course for their organisation's journey towards designing culturally safe and security healthcare governance for Australia's First Peoples. The aim is to promote research that is useful for culturally safe and secure healthcare governance. The audience is governance policy makers who need to select knowledge to inform their decision-making, but who do not have criteria about the cultural safety and security of that knowledge.

The Ambiguity of the 'Culture' Word

In that knowledge base, 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.^{6, 37-44} This mix of ingredients makes for a 'cultural concept soup'. Without any clarity, the phrase 'cultural safety' could easily be confused with the safety of the workforce or the organisation or the workplace, especially given that the phrase 'cultural safety' is unknown in mainstream healthcare services,^{45, 46} although its prominence is increasing.

As such, the effectiveness of the phrase 'cultural safety' is diminished within a mainstream context dominated by the 'cultural concept soup'. 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 \(2017\)](#).⁴⁷ Additionally, the [National Safety and Quality Health Service Standards \(Second edition\)](#) (NSQHS Standards 2) adopts the phrase 'a culture of safety and quality'⁴⁰ which refers to organisational culture. Therefore, a key task is to clarify the cultural concept soup theoretically, empirically, intellectually, and philosophically through detailed analysis and critique of all the 'cultural' ingredients, a task that this critique contributes to.

The cultural concept soup has the base ingredient of 'culture', but its components are not teased-out to connect with the other cultural concepts. 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'.⁴⁸ A nuanced definition, 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'.⁴⁹ While it is difficult to define and measure culture, as noted by one review of the concept,⁵⁰ I think this needs to be attempted if the concepts of 'cultural safety' and 'cultural security' are to reverberate through the healthcare governance textscape.

Therefore, as a starting point, this critique works off the definition of human culture provided by Cross et al. (1989) with the concepts of: integrated, pattern, behaviour, thoughts, communication, action, custom, belief, values, institutions, and Australia's First Peoples (of a racial, ethnic, religious, and social group). As an aside, it is interesting to note that Australian definitions of corporate governance (below) look like statements of culture but at that same time they rule-out 'human culture' as though a 'corporate entity' (defined in Australian law as being an 'individual') is separate from the human cultural values that infuse it. Analysis of definitions of governance – briefly quoted below – will be undertaken in future critique.

Culturally Unsafe and Insecure by Design

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. Therefore, the range of governance documents used to inform healthcare organisations are culturally unsafe and insecure by design:

1. Australian Public Service Commission, (2007). *Building Better Governance*.⁵¹

Public sector governance covers: '...the set of responsibilities and practices, policies and procedures, exercised by an agency's executive, to provide strategic direction, ensure objectives are achieved, manage risks and use resources responsibly and with accountability.' (citing the Australian National Audit Office and the Department of Prime Minister and Cabinet)

2. NSW Ministry of Health, (2012). *Corporate Governance and Accountability Compendium for NSW Health*.⁵²

'Good governance is those high-level processes and behaviours that ensure an agency performs by achieving its intended purpose and conforms by complying with all relevant laws, codes and directions and meets community expectations of probity, accountability and transparency. Governance should be enduring, not just something done from time to time.' (citing the Audit Office of NSW).

3. ASX Corporate Governance Council, (2014). *Corporate Governance Principles and Recommendations (3rd Edition)*.⁴²

'The phrase "corporate governance" describes "the framework of rules, relationships, systems and processes within and by which authority is exercised and controlled

within corporations. It encompasses the mechanisms by which companies, and those in control, are held to account.” (citing Justice Owen in the HIH Royal Commission)

4. [Australian National Audit Office, \(2014\). Public Sector Governance - Strengthening Performance through Good Governance. Better Practice Guide.](#)⁴⁴

‘Public sector governance refers to the arrangements and practices which enable a public sector entity to set its direction and manage its operations to achieve expected outcomes and discharge its accountability obligations. Public sector governance encompasses leadership, direction, control and accountability, and assists an entity to achieve its outcomes in such a way as to enhance confidence in the entity, its decisions and its actions. Good public sector governance is about getting the right things done in the best possible way, and delivering this standard of performance on a sustainable basis.’

5. [New South Wales Auditor-General, \(2015\). Appendix One - Governance Lighthouse - Strategic Early Warning System.](#)⁵³

‘Good governance is those high-level processes and behaviours that ensure an organisation performs by achieving its intended purpose, and conforms by complying with all relevant laws, codes and directions while meeting community expectations of probity, accountability and transparency.’

6. [Australian Commission on Safety and Quality in Health Care \(2017\). National Safety and Quality Health Service Standards \(Second edition\).](#)⁴⁰

‘Clinical governance is an integrated component of corporate governance of health service organisations. It ensures that everyone – from frontline clinicians to managers and members of governing bodies, such as boards – is accountable to patients and the community for assuring the delivery of health services that are safe, effective, integrated, high quality and continuously improving.’ (p.41).

‘governance: the set of relationships and responsibilities established by a health service organisation between its executive, workforce and stakeholders (including patients and consumers). Governance incorporates the processes, customs, policy directives, laws and conventions affecting the way an organisation is directed, administered or controlled.’ (p.71)

As for the intellectual history of healthcare governance, the above definitions of governance (public sector, corporate, clinical, and ‘good’) were developed without the cultural voice of Australia’s First Peoples and therefore exclude their cultural knowledge, values and history from the leadership and stewardship of the Australian health system. Therefore, the cultural voice of Australia’s First Peoples is excluded from informing the intellectual development of Australian healthcare governance.

Methodology of the Critique

The following section steps through each publication in year order, where the intention was to gain a sense of the evolution of meaning creation about cultural safety and security for Australia's First Peoples in the health domain. The analysis proceeded through several stages with a first stage to quickly read the articles and achieve a surface level familiarity with them. The second stage involved deep reading of each article, highlighting, chasing references, and critiquing each article by writing in annotated format. In the third stage, a deeper level of knowledge was gained for each article in themselves and in relation to each other, and involved critical analysis, cross-referencing, and more writing about each article. The fourth stage involved re-reading each article with the cumulative knowledge gained through the first three stages. The fifth stage was tidying the narrative and binding it together into a coherent flow.



Results – Australian Journal Articles in the Health Domain

These are published articles in academic journals. They are specific to Australia and contain the key words (cultural safety, cultural security) in the title. They apply to Australian Aboriginal and Torres Strait Islander peoples as detected in key words or in the body text of journal articles that focus on the health sector.

Table 1: Australian Cultural Safety and Cultural Security References

Year [∞]	Title of Journal Article ^{\$}
1999	1. Cultural Safety-What Does It Mean for Our Work Practice? (182 citations)*
2002	2. Cultural Security: Some Cost Estimates from Derbarl Yerrigan Health Service (17 citations, AUD\$4)
2003	3. Cultural Safety: Let's Name It! (108 citations, US\$25)
2004	4. Factors That Prevent Equitable Access to Rehabilitation for Aboriginal Australians with Disabilities: The Need for Culturally Safe Rehabilitation (50 citations, US\$11.95)
2006	5. Cultural Safety and Maternity Care for Aboriginal and Torres Strait Islander Australians (73 citations, US\$35.95) (repository link)
2007	6. Rising to the Challenge in Aboriginal Health by Creating Cultural Security (97 citations, AUD\$4)
2007	7. An Exploration of the Notion and Nature of the Construct of Cultural Safety and its Applicability to the Australian Health Care Context (72 citations, AUD\$40)
2007	8. Health Care Provider and Consumer Understandings of Cultural Safety and Cultural Competency in Health Care: An Australian Study (34 citations, US\$30, repository link)
2007	9. Why 'Culturally Safe' Health Care? (31 citations)
2008	10. Patient Centred Care - Cultural Safety in Indigenous Health (69 citations)
2010	11. Cultural Safety and its Importance for Australian Midwifery Practice (35 citations)
2010	12. Cultural Safety in Health for Aboriginal People: Will it Work in Australia? (7 citations)
2011	13. Closing the Gap: Cultural Safety in Indigenous Health Education (36 citations, US\$42.50)

<u>2012</u>	14. Cultural Awareness and Cultural Safety (5 citations, AUD\$4)
<u>2013</u>	15. Aboriginal and Torres Strait Islander Worldviews and Cultural Safety Transforming Sexual Assault Service Provision for Children and Young People (11 citations)
<u>2013</u>	16. Beyond Cultural Security; Towards Sanctuary (2 citations)
<u>2014</u>	17. Aboriginal Practitioners offer Culturally Safe and Responsive CBT: Response to Commentaries (8 citations)
<u>2014</u>	18. Cultural Safety for Aboriginal and Torres Strait Islander Adults within Australian Music Therapy Practices (1 citation)
<u>2014</u>	19. Addressing Uncomfortable Issues: Reflexivity as a Tool for Culturally Safe Practice in Aboriginal and Torres Strait Islander Health (7 citations, USD\$25)
<u>2014</u>	20. The Ideas of Frantz Fanon and Culturally Safe Practices for Aboriginal and Torres Strait Islander People in Australia (5 citations, US\$54)
<u>2015</u>	21. Measuring Organisational-level Aboriginal Cultural Climate to Tailor Cultural Safety Strategies (3 citations)
<u>2015</u>	22. Achieving Cultural Safety in Australian Indigenous Maternity Care (2 citations)
<u>2015</u>	23. Exploring Undergraduate Midwifery Students' Readiness to Deliver Culturally Secure Care for Pregnant and Birthing Aboriginal Women (4 citations)
<u>2016</u>	24. Creating Culturally Safe Vocational Rehabilitation Services for Indigenous Australians: A Brief Review of the Literature (no citations, USD\$35)
<u>2016</u>	25. Review of the Cultural Safety of a National Indigenous Point-of-Care Testing Program for Diabetes Management (6 citations, AUD\$25)
<u>2016</u>	26. The Deconstruction Exercise: An Assessment Tool for Enhancing Critical Thinking in Cultural Safety Education (5 citations)
<u>2016</u>	27. Cultural Safety and Midwifery Care for Aboriginal Women - A Phenomenological Study (8 citations AUD\$31.50)
<u>2016</u>	28. Development of the Awareness of Cultural Safety Scale: A pilot Study with Midwifery and Nursing Academics (1 citation, USD\$14)
<u>2016</u>	29. Culturally Capable and Culturally Safe: Caseload Care for Indigenous Women by Indigenous Midwifery Students (2 citations, USD\$35.50)

2017	30. Embedding Cultural Safety in Australia's Main Health Care Standards (1 citation)
2017	31. Impact of a Continuing Professional Development Intervention on Midwifery Academics' Awareness of Cultural Safety (no citations, USD\$35.95).
2017	32. Development and Validation of a Questionnaire to Measure Attitude change in Health Professionals after Completion of an Aboriginal Health and Cultural Safety Training Programme (1 citation, USD\$25)
2018	33. Experience of Providing Cultural Safety in Mental Health to Aboriginal Patients: A Grounded Theory Study (4 citations)
2018	34. The Power of Talk and Power in Talk: A Systematic Review of Indigenous Narratives of Culturally Safe Healthcare Communication (0 citations)
2018	35. Cultural Safety Continuing Professional Development for Midwifery Academics: An Integrative Literature Review (no citations, USD\$35.95).
2018	36. Evaluating Awareness of Cultural Safety in the Australian Midwifery Workforce: A Snapshot (no citations, USD\$35.95)

[∞]Internet links embedded. ^{*}Total cost of articles: USD\$441.75, AUD\$108.50. ^{*}Citation count as of November 2018.

An Australian Critique of Cultural Safety & Security

The critique begins with the first published Australian journal article by an author steeped in the education of Australia's First Peoples students. This article, in 1999, appeared eleven years after the rise of the Māori concept of *kawa whakaruruhau* /cultural safety in Aotearoa / New Zealand.^{54, 55}

Williams's Cultural Safety

1. [Robyn Williams](#) (Senior Lecturer and PhD student at Charles Darwin University, 2017 recipient of the [Australian Health Promotion Association's President's Award](#)) published a personal reflection on *Cultural Safety – What Does it Mean for Our Work Practice?* (1999, Northern Territory) in the context of tertiary education environments being safe for Indigenous people to enter into health and education disciplines.

Williams (1999) asks¹ 'Why is there still so much unwillingness to genuinely engage in discourse in relation to the issue?'⁵⁶ Williams (1999) was influenced by hearing Ramsden's (1992) Cultural safety in nursing education in Aotearoa (a conference presentation at the Year of Indigenous Peoples Conference, Brisbane) because for Williams it 'struck a cord [sic] with this author especially in terms of issues that were impacting on her work practice as a lecturer of Indigenous students' (see the article on [ResearchGate](#)). Williams, influenced by Indigenous colleagues and students and the practice work of Eckermann et al. (1994), wrote this only Australian definition of cultural safety as:⁵⁷

an environment, which is safe for people; where there is no assault, challenge or denial of their identity, of who they are or what they need. It is about shared respect, shared meaning, shared knowledge and experience, of learning together with dignity, and truly listening.

This definition is modified (Bin-Sallik 2003) and paraphrased (Skellet 2012) in other articles in this critique. Williams's key message is that 'culturally safe service delivery is critical in enhancing personal empowerment and, as a result, should promote more effective and meaningful pathways to self-determination for Indigenous people',⁵⁶ but it represents the kind of naïve policy statement that academics promote through their journal articles because there is no theoretical argument or empirical basis or academic reference to justify that proposition. As this critique reveals, it is a routine academic practice to make naïve policy statements.

Furthermore, as an unintended consequence, Williams's own 'practice' of writing and publishing discursively disenfranchises the voices of Australia's First Peoples, who had no explicitly reported say in the production of this article. Being critically reflective with the view to power sharing should also be about knowledge production processes. Of course,

¹ The use of the present continuing tense is deliberate because these articles show the unwillingness to genuinely engage in discourse about cultural safety and security for Australia's First Peoples.

Williams was writing through her context as an academic at an academic organisation and these are very much a part of the negative history of Australia's First Peoples, which is well-covered in an upcoming article by Kija academic Maryann Bin-Sallik (2007).

However, the power of Williams' Australian definition of cultural safety lies in her deep, long, and respectful education practice with Indigenous Australians. While Williams's article is often cited, her 'loudest and most pressing' questions (as stated in the [ResearchGate](#) article) are not: 'How can we ensure meaningful development and delivery of effective and appropriate services for Indigenous peoples in Australia?' What are the key factors that facilitate effective access, participation and control for Indigenous peoples in the current systems of governance?' Questions that have not been addressed in any meaningful way in the 20 years (1999-2018) since this germinal work.

Criterion 1 – Culturally Safe Knowledge Governance

A key factor for reflecting cultural values in knowledge production governance is to include Australia's First Peoples in them. This would improve the validity and credibility of culturally-based definitions of health in accordance with the notion of shared knowledge.

Criterion

Does the knowledge base explicitly attribute the intellectual contribution of Australia's First Peoples?

Relevance (for stakeholder engagement)

[Corporate Governance and Accountability Compendium for NSW Health \(2012\)](#) - Standard 6: **Involve stakeholders** in decisions that affect them, where 'Health organisations must have systems and processes in place to ensure the rights and interests of key stakeholders are incorporated into the plans of the organisation...' (p.2.05 at December 2016).⁵²

[National Safety and Quality Health Service Standards - 2nd Ed \(2017\)](#). Partnering with Consumers Standard. Criteria: **Partnering** with consumers in organisational design and governance. Item: Partnerships in healthcare governance planning, design, measurement and evaluation. Action 2.11a 'Involves consumers in partnerships in the governance of, and to design, measure and evaluate, health care' (p.19).⁴⁰

[National Safety and Quality Health Service Standards user guide for Aboriginal and Torres Strait Islander Health \(2017\)](#). Action 1.2: Addressing health needs of Aboriginal and Torres Strait Islander people. Item: Promote Aboriginal and Torres Strait Islander **representation** in governance structures. Suggested approach: 'Ensure that Aboriginal and Torres Strait Islander communities are involved in identifying priorities, targets, strategies and indicators of success through the governance process and monitoring system' (p.16).¹⁶

It was just two years later – 2001 – that saw the germination of a uniquely Australian concept of 'cultural security' which thematically links to Williams' question about the meaningful delivery of services to Aboriginal people.

Houston's Cultural Security

2. [Ted Wilkes](#) (a Nyungar man from Western Australia), [Shane Houston](#) (a Gangulu man from Central Queensland), and [Gavin Mooney](#) (health economist) published *Cultural Security: Some Cost Estimates from Derbarl Yerrigan Health Service* (2002) which is a short opinion article about costing some elements of 'cultural security'.⁵⁸

This is the first journal appearance of the phrase 'cultural security' and is attributed to Houston's *Aboriginal cultural security: a background paper* (Western Australian Department of Health 2001), and the definition is:

'Cultural Security is a commitment that the construct and provision of services offered by the health system will not compromise the legitimate cultural rights, views, values and expectations of Aboriginal people. It is a recognition, appreciation and response to the impact of cultural diversity on the utilisation and provision of effective clinical care, public health and health systems administration.

Cultural Security is about ensuring that the delivery of health services is of such a quality that no one person is afforded a less favourable outcome simply because they hold a different cultural outlook' (p. 13)

The first thing to note is the difference in phrasing between cultural security and Williams' (1999) cultural safety definition because of their distinctiveness: different authors, genders, cultures, experiences, and locations (Williams in Darwin and Houston in Perth, at the time of their respective publications). They share similarities in their lack of rigorous academic style and conventions, and in the positive bias inherent in personal experiences. However, they are written from deep and rich experience in practice and their genuine intent is to advocate for improved service delivery to Australia's First Peoples.

Houston's extensive experience in public health administration probably underscores some critical aspects of cultural security: the emphasis on effective public health and health systems administration. This contrasts with most discourse about cultural safety with its view limited to the micro-level clinician and patient interaction. Both Williams – through the use of the phrase 'an environment' – and Houston widen the cultural safety lens to the meso-level of 'services' (meaning organisations and professional services delivered through them). However, organisations exist within a wider public health and health system and this means that cultural values should be considered in the practice of public administration and governance, a macro-level perspective. Therefore, combining the phrases cultural safety and security means to consider their influence at the micro, meso, and macro levels of Australian healthcare.

A powerful phrase in Houston's definition is 'legitimate cultural rights, views, and values'. Wilkes et al. (2002) expand on this point to reference four domains of cultural obligations – physical, mental, spiritual, and environmental – and claim that to 'Aboriginal people holistic care is...fundamentally a cultural obligation'. As is identified in the healthcare governance literature (above) there is no consideration of cultural obligations in mainstream Australian healthcare governance policy or literature. Hereafter, the phrase 'Wilkes' cultural obligations' will refer to this intellectual development.

Wilkes et al. (2002) noted the 'lack of operational guidance as to what precisely a cultural secure service would look like' and 'their cost'. To this end the article presents dubious research (no empirical methodology, rigorous data collection and analysis, ethical approval, or independently peer-reviewed) to support the idea of differences in costs for providing cultural secure services. Nevertheless, the attempt to cost compare culturally secure Aboriginal services and mainstream health services signals the necessity to undertake that task which has not occurred since this publication, in contrast to the sheer density of costing and budgeting for mainstream healthcare services seen in government budget papers.

Houston's cultural security has enormous influence in Western Australia and Northern Territory by being used in the [Textbook of Australian Rural Health \(2008\)](#),⁵⁹ in an [Aboriginal Cultural Security Guide for Human Service Organisations \(no date\)](#),⁶⁰ in the [Strong Spirit Strong Mind Model \(2014\)](#),⁶¹ the [Northern Territory Aboriginal Security Framework 2016-2026 \(2016\)](#),²⁶ and in academic research by Rosalie Thackrah ([2015](#), [2016](#)).^{62, 63} The phrasing and wording of the cultural security definition are reflected in the definition of 'cultural respect' as the 'recognition, protection and continued advancement of the inherent rights, cultures and traditions of Aboriginal and Torres Strait Islander Peoples'.^{15, 64} This is most likely due to Houston's membership of the Standing Committee on Aboriginal and Torres Strait Islander Health Working Party which constructed the [2004-2009 Cultural Respect Framework for Aboriginal and Torres Strait Islander Health \(2004\)](#).⁶⁴

Criterion 2 – Culturally Secure Knowledge Governance

The combined phrase 'cultural safety and security' means to consider their influence at the micro, meso, and macro levels of Australian knowledge governance.

Criterion

Is cultural safety and security considered in and through knowledge production processes?

Relevance (to 'frameworks' and 'all levels')

[Corporate Governance and Accountability Compendium for NSW Health \(2012\)](#) - Standard 1: Establish robust governance and **oversight frameworks**. Health organisations should ensure that, inter alia, 'Leadership and accountability responsibilities for Aboriginal health are built into the roles of executives and managers at all levels of the system'(p.2.02, December 2016).⁵²

[National Safety and Quality Health Service Standards - 2nd Ed \(2017\)](#). Standard: Partnering with Consumers (Explanatory notes: 'Different types of partnerships with patients and consumers exist within the healthcare system. These partnerships are not mutually exclusive, and are needed at **all levels** to ensure that a health service organisation achieves the best possible outcome for all parties' (p.15).⁴⁰

[National Safety and Quality Health Service Standards user guide for Aboriginal and Torres Strait Islander Health \(2017\)](#). Action 1.21: Improving cultural competency. Item: Develop and implement a cultural competency strategy. Suggested approach: 'Support and grow the Aboriginal and Torres Strait Islander workforce at **all levels** of the organisation' (p.24)¹⁶

A year after Wilkes' cultural obligations and Houston's cultural security, the next publication appeared with an historical overview of developments in higher education institutions from which springs the idea of moral obligations in knowledge governance.

Consider Moral Obligations

3. [Maryann Bin-Sallik](#) AO (Descendant of the Kija people of the Turkey Creek area, Broome, [NAIDOC 2016 Female Elder of the Year](#), and [2017 Officer of the Order of Australia](#)) published *Cultural Safety: Let's Name It!* (2003, Northern Territory) as a reflective description on cultural safety and Indigenous participation in the higher education sector.⁶⁵

Bin-Sallik (2003) provides an 'overview of the Australian Indigenous higher education sector' from the 1970s to 2003, and she states that the 30 years of Indigenous participation in the higher education sector 'has been a very difficult process' and that 'I have come to believe that all the trials and tribulations have revolved around issues of 'cultural safety' but we have never named it as such'.⁶⁵ Bin-Sallik (2003) modified Williams' (1999) definition as:

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.

The re-phrasing and paraphrasing of definitions also occurs for the holistic view of Aboriginal health,⁶⁶ and is a writing practice that adds to the conceptual confusion faced by health service managers when they need to engage with these concepts and interpret them into administrative practice. Concepts are important, as they are draw-upon as policy memes because academics neither have the time nor the space to recreate their full history. Importantly, Bin-Sallik expands on Williams' (1999) term 'environment' with the concepts 'spirituality', 'socially', 'emotionally', and 'physically' to reflect the Aboriginal definition of health ('not just the physical wellbeing of an individual but refers to the social, emotional and cultural wellbeing of the whole community...'⁶⁷).

Bin-Sallik's proposition is that the phrase 'cultural safety' be used in higher education to counter negative sentiments (e.g. that Aboriginal people get too much equal opportunity) in Australian society associated with the phrases 'positive discrimination', 'equal opportunity', and 'culturally appropriate'. She argues, 'cultural safety is a term that all cultural groups can relate to and it does not have connotations of special treatment'.⁶⁵ This touches-on an Australian social norm ([tall-poppy syndrome](#)) which invokes another norm of [institutional racism](#) that Bin-Sallik mentions several times in her article. As an example, she states that for Indigenous academics 'There has never been a situation where we have been approached

and encouraged to participate in real decision-making. We have always had to go cap in hand.’⁶⁵

Although the higher education landscape has changed⁶⁸ it is beyond the scope of this critique of health journal articles to tap into the implications of those changes for cultural safety and assess if Indigenous academics now participate in real decision-making. However, in the book *Serious Whitefella Stuff* (2016),⁶⁹ Professor [Mark Moran](#) writes about community development and observes, ‘governments often make decisions on policies and programs with little input from the Aboriginal and Torres Strait Islander Australians on programs and policies designed for them’.⁷⁰ Moran writes from a completely different context to Bin-Sallik, from environment and land use compared to higher education, but the key messages about the lack of input indicates an Australian norm of excluding cultural voice from influencing decision-making processes.

That this is ‘institutionalised’ behavior may be inferred by comparing the decades and domains written about by different authors. Bin-Sallik wrote about higher education (1970-2003), Moran wrote about community development (1990-2016), and Rosalie Thackrah (2016) wrote about higher education and health. Thackrah’s (2016) Doctoral Thesis states, ‘My involvement in Aboriginal health and education dates back to the mid-1970s when, as a freshly minted non-Aboriginal teacher with a major in anthropology, a graduate diploma in education and two years teaching experience, I secured a position as an Aboriginal Education Officer with the Commonwealth Department of Education. Even then the title seemed odd as all those employed in this role were non-Aboriginal people; it was many years before this changed.’⁶² Further comparative work is needed to understand the extent of these shifts in social norms.

Bin-Sallik also refers to the eras of civilisation, segregation, assimilation, self-determination, self-management, and reconciliation. Higher education organisations are an implacable part of this history. Therefore, Bin-Sallik raises a point that is missed in healthcare corporate governance, where higher education institutions ‘have a moral obligation to deconstruct what they are responsible for constructing in the first place.’⁶⁵ There is no discussion of moral obligations or human rights or the historical roots of governance in Australian healthcare governance literature.^{2, 4, 6, 42, 43, 52, 71-75}

Bin-Sallik’s article provides a broad-brush ‘context’ of the culturally unsafe institution of education, and the strength and power of Bin-Sallik’s cultural voice comes through in her writing to signal that it comes from genuine, first-hand and first-voice experience. It is a rare article from a Kija (First Nation) academic and so becomes a discursive lighthouse to which healthcare executives should navigate towards as guidance into the selection of evidence to justify changes in healthcare governance.

Criterion 3 – Consider the Moral Obligations of Knowledge Governance

The leaders and stewards of higher education systems have a moral obligation to deconstruct knowledge governance practices that have historically disregarded the cultural voice of Australia's First Peoples.

Criterion

Do knowledge production processes reflect moral obligations to Australia's First Peoples?

Relevance (to the concept of obligations)

[Corporate Governance and Accountability Compendium for NSW Health \(2012\)](#) - Standard 1: Establish robust governance and oversight frameworks. 'The legal and policy **obligations** of the organisation are identified and understood; and responsibilities for compliance are allocated' (p.2.02, December 2016)⁵²

[National Safety and Quality Health Service Standards - 2nd Ed \(2017\)](#). Standard: Clinical Governance. Item: Safety and Quality Training. Action 1.21: 'The health service organisation has strategies to improve the cultural awareness and cultural competency of the workforce to **meet the needs** of its Aboriginal and Torres Strait Islander patients' p.10).⁴⁰

[National Safety and Quality Health Service Standards user guide for Aboriginal and Torres Strait Islander Health \(2017\)](#). Action 1.33: Creating a welcoming environment. Item: Respond to the cultural needs, **obligations** and responsibilities of Aboriginal and Torres Strait Islander employees, patients and their families. Suggested approach: Allocate time to listen to Aboriginal and Torres Strait Islander patients, their families and the Aboriginal and Torres Strait Islander workforce about their specific cultural needs (p.32).¹⁶

The next article shows the - now routine - academic practice of 'acknowledging' the contribution from Australia's First Peoples, and it shows exceptional sensitivity to the research enterprise and Australia's First Peoples.

Culturally Safe Research Methodology

4. [Elizabeth Kendall](#) and [Catherine A. Marshall](#) published *Factors That Prevent Equitable Access to Rehabilitation for Aboriginal Australians with Disabilities: The Need for Culturally Safe Rehabilitation* (2004, Queensland) to 'investigate the barriers that prevent Aboriginal people with disabilities from accessing rehabilitation services'⁷⁶ through a single-person case study design involving interviews (n=16) with all care providers (Aboriginal and non-Aboriginal) in a small remote location of majority Aboriginal population.

The first empirical research article where the methodology is explicitly tied to the concept of cultural safety, where all aspects of the research are carefully designed to produce culturally safe research, thus adding credibility to their assertions that ‘Principles derived from our research that can be used in the development of culturally safe services are presented’.⁷⁶ Though there is no reference to Williams’ (1999) or Bin-Sallik’s (2003) articles, instead they drew on Ramsden’s (1990) view that ‘Culturally safe environments have been defined as those in which there is no assault on a person’s identity caused by the fact that service delivery methods or processes are alien to the Aboriginal culture’⁷⁶ which Ramsden (1990) phrased as ‘As long as Māori people perceive the health service as alien and not meeting our needs in service, treatment, or attitude, it is culturally unsafe. A dangerous place to be.’⁵⁵ And this danger is seen in the findings of the study of Kendall and Marshall.

Indeed, they found six cultural factors that spoke to the ‘nexus between culture and disability’⁷⁶ and from these provided five strategies ‘that must be considered if culturally safe services are to be delivered for Aboriginal people in Australia.’⁷⁶ These are evidence-based suggestions pitched to health service managers and educators. However, it is interesting to note the Kendall and Marshall (2004) work is not explicitly cited in the reference list for: [Disability within the Indigenous community](#),⁷⁷ in the [National Standards for Disability Services – Implementation for Aboriginal people with disability](#),⁷⁸ or in the [2010-2020 National Disability Strategy](#).⁷⁹

Perhaps, as they paraphrase Morgan et al. (1997)⁸⁰ ‘However, in current service provision, non-Aboriginal people continue to define the parameters within which Aboriginal people can participate in rehabilitation services, with consequences for their participation in the larger society’.⁷⁶ A sentiment that echoes Bin-Sallik’s (2003) ‘hat-in-hand’ statement about referring to need for Aboriginal people to advocate for participation in decision-making process, rather than being routinely included in them. Two articles point the failure of Australian disability policy to adequately address the disability needs of Australia’s First Peoples ([Gilroy 2011](#), [Gilroy 2016](#)) and the report [Shut Out: The Experience of People with Disabilities and their Families in Australia](#) ([2009](#)) noted that ‘Aboriginal and Torres Strait Islander people rarely have the opportunity to have meaningful strategic input into the design and management of services and support’.⁸¹

Criterion 4 – Include Australia’s First Peoples in Knowledge Services

The proposition that Australia’s First Peoples should be included in the decision-making processes in the development of services should also be reflected in the knowledge governance of research processes.

Criterion

Are Australia’s First Peoples included in the knowledge production process?

Relevance (to the concept of ‘integration’)

Corporate Governance and Accountability Compendium for NSW Health (2012) –

Standard 6: Involve stakeholders in decisions that affect them. Activity: Respect the rights of stakeholders. Under the section ‘Stakeholder engagement’ is stated, inter alia, ‘the **integration** of diversity and innovation into health services to reduce social disadvantages and to meet community health needs’ (p.10.02, May 2013).⁵²

National Safety and Quality Health Service Standards - 2nd Ed (2017). Glossary, ‘policy: a set of principles that reflect the organisation’s mission and direction. **All procedures** and protocols are linked to a policy statement’ (p.74).⁴⁰

National Safety and Quality Health Service Standards user guide for Aboriginal and Torres Strait Islander Health (2017). Action 2.13: Working in partnership. Item: Agree on the structure, mechanisms and responsibilities of partnerships. Suggested approach, inter-alia, ‘Developing a set of principles for working in partnership that cover issues such as reciprocity (that is, the Aboriginal or Torres Strait Islander community involved gains value from the partnership arrangements), communication, **involvement**, and sharing of knowledge’ (p.11).¹⁶

In contrast to the care and sensitivity shown by Kendall and Marshall (2004), the next article shows how uncared academics are in selecting examples of programs that suite their purpose rather than being a genuine attempt at intellectual engagement.

Unsafe Literature Reviews

5. [Sue Kruske](#), [Sue Kildea](#), and [Lesley Barclay](#) published *Cultural Safety and Maternity Care for Aboriginal and Torres Strait Islander Australians* (2006, Northern Territory) to ‘discuss cultural safety and critique the provision of culturally appropriate maternity services to remote Aboriginal and Torres Strait Islander women in Australia’⁸²

Kruske et al. (2006) provide a succinct yet nuanced overview of the concepts of ‘culture’ and ‘cultural safety’ that highlight some key themes of cultural safety: culture is dynamic and heterogeneous; health professionals need to be reflexively aware of their cultural biases and professional power; that culture and professions and patients operate within political and historical and power frameworks; and it is the patient that defines the cultural safety experience. Clearly, Kruske et al. (2006) have paid close attention to the cultural safety literature of Ramsden (1990, 1992, 1993, 1996), the Nursing Council of New Zealand (1996), and Eckermann et al. (2006) although this is the only reference to an Australian cultural safety publication, which is interesting considering the existence of Williams’s (1999) and Bin-Sallik’s (2003) Northern Territory publications.

Kruske et al. (2006) note the absence of any guidelines or policies covering cultural safety in maternity care. Compared to the depth of cultural safety embedded in the Nursing Council of New Zealand standards (2011),⁴⁸ the Australian [National Competency Standards for the Midwife \(2006\)](#) contained just one sentence ‘A graduate midwife has a commitment to cultural safety within all aspects of her practice and acts in ways that enhance the dignity and integrity of others’⁸³ (without providing any references as to ‘how to do’ cultural safety). Kruske et al. (2006) provide numerous references to published literature that substantiate the cultural considerations needed for a culturally safe birthing environment.

Unfortunately, part of that environment is the combination of cultural ethnocentrism and institutional racism in the statement that ‘Many health practitioners are constrained by their own cultural perspective with little understanding of institutional racism and discrimination inside the health service or society in general’,⁸² which is amply demonstrated in the research published ten years later by Brown et al. (2016). Therefore, they state later in the article, the phrase *tenet of cultural safety* in the statement ‘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’. For example, the Australian Psychological Association has demonstrated profession reflexivity in their apology to Australia’s First Peoples ([2016](#)).⁸⁴

Overall, this article highlights a key problem in engaging with cultural safety – the lack of an aggregated evidence base from which healthcare executives can use to guide their organisations. Furthermore, Kruske et al. (2006) is the first article that references an Aboriginal community-based program as exemplifying cultural safe practice – the [Townsville Mums and Bubs program](#).⁸⁵ Although ‘cultural safety’ *per se* was not mentioned in the cited research and, therefore, shows how academics can cherry-pick examples to support their own arguments. This signals the need to develop a set of criteria for the assessment of if a practice or service is, in fact, culturally safe.

Such criteria could be pegged to key themes from this literature. The three themes evident from the work of Kruske, Kildea, and Barclay (2006) are lack of service-specific (e.g. maternity care) knowledge about cultural safety (practice, guidelines, and policy), the persistent social values of institutional racism and cultural ethnocentrism in maternity care, and the lack of Australian specific evidence and knowledge about cultural safety.

Criterion 5 – Culturally Safe Literature Reviews

Literature reviews are an important aspect of knowledge production for evidence base development and could include Australia’s First Peoples in them.

Criterion

Do literature reviews explicitly include Australia’s First Peoples?

Relevance (for ‘strategic planning’ and ‘co-design’)

[Corporate Governance and Accountability Compendium for NSW Health \(2012\)](#) - Standard 3: Set the strategic direction for the organisation and its services because 'Health improvement is an integral aim of **service planning**, and all service plans should address, among other things, desired health outcomes and how these will be measured for the specified service' (p.6.06, July 2014).⁵²

[National Safety and Quality Health Service Standards - 2nd Ed \(2017\)](#). Clinical Governance Standard. Criteria: Clinical Performance and Effectiveness. Item: evidence-based care. Action 1.27(a) 'Provide clinicians with ready access to **best-practice guidelines**, integrated care pathways, clinical pathways and decision support tools relevant to their clinical practice' (p.11).⁴⁰

[National Safety and Quality Health Service Standards user guide for Aboriginal and Torres Strait Islander Health \(2017\)](#). Action 2.13: Working in partnership. Item: Ensure representation of Aboriginal and Torres Strait Islander communities on health service organisation's decision-making bodies. Examples of supporting evidence, 'Evidence-based clinical guidelines and decision support tools which have been **co-designed** in partnership with Aboriginal and Torres Strait Islander people'.¹⁶

The development of themes and associated criteria would establish an organisational practice of continuous quality improvement for cultural safety and security. This could help to counter academic confirmation bias as demonstrated by Kruske et al.'s (2006) post-hoc choice of the Townsville Mums and Bubs as an example of cultural safety. Additionally, who is to say a program demonstrates cultural awareness, sensitivity, respect, competence, or safety when these terms are used interchangeably? Juli Coffin, in the next article, wants health service providers to consider the concept of cultural security.

Coffin's Cultural Security Scale

6. [Juli Coffin](#) (Aboriginal Western Australian from the Pilbara region, manager of the [Solid Kids](#) program, [Head of the University of Notre Dame's Broome Campus](#)) published *Rising to the Challenge in Aboriginal Health by Creating Cultural Security* (2007, Western Australia) to 'discuss the concepts of cultural awareness, safety and security and to propose how health care providers can gauge the degree of cultural security in their practice'.⁸⁶

This is the first article to explicitly link cultural safety with security, though she provides no reference to the source of cultural security which is important because the concept is attributed to Shane Houston (2001 in Wilkes et al. 2002)⁸⁷ and Coffin did not proffer an alternative definition. This paper is also reproduced by Coffin et al. (2008) in the chapter 'Ways forward in Indigenous health' in the [Textbook of Australian Rural Health \(2008\)](#).⁵⁹ In both works, Coffin provides one practical example to explain the transition from awareness to safety to security. These transitions are useful for corporate governance

practice because of the transition through different levels from the *individual* ad-hoc awareness to *team* actions to *organisational* policies and procedures; levels that healthcare executives seek to influence through their stewardship (such as the ‘levels’ denoted in the NSW Corporate Governance Lighthouse⁷¹).

Coffin’s cultural security scale signals a germinal point of intellectual growth in the Australian cultural safety literature. She argues that ‘cultural awareness and cultural safety are important foundations for the attainment of cultural security’ and that ‘the first two levels must be addressed in order to progress to the next level’.⁸⁶ The premise of ‘must’ is dubious because there are many permutations within the complexity of the healthcare system as noted in governance schematic diagrams.

For example, ‘must’ all clinicians be at the same level of cultural awareness before the organisation is deemed culturally aware enough to legitimise its workforce move into cultural safety training? The lack of evidence in general and that derived from specific health disciplines suggests an abject lack of knowledge about cultural safety (as noted by Kruske et al. 2006, McGough et al. 2018) and the lack of evidence about the effectiveness of cultural competence training (remembering that competence is about awareness, knowledge and skills),⁸⁸ suggests that all the health workforce could not even be deemed to be at a pre-awareness stage.

Another criticism is that Coffin’s linear and stepwise progression is based on Abraham Maslow’s theory of self-actualisation to underscore the notion that higher-level needs (self-actualisation, esteem, and love) cannot be reached until more basic needs (physiological and safety) are met. However, Coffin’s interpretation of Maslow’s work is incorrect because Maslow stated that ‘behaviour tends to be determined by several or all of the basic needs simultaneously rather than by only one of them’.⁸⁹ This undermines the credibility of Coffin’s proposition of a stepwise and linear progression that the ‘first two levels must be addressed in order to progress to the next level’.⁸⁹ Additionally, Coffin’s advocacy for a linear model based on attaining physiological needs *first*, contrasts with reported Aboriginal notions of health as physical, social, emotional, and cultural dimensions simultaneously interacting in a relational manner between individuals, families and communities.⁶⁶ Does it make sense to use a linear scale of development in a cultural context of simultaneously interacting and multiple facets of holistic health?

Leaving that question aside for another version of this critique, Coffin’s cultural security scale is intellectually pegged to Maslow’s theory whose unquestioned acceptance and use of is heavily criticised.⁹⁰ For example, for being culturally ethnocentric in failing to account for definitions of the quality of life being culturally dependent, and its bias towards individualistic societies over collectivist societies.⁹¹ This raises the issue of how academics’ choice of theory appears opportunistic and not intellectually argued for by comparison with the intellectual development and implications of cultural safety (a continuing theme of this critique).

But Coffin acknowledges that ‘achieving cultural security is about the meeting of two different approaches in health’ - which is a thematic link to Williams’ ‘sharing’ ethic in

cultural safety - and the different views of health meet through the processes of *brokerage* and *protocol* in her cultural security scale of: awareness-*brokerage*-safety-*protocol*-security-sustainability. Coffin's cultural security scale is a unique Australian perspective and has been cited in other published Australian work.⁹² It contrasts with Ramsden's (2002) view of the steps from cultural awareness to cultural sensitivity to cultural safety which is fixed at the individual level. Although not providing any definitions or references to cultural awareness, safety or security, Coffin (2007) provides an example of how directly linking understandings and actions leads to cultural security, the first article to do so.

The concepts of brokerage and protocol 'can be likened to the vehicle to reach cultural security in the appropriate way that will then be sustainable',⁸⁶ and these two themes are only briefly mentioned in Australian literature by McLellan et al. (2016) and Milne et al. (2016). What is evident is that both 'brokerage' and 'protocol' appear to be consonant with the cultural voice of Australia's First Peoples because they signal the start of the pathways to mutual and collaborative understanding of cultural norms,⁹³⁻⁹⁶ which reflects Wilkes' cultural obligations and Bin-Sallik's moral obligations.

The humanistic tone and emphasis on human cultural values and norms of Williams (1999), Wilkes et al. (2002), Bin-Sallik (2003) and Coffin (2007) starkly contrasts to mainstream healthcare literature. This literature uses 'stakeholder' and 'consumer' terminology which appear more aligned to 'market' terms of reference, whereas brokerage and protocol are more aligned to community development discourse. The difference between the use of terminology could signal a deeper socio-cultural rift between classic liberalism or right-wing notions of individualism and individual behaviour change versus civic republicanism or left-wing values of mutual integration.⁹⁷ Further discussion of this topic is outside the scope of this critique but should be noted because it is relevant for the expansion of Wilkes' cultural obligations and Bin-Sallik's moral obligations into healthcare governance development.

Overall, Coffin's cultural security scale is a unique and Aboriginal intellectual development in the cultural safety literature because it shifts thinking away from the sole focus on the clinician and patient interface to include teams, organisations, and the health system. As Coffin (2007) implies, it could be through engaging in processes of brokerage and protocols that the individual, the team, and the organisation can be aligned to provide a consistently secure organisational context for Australia's First Peoples.

Criterion 6 – Assess Progress using Coffin's Cultural Security Scale

Different levels of knowledge governance can be assessed against Coffin's cultural security scale to gain a sense of the overall security of knowledge production processes.

Criterion

Is a consideration of cultural security evident in the knowledge base?

Relevance (for 'system')

[Corporate Governance and Accountability Compendium for NSW Health \(2012\)](#) - Standard 1: Establish robust governance and oversight frameworks. Health organisations should ensure that, inter alia, 'A **system** is in place to ensure that the policies and procedures of the organisation are documented, endorsed by the board and/or chief executive and are readily accessible to staff' (p.2.02, December 2016).⁵²

[National Safety and Quality Health Service Standards - 2nd Ed \(2017\)](#). Partnering with consumers standard. Criteria: Clinical governance and quality improvement **systems** to support partnering with consumers, 'Systems are designed and used to support patients, carers, families and consumers to be partners in healthcare planning, design, measurement and evaluation'. Item: Integrating clinical governance. Action 2.1: Clinicians use the safety and quality systems from the Clinical Governance Standard (with sub-sets of action items) (p.14).⁴⁰

[National Safety and Quality Health Service Standards user guide for Aboriginal and Torres Strait Islander Health \(2017\)](#). Action 1.4: Implementing and monitoring targeted strategies. Suggested strategy: Adopt a **whole-of-organisation approach**. Suggested approach: Implement policies, procedures, strategies and protocols using a whole-of-organisation approach to change management, with support from clinical and non-clinical leaders (p.21).¹⁶

In the following sections of this critique, the phrase 'cultural safety and security' is used because it marks an intellectual shift to cultural safety being considered throughout the different points and pathways of the health institution. Vastly more development is needed so that clear marketing and communication about cultural safety and security is achieved to buffer against political appropriation of concepts, as the next article shows.

Academic Political Appropriation

7. [Megan-Jane Johnstone \(Retired Professor of Nursing\)](#) and [Olga Kanitsaki \(Retired Professor of Transcultural Nursing\)](#) published *An Exploration of the Notion and Nature of the Construct of Cultural Safety and its Applicability to the Australian Health Care Context* (2007a, Victoria) and stated 'Findings from the study indicate that the notion of cultural safety is conceptually problematic, poorly understood, and underresearched and, unless substantially revised, cannot be meaningfully applied to the cultural context of Australia.'⁴⁵

Johnstone and Kanitsaki's (2007a) research is deficient by that fact that they assumed their small and unrepresentative sample in Melbourne reflects the entire cultural context of Australia. However, the article is insightful because the research sought to know if cultural

safety was understood and accepted outside of its usual home of Māori and Australia's First Peoples' contexts (the answer is no). They rephrase Williams' (1999) definition of cultural safety and propose that **unsafe** cultural practice is:⁴⁵

an environment that is unsafe for people; where their identity, needs, and well-being are assaulted, challenged, and/or denied; and where there is no shared respect, shared meaning, shared knowledge and experience, of learning together with dignity, and truly listening, and as a consequence of this, there is a risk of harm.

The key understanding to gain from this paper is that the 'rhetorical framing' of cultural safety needs major modification and adjustment through research, critique and argumentation, and public relations marketing. For example, propose Johnstone and Kanitsaki (2007a), cultural safety 'needs to be reconceptualized and positioned as a process outcome of cultural competence'.⁴⁵ Unfortunately, this proposition further complicates the 'conceptually problematic' status of cultural safety instead of clarifying it. Now, cultural competence appears and later McLennan et al. (2016) adds cultural humility into the Australian cultural safety discourse.

Elaine Papps (2015) notes that cultural competence has its roots in transcultural nursing whose 'anthropological framework advocates the study of 'exotic' cultures where the health professional is considered acultural and normal'⁹⁸ and where there is no consideration of the power differential between the health professional and the patient, or the need to consider 'safety' as defined from the patient's point of view instead of the 'competent' professional. Papps articulates the view of 'an apparent political agenda to have cultural safety renamed as something it clearly was not' such as how Johnstone and Kanitsaki (both firmly entrenched in the discourse of transcultural and cross-cultural discourse) seek to position cultural safety as a process outcome of cultural competence.

Interestingly, Johnstone's (2016) book *Bioethics: A Nursing Perspective* (6th edition) has a section on cultural competency, cultural safety and cultural humility (p.82) where cultural safety is framed negatively for example, by ignoring the socio-political dimensions of power imbalance between colonisers and Indigenous peoples. It is also an extremely brief treatment of the topic which has considerable intellectual attention, signally a poor research methodology. Furthermore, Johnstone's (2007) publication [Research ethics, reconciliation, and strengthening the research relationship in Indigenous health domains: An Australian perspective](#) (US\$35 to purchase pdf, [#lockedupknowledge](#)) proposes that strengthening the research relationship in Indigenous health involves processes of recognition and reconciliation. However, Johnstone's perspectives and work have not occurred in collaboration with Australia's First Peoples or through seeking their perspectives on her written work.

Overall, Johnstone and Kanitsaki's (2007a) article signals a key outcome of this critique, that Australian cultural safety is poorly defined and understood and therefore, open to ambiguous interpretations and misappropriation. The underlying theme is of a deep struggle between the philosophy of cultural competence and that of cultural

safety, perhaps representing a continuing struggle between colonisation (competence) and decolonisation (safety)? The term ‘perhaps’ signals the need to explicitly engage with difficult-to-understand concepts and to have lengthy intellectual debates about their implications. Unfortunately, no such debates are apparent within this cadre of Australian cultural safety and security literature.

Criterion 7 - Examine the Potential for Cultural Appropriation

Discuss, define, and debate the potential for colonisation through the appropriation of cultural concepts.

Criterion

Could the proposition for the use of a cultural concept reflect academic political appropriation?

Relevance (for ‘future’, ‘design’, and ‘welcoming environment’)

[Corporate Governance and Accountability Compendium for NSW Health \(2012\)](#) - Standard 3: Set the strategic direction for the organisation and its services. Strategic plans ‘are a mechanism to link the **aspirations of the future** with the reality of the present’ which could occur through the development of a ‘corporate governance plan’ (p.2.03, December 2016).⁵²

[National Safety and Quality Health Service Standards - 2nd Ed \(2017\)](#). Partnering with consumers standard. Criteria: Partnering with consumers in organisational design and governance. Item: Partnerships in healthcare governance planning, **design**, measurement and evaluation. Action 2.1.1a: Involves consumers in partnerships in the governance of, and to design, measure and evaluate, health care.⁴⁰

[National Safety and Quality Health Service Standards user guide for Aboriginal and Torres Strait Islander Health \(2017\)](#). Action 1.33: The health service organisation demonstrates a welcoming environment that recognises the importance of cultural beliefs and practices of Aboriginal and Torres Strait Islander people. Suggested strategy: Work in partnership with local Aboriginal and Torres Strait Islander communities to identify ways to create a welcoming environment. Suggested approach: Involve the Aboriginal and Torres Strait Islander workforce and community members in the design and creation of a **welcoming environment** (p.31).¹⁶

Following-on from the implications of Johnstone and Kanitsaki’s (2007a) article of cultural safety being conceptually problematic is the implications for research design. In the next article, Johnstone and Kanitsaki (2007b) research the *intersection* of the knowledge and understanding about cultural safety and cultural competence.

8. [Megan-Jane Johnstone](#) and Olga Kanitsaki published *Health Care Provider and Consumer Understandings of Cultural Safety and Cultural Competency in Health Care: an Australian Study* (2007b, Victoria) and state that ‘The findings of this study strongly indicate that, despite over 30 years of multicultural policies and programs in Australia, and the current plethora of government requirements and guidelines for managing the effective delivery of ‘diversity services’ to Australia’s culturally and linguistically diverse population...health services providers lack knowledge and understanding of the nature and implications of cultural safety and cultural competence in health care’.⁴⁶

Johnstone and Kanitsaki (2007b) used the same study participants and methodology as in the previous article (2007a) but broaden the questions to be about safety and competence.

Following from this, they propose that ‘there is a strong basis for suggesting that until and unless the matter of ‘culturally responsive health care’ is framed and positioned as a national priority and progressed at a national level, it is unlikely that the known disparities in health and health care of Australia’s minority racial, ethno-cultural and language groups will be addressed’,⁴⁶ but it is a naïve policy statement that is unsupported by theoretical argumentation and empirical research from the Australian context. Just a glance at the previous article (Johnstone and Kanitsaki 2007a) where the authors proposed cultural competence and now to this is added the ‘culturally responsive’ concept, again shows an academic penchant for cherry-picking concepts without meaningful consideration of the literature or engagement with the subjects of the article.

If that was undertaken, it would reveal the problem of excising constructs derived from different countries and mashing them together into a solution for Australia. Johnstone and Kanitsaki (2007b) pull-in sources from America, New Zealand, Canada, and Australia (Williams 1999) without considering derivation of different concepts rooted in varying historical, social, political, health professional, and citizen dynamics – ‘contexts’ – as noted by Kruske et al. (2006). And perhaps that raises an uncomfortable issue with Ramsden’s work which, being so deeply grown in the soil of colonization and Māori people, may not be readily transplantable to different socio-political and historical power dynamics of immigrants in Australia.

Perhaps, the signification that *karwa whakaruruhau* (cultural safety within the Māori context)⁴⁸ should stay as *karwa whakaruruhau* to maintain the integrity of its heritage? No authors in the cited papers of this critique used the Māori language form of cultural safety, and there is no use of language terms from Australia’s First Peoples, and no use of language terms from the diversity of languages in multicultural Australia. The assumption that the English language construction of ‘cultural safety’ represents a meta-construct subsuming hundreds of different cultures – without asking people from those cultures – appears to represent cultural ethnocentrism in written form. And remembering a core ethic of *karwa*

whakaruruhau is that empowering patients in the health care experience rests on their interpretation of it.

Criterion 8 – Value Local Cultural Provenance

The cultural provenance of the constructs and concepts – such as safety and quality – are uncritically assumed to be relevant for Australia’s First Peoples. Therefore, academics need to carefully consider the cultural provenance of ‘cultural’ concepts and actively use Australia’s First Peoples’ local language concepts to signal the cultural provenance of cultural concepts.

Criterion

Are local language terms from Australia’s First Peoples used for cultural concepts in the knowledge base?

Relevance (the ‘local’ ethic)

[Corporate Governance and Accountability Compendium for NSW Health \(2012\)](#) For example, Standard 3: Set the strategic direction for the organisation and its services, ‘A **Local** Healthcare Services Plan and appropriate supporting plans including operations/business plans at all management levels.’ (p.2.03, December 2016).⁵²

[National Safety and Quality Health Service Standards - 2nd Ed \(2017\)](#). Clinical governance standard. Explanatory notes: ‘Each health service organisation needs to put in place strategies for clinical governance that consider its **local** circumstances.’ Criteria: Governance, leadership and culture. Item: Organisational leadership. Action 1.3: ‘The health service organisation establishes and maintains a clinical governance framework, and uses the processes within the framework to drive improvements in safety and quality’ (p.6).⁴⁰

[National Safety and Quality Health Service Standards user guide for Aboriginal and Torres Strait Islander Health \(2017\)](#), ‘It is important to note that each language group has its own unique values and belief systems’ (p.5). Action 1.21: Improving cultural competency. Suggested strategy: Develop and implement a cultural competency strategy. Suggested approach: Describe how **local** cultural practices and beliefs (and acknowledgement of important cultural days and events) are incorporated into the organisation’s policies and processes (p.24).¹⁶

For example, an Australian Aboriginal program evaluation framework is Dr Megan Williams’ ([2018](#)) [Ngaa-bi-nya Aboriginal and Torres Strait Islander Program Evaluation Framework](#) where ‘Ngaa-bi-nya (pronounced naa-bi-nya) means to examine, try, and evaluate in the language of the Wiradjuri peoples of central New South Wales’.⁹⁹ In contrast to the meta-cultural attempt of Johnstone and Kanitsaki (2007a, b), the next article

shows how cultural immersion of one-year duration may be a necessary strategy to enable a transformational understanding of cultural voice.

Promoting Exotic Immersion

9. [Mary Belfrage](#) (Medical Director at the Victorian Aboriginal Health Service, Melbourne) published *Why 'Culturally Safe' Health Care?* (2007, Northern Territory) as a personal reflective article based on a speech given at a general practitioners' dinner.

Belfrage, a non-Aboriginal medical student, spent the year of 1989 in a remote Aboriginal community and came to the realisation that 'I had my first adult glimpse into Indigenous cultures and came away fascinated and respectful, knowing that we — me and my culture and they and their cultures — had fundamentally different ways of experiencing the world'.¹⁰⁰ But this occurred through the Australian stereotypical practice of leaving metropolitan cities for the remote locations for an 'authentic' experience, implicitly perpetuating essentialist mythology of the 'real' Aborigine in the North of Australia compared to the 'fake' urban Aborigines in Australia's South.^{101, 102}

As it continues, the speech portrays the combination of medical professional power and cultural ethnocentrism. Absent from the speech is any sign of objectivity, reflexivity, methodology, or sense of politics (as is the nature of such articles). The simple description of activities to support assertions of culturally safe practice without any empirical justification (methodology - confirmation bias), lack of validation by not seeking the views of clients (safety defined by the patient), absence of reflection about the dominant and privileged position of medical professionals in remote locations (reflexivity) and contributing to the ethos of the Western medical saviour for Australia's First Peoples (politics).

Belfrage's (2007) story (published 17 years after her experience) of self-awareness represents the extreme end of critical self-examination and produced more rhetoric about cultural safety: 'People need to feel like themselves and believe that the health care is connected to their lives, that they are involved and have choices, that it's not primarily someone else's agenda. It's often not so much about empowering people as not disempowering. This is what I think of as cultural safety.'¹⁰⁰ It is difficult to extract any practical value for healthcare governance from this story, which is also the case for the following article, both representing culturally unsafe articles.

Criterion 9 – Critically Evaluate Exotic Experiences

Take a strengths-based approach to the uniqueness and diversity of Australia's First Peoples. The exoticized personal experiences of immersion in rural and remote Aboriginal

communities needs to be tempered by positive self-report bias, lack of independent evidence, professional dominance, absence of Aboriginal perspectives, and colonisation mentality.

Criterion

Is the uniqueness and diversity of local cultures reflected in the knowledge base?

Relevance (on the concept of 'diversity')

Corporate Governance and Accountability Compendium for NSW Health (2012)

Stakeholder Engagement through, 'the integration of **diversity** and innovation into health services to reduce social disadvantages and to meet community health needs'(p.10.02, May 2013).⁵²

National Safety and Quality Health Service Standards - 2nd Ed (2017). Patient safety and quality systems, 'Safety and quality systems are integrated with governance processes to enable organisations to actively manage and improve the safety and quality of health care for patients'. Item: Diversity and high-risk groups. Action 1.15c- 'Incorporates information on the **diversity** of its consumers and higher risk groups into the planning and delivery of care' (p.9).⁴⁰

National Safety and Quality Health Service Standards user guide for Aboriginal and Torres Strait Islander Health (2017), Why have Aboriginal and Torres Strait Islander-specific actions? 'The unique and **diverse** cultures of Aboriginal and Torres Strait Islander people'. (p.4).¹⁶

Further to assessing the cultural safety and security of published literature is to apply that scrutiny to the authors because they have a moral and cultural obligation to reflect on their writing practice.

Culturally Unsafe Writing Practice

10. Dr Hung The Nguyen (Board Director at South Eastern Melbourne Primary Health Network at [2018](#)) published *Patient Centred Care - Cultural Safety in Indigenous Health* ([2008](#), Victoria) as a personal perspective on cultural safety and cultural competency.

This article is an example of a poor literature review, with no reference to Williams's (1999), Wilkes et al. (2002), Bin-Sallik's (2003), or Coffin's (2007) articles. Furthermore, it displays insensitivity to conventions of writing about Indigenous Australians: 'Thus, although the following discussion focuses on the indigenous context, it is equally applicable to culturally and linguistically diverse (CALD) populations.' This contrasts with the findings of Johnstone and Kanitsaki (2007a) that 'it cannot be meaningfully applied to the

cultural context of Australia,’ and the claim of ‘equally applicable’ is made without recourse to any population demographics.

Ramsden (2002) disagreed with connecting cultural safety with the discourse of ‘ethnicity’ and transcultural nursing.⁵⁴ Cultural safety is fertilized in a much different socio-political history than that of Australian multicultural and CALD people. The writing of Nguyen displays a disrespect of the history and uniqueness of Australia’s First Peoples and is reflected in his practice of writing. Unfortunately, it is a key reference for the [Queensland Health Aboriginal and Torres Strait Islander Cultural Capability Framework 2010-2033 \(2010\)](#) to support the proposition ‘An essential component is ensuring a culturally capable workforce’ (p. 16), which demonstrates how culturally unsafe writing can inform state policy, and the poor academic standards of policy making.

Criterion 10 – Critically Reflexive Writing Practice

The authors of articles for, about, and of Australia’s First Peoples need to critically reflect on the ethics of their writing practice.

Criterion

Is the writing practice of authors evaluated for their objectivity, reflexivity, methodology, sense of politics, and moral, cultural, and ethical dimensions?

Relevance (for ‘professional conduct’)

[Corporate Governance and Accountability Compendium for NSW Health \(2012\)](#) NSW Health Code of Conduct – ‘A Code of Conduct ensures a clear and common set of standards of ethical and professional conduct that apply to everyone working in NSW Health, the outcomes we are committed to, and the behaviours which are unacceptable and will not be tolerated’ (p.9.01, July 2014).⁵²

[National Safety and Quality Health Service Standards - 2nd Ed \(2017\)](#). Glossary – person-centred care...is respectful of, and responsive to, the preferences, needs and values of patients and consumers (p.74).⁴⁰

[National Safety and Quality Health Service Standards user guide for Aboriginal and Torres Strait Islander Health \(2017\)](#). Action 1.21: Improving cultural competency – what does this mean for health service organisations? An understanding that, ‘These historical events and experiences, coupled with personal and family experiences of institutionalised racism and **disrespectful communication**, contribute to mistrust in the system by Aboriginal and Torres Strait Islander people and, at times, an unwillingness to engage with healthcare services at all. (p.22).¹⁶

An element of the phenomenon of culturally unsafe writing practice is the assumption that concepts and literature from different countries and contexts can be grouped together into an argument of relevance for Australia, as the next article demonstrates.

Reflexive Publishing

11. Jasten Phiri, [Elaine Dietsch](#), and [Ann Bonner](#) published *Cultural Safety and Its Importance for Australian Midwifery Practice* (2010, New South Wales) which, 'explores how cultural safety has evolved from cultural awareness and cultural sensitivity. It examines the importance of cultural safety in nursing and midwifery practice. Finally, it explores the literature to determine how midwives can apply the concept of cultural safety to ensure safe and woman centred care.'¹⁰³

Phiri et al. (2010), as for Johnstone and Kanitsaki (2007b) begin by using cultural safety as a meta-construct to overlay over different cultures of Māori people, Australian immigrants from Europe and Africa, and Australia's First Peoples. Therefore, this represents a continuing academic practice of cultural ethnocentrism by assuming that an English language construct, published in an English-only journal article, is consonant with the cultural constructs of hundreds of different languages, 'because concepts in one language may be understood differently in another language'.¹⁰⁴ This implies that the notion of reflexivity in the communication act between a midwife and a patient also needs to occur when academics publish in the knowledge economy and promote their findings to policy makers.

Nevertheless, Phiri et al. (2010) demonstrate good academic standards in identifying relevant Australian literature on cultural safety: Bin-Sallik (2003), Belfrage (2007), Coffin (2007), Eckermann et al. (2006), Johnstone and Kanitsaki (2007a), Kruske et al. (2006), and Williams (1999), and note the lack of published research 'which specifically examined cultural safety in midwifery care'. Therefore, they discuss 'how' cultural safety has evolved through awareness, sensitivity, safety, and security; however, it is a *more* descriptive overview through cobbling together different sources of literature *rather than* an emphasis on the mechanics of 'how'. A read of the methodology of Kendall and Marshall (2004) shows the empirical methodology necessary to detect and describe the 'how'. A discussion would have been informative for 'how' the concept of 'safety' is attached to the concept of 'security' (citing Coffin 2007), especially to justify the assertion that they have a 'similar philosophical foundation' however, space prevented this discussion from occurring in the article.

Phiri et al. (2010) reference the [National Competency Standards for the Registered Nurse \(2006\)](#) as an example of 'integrated cultural safety into nursing and midwifery curricula' however, the only reference to cultural safety occurs in the mixed salad sentence 'Facilitates a physical, psychosocial, cultural and spiritual environment that promotes individual/group safety and security'¹⁰⁵ which can be hardly held as an example of 'integration' compared to

the [Nursing Council of New Zealand's Guidelines for cultural safety, the Treaty of Waitangi, and Māori health in nursing education and practice \(2017\)](#).⁴⁸

They also cite the 2006 edition of the [Australian National Competency Standards for the Midwife \(2006\)](#),⁸³ as do Kruske et al. (2006), as an example of integration of cultural safety into professional standards, however there is no substance provided for the 'how' only the ethos of 'respect and embrace the relationship between cultural safety and health outcomes'.¹⁰³ The logical faults in that assertion and, in conjunction with the heavy use of references focussed on cultural competence (which is unstated in the objective) and references drawn from different countries, devalue the article's veracity and credibility for use in informing health service governance. Nevertheless, the paper of Phiri et al. (2010) is used in the [Clinical Practice Guidelines: Pregnancy Care \(2018\)](#),¹⁰⁶ that are 'based on the identification and synthesis of the best available scientific evidence', which means that the standard for "best available" needs to be modified.

Criterion 11 – Practice Critical Reflexivity in Publication Practice

The culturally safe principle of health professional self-reflection in the communication act between a midwife and a patient also needs to occur when academics publish in the knowledge economy and promote their findings to policy makers.

Criterion

Does the publication process reflect an understanding of the social and political construction of knowledge about Australia's First Peoples?

Relevance (for the concepts of 'integrity' and 'evidence')

[Corporate Governance and Accountability Compendium for NSW Health \(2012\)](#). Ethical Framework and External Agency Oversight. 'The core values for the government sector and the principles that guide their implementation are as follows [inter alia]: **Integrity** (a) 'consider people equally without prejudice or favour' (p.9.03, July 2014).⁵²

[National Safety and Quality Health Service Standards - 2nd Ed \(2017\)](#). Glossary – 'best practice: when the diagnosis, treatment or care provided is based on the best available **evidence**, which is used to achieve the best possible outcomes for patients'. (p.68).⁴⁰

[National Safety and Quality Health Service Standards user guide for Aboriginal and Torres Strait Islander Health \(2017\)](#). Examples of Good Practice, e.g. 'The Uti Kulintjaku project is highly regarded for the **integrity**, authenticity and relevance of its work and its resources'. (p.45).¹⁶

The next article shows the variance in article styles of Australian cultural safety and security journal article literature. The contrast lies in the expression and tone of voice as

presented in text. Coming from Phiri et al. (2010) is a technical, objective style of tone emblematic of the values attributed to technical works of this nature. Where is the feeling? Where is the sense of emotion? Williams (1999), Coffin (2007), and van den Berg (2009) wrote articles where feeling and emotion come through the text, and perhaps set textmarks (akin to landmarks) in the literature scape for governance officers to emotionally rig to when attempting to transfer genuine meaning into bland corporate governance documents.

White Knowledge Privilege

12. [Rosemary van den Berg](#) published *Cultural Safety in Health for Aboriginal People: Will it Work in Australia?* (2010, Western Australia), a personal essay for the Ross Ingram Memorial Essay competition of the Medical Journal of Australia. She proposed, 'If implementing and maintaining cultural safety for Aboriginal people means improving their wellbeing and survival, then it should be compulsory in all spheres of health practice in this country.'¹⁰⁷

She provides the emblematic quote for cultural safety from Ramsden's (2002) thesis, where a Māori nursing student – Ms Hinerangi Mohi – said, 'You people talk about legal safety, ethical safety, and safety in clinical practices and a safe knowledge base, but what of cultural safety?'⁵⁴ Nevertheless, a brief review of the Māori context of cultural safety ends with the contrast of Australia where – in van den Berg's powerful voice – there is still the struggle to overcoming 200 years of 'colonial mentality and inherent racist attitudes' and 'invisibility and exile'. This happened through governments and their laws and policies so that Australia's First Peoples were subjugated and controlled (as noted in Bin-Sallik's article, above).⁵⁴

Although changes in those laws and policies have occurred to recognise human rights, she states that 'these days, racist attitudes have become more covert, and are a subtle mixture of paternalism, arrogance and the assumption of white privilege'.¹⁰⁷ In van den Berg's view, the solution lies - firstly - in changing the attitudes of medical and nursing staff and – secondly - in changing attitudes of Aboriginal people to work with staff to find mutually acceptable solutions (reflecting the 'shared' notion of Williams' [1999] cultural safety definition). While van den Berg's reflective piece is subject to similar criticisms of any personal reflection (as noted for Belfrage 2007, above), it is valuable as being the voice of a First Australian, voices that are rare in published academic literature about cultural safety and security.¹⁰⁸

A limitation of van den Berg's article is the focus on personal attitude change through self-awareness and reflexivity for the clinician and patient interaction moment and journey. There is no mention of Coffin's (2007, also from Western Australia) article which extends cultural safety as relevant to situations outside of clinician and patient interaction. However, van den Berg is the first author to link cultural safety and 'white privilege', a phrase not

mentioned in the [Guidelines for cultural safety, the Treaty of Waitangi, and Māori health in nursing education and practice](#) (2011) or in Ramsden's (2002) thesis.

Criterion 12 – Address White Privilege in Knowledge Governance

Assumptions of white privilege underly attitudes about safety in legal, ethical, clinical, and knowledge domains.

Criterion

How is white privilege reflected in knowledge governance?

Relevance (for culturally safe safety standards)

[Corporate Governance and Accountability Compendium for NSW Health \(2012\)](#). Standard 5: Maintain high standards of professional and ethical conduct. Health organisations should ensure that [inter alia]: 'Models of good practice are implemented that provide **culturally safe** work environments and health services through a continuous quality improvement model' (p.2.05, December 2016).⁵²

[National Safety and Quality Health Service Standards - 2nd Ed \(2017\)](#). 'The primary aims of the NSQHS Standards are to protect the public from harm and to improve the quality of health service provision. They provide a quality assurance mechanism that tests whether relevant systems are in place to ensure that **expected standards of safety and quality are met**' (p.1).⁴⁰

[National Safety and Quality Health Service Standards user guide for Aboriginal and Torres Strait Islander Health \(2017\)](#). Action 1.2: Addressing health needs of Aboriginal and Torres Strait Islander people. Where, 'The governing body has ultimate responsibility for the safety and quality of a health service organisation', and among the benefits for taking action are '**reduced institutionalised racism**' (p.14).¹⁶

The next article moves to a different 'level' by writing about an *organisational context* in higher education.

Culturally Safe Textmarks

13. [Wayne Rigby](#), [Elaine Duffy](#), [Jan Manners](#), [Heather Latham](#), [Lorraine Lyons](#), [Laurie Crawford](#) and Ray Eldridge published [Closing the Gap: Cultural Safety in Indigenous Health Education](#) (2011, New South Wales) in the context of stemming the attrition

rates of Indigenous students in higher education organisations by identifying strategies conducive to provide a culturally safe learning environment.

Rigby et al. (2011) conducted their research aligned with cultural safety as proposed by Ramsden (2002) and Eckermann et al. (2006) and cite that Williams' (1999) phrase 'learning together with dignity, and truly listening' underscored the intent of their study. This article contains multiple textmarks that is culturally safe. There is the footnote stating that 'In this study four of the seven members of the research team are of Indigenous descent including the lead author', then the word [Djirruwang](#) for the program, Indigenous value of 'Country', welcoming of Indigenous students by Wiradjuri Elders, Indigenous staff, an external Aboriginal advisory committee, internal organisational support from an Indigenous support unit, and a Wiradjuri Elder working alongside the research assistant to ensure a safe environment for students to express their views. These points mark the article as unique and original in Australia.

Rigby et al. (2011) stated that 'It is important to preserve the *processes* [emphasis mine] that sustain an environment in which the students feel welcomed, informed and culturally safe.'¹⁰⁹ The term 'processes' is not explicitly mentioned in either Williams' (1999) cultural safety definition or in Houston's cultural security definition although Coffin (2007) refers to brokerage and protocols as 'vehicles'. And the term 'process' is a missing part of the 'how' for Phiri et al.'s (2010) discussion because it is about 'how' the meaning of cultural safety is transferred in the development of services (any service). The use of 'processes' is significant because it can be linked to the phrase 'sustain an environment' and because 'sustainability' is included in Coffin's cultural security scale.

Additionally, as a governance phrase - 'sustain an environment' - implies the importance of the organisational context to be safe irrespective of constituent staff and people, which is similarly noted by Coffin (2007) as 'cultural security is essential to every aspect of the health system.'⁸⁶ However, the Djirruwang program's environment did not create a 'shared' space because the entry of a single non-Indigenous student into the all-Indigenous student course meant that 'all agreed and felt strongly that they did not feel safe and felt the presence of the student compromised their learning.'¹⁰⁹ Therefore, the strong Indigenous ownership of the course shows that **all** the processes of the program may not be transferrable to mainstream health organisations where the staff are mostly non-Indigenous.

Criterion 13 – Promote Culturally Safe Textmarks

The specific processes of inclusion of the voice of Australia's First Peoples is the vehicle for the projection of genuine meaning of cultural safety into knowledge production processes and should be reflected in textmarks throughout the writing.

Criterion

Does the text contain markers of cultural safety?

Relevance (for 'inclusive')

Corporate Governance and Accountability Compendium for NSW Health (2012). Standard 4: Monitor financial and service delivery performance. Health organisations should ensure that [inter alia], 'Aboriginal health performance, service access, service utilisation and quality measures are **included** in all relevant service agreements.' (p.2.04, December 2016).⁵²

National Safety and Quality Health Service Standards - 2nd Ed (2017). Clinical Governance Standard, where 'Leaders of a health service organisation have a responsibility to the community for **continuous improvement** of the safety and quality of their services, and ensuring that they are person centred, safe and effective.' (p.4).⁴⁰

National Safety and Quality Health Service Standards user guide for Aboriginal and Torres Strait Islander Health (2017). Action 1.21: Improving cultural competency, where, 'Cultural competency extends beyond individual skills or knowledge to influence the way that a system or services operate across cultures. It is a **process** that requires ongoing learning' (p.22).¹⁶

Other than health program design, there is also the need change the governance of professions, as noted in the next article.

Flattening Power Hierarchies

14. Lucy Skellet (Pharmacist, Melbourne) published *Cultural Awareness and Cultural Safety* (2012, Victoria) as a commissioned work for the Pharmaceutical Society of Australia to produce this article for a continuing professional development series. The topic of the article is the importance of cultural awareness and cultural safety in the provision of pharmacy services.

Skellet (2012) promotes the value of cultural awareness and cultural sensitivity for pharmacists to provide more effective services to all people of different cultures (which is consistent with the cultural safety principle in New Zealand). She points to the effects of 'underlying negative attitudes' and 'preconceptions about other cultures' and 'unconsciously be prejudiced and judgemental about cultural differences' on access to pharmacies, such attitudes noted by Kendall and Marshall (2004), van den Berg (2010), and Brown et al. (2016). She asserts that 'cultural training for all staff is an excellent way to improve the effectiveness of services' - to which there is now evidence contrary to that point.⁸⁸

Skellet (2012) – as for van den Berg (2010) – provides the emblematic quote for cultural safety (Ramsden 2002), and she quotes Williams' (1999) definition of cultural safety. She provides five practice-specific questions for pharmacists to assess their patients' responses,

with no empirical or theoretical justification for those suggestions, as for Belfrage (2007). At least the article raises the point of cultural safety being relevant to disciplines and services. However, Skellet used several concepts (awareness, sensitivity, appropriate, and safety) loosely without acknowledging their differences or citing relevant literature on that point. This is what Johnstone and Kanitsaki (2007a) refer to as ‘conceptually problematic’.

Nevertheless, Skellet (2012) points to the significance of power differentials between patients and pharmacists who need to examine the ‘hierarchy of power relationships with their patients and realising the detrimental effects this can have on health outcomes.’ Skellet (2012) notes the concept of ‘power distance’ that prevents people from speaking up, recommending that pharmacists ‘flatten the hierarchy, create familiarity and make it feel safe to speak up and participate’ (quoting Lowell, A. 2001. Communication and cultural knowledge in Aboriginal health care). How does one ‘flatten the hierarchy’?

The lessons for culturally safe knowledge governance are numerous. Skellet’s (2012) article forms the backbone for a ‘cultural sensitivity’ statement in the *Accreditation Standards for Pharmacy Programs in Australia and New Zealand* (2012)¹¹⁰ when the article is about cultural safety. It privileges the interpretation of a single pharmacist to be relevant to the entire pharmacy profession in Australia and New Zealand. The low academic standard of the ‘independently researched’ article is poor as seen in errors in the citation and reference list. The Accreditation Standards need to be updated with the better quality [Guide to providing pharmacy services to Aboriginal and Torres Strait Islander people](#) (2014)¹¹¹ which references the publication [Culturally Responsive Health Care](#) (Indigenous Allied Health Australia 2013).¹¹²

Criterion 14 – Peer Review Commissioned Articles

Commissioned articles can inform clinical care guidelines and practice standards but are not peer-reviewed, thus introducing poor quality into the health workforce who train by those standards.

Criterion

Are commissioned articles peer-reviewed?

Relevance (for workforce)

[Corporate Governance and Accountability Compendium for NSW Health](#) (2012). Standard 3: Set the strategic direction for the organisation and its services. Section 6.2.2. The NSW State Health Plan with four strategies [inter alia], ‘supporting and developing our **workforce**.’ (p.6.03, July 2014).⁵²

[National Safety and Quality Health Service Standards - 2nd Ed](#) (2017). Clinical Governance Standard, in Clinical Performance and Effectiveness, where ‘The **workforce** has the right

qualifications, skills and supervision to provide safe, high quality health care to patients.’ (p.4).⁴⁰

National Safety and Quality Health Service Standards user guide for Aboriginal and Torres Strait Islander Health (2017). Action 1.33: Creating a welcoming environment, where, ‘clinicians and health service organisations need to be aware of, and sensitive to, the complexity of Aboriginal and Torres Strait Islander cultural beliefs and practices (p.30).¹⁶

Interestingly, the next article moves deeper into a profession (psychology) with an emphasis on a specific tool used in that profession.

Decolonise Knowledge Governance

15. [Leticia Funston](#) published *Aboriginal and Torres Strait Islander Worldviews and Cultural Safety Transforming Sexual Assault Service Provision for Children and Young People* (2013) to describe the outcomes of a two-day forum National Yarn Up: Sharing the Wisdoms and Challenges of Young People and Sexual Abuse.

This was a difficult article to include in this critique because it did not specifically qualify as a ‘health article’ with its focus on child sexual assault in the domestic violence policy domain. However, it was funded by the [NSW Health Education Centre Against Domestic Violence](#) and was published in a public health journal. It is a descriptive report and therefore not a high-quality research article compared to Kendall and Marshall’s (2004) work. There is no ethical approval for the article, although consideration was given to ethical principles and Aboriginal people led the Yarn Up forum and oversaw the article’s writing. There is no reference to any cultural safety or cultural security literature as used in this review.

Nevertheless, it is evident that cultural safety was a strong theme in the Yarn Up where ‘Aboriginal participants emphasised that in order to decolonise services and create cultural safety within the service system, it is necessary to view violence as a product of the socio-political context.’¹¹³ This is the first Australian article to explicitly link cultural safety to ‘decolonisation’ and ‘socio-political context’ although they are implied in statements about addressing power imbalance (Skellet 2012) and Australia’s cultural context (Johnstone and Kanitsaki 2007a). Ramsden (2002) did not mention ‘decolonisation’ in her thesis ‘which is set in a context experienced by colonised peoples’⁵⁴ and this is reflected in the [Guidelines for cultural safety, the Treaty of Waitangi, and Māori health in nursing education and practice](#) (2011, p.4).

Criterion 15 – Decolonise Knowledge Governance

The emergence of a link between ‘decolonisation’ and ‘cultural safety’ marks the entry of a new thread in Australian cultural safety and security discourse and should be extended into knowledge governance.

Criterion

Does the knowledge base reflect an ethic of decolonisation?

Relevance (for the concepts of ‘innovation’ and ‘best-practice’)

[Corporate Governance and Accountability Compendium for NSW Health \(2012\)](#). In the sense of ‘innovation’ in the health system. Stakeholder Engagement, in ‘areas where a public health organisation may engage stakeholders and the community include [inter alia]: ‘the integration of diversity and innovation into health services to reduce social disadvantages and to meet community health needs.’(p.10.02, May 2013).⁵²

[National Safety and Quality Health Service Standards - 2nd Ed \(2017\)](#). Clinical Governance Standard. Criteria: Clinical Performance and Effectiveness. Item: Evidence-base care. Action 1.27(a) ‘Provide clinicians with ready access to best-practice guidelines, integrated care pathways, clinical pathways and decision support tools relevant to their clinical practice’ (p.11).⁴⁰ For example, the reference list (p.77-81) shows three references about ‘concepts’: the care pathway concept; shared meanings: preferred terms and definitions for safety and quality concepts; and Mental health services in Australia: key concepts.

[National Safety and Quality Health Service Standards user guide for Aboriginal and Torres Strait Islander Health \(2017\)](#). Glossary. The essential features of cultural safety are [inter alia]: ‘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’ (p.75).¹⁶

Another difficult concept that recurs in cultural safety and security literature is ‘other’¹¹⁴ which refers to the practice of viewing cultural differences as foreign and exotic compared to one’s own normal frame of reference, demonstrated in the next article.

Double ‘Othering’ and Cultural Security

16. [Helen Milroy](#) (a descendant of the Palyku people of the Pilbara region of Western Australia) published [Beyond Cultural Security; Towards Sanctuary \(2013\)](#) as a commissioned opinion piece on the topic of trauma-informed care.

This is a short article about Professor Milroy's transformational experience in Israel to visit children's trauma treatment programs and one 'was set up as an oasis in the desert, a place of beauty and tranquillity, yet vibrant and full of life'¹¹⁵ which she metaphorically proposes for Australia 'can we continue to build a culturally secure, trauma-informed model of care and provide an oasis in the desert'? Unfortunately, it appears to be the same sentiment expressed by non-Aboriginal people about their transformative experiences in remote Aboriginal communities (e.g. Belfrage 2007, Wilson 2014) but it is expressed by an Aboriginal person after visiting another country. This represents a double 'othering' effect because non-Aboriginal people 'other' Aboriginal people and in this case, an Aboriginal person 'others' another culture.

Criterion 16 – Critically reflect on 'othering' exotic cultures

There is no published literature written about Australia's First Peoples needing to be critically reflexive of how they view cultural differences and how they can be unwitting participants in perpetuating hegemonic discourse. An important task to undertake because of the cultural diversity within Australia's First Peoples.

Criterion

Do Australia's First Peoples writers critically reflect on their cultural assumptions when travelling abroad to **view** other cultures and bring their lessons to Australian practice?

Relevance

With respect to the notion of different cultural 'views', the word 'view' is evident in the word 'review' which implies a critically reflexive process.

[Corporate Governance and Accountability Compendium for NSW Health \(2012\)](#). The word 'review' is noted in, for example: the annual performance review of Corporate Governance Attestation Statements (p.2.06, December 2016); in the review of the Asset Strategic Plan (p.2.07); review the financial and service delivery performance (p.2.07); review corporate and clinical incidents (p.2.08); and 'to seek the views of providers and consumers of health services...' (p.3.02, May 2013).⁵²

[National Safety and Quality Health Service Standards - 2nd Ed \(2017\)](#). The word 'review' is noted in, for example: 'reviews reports and monitors the organisation's progress on safety and quality performance' (p.6); 'Set out, review, and maintain the currency and effectiveness of, policies, procedures and protocols' (p.7); 'Involve consumers and the workforce in the review of safety and quality performance and systems' (p.7); and 'The health service organisation has valid and reliable performance review processes (p.10).⁴⁰

[National Safety and Quality Health Service Standards user guide for Aboriginal and Torres Strait Islander Health \(2017\)](#). The words 'views' and 'review' are noted in, for example: Aboriginal and Torres Strait Islander people have world views that differ from other

Australians (p.4); the holistic view of health (p.5); 'reviewing key Aboriginal and Torres Strait Islander performance measures for the organisation' (p.9); 'Review the health service organisation's performance data against indicators that are reported at national, state or territory, and local levels' (p.17); and 'Develop, review and implement an ongoing program of cultural awareness and cultural competency training' (p.25).¹⁶

The uncritical use of theories, concepts, and tools from different social, cultural, political, geographical and historical contexts is a leading theme of this review. The next article by Nelson et al. (2014) describes an attempt to modify a Western concept through an Aboriginal lens, showing that different 'worldviews' can be intertwined, which reflects the theme of 'sharing' (Williams 1999), 'mutual' (van den Berg 2009), and 'meeting of two worlds' (Coffin 2007).

Culturally Unsafe Methodology

17. [Jeff Nelson](#) (an Aboriginal man from Cairns), [Kelleigh Ryan](#), Darlene Rotumah, [James Bennett-Levy](#), Wayne Budden, Janelle Stirling, [Shawn Wilson](#), and Dean Beale published *Aboriginal Practitioners Offer Culturally Safe and Responsive CBT: Response to Commentaries* (2014, Queensland) as a commentary to argue that the so-called 'Western therapy' CBT (Cognitive Behavioural Therapy) 'can be adapted by culturally competent practitioners to be culturally safe in Australia.'¹¹⁶

Nelson et al. (2014) do not provide or cite any definition of cultural safety, and it was not the design intent of the original article ([Can CBT be effective for Aboriginal Australian's?](#))¹¹⁷ to assess if CBT could be culturally safe. However, they argue for the consonance between cultural safety and CBT on many points which appear rhetorically attractive. For example, that the therapy is adaptable to different client characteristics (urban, rural or remote communities) and is versatile with different components suitable for different applications (echoing Houston's point in cultural security about responding to diversity); that the therapists need to be culturally competent; and that the development of therapies involves Aboriginal counsellors and discussions with relevant stakeholders. This is the first Australian article to investigate how a specific 'Western' health tool could be modified with Aboriginal knowledge.

However, the suggestions are not supported with reference to Australian cultural safety literature, or international literature that questions the effectiveness of CBT with cultural diverse populations.¹¹⁸ Unfortunately, this article continues the cherry-picking trend of academics to grab a concept that can be worked into supporting their main proposition. Nevertheless, it points to the need to consider how different disciplines (psychology) and the different therapies available within a discipline, may be 'made' culturally safe and secure.

This means that the article goes against the grain of dominant discourse about the dichotomy between Western and Indigenous views of the world. But it also indicates the assertion of Coffin (2007) about ‘the meeting of two different approaches’ and reflects the ethos of ‘sharing’ embedded in Williams’ (1999) definition of cultural safety. Sharing is evident in the extensive author list (Aboriginal and non-Aboriginal) which indicates the inclusion of different stakeholders and their perspectives in collaboration. The notions of adapting Western practices, sharing and collaboration speak to several tensions in the article.

These tensions (individuals are not ‘of the community’, individual behaviour change, and the assumption that including Aboriginal researchers equates to cultural safety) are difficult to disentangle because Nelson et al. (2014) do not – in this article – disclose or reflect on or challenge their biases. The methodological flaws, in the original study,¹¹⁷ show in the absence of control subjects or cases, the lack of theoretical review for alternative constructs (why not cultural inclusion, sensitivity, awareness, or competence?) and an absence of comparative psychological methods in the discussion. As Anton, Doran, and Tsey (2013) note, suicide prevention research is weakened by selection bias, allocation bias and confounding.¹¹⁹ Overall, these biases imply that the authors wanted the therapy and the study to be successful. Furthermore, the view of the recipients of care were not considered, thus violating a key principle of cultural safety.

Criterion 17 – Promote Culturally Rigorous Research Methodology

The methodology of research is a critical aspect to the acceptability of the findings to inform evidence-based policy and practice.

Criterion

Does the methodology of the knowledge base reflect considerations of cultural safety and security?

Relevance (for ‘quality’)

[Corporate Governance and Accountability Compendium for NSW Health \(2012\)](#). The word ‘**quality**’ is noted in, for example: quality assurance processes; ‘Models of good practice are implemented that provide culturally safe work environments and health services through a continuous quality improvement model’ (p.2.05, December 2016); and in clinical governance, the Clinical Excellence Commission, the Agency for Clinical Innovation, the Bureau of Health Information, clinical management structures, a Health Care Quality Committee of the Board, and in accreditation (against the NSQHS Standards).⁵²

[National Safety and Quality Health Service Standards - 2nd Ed \(2017\)](#). ‘The primary aims of the NSQHS Standards are to protect the public from harm and to improve the **quality** of health service provision. They provide a **quality** assurance mechanism that tests whether

relevant systems are in place to ensure that expected standards of safety and quality are met. (p.1).⁴⁰

National Safety and Quality Health Service Standards user guide for Aboriginal and Torres Strait Islander Health (2017). 'Like safety and quality more broadly, the safety and **quality** of care for Aboriginal and Torres Strait Islander people can only be improved when everyone who works in the health service organisation recognises that they are responsible for providing equitable care – it is not solely the responsibility of Aboriginal and Torres Strait Islander employees and services' (p.2).¹⁶

The biases (which could also be said of the article by Rigby et al. 2011) and cherry-picking are factors that undermine the marketability of cultural safety and security to health care executives that administer corporate governance. This is no more obvious than in the next article which is an archetype of poor research with Australia's First Peoples.

An Archetype of Culturally Unsafe Research

18. [Sian Truasheim](#) published *Cultural Safety for Aboriginal and Torres Strait Islander Adults within Australian Music Therapy Practices* (2014, Queensland) to 'increase the consideration of cultural safety within music therapy programs accessed by Aboriginal and Torres Strait Islander peoples'.¹²⁰

In contrast to the high-end research of Kendall and Marshall (2004) and the quality of Rigby et al.'s (2011) research processes, Truasheim (2014) provides no explanation of her methodological or empirical design, no reporting of ethics process, used untrained researchers, published client health information, and had no inclusion of Aboriginal academics or oversight process. It is also an example of 'cultural concept soup' – using 'awareness', 'safety', 'sensitivity', 'appropriate' health care, and 'appropriate services', jumbling them together without any theoretical thinking. Truasheim's article exemplifies the insensitivity to the history of the politics of research processes and Australia's First Peoples¹²¹ and reflects poorly on the research governance of the [Institute for Urban Indigenous Health](#) (the attribution for this paper).

Along with Belfrage (2007), Nguyen (2008), and Skellet (2012), the article from Truasheim (2014) continues the trajectory where non-Aboriginal professionals write about their interpretation of a culturally safe experience - which is not checked with the recipients – but are naïve to academic writing practice as an extension of the colonising research ethic.¹²¹ Therefore, while they acknowledge power differentials at the clinician and patient micro-level, they simultaneously perpetuate power imbalance in the knowledge economy.

Criterion 18 – Organisational Responsibility for Culturally Safe Knowledge Governance

Culturally unsafe research practice diminishes, demeans and disempowers Aboriginal people through poor research design, unethical processes, untrained researchers, using participant information without consent, and excludes Aboriginal peoples' perspectives.

Criterion

Does an organisation have a cultural safety review process of all its publications?

Relevance (for 'risk' and 'incident')

Unsafe cultural practice, as noted by Johnstone and Kanitsaki (2007a): 'an environment that is unsafe for people; where their identity, needs, and well-being are assaulted, challenged, and/or denied; and where there is no shared respect, shared meaning, shared knowledge and experience, of learning together with dignity, and truly listening, and as a consequence of this, there is a risk of harm'.⁴⁵ Therefore, unsafe knowledge production could be considered as an 'incident' of patient harm.

[Corporate Governance and Accountability Compendium for NSW Health \(2012\)](#). Activity: Recognise and **manage risk**. Requirement [inter alia]: 'A risk management plan is established which identifies the responsibilities of managers and staff in responding to/and escalating risks and opportunities' (p.2.08, December 2016).⁵²

[National Safety and Quality Health Service Standards - 2nd Ed \(2017\)](#). Standard: Governance, leadership and culture. Item: **Incident management** systems and Open Disclosure. Action 1.11, 'The health service organisation has organisation-wide incident management and investigation systems' (p.8).⁴⁰

[National Safety and Quality Health Service Standards user guide for Aboriginal and Torres Strait Islander Health \(2017\)](#). Relevant for the provision of evidence where, 'The Australian health workforce is diversely qualified, highly skilled, and competent to deliver **safe**, high quality, evidence-based care. (p.1). And, is also relevant for the processes that underpin the production of 'examples of supporting evidence'.¹⁶

Another lens through which to consider relationships in healthcare is that of 'white power' which can be unintentionally perpetuated in the knowledge production process.

White Anti-Racist Empowerment

19. [Annabelle Wilson](#) published *Addressing Uncomfortable Issues: Reflexivity as a Tool for Culturally Safe Practice in Aboriginal and Torres Strait Islander Health* (2014, South

Australia) to, 'provides an example of how reflexivity, from a number of positions and paradigms, can be used to undertake such research.'¹²²

Like Truasheim (2014), Wilson (2014) begins with an acknowledgment to Australia's First Peoples and the help that she received from them during her research. It is important to consider that this type of article about reflexivity is inherently biased because it is without objectivity, rigour, and external critique, but it is an example of the reflexivity called for in cultural safety discourse. The resulting article is of the same ilk as Belfrage's (2007) white person's immersive and transformative experience in a remote community. Having gained trust, understanding and knowledge for her doctoral research, Wilson leaves the remote community to return to an urban location and establish a career working in projects for Australia's First Peoples.

It exposes an uncomfortable issue where white privilege, through immersion and then emergence to a position of white anti-racism,¹²³ marginalises the voice of Australia's First Peoples through continued academic practice. The subsequent privilege is established using Wilson's single piece of work to inform the resource [New to Indigenous Health? Dietetics and nutrition with Indigenous communities: A starting point](#) (2015), and with other publications about Australia's First Peoples.¹²⁴ This continuing trajectory of white anti-racist empowerment about Australia's First Peoples^{125, 126} suggests a culturally unsafe knowledge production system.

Furthermore, it reveals a key problem that the positive notion of self-reflexivity and personal transformation is without an anchoring strategic framework within the dietetic profession. That is, the sole burden falls on Wilson to undergo this transformation, to discover reflexivity and develop a methodology to implement it without being supported by the profession (or have external and peer reviewed oversight). By contrast, to become a dietitian one follows a standardised pathway of learning, training, accreditation, practice, and ongoing professional development. This is an institutionalised system where Wilson does not need to figure it out but relies on the profession and the education system to provide the governance for the learning pathway. In comparison, reflexivity is self-governed and self-awarded.

Reflexivity, by design, occurs within the vacuum of the 'self' under the assumption that professional practice becomes culturally competent.¹²⁷ However, the power gained through this knowledge still privileges the white practitioner, who, unintentionally, maintains professional power over Australia's First Peoples. It is quite clear in Ramsden's (2002) thesis and work that reflexivity should include an awareness of profession power and how a profession is implicated in culturally unsafe practice.⁵⁴ Professions have their own social, cultural and political contexts that have contributed to the colonisation of Australia's First Peoples.¹²⁸ Therefore, self-reflexivity needs the support of profession reflexivity so that Wilson's reflective practice is the origin of a larger body of dietetic reflective work that is collated to inform the dietetic curricula, in the spirit of increasing cultural safety (not only awareness) of the dietetic profession.¹²⁹

Criterion 19 – Consider White Anti-Racist Privilege

White privilege can be unintentionally empowered and marginalise the voices of Australia's First Peoples in and through knowledge production processes.

Criterion

Does the knowledge base privilege the cultural lens and reflexivity of white anti-racist academics?

Relevance (to ethical behaviour applied at the institutional level)

[Corporate Governance and Accountability Compendium for NSW Health \(2012\)](#). Ethical Framework and External Agency Oversight. Declaration of **Ethical Behaviour** and Confidentiality Undertaking, where 'By signing the declaration board and committee members make a commitment to abide by ethical principles in carrying out their duties as a member, including [inter alia]: 'to take all reasonable steps to be satisfied as to the soundness of all decisions taken by the public health organisation' (p.9.02, July 2014).⁵²

[National Safety and Quality Health Service Standards - 2nd Ed \(2017\)](#). Standard: Governance, leadership and culture. Item: Organisational leadership. Action 1.5, 'The health service organisation **considers** the safety and quality of health care for patients in its business decision-making' (p.6).⁴⁰

[National Safety and Quality Health Service Standards user guide for Aboriginal and Torres Strait Islander Health \(2017\)](#). 'A culturally safe workforce considers power relations, cultural differences and the rights of the patient, and encourages workers to **reflect** on their own attitudes and beliefs' (p.22).¹⁶

However, the biggest challenge is to develop health profession governance that is sensitised to unconscious processes, highlighted in the concepts of 'decolonisation' and 'white privilege', that sustain unsafe cultural practice, as indicated in the next article.

Decolonisation Lens

20. [Luke Molloy](#) and [John Grootjans](#) published *The Ideas of Frantz Fanon and Culturally Safe Practices for Aboriginal and Torres Strait Islander People in Australia* (2014, New South Wales) based on the proposition that 'Frantz Fanon explored the forms of exploitation and racism that provided the foundations of colonialism and the conscious and unconscious processes that sustain it.'¹³⁰

Molloy and Grootjans (2014) have carefully written their article to convey an authentic sense of feeling about the colonial history of Australia. They keep faith with Ramsden's (2002) view of cultural safety to establish a 'critical theoretical perspective linking power imbalance and inequitable social relationships in health care, thus complementing the aims of cultural safety' and demonstrate their understanding by describing the period of colonisation in strong terms by using references and phrases that are not cited by other authors included in this critique. For example, they quote Kevin Gilbert (1977):

'It is my thesis that the Aboriginal Australian underwent a rape of the soul so profound that the blight continues in the minds of most blacks today. It is this psychological blight, more than anything else that causes the conditions that we see on the reserves and missions, and it is repeated down the generations' (p. 3)

They argue for critical reflexivity as a conceptual strategy so that nurses 'challenge the ideology supporting the assumptions and promote an alternative consciousness', for 'reflection on both the practices we are involved in and the setting in which they take place', as 'a critical theoretical perspective that links power imbalances and inequitable social relationships in health care.' They refer to Fanon's idea about the 'oppressed demanding humanity' which recalls Kendall and Marshall's (2004) phenomenon of 'Aboriginal fatalism' where 'regardless of the adversity they faced...there was an unwillingness to demand anything for themselves'.⁷⁶

Molloy and Grootjans (2014) quote, 'Unsafe cultural practices comprise any action that diminishes, demeans, or disempowers the cultural identity and well-being of the individual' (Nursing Council of New Zealand, 2011),⁴⁸ and promote the view that 'services should provide approaches to care and treatment that are defined by Aboriginal and Torres Strait Islander people and that do not perpetuate colonialist attitudes by imposing definitions on Aboriginal and Torres Strait Islander people.' This implies that whatever service development strategies are undertaken, their intent needs to consider how they reframe dominant practices and hegemony into a form that supports Aboriginal people (see Rigby et al. 2011)

However, Molloy and Grootjans (2014) make several claims that are unsupported by reference to empirical research, e.g. 'this critical reflection can challenge the ideology supporting assumptions and promote an alternative consciousness'. And they rely on New Zealand writing on cultural safety rather than that of Australian authors (Williams, Bin-Sallik, and Coffin). Nevertheless, the tone and feeling of the article conveys a sense of genuine engagement with the ethos of cultural safety as formulated by Ramsden and echoed by Williams (1999).

One of their most challenging statements relevant for knowledge governance is 'a hegemony of service delivery by institutions and individuals alike'¹³⁰ which refers to the unconscious bias that Western medical traditions are inherently superior modes of epistemology which Molloy and Grootjans believe is linked to 'cultural hegemony' that 'reinforces the sense of inferiority and acts to reaffirm rather than lessen health disparities'.¹³⁰ The point to understand is how professional practice is intrinsically linked to

broader Western culture which means that it needs to be rigorously assessed through engaging with ideas from theorists like Frantz Fanon.

Criterion 20 – Engage with Decolonisation Theorists

Power imbalances are implicated in the inequitable health outcomes of Australia's First Peoples and this can occur unintentionally and therefore requires an expert outsider to assess the colonial hegemony of knowledge governance.

Criterion

Does the knowledge base refer to decolonisation theories?

Relevance (for 'empowerment')

[Corporate Governance and Accountability Compendium for NSW Health \(2012\)](#). The value of 'empowerment' is one of four CORE values that support the governance framework of the NSW health system. The '**empowerment**' values includes that 'patients should be given an opportunity to take greater control of their own health care in collaboration with care providers' (p.9.01, July 2014) and implies that Aboriginal communities (as 'patients') could collaborate on governance decisions with healthcare executives (as 'care providers').⁵²

[National Safety and Quality Health Service Standards - 2nd Ed \(2017\)](#). No mention of 'empowerment' but it is implied in the Standard: Partnering with consumers. Criteria: Partnering with consumers in organisational design and governance. Action 2.11 (a) 'Involves consumers in partnerships in the governance of, and to design, measure and evaluate, health care' (p.19).⁴⁰

[National Safety and Quality Health Service Standards user guide for Aboriginal and Torres Strait Islander Health \(2017\)](#). Action 2.13: Working in partnership. Key task: 'Identify Aboriginal and Torres Strait Islander communities within the organisation's catchment, and the relevant cultural protocols to guide building of partnerships' (p.8).¹⁶

One of the greatest difficulties for the decolonisation criterion lies in how to convert 'understandings' and audit 'findings' into hard activities and indicators for knowledge governance practice. That challenge is made more difficult when there is limited conceptualisation of what constitutes organisational-level factors, as the next article demonstrates.

21. [Justin Gladman](#) (Wiradjuri doctor), [Courtney Ryder](#) (Nunga researcher), and [Lucie Walters](#) (Professor of Rural Medical Education), published *Measuring Organisational-level Aboriginal Cultural Climate to Tailor Cultural Safety Strategies* (2015, South Australia) to discuss their project to ‘measure and reflect on the cultural climate of an Australian rural clinical school (RCS)’ through an online survey of 41 clinical, academic, and professional staff.¹³¹

This article has many methodological, empirical, and theoretical flaws. It states that ‘In recent years cultural safety training programs have become commonplace across the Australian health sector...’ but cites only one reference from Westwood et al.’s (2010) work on cultural awareness training.¹³² They state that ‘Many programs [medical education] have sought to improve cultural safety...’ but just provide two examples (Rigby et al. 2011) and do not refer to Bin-Sallik (2003) or Williams (1999) but rely on New Zealand writing on cultural safety.

Their survey is not logically linked to providing data about organisational-level cultural climate (whatever that may be). The survey of Carr et al. (2011) used is based on non-Aboriginal dental students and does not contain any ‘cultural safety measurement’ as implied in this article. Finally, the use of Mezirow’s Transformation Theory occurs without any consideration of the socio-political and cultural context in which it was developed (United States).

These factors indicate that academics who are First Peoples may not have a pan-understanding of cultural safety. Australia has hundreds of First Nations and so it should not be assumed that all of its member have shared understandings about concepts such as health.^{80, 133} The recent [Wentworth Lecture](#) by Dr Martin Parkinson noted the need to recognize diversity and be specific to communities rather than have a one-size-fits-all approach.¹³⁴

Criterion 21 – Identify Junk Research

Poor methodological, empirical, and theoretical research design undermines the veracity of ‘cultural’ concepts used in health policy for Australia’s First Peoples.

Criterion

Does the knowledge base display an acceptable level of rigour?

Relevance (to ‘high standards’, ‘quality improvement’, and ‘safety and quality’)

[Corporate Governance and Accountability Compendium for NSW Health \(2012\)](#). Standard 5: Maintain high standards of professional and ethical conduct. Health organisations should

ensure that [inter alia]: ‘Models of good practice are implemented that provide culturally safe work environments and health services through a continuous **quality improvement** model’ (p. 2.05, December 2016).⁵²

National Safety and Quality Health Service Standards - 2nd Ed (2017). Standard: Partnering with consumers. Criteria: Clinical governance and **quality improvement** systems to support partnering with consumers. Item: Integrating clinical governance. Action 2.1 ‘Clinicians use the safety and quality systems from the Clinical Governance Standard when:’ (c) ‘Identifying training requirements for partnering with consumers’ (p.16).⁴⁰

National Safety and Quality Health Service Standards user guide for Aboriginal and Torres Strait Islander Health (2017). Under ‘purpose of this guide’ is a point to ‘ensure **equity in access and quality of care**, according to need’ (p. 5). Action 1.2: Addressing health needs of Aboriginal and Torres Strait Islander people. Suggested strategy: set safety and quality priorities, and ‘Recommend to the governing body priority areas to be addressed, including timelines, targets, deliverables, and accountabilities for success’. (p. 15).¹⁶

Interestingly, neither the phrase ‘cultural safety’ nor ‘cultural security’ appear in the **Values and Ethics: Guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander Health Research** (NHMRC [2003](#))¹³⁵ or in its evaluation¹³⁶ but it did appear in a domestic and international literature review ([2013](#))¹³⁷ from the Māori ethical framework. This is a significant gap in research ethics which could explain ad-hoc research practices and methodologies employed in articles used in this critique, as shown in the next article.

Erasing the Copy and Paste approach to ‘Cultural Safety’

22. Catherine Fenton and [Linda K Jones](#) published *Achieving Cultural Safety in Australian Indigenous Maternity Care* ([2015](#), Victoria) to describe the findings of their study ‘to examine what practices healthcare workers in a maternity service employ to support Indigenous women through maternity care’ using ethnographic methods of nine participants in a specific rural location of Victoria.¹³⁸

Fenton and Jones (2015) reference Bin-Sallik (2003), and Johnstone & Kanitsaki (2007a), Eckermann (2009) and Williams’ (1999) definition of cultural safety and they cite the work of Kruske, Kildea, and Barclay (2006) but not Phiri et al. (2010), showing a good level of awareness of Australian literature. They cite Bin-Sallik (2003) in the sentence ‘Cultural safety is then about empowering people and facilitating the achievement of positive outcomes by recognising cultural identity and the impact of personal culture on professional practice’. However, they fail to consider the intellectual lineage of Bin-Sallik’s (2003) and Williams’ (1999) use of cultural safety in the context of Australian higher education

organisations, as do many authors who copy the concept of cultural safety and paste it into whatever is the context of their professional interest.

Whilst they note the need to ‘find better ways forward through collaboration with Indigenous people’ they do not action that by having an Aboriginal collaborator in their research, compared to the lengths taken by Rigby et al. (2011) or Kendall and Marshall (2004) to reach a culturally safe research approach. Indeed, the varying approaches to the research process displayed in the articles of this review indicate that academics fail to observe a basic research principal – to learn from the methodological approaches of one another – a continuous quality improvement approach to the cultural safety and security in research processes. Therefore, in a meta-analytic approach like this critique, how are findings and recommendations meant to be taken seriously by health care executives when there is an inconsistent methodological basis in research practice?

That question aside, Fenton and Jones’s (2015) data analysis and interpretations occurred through an ethnocentric lens without validation in collaboration with Aboriginal colleagues. There was no sense of reflexivity or bias on part of the researchers about how their professional and academic power in this research process might represent a culturally unsafe approach, which contrasts with the sensitivity shown by Fleming et al. (2018). Furthermore, the proposition ‘The findings of the study indicated the importance of cultural safety’ are unsupported because there is no comparative discussion with other research (either Australian or Internationally), no mention of the Nursing Council of New Zealand’s (2011) guidelines, and no mention of any Australian State or Territory policy and strategy (e.g. Victorian Aboriginal Cultural Competence Framework 2008).³²

Criterion 22 – Detect Tokenism in the use of Cultural Concepts

The norm of copying and pasting ‘cultural’ concepts from one social policy domain into another diminishes and demeans the intellectual, social, political, historical, and cultural voice context of development of ‘cultural’ concepts.

Criterion

Does the knowledge base demonstrate justification for the choice of ‘cultural’ concepts?

Relevance (evidence base as relevant to ‘quality’, ‘best practice’, and ‘evidence-based’)

[Corporate Governance and Accountability Compendium for NSW Health \(2012\)](#). Standard 5: Maintain high standards of professional and ethical conduct. Health organisations should ensure that [inter alia]: ‘**Models of good practice** are implemented that provide culturally safe work environments and health services through a continuous quality improvement model’ (p. 2.05, December 2016).⁵²

[National Safety and Quality Health Service Standards - 2nd Ed \(2017\)](#). Clinical Governance Standard. Criteria: Clinical Performance and Effectiveness. Item: evidence-based care.

Action 1.27(a) 'Provide clinicians with ready access to **best-practice** guidelines, integrated care pathways, clinical pathways and decision support tools relevant to their clinical practice' (p.11).⁴⁰

[National Safety and Quality Health Service Standards user guide for Aboriginal and Torres Strait Islander Health \(2017\)](#). Under 'Preamble' is a point to access good health care that is culturally appropriate, and evidence based should be a right for all citizens' (p. 1). Action 2.13: Working in partnership. Addressing health needs of Aboriginal and Torres Strait Islander people. Suggested strategy: Ensure representation of Aboriginal and Torres Strait Islander communities on the health service organisation's decision-making bodies. Examples of supporting evidence [inter alia]: '**Evidence-based** clinical guidelines and decision support tools which have been co-designed in partnership with Aboriginal and Torres Strait Islander people' (p. 12).¹⁶

Improved quality of the evidence base would help the confidence of health executives to make decisions to steer their organisations towards being more cultural safe and secure. Additionally, a quality evidence base also informs health curriculum development, the topic of the next article, so that health professionals exit the formal education system to enter healthcare organisations whose governance is also informed by a culturally safe and secure knowledge base.

Curriculum Power

23. [Rosalie Thackrah](#), [Sandra Thompson](#), and [Angela Durey](#) published *Exploring Undergraduate Midwifery Students' Readiness to Deliver Culturally Secure Care for Pregnant and Birthing Aboriginal Women* (2015, Western Australia) to report on a survey of 44 undergraduate midwifery students about their 'knowledge and attitudes towards Aboriginal people, and the impact of Aboriginal content on their program'.⁶³

This is only the third journal article where cultural security is the main concept (the first being Wilkes et al. in 2002), with the second article being Coffin (2007). Thackrah et al. paraphrase Houston's (2001) definition of cultural security, 'a culturally secure service recognises and responds to the legitimate cultural rights of the recipients of care', whereas the original statement contains the phrase 'legitimate cultural rights, views, values and expectations of Aboriginal peoples' and implies that Aboriginal peoples' voices should be included in the methodology of Thackrah's research but were not (compared to Kendall and Marshall 2004, Rigby et al. 2011). The academic practice of paraphrasing concepts could be considered culturally unsafe because Houston's words are an expression of Aboriginal voice and so to edit and re-interpret them could be disrespectful. The integrity of Houston's voice should be maintained.

In the [Independent Review of the National Registration and Accreditation Scheme](#) for health professionals ([NRAS Review](#)), referring to the development of health profession

competency standards ‘few mention the involvement of consumers and others’ (such as Aboriginal and Torres Strait Islander advocates).¹³⁹ It is clear in the article of Rigby et al. (2011) that the intentional and specific inclusion of the voice of Australia’s First Peoples is the vehicle for the genuine meaning of cultural safety. In contrast, Thackrah’s claim that for the undergraduate course, ‘the unit was conceived and designed with substantial Aboriginal input’ (Thackrah et al. 2018) occurs without any detail or reference compared to that provided by Rigby et al. (2011). Unfortunately, there is no demonstration of shared understanding of how to undertake curriculum development in a culturally safe and secure manner. As one of the ‘tools’ of professional teaching practice, it needs to be considered as another point where power imbalance can be perpetuated.

Thackrah et al. (2015) provide a valuable background on curriculum developments in the higher education sector because they reference curriculum reforms and how they incorporate different cultural concepts, e.g. [CDAMS Indigenous Health Curriculum Framework \(2004\)](#)¹⁴⁰ and the [Aboriginal and Torres Strait Islander Health Curriculum Framework \(2014\)](#).¹⁴¹ However, they do not cite either Williams’ (1999) or Bin-Sallik’s (2003) literature written from within, and about, cultural safety and higher education. Therefore, they miss the point about power imbalance in higher education governance and perpetuate the practice where non-Indigenous people control the curriculum design, development and implementation.

The power imbalance in curriculum design is partially addressed in the [Final Report of the Independent Review of Accreditation Systems within the National Registration and Accreditation Scheme for Health Professionals \(2018\)](#), where the [Congress of Aboriginal and Torres Strait Islander Nurses and Midwives](#) stated ‘Aboriginal and Torres Strait Islander communities and their representatives must be systematically engaged in curriculum planning and review’.¹⁴² The points of ‘curriculum planning’ and ‘review’, however, are fragments in the framework of academic governance ‘structures, relationships, systems and processes’¹⁴³ that encapsulate all health professional curricula. The challenge is to consider the implications for cultural safety and security for all the points and pathways in academic governance.

Criterion 23 – Consider the Power Imbalance in Health Curriculum Governance

Health professional curricula governance can perpetuate the power imbalance between non-Indigenous health professionals and Australia’s First Peoples patients.

Criterion

Do education and training programs for cultural safety and security demonstrate that Australia’s First Peoples are included in the control of their curriculum governance?

Relevance (for ‘control’ and ‘partnership’)

[Corporate Governance and Accountability Compendium for NSW Health \(2012\)](#).

Governance Standards – Checklist. Activity: Respect the rights of stakeholders.

Requirements [inter alia]: ‘A Local **Partnership** Agreement is in place with Aboriginal

Community **Controlled** Health Services and Aboriginal community services within their boundaries (p. 2.08, December 2016).⁵²

National Safety and Quality Health Service Standards - 2nd Ed (2017). Glossary.

‘Governance incorporates the processes, customs, policy directives, laws and conventions affecting the way an organisation is directed, administered or controlled. (p.71). Partnering with Consumers Standard, where ‘These **partnerships** relate to the planning, design, delivery, measurement and evaluation of care’ and ‘consumers are **partners** in the design and governance of the organisation’ (p. 14).⁴⁰

National Safety and Quality Health Service Standards user guide for Aboriginal and Torres Strait Islander Health (2017). Action 2.13: Working in **partnership**, where [inter alia], ‘Partnerships can be strengthened when they are developed at all levels of the organisation and include decision-making bodies’ (p. 7).¹⁶

One of the additional issues with Thackrah et al.’s (2015) paper is the uncritical reliance on ‘cultural competence’ literature because of the philosophical distinctions between ‘competence’ and ‘security’.⁹⁸ The emphasis on ‘competence’ maintains the power of the professional when they learn about ‘other’ cultures and apply their knowledge at the communication interface between a clinician and a patient. In contrast to the technical application of cultural knowledge in a clinical encounter, ‘security’ has deeper implications where, following Wilkes’ cultural obligations (above), it is about integrated patterns of behaviour encompassing ‘physical, mental, spiritual, and environmental domains of life’⁸⁷ which implies security to be a normative aspect of organisational culture rather than applied at only a clinical encounter with an Aboriginal patient.

Furthermore, an additional poor intellectual practice by academics is to add other terms about culture (e.g. cultural competence) into the discourse about cultural safety and security without any theoretical reconciling of the merits for and against, a practice highlighted in the next article.

Cherry Picking Norm

24. [Vanette McLennan](#), [Natalie Taylor](#), [Amanda Rachow](#) (descendant of Dalla people), [Grant South](#) and [Kelsey Chapman](#) published *Creating Culturally Safe Vocational Rehabilitation Services for Indigenous Australians: A Brief Review of the Literature* (2016, Queensland) to review ‘the research evidence on vocational rehabilitation services and rehabilitation counselling practice with Indigenous Australians’.¹⁴⁴

Although they claim to have ‘applied a context sensitive, cultural safety and reflexivity approach to construct salient themes from the research evidence’¹⁴⁴ the article includes the perspectives of one Aboriginal social worker and relied only on published research whereas Aboriginal peoples’ oral perspectives need to be considered.¹⁴⁵ They briefly

mentioned Ramsden's work on cultural safety, and drew on cultural safety literature from Canada, with no respectful engagement with Australian cultural safety literature, citing only Molloy and Grootjans (2014), and Kendall and Marshall (2004). Furthermore, the review included 'cultural safety' and 'cultural humility' about 'ATSI' people (displaying lack of awareness about culturally sensitive writing).¹⁴⁶

However, it is the first article to reference 'cultural humility' and link it to cultural safety, though it is an example of using the concept of 'cultural safety' as a cherry-picked phrase, along with 'cultural humility', without providing a rationale to doing so. Why not 'cultural respect' or 'cultural capability'? Especially in the State of Queensland where the emphasis is on cultural capability in the [Aboriginal and Torres Strait Islander Cultural Capability Framework 2010-2033 \(2010\)](#).³¹ Furthermore, the source of 'cultural humility' is drawn from the context of multicultural education in the United States which has no scent of context from the native American experience.¹⁴⁷ This crystallises a trend where concepts are chosen without deep and thoughtful engagement as implied by reflexivity in cultural safety practice.

Nevertheless, it does add to the trend of limited research about cultural safety and Australia's First Peoples. McLennan, Taylor, and Rachow (2016) found that 'it became apparent that there has been next to no research or publication in this area, especially that relating specifically to vocational rehabilitation access and service provision for Indigenous Australians.'¹⁴⁴ They note that 'contemporary vocational rehabilitation' practice has no 'explicit requirement for culturally appropriate communication with clients'¹⁴⁴ and note the publication [Cultural Responsiveness in Action: an IAHA Framework \(2015\)](#).¹⁴⁸ This is the first article to specifically cite such a 'framework' policy document from an Indigenous peak organisation.

However, note the phrase 'cultural responsiveness' forms the philosophical underpinning to the IAHA framework. Another example of conceptual confusion as noted by Johnstone and Kanitsaki (2007a). And McLennan et al. were aware of the importance of the philosophy underlying concepts in the point that 'cultural appropriateness...focus on sensitivity in relation to ethnicity and cultural practices without challenging power or social inequalities (DeSouza, 2008)'.¹⁴⁴

Engaging with the conceptual arguments and creating clear and consistent messaging is necessary for marketing cultural safety to all Australian healthcare organisations. This would support McLennan et al.'s (2016) call for cultural safety to be included in accreditation requirements and education curricula. Recently (2017) the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives advocated for a '[push for cultural safety into legislation](#)'.¹⁷ However, more critical theoretical work needs to be undertaken to develop clear distinctions between different cultural concepts so that consistent messages can be provided to legislators.

Criterion 24 – Uncover Cherry Picking Bias

More work is needed to achieve consensus on the philosophy, definition, scope, and requirements of different cultural concepts so that consistent messages can be presented to decision makers and healthcare executives to justify reforms throughout their organisations. Currently, there is a high degree of confusion about the use of different ‘cultural’ concepts resulting in them being picked to suit any academic argument.

Criterion

Does the knowledge base provide a rationale to justify the selection and use of the ‘cultural safety’ and ‘cultural security’ concepts?

Relevance (on the concept of ‘clarity’)

[Corporate Governance and Accountability Compendium for NSW Health \(2012\)](#). Standard 2: Ensure clinical responsibilities are **clearly** allocated and understood. (p. 2.03, December 2016). Clinical management structures, where ‘the successful implementation of clinical governance requires [inter alia]: ‘the identification of **clear** lines of responsibility and accountability for clinical care and ensuring these are communicated throughout a public health organisation’ (p. 5.03, December 2016)⁵²

[National Safety and Quality Health Service Standards - 2nd Ed \(2017\)](#). Glossary. ‘Effective governance provides a **clear** statement of individual accountabilities within the organisation to help align the roles, interests and actions of different participants in the organisation to achieve the organisation’s objectives’. (p.71). Governance, leadership and culture. Action 1.1 (e) ‘Ensures that roles and responsibilities are **clearly** defined for the governing body, management, clinicians and the workforce’ (p. 6).⁴⁰

[National Safety and Quality Health Service Standards user guide for Aboriginal and Torres Strait Islander Health \(2017\)](#). Action 1.4: Implementing and monitoring targeted strategies. Suggested strategy: Develop a monitoring and reporting framework. Suggested approach [inter alia]: ‘Establish routine monitoring processes, with documentation of **clear** reporting structures to ensure accountability’ (p. 20).¹⁶

Legislators, as the ultimate leaders of Australian health governance, need to trust in the clarity of the information briefs that they receive. The next article shows how poor research process could be an easy argument to undermine advocacy for taking up cultural safety into legislation.

25. [Mark Shephard](#), [Christopher O'Brien](#) (Yorta Yorta), Anthony Burgoyne, [Jody Croft](#) (Barngala), [Trevor Garlett](#), Kristina Barancek, [Heather Halls](#), [Bridgit McAteer](#), [Lara Motta](#) and [Anne Shephard](#) published *Review of the Cultural Safety of a National Indigenous Point-of-care Testing Program for Diabetes Management* (2016) to describe the results of the study to review the cultural safety of the Quality Assurance for Aboriginal and Torres Strait Islander Medical Services (QAAMS) program.

Another example (see Truasheim's 2014 publication) of a poor-quality research on multiple points. There is a lack of objectivity in this study, as it is conducted by the people that run the program to which the article refers (called confirmation bias). It lacks scientific rigour where the focus group questions and the survey questionnaire were developed by the authors in conjunction with staff of the project but not validated with a community reference group or external assessment process. Furthermore, while two questions specifically mention 'culturally safe' that is not the overall focus of the methodology.

Additionally, most of the citations are self-referencing to Shephard. There are no references to any cultural safety literature. And there is no mention of any ethical approval for the research with Australia's First Peoples (compared to Brown et al. 2016 whose research is also from South Australia) in agreement with the [South Australian Aboriginal Health Research Accord](#) (2014) of which Flinders University is a member. Furthermore, although there are many authors from Australia's First Peoples background, this did not translate into a safe research process.

This example of defective health research governance oversight undermines the credibility of its findings. It also serves as an example that including Australia's First Peoples in the development phase of the study should not shortcut research process rigour and guidelines for research conduct with Australia's First Peoples.¹³⁵ Awareness of these issues are missed by Shephard et al. (2016) due to not engaging with the cultural safety literature and seemingly having no reflection on the politics of research and publication about Australia's First Peoples.¹²¹

Criterion 25 – Ensure Culturally Rigorous Research Governance Process

The unethical and immoral use of research contributes to the perception of it as an extension of the colonisation process.

Criterion

Does the knowledge base demonstrate high ethical and moral qualities?

Relevance (on the concepts of 'integrity' and 'trust')

Corporate Governance and Accountability Compendium for NSW Health (2012). ‘Core values for the government sector and the principles that guide their implementation as follows [inter alia]: **Integrity** (b) ‘Act professionally with honesty, consistency and impartiality’, and (c) Take responsibility for situations, showing leadership and courage (p. 9.03, July 2014)⁵²

National Safety and Quality Health Service Standards - 2nd Ed (2017). Clinical governance ‘ensures that the community and health service organisations can be **confident** that systems are in place to deliver safe and high-quality health care and continuously improve services’ (p. 5).⁴⁰

National Safety and Quality Health Service Standards user guide for Aboriginal and Torres Strait Islander Health (2017). Action 1.33: Creating a welcoming environment, where ‘A welcoming environment in a health service organisation is about creating a place where Aboriginal and Torres Strait Islander people feel safe, comfortable, accepted, and **confident** that they will be respected, will be listened to and will receive high-quality care. (p. 30).¹⁶

Reading the literature about research with Australia’s First Peoples provides an understanding of the role of research in the colonisation processes and how researchers and research organisations can disempower Australia’s First Peoples.^{121, 149} A fundamental element of that history is racism and the next article shows how the politics of racism are managed with non-Indigenous students.

Language Power Imbalance

26. [David Sjoberg](#) and [Dennis McDermott](#) published *The Deconstruction Exercise: An Assessment Tool for Enhancing Critical Thinking in Cultural Safety Education* (2016, South Australia) to describe their anti-racism strategy which is focussed on giving ‘non-Indigenous health profession students the ability to recognise language that is imbued with power imbalance, so as to avoid the perpetuation of racialised ways of interacting with Indigenous peoples in the health system.’¹⁵⁰

This is a description of a program designed, developed, and administered by the authors and so is without a critical objectivity that would be brought about by external evaluation. The absence of external objectivity is a phenomenon noted with many articles written by academics about the courses/programs in which they have a vested interest for success, for example Rigby et al. (2011), Nelson et al. (2014), and Thackrah et al. (2015). The question then arises of what mechanisms would be relevant to provide external critique of academic programs?

Combined the lack of external objectivity is the absence of academic rigour displayed where the concept of cultural safety is liberally used throughout the text but without any

explicit theoretical reasoning that unpacks it and teases out the threads of its meaning to be compared with the concepts of anti-racism, power, and language. For example, there are no references to any Australian cultural safety and security journal articles used in this critique.

The sole source of connection between cultural safety and language is the work of Taylor's (2011) thesis *Intercultural communication in Central Australian Indigenous health care: A critical ethnography* (2010)¹⁵¹ which is the basis of her book *Health care and Indigenous Australians: cultural safety in practice* (2010)¹⁵² both of which take Ramsden's thesis (2002) as the source of cultural safety (why not Williams' definition?). This book is also the source for cultural safety in the article by Lavery, McDermott, and Calma (2017). Taylor's thesis cites some Australian articles in this critique (Bin-Sallik 2003, Belfrage 2007, and Johnstone and Kanitsaki 2007a) but in a cursory fashion. A critique of theses and books is outside of the scope of this review but needs attention for future work.

Criterion 26 – External Evaluation of Academic Programs

Academics that describe their own work are biased to describe it positively and should commission independent evaluations of their programs.

Criterion

Is positive report bias reduced through external critique of academic programs?

Relevance (on the concepts 'bias', 'integrity', and 'best')

Corporate Governance and Accountability Compendium for NSW Health (2012). 'Core values for the government sector and the principles that guide their implementation as follows [inter alia]: **Integrity** (b) 'Act professionally with honesty, consistency and impartiality' (p. 9.03, July 2014).⁵²

National Safety and Quality Health Service Standards - 2nd Ed (2017). Clinical governance standard. Criteria: Clinical performance and effectiveness. Item: evidence-based care. Action 1.27 (b) 'support clinicians to use the **best** available evidence' (p. 11).⁴⁰

National Safety and Quality Health Service Standards user guide for Aboriginal and Torres Strait Islander Health (2017). Action 5.8: Identifying people of Aboriginal and/or Torres Strait Islander origin, 'Importantly, this lack of detail can potentially lead to **biased** analysis and reporting of information that informs policy and practice' (p. 35).¹⁶

For the Sjöberg and McDermott article, despite its limited rigour, validity, and objectivity, it is an incredibly challenging read and shows the degree of strength and commitment required by Sjöberg and McDermott to operate the program. It indicates

the kind of strategy required to address deep and ingrained attitudes, such as those found by Kendall and Marshall (2004) and in the next article by Brown et al. (2016).

Assumptions of Cultural Fit

27. [Angela E. Brown](#), [Philippa F. Middleton](#), [Jennifer A. Fereday](#), and [Jan I. Pincombe](#) published *Cultural Safety and Midwifery Care for Aboriginal Women - A Phenomenological Study* ([2016](#), South Australia) with the aim ‘To explore the lived experiences of midwives providing care in the standard hospital care system to Aboriginal women at a large tertiary teaching hospital’¹⁵³ through 13 interviews with thirteen non-Aboriginal midwives from a single tertiary hospital.

Brown et al. (2016) demonstrate an average coverage of the Australian cultural safety literature by citing Coffin (2007), Johnstone and Kanitsaki (2007), Kruske et al. (2006), and Phiri et al. (2010). They also bring-in grey literature as the first authors to reference the *Congress of Aboriginal and Torres Strait Islander Nurses and Midwives’s* publication *Towards a shared understanding of terms and concepts: strengthening nursing and midwifery care of Aboriginal and Torres Strait Islander Peoples* ([2013](#) – based on work done by McDermott).¹⁸ In that publication, the definition of cultural safety is drawn from the Nursing Council of New Zealand’s (1992) *Guidelines for cultural safety, the Treaty of Waitangi, and Māori health in Nursing Education and Practice* (amended in [2011](#)).⁴⁸ Despite the existence of the Williams and Bin-Sallik Australian definition of cultural safety, Australian academic and policy practice is to appropriate the concept of *Kawa whakaruruhau* (Māori cultural safety) and assume that it fits to the contexts of Australia’s First Peoples.

Assessing the extent of cultural fit involves considering the ingredients of cultural safety. Brown et al. (2016) is the first study that touches on comparing and contrasting findings against some core themes of cultural safety (power, respect, and reflexivity): ‘None of the midwives recognised the position of power they were afforded as caregivers, there was no clear respect for difference or even an understanding of their own cultures and the impact that might have on the women they cared for.’¹⁵³ This confirms a persistent theme that it appears incredibly difficult for individuals to crack and unpack the notions of ‘culture’ and ‘power’ and adjust their practice accordingly (including academic writing practice).

It is also necessary to consider the organisation level context. The study found barriers to health service access: ‘The midwives identified perceived barriers within mainstream services which included the time constraints in a busy hospital; lack of flexibility in the hospital and policies; the system whereby women were required to relocate to birth; lack of continuity of care; lack of support 24 hr a day from the Aboriginal workforce and the speed at which women transitioned through the service.’ But midwives ‘were not in a position to challenge this policy and enact change’, although most of the midwives had not heard of cultural safety, echoing the findings of Johnstone and Kanitsaki (2007a). The

hospital in the study could benefit from the lessons of the [Improving the Culture of Hospitals Project](#)^{92, 154, 155} and perhaps also from national health care standards that reflect cultural safety.¹⁵⁶

But it may take generations to shift entrenched attitudes that can persist despite social, and organisational policies and strategies, as evident in the article by Sjoberg and McDermott (2016). Brown et al. (2016) reported a number of troubling attitudes such as grouping Aboriginal women with other cultures (Asian, Vietnamese, etc.); expressed resentment that ‘other cultural groups were missed in favour of the Aboriginal women’; that ‘your cultures different but you’re not different’; and ‘discrimination was woven throughout the transcripts’ and ‘there was an undertone of both overt and covert racist views’; an assumption that Aboriginal women from rural/remote areas ‘were somehow more authentic in her ties to her culture’ than urban Aboriginal women (who had lost their culture). Noting that this cohort of midwives trained in a different era prior to the increase in the recognition for culturally safe practice means that continuous quality improvement approaches would be as necessary for cultural safety as well as clinical safety,¹⁵⁷ so that health professionals are in an organisational governance context where the think-do-act-learn cycle and cultural safety are institutionalised.

Unfortunately, it is also institutionalised that empirical research articles do not contain the voices of the other side of equation – that of the patient, especially the voices of Australia’s First Peoples. In contrast to the Kendall and Marshall (2004) article, Brown et al. (2016) gave a token reference to a ‘cultural consultant’ for the project, and made no mention of collaboration with Australia’s First Peoples academics or community members, but at least the research was assessed through the South Australian Aboriginal Health Research Ethics Committee. This continues a theme of the critique where research processes, academic processes, and knowledge production processes escape the cultural safety treatment which appears only to be relevant at the interface between the clinician and the patient.

It is also interesting that Brown et al. (2016) noted the Nazi party links of Heidegger¹⁵⁸ and used his phenomenological approach to sensitize the methodology and the analysis, though the ensuing discussion did not contextualise the results by comparing and contrasting them against Heidegger’s concepts – he was absent in the discussion. Fundamentally, the roots of cultural safety as written by Ramsden (2002) reject Heidegger’s anti-Semitic notes. An alternative theoretical method could have been adopted in Brown et al. (2016) if they genuinely engaged with the philosophical roots of cultural safety. One of the articles missed by Brown et al. (2016) is that from Molloy and Grootjans (2014) which demonstrated a good theoretical match between Frantz Fanon and the roots of cultural safety in New Zealand.

Criterion 27 – Assess the Cultural Fit of Knowledge

Knowledge producers can draw on worldwide literature about ‘cultural safety’ but assume that it is transportable across cultural boundaries and matches any “Indigenous” population. As an intellectual act of unsafe cultural practice, it discounts the culturally rich and nuanced histories of Australia’s First Peoples to be the same as colonised Indigenous peoples worldwide.

Criterion

Does the knowledge base reflect the voice of Australia’s First Peoples?

Relevance (on the concept ‘collaboration’)

[Corporate Governance and Accountability Compendium for NSW Health \(2012\)](#). CORE values of NSW Health include ‘**collaboration**’, and the governance framework ‘is supported by the organisation’s CORE values’ (p. 2.01, December 2016).⁵²

[National Safety and Quality Health Service Standards - 2nd Ed \(2017\)](#). Partnering with Consumers Standard, where ‘participation and **collaboration** in healthcare processes are encouraged and supported to the extent that people choose’ (p. 15).⁴⁰

[National Safety and Quality Health Service Standards user guide for Aboriginal and Torres Strait Islander Health \(2017\)](#). The concept of **collaboration** is explicitly cited in: Action 1.2, Action 1.4, Action 1.21, and Action 1.33, e.g. ‘Develop or adopt an indicator set to measure change in processes and patient outcomes’ (p. 19).¹⁶

Brown et al.’s (2016) article also shows that assessing the merits of different theories, and using theory in methodology to inform research design, is absent from the articles in this critique. The following article continues that trend.

Absence of Theoretical Merit

28. [T. Milne](#), [D.K. Creedy](#), and [R. West](#) published *Development of the Awareness of Cultural Safety Scale: a Pilot Study with Midwifery and Nursing Academics* (2016, Queensland) with the objective ‘to develop and validate a self-report tool that aims to measure nursing and midwifery academics’ awareness of cultural safety’ in order to improve Indigenous student success in higher education organisations.¹⁵⁹

The first article in this critique to explicitly demonstrate a methodology that respected the research process method developed by another academic. The methodology used a process which ‘aimed to respect and privilege Indigenous voices in the scale development process by

applying an Indigenous approach as described by Rigney (2006)',¹⁵⁹ and so included, for example, an Indigenous cultural reference group and an Indigenous academic.

Confusingly though, the basis of the survey was a comprehensive review of the literature, *but* the article did not cite any of the Australian cultural safety references in this critique. This becomes apparent when the items selected for the 14 question survey were not substantiated with respect to intellectual arguments justifying the rationale for their inclusion, for example, against the principles of cultural safety outlined by the Nursing Council of New Zealand.⁴⁸ Therefore, the selection process may be seen as culturally unsafe because through what conceptual criteria are decisions made about the survey items?

The authors do display an awareness of conceptual issues. Milne et al. (2016), citing Papps (2015 – a chapter in [Cultural Safety in Aotearoa New Zealand](#)) in that 'Multicultural awareness emphasises cultural sensitivity, and unlike cultural safety, there is little consideration of power imbalance or the lived experience of recipients', as similarly noted by Fenton and Jones (2015) except for cultural appropriateness. Clearly, 'awareness' did not translate into safe practice in the selection and validation of survey items (as for Shephard et al. 2016).

Furthermore, Milne et al. (2016) referred to the [Aboriginal and Torres Strait Islander Health Curriculum Framework \(2014\)](#)¹⁴¹ with its focus on 'cultural capability' reflecting the concept soup phenomena, which is made worse through poor logic in the statement 'In order to transform learning for academics participating in training, a cultural safety framework that builds on cultural awareness needs to be developed'¹⁵⁹ because there is Australian research (published in 2010) showing poor effectiveness of cultural awareness training¹³² and that 'they are insufficient in terms of achieving genuine change in Aboriginal Peoples' experience of health services and health outcomes'.¹⁴ The confusing use of different concepts, lack of sensitivity in survey item selection, and poor logical arguments, undermine the quality of this article.

Principle 28 – Include a Theory of Change

Academics could provide better theoretical reasoning and argumentation behind their research so that healthcare executives have a clear understanding of the rationale for promoting actions to improve cultural safety and security.

Criterion

Are theoretical reasoning and argumentation clearly provided to explain the arguments and propositions in academic research?

Relevance (on the concept 'soundness' or 'best')

[Corporate Governance and Accountability Compendium for NSW Health \(2012\).](#)

Declaration of Ethical Behaviour and Confidentiality Undertaking, where board and

committee members [inter alia]: ‘take all reasonable steps to be satisfied as to the **soundness** of all decisions taken by the public health organisation ’ (p. 9.02, July 2014).⁵²

National Safety and Quality Health Service Standards - 2nd Ed (2017). Glossary, best-practice guidelines: ‘a set of recommended actions that are developed using the **best** available evidence.’ (p. 68).⁴⁰

National Safety and Quality Health Service Standards user guide for Aboriginal and Torres Strait Islander Health (2017). Action 1.21: Improving cultural competency. Key task [inter alia]: ‘Use continuous **quality** improvement processes to improve the cultural safety of the health service organisation (p. 23).¹⁶

The Milne et al. (2016) article is an example of the poor quality of evidence the characterises the knowledge base for the cultural safety and security of Australia’s First Peoples, as substantively flawed. Therefore, advocates for cultural safety and security are without a coherent evidence base for their arguments. The next article is an example for that point.

Narrow Focus on Health Professional/Patient Communication

29. [Roianne West](#), [J. Gamble](#), [J. Kelly](#), [T. Milne](#), [E. Duffy](#), [M. Sidebotham](#) published *Culturally Capable and Culturally Safe: Caseload Care for Indigenous Women by Indigenous Midwifery Students* (2016, Queensland) to ‘To explore Indigenous students’ perceptions of providing continuity of midwifery care to Indigenous women whilst undertaking a Bachelor of Midwifery’ based on narrative inquiry with three participants.¹⁶⁰

This paper provides a number of points to indicate that the research process was culturally safe: Aboriginal leader, a narrative inquiry approach, engagement with Aboriginal communities, an ethical approach, sensitivity to the history of research with Australia’s First Peoples, and an ethic to ‘privilege Indigenous voices and Indigenous lives’ (p. 526). It is also the first study to gather the perspectives of Indigenous patients involved in the same study as the Indigenous health professionals, and compare and contrast the findings as referred to in another publication.¹⁶¹ These aspects appear to reflect the governance ethic of the [First Peoples Health Unit](#) (Griffith University, Brisbane - of which Professor West is the [Director](#)) which contrasts to the culturally unsafe research governance of Truasheim’s (2014) paper.

The research strongly emphasised the cultural basis of interactions in the three themes *facilitating connection*, *being connected*, and *journeying with the woman* which links to the ethic that to Aboriginal people, holistic healthcare is ‘fundamentally a cultural obligation’ (Wilkes et al. 2002). This was expressed in the voices of the Indigenous students who talked about ‘identity’, ‘relationships’, and ‘community’ as being significant points of cultural connection with their patients, and how these points could be used to open the doorway to trusting

relationships and the provision of safe care. But it is difficult to see how the three themes could be relevant to healthcare executives focussed on non-clinical governance interactions.

The point of ‘relevance’ is a major theme of this critique where cultural safety researchers are mostly naïve about the significance of governance as a contextual factor in clinician and patient relations. Brown et al. (2016) noted governance factors (see ‘assumptions of cultural fit’, above) while West et al. (2016) point to the enabling governance factor of the ‘continuity of care experiences’ policy in the [Australian Midwife Education Standards \(2014\)](#).¹⁶² Indeed, the word ‘governance’ is rarely used in cultural safety and security publications (and as a keyword).

Undermining the relevance of this work is the joining of ‘culturally capable’ and ‘culturally safe’ without any rationale for doing so, or any argumentation for or against that case, as for McLennan et al. (2016) who added ‘cultural humility’. The use of the phrase ‘culturally capable and culturally safe’ appears to be derived from similar phrasing in the [Aboriginal and Torres Strait Islander Health Curriculum Framework \(2014\)](#) for example, ‘Graduate Capabilities For Culturally Safe Aboriginal And Torres Strait Islander Health Care’.¹⁴¹ West et al. (2016) neither reference any cultural safety publications used in this critique nor any publications about cultural capability. Therefore, the link between the research outcomes and those concepts is unexplained (and obliquely links to West’s other publications on cultural capability^{163, 164}).

Furthermore, there is a long bow drawn between the research outcomes as an example of the philosophical alignment between the principles of Midwifery Care ([International Confederation of Midwives](#)) and Indigenous health care. This alignment is provided as a ‘theoretical framework’ for the research but no argumentation occurs to detail how the three themes are linked to either the philosophy of Indigenous healthcare or midwifery care. The work of [Ruth DeSouza](#) ‘Navigating the Ethics of Cultural Safety’ (2015)¹⁶⁵ reveals the cultural relativism of ethics, morals, and values that occur in clinical interactions, and imply a problematic philosophical relationship between the diversity of Australia’s First Peoples and international midwives of different cultures. The [International Confederation of Midwives](#) has 132 midwives’ associations representing 113 countries¹⁶⁶ and so West et al. (2016) continue the academic tradition of cultural ethnocentrism by assuming ethical alignment across culturally diverse populations.

Criteria 29 – Assess the Relevance of the Research Focus

Healthcare executives look for relevant knowledge that supports their creation of culturally safe and secure governance, and while academics cursorily deploy concepts such as ‘policy’ and ‘strategy’ and ‘system’ and ‘governance’ in their articles, the results are still pitched at the interaction between the health professional and the patient.

Criterion

Is the relevance of the knowledge base argued for against the principles of cultural safety and security?

Relevance (on the concept ‘views’ and ‘perspectives’ from different parts of the health system)

Corporate Governance and Accountability Compendium for NSW Health (2012). Role of **Boards** is, inter alia, to ‘to seek the views of providers and consumers of health services and of other members of the community’ (p. 3.02, May 2013).⁵²

National Safety and Quality Health Service Standards - 2nd Ed (2017). Partnering with Consumers Standard. Criteria: Partnering with consumers in **organisational design and governance**. Item: Partnerships in healthcare governance planning, design, measurement and evaluation. Action 2.14 ‘The health service organisation works in partnership with consumers to incorporate their views and experiences into training and education for the workforce’ (p. 19).⁴⁰

National Safety and Quality Health Service Standards user guide for Aboriginal and Torres Strait Islander Health (2017). Action 1.33: Creating a welcoming environment. Examples of supporting evidence, inter alia, ‘Evidence that Aboriginal and/or Torres Strait Islander people are involved in the development and implementation of the **strategies**, and that their views are sought routinely, particularly when the effectiveness of welcoming strategies are evaluated’ (p. 34).¹⁶

The routine inclusion of the views and perspectives of the recipients of care is a key principle in Australian healthcare governance, and the challenge is to extend that principle to situations outside of clinical care such as the myriad interactions that occur in healthcare governance processes. The evidence base for cultural safety and security would be substantially improved through the inclusion of such views. The next paper indicates why it is important to improve the quality of the evidence base and knowledge generation processes.

Unsubstantial Political Rhetoric

30. [M. Laverty](#), [D.R. McDermott](#), and [T. Calma](#) published *Embedding Cultural Safety in Australia’s Main Health Care Standards* (2017, Australian Capital Territory) as a perspective article with the proposition that ‘Accreditation with nationally consistent standards for culturally safe clinical care will improve Indigenous health outcomes’.¹⁵⁶

As a ‘perspective’ piece it contains many political statements that lack tight academic arguments and justification based on intellectual and theoretical reasoning. And to underscore this point it does not contain a single citation to any article in this critique. This

is a problem because the three authors are executives that oversee the corporate governance of their organisations and so, through the framing of this article, authorise a rhetorical approach to cultural safety. But rhetoric has limited currency in an evidence-based clinical care system. Hard targets are abundant in Australia's [National Safety and Quality Health Service Standards](#)¹⁶⁷ which underwent review in 2015/16 in the project [Improving care for Aboriginal and Torres Strait Islander People](#)¹⁶⁸ and produced updated standards on the basis of cultural competence¹⁶⁹⁻¹⁷⁶ - which escaped the attention of these authors.

This is significant because Lavery, McDermott, and Calma are influential in political circles and could be agents to drive reforms in legislation but their article displays a disconnection with Australian academic work on cultural safety – there is no substance to their rhetoric. This highlights an important point for enabling cultural safety throughout the health system, in the need to consider the views of non-patients who do not routinely interact with Australia's First Peoples. The policy and practice gap noted in articles of this critique is starkly demonstrated in the paper of Lavery et al. (2017) and shows the need for academics to connect with healthcare executives to create shared knowledge.

Criterion 30 – Connect with Healthcare Leader and Stewards

Rhetorical arguments for the validity of cultural safety and security in Australian healthcare need to be underpinned by a high-quality evidence base so that it achieves credibility and validity for use in governance strategic planning. This should be achieved through academics connecting to healthcare leaders and stewards and creating a relevant knowledge base.

Criterion

Does the knowledge base reflect the views of non-patients?

Relevance (on the concept 'strategic direction')

[Corporate Governance and Accountability Compendium for NSW Health \(2012\)](#). Standard 3: Set the **strategic direction** for the organisation and its services, because 'Strategic plans provide a mechanism for the progressive achievement of the long term vision of an organisation. As such, they are a mechanism to link the aspirations of the future with the reality of the present.' (p. 2.03, December 2016).⁵²

[National Safety and Quality Health Service Standards - 2nd Ed \(2017\)](#). Clinical Governance Standard. Criteria: Governance, leadership and culture. Item: Governance, leadership and culture. Action 1.1 The governing body, inter alia, 'Sets priorities and **strategic directions** for safe and high-quality clinical care, and ensures that these are communicated effectively to the workforce and the community' (p. 6).⁴⁰

[National Safety and Quality Health Service Standards user guide for Aboriginal and Torres Strait Islander Health \(2017\)](#). Action 1.2: Addressing health needs of Aboriginal and Torres

Strait Islander people. Suggested strategies: set safety and quality priorities, inter alia, 'Consider the needs of Aboriginal and Torres Strait Islander people in **strategic** planning, including for capital works, workforce, information technology and operational strategic plans.' (p. 15).¹⁶

Part of the problem for executives like Lavery, McDermott, and Calma is the lack of intervention studies to provide empirical evidence for their propositions. The next article represents the **first intervention** study specifically based on the concept of cultural safety.

High Standard Intervention Study

31. [Tania Fleming, Debra K. Creedy, and Roianne West](#) published *Impact of a Continuing Professional Development Intervention on Midwifery Academics' Awareness of Cultural Safety* (2017, Queensland) to report on the their research to, 'implement and evaluate a continuing professional development intervention to improve midwifery academics' awareness of cultural safety in supporting First Peoples midwifery students success'.¹⁷⁷

The article of Fleming et al. (2017) provides the most sophisticated empirical research specifically generated from the concept of cultural safety as applied in Australia, and is impressive on many fronts from the consideration of whiteness (stating 'non-First Peoples researcher' and that 'the reframed standpoint has come from a place of deep respect and with the best intent'), the sensitivity to the politics of research with Australia's First Peoples, the depth of understanding of policy documents, a mixed-methods approach with research techniques informed by theory, oversight by a First Peoples expert reference group, justification for the relevance of the research, an Aboriginal mentor and co-author (R. West), and research ethics approval. A standard-setting high point in research about Australia's First Peoples cultural safety in healthcare.

More significantly, it comes from a trajectory of research developed and pursued by Fleming (nee-Milne) and the First Peoples Health Unit of Griffith University. The papers from their work (Milne et al. 2016; West et al. 2016; Fleming et al. 2017; and Fleming et al. 2018a,b) are included in this critique. This contrasts to most other papers in this critique where the concepts of 'cultural safety' or 'cultural security' are used as strategic key words for one article only, rather than as the formative basis of a research platform (excepting the work of McGough et al. 2018, below). Furthermore, the body of work generated is specific to the midwifery profession and this is a strategy that could be pursued for all health professions so that profession-specific recommendations are developed. Additionally, if all health professions followed a similar line of research and development than an extensive body of work could evolve to the point where general Australian principles of cultural safety would emerge.

An extensive empirical evidence base would inform cultural policy development. The article displays the best policy awareness of any cultural safety in healthcare article, and the policy alignment is interesting because of the gaps revealed. Cited are the [Closing the Gap](#) movement (2018) and Reports (2018),¹⁷⁸ the [Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2004-2009](#) (2004),⁶⁴ [National Best Practice Framework for Indigenous Cultural Competency](#) (2009),¹⁷⁹ [NACCHO cultural safety training standards](#) (2011),¹⁴ [Health Performance Framework Report](#) (2014),¹⁸⁰ the [Aboriginal and Torres Strait Islander Health Curriculum Framework](#) (2015),¹⁴¹ [Midwife Accreditation Standards](#) (2014),¹⁶² the [CATSINaM Strategic Plan 2013-2018 evaluation](#) (2015),²² the [CATSINaM Cultural Safety position statement](#) (2013),¹⁰ and the [National Competency Standards for the Midwife](#) (2006).⁸³ This selection of policy documents reveals the gap between the rhetoric for ‘cultural training’ and practical implementation suggestions: ‘these documents give little guidance in regards to application by midwifery academics nor other academics teaching into health programs’.¹⁷⁷

Additionally, the cited policy documents reproduce the ‘cultural concept soup’ phenomenon where they take various standpoints of cultural competence (3 policy documents), cultural safety (4 policy documents), and cultural respect (1 policy document). This is noted by West et al. (2017) where ‘cultural awareness, cross-cultural, and cultural safety terms are used interchangeably and cause confusion’ which was also noted by Johnstone and Kanitsaki (2007a). Interestingly, West et al. (2017) miss the framework used in their home State of Queensland - the [Queensland Health Aboriginal and Torres Strait Islander Cultural Capability Framework 2010-2033](#) (2010) – which is perhaps deliberate so as not to be confused with the ‘cultural capability’ work of Roianne West,^{163, 164} although this did occur in the ‘culturally capable and culturally safe’ article by West et al. (2016, above).

What the policy documents also reveal is a lack of theoretically-informed objectives which is a problem because it is impossible to divine the rationale for the links between vision to purpose to outcomes to strategies (e.g. in the [Queensland Health Aboriginal and Torres Strait Islander Cultural Capability Framework 2010-2033](#)). Fleming et al. (2017) used ‘standpoint theory’ in contrast to other theories used in papers in this critique – Maslow’s theory of self-actualisation (Coffin 2007), Fanon’s ‘oppressed demanding humanity’ (Molloy and Grootjans 2014), Mezirow’s transformation theory (Gladman et al. 2015), Heidegger’s phenomenological approach (Brown et al. 2016), and grounded theory (McGough et al. 2018). This grab-bag of theories underscores the need for a comparative analysis of theories that could be used in cultural safety and security research.

It would be good to know the theoretical rationale behind Fleming et al.’s ‘Aboriginal Cultural Safety Scale’ (Milne et al. 2016, see ‘absence of theoretical merit’, above), which is based on Ramsden’s (2002) work instead of genuine and meaningful engagement with the Williams and Bin-Sallik definition. Although, it is normal for Australian academics and policy makers to copy and paste Ramsden’s definition into the Australian context, as performed in the [NACCHO Cultural Safety Training Standards and Assessment Process](#) (2011).¹⁴ The practice of excluding Australian literature on cultural safety and security, by Australian academics and policy makers, appears to be disrespectful and demeaning to Australian intellectual developments.

Nevertheless, this is the **first article** to provide interpretive criteria for (Ramsden's) cultural safety principles into criteria: gain an awareness of difference (explore their own culture, values, and beliefs); cultural sensitivity (acknowledge difference); cultural safety (develop an understanding of the theory of power relations and politics of cultural safety [including white privilege, racism, and 'othering'], and gain an understanding of the experience of the recipient). More of this interpretive work is needed to because it could help overcome the barriers that policy makers and health clinicians face – taking difficult to understand concepts and converting them into relevant criteria. Overall, this article has many positive points to easily be the best Australian article on cultural safety research.

Criterion 31 – Aim for High Quality Knowledge

High quality knowledge is especially valuable for healthcare executives who need to justify their governance decisions based on quality research.

Criterion

Is the knowledge produced of high quality?

Relevance (on the concept 'best' or 'high')

[Corporate Governance and Accountability Compendium for NSW Health \(2012\)](#). Contains a number of points that mention '**high**': 'high level processes and behaviours' (good governance definition, p. 2.01), 'high standards of professional and ethical conduct' (p. 2.04), 'ensuring that hospital/s deliver high quality health and related services' (p. 5.04), 'promoting and supporting a high performance culture' (p. 7.04), empowerment: 'decisions should be based on clear information about what works best' (p. 9.01).⁵²

[National Safety and Quality Health Service Standards - 2nd Ed \(2017\)](#). Clinical governance standard: 'to implement a clinical governance framework that ensures that patients and consumers receive safe and **high-quality** health care' (p.4).⁴⁰

[National Safety and Quality Health Service Standards user guide for Aboriginal and Torres Strait Islander Health \(2017\)](#). Refers to the a principle that 'it is important that people experience safe and **high-quality** health care based on need' (p.4).¹⁶

The article of Fleming et al. (2017) represents a high peak in the textscape of Australian cultural safety research and provides a clear signal to follow for research practice. A critical part of high-quality research should be developing measurement tools, as demonstrated in the next article.

32. [Courtney Ryder](#), [Tamara Mackean](#) (Waljen woman), [Shahid Ullah](#), [Heather Burton](#), [Heather Halls](#), [Dennis McDermott](#), and [Wendy Edmonson](#) published *Development and Validation of a Questionnaire to Measure Attitude change in Health Professionals after Completion of an Aboriginal Health and Cultural Safety Training Programme* ([2017](#), South Australia) as an article about ‘a research questionnaire to measure thematic areas of transformative unlearning, cultural safety and critical thinking in Aboriginal Health for application on undergraduate and postgraduate students and faculty staff’.¹⁸¹

This first article to link the concept of ‘implicit bias’ to Australian cultural safety discourse. It is also the first paper to reference bio-power as cited in Dr Gregory Phillips doctoral dissertation, [Dancing with power: Aboriginal health, cultural safety and medical education](#) ([2015](#)).¹⁰²

The article provides a good background on the reason for accreditation requirements of health professionals, and provides a list of organisations with that intent: [Australian Medical Council’s Assessment and Accreditation of Medical Schools: Standards and Procedures](#) ([2017](#))¹⁸² which does not mention cultural safety, and [Standards for Assessment and Accreditation of Primary Medical Programs](#) (2012)¹⁸³ that focuses on cultural competency; the [Australian Nursing and Midwifery Accreditation Council’s Registered Nurse Accreditation Standards](#) ([2012](#))¹⁸⁴ that emphasise cultural safety, the [Occupational Therapy Council’s Accreditation Standards for Entry-Level Occupational Therapy Education Programs](#) ([2013](#))¹⁸⁵ that emphasise cultural safety; and the [Dietitians Association of Australia’s National Competency Standards for Dietitians](#) ([2015](#))¹²⁷ that emphasises cultural competence. Ryder et al. (2017) notice that there are varying approaches taken by health professional programmes to meet core accreditation requirements and this raises two interesting points about transparency and accountability.

For transparency, the documents provided on health profession websites to the public are very limited in detail. For example, in occupational therapy training, a program ‘prepares graduates to engage in culturally safe practices’ and two pieces of evidence are required of education organisations like ‘provide specific description of content with particular relevance for the health and well-being of Aboriginal and Torres Strait Islander people’ (p. 16). This vague criterion allows for generous interpretation of ‘content’, and there is no transparency about the definition of cultural safety. For accountability, there is no publicly accessible documentation of the information that occupation therapy training organisations provide to receive accreditation. I argue that for cultural safety and Australia’s First Peoples, transparency and accountability of information could be a governance criterion for education providers.

Furthermore, it has become apparent when reading the articles in this critique, that there are no universal cultural safety accreditation standards in the Australian health system.

That is, every organisation has the leeway to interpret cultural safety as they see fit, develop training and education programs ‘in-house’, are not required to publicly provide the details of the rationale and methodology underlying their approach, do not undergo independent evaluation, and provide no measures of effectiveness of their cultural safety programs. It is a closed, secret, and self-regulated cultural training system that, perhaps, reflects what Ryder et al. (2017) refer to as a ‘colonial mindset’ of being ‘white, privileged, colonised, and ethnocentric’. The challenge is to change the mindset of health professional accreditation *at every level* to be open, transparent, and accountable in the spirit of empowerment – a ‘shift in paradigm’.¹⁸¹

A paradigm shift in thought is needed – as referenced by Ryder et al. (2017) – and harks back to the Williams (1999) reflecting on the ‘unwillingness to genuinely engage in discourse in relation to the issue [of cultural safety]’ and Bin-Sallik’s (2003) call for a ‘moral obligation to deconstruct’ culturally unsafe education organisations. As an example, Ryder et al. (2017) provide a genuine engagement with the concept of cultural safety in the tone and style of the ‘background’ section but alas, reproduce the tokenism in Australian academic practice of the ‘cultural mash’ (mashing together literature from different countries) with limited reference to Australian cultural safety literature (citing the journal articles of Wilson 2014, and McGough et al. 2017), a book chapter (‘The cultural safety journey: An Australian nursing context’ 2018), and Dr Gregory Phillip’s doctoral thesis (‘Dancing with power: Aboriginal health, cultural safety and medical education’ 2015). In the context of the journal articles in this critique, it would be a paradigm shift for Australian researchers to consider the intellectual and cultural roots of Australian-only publications.

Unfortunately, the great idea of Ryder et al. (2017) to develop ‘a validated tool to measure the effectiveness of the transformative unlearning process’ for staff and students at a university began with a literature review that missed Williams and Bin-Sallik’s Australian definition of cultural safety and the majority of articles in this critique. This culturally unsafe literature review underpinned the questionnaire development where the ‘subject and content experts’ were from Flinders University – the same university as the research team – and therefore biased the project’s outcomes. The sole reliance on university experts (including Australia’s First Peoples academics) highlights ‘profession power’ in academic research – a ‘profession’ without a professional body or professional accreditation standards.

If Ryder et al. (2017) had conducted a more rigorous review, they would have found the research of Rigby et al. (2011) that provides a high standard in culturally safe research design. But – and signalling a key theme of this critique – it appears to be an Australian academic norm to ignore the work from competing academics and competing universities. Rigby et al. (2011) published through Charles Sturt University in New South Wales while Ryder et al. (2017) published through Flinders University in South Australia. The ethic of ‘shared learning’ is not practised by Australian academics.

Furthermore, the ‘profession power’ appears to be central – arguably – in the so-called ‘five key principles’ of the cultural safety framework (reflective practice, power differential minimisation, engagement and discourse, decolonisation, and regardful care) where the locus of actions are firmly located with the competent health professional to determine and

administer to the patient. In the wording of these ‘five principles’ by Ryder et al. (2017), there appears to be limited scope for Australia’s First Peoples to challenge health profession power and indicates the need for transformative unlearning to occur by research academics and the health professionals that they train. For example, an external Aboriginal community consultative education reference group could have been consulted – the [South Australian Aboriginal Education and Training Consultative Body \(2011\)](#).¹⁸⁶

A central aspect of community-based Aboriginal education consultative bodies is to project ‘Aboriginal voices in education and training’¹⁸⁶ but these voices were marginalised in Ryder’s research methodology. For example, the subject and content experts, asked to assess the relevance of potential questions, ‘were asked to support their rankings with references from the literature’¹⁸¹ which rarely contains the perspectives of Australia’s First Peoples on cultural safety in healthcare.¹⁰⁸ As noted earlier in this critique (see ‘culturally unsafe research governance, above), the privileging of knowledge of Australia’s First Peoples academics and experts over that of community members and community organisations should not be a short-cut to justify the research as culturally safe.

Additionally, the use of extremely technical mathematical modelling (exploratory factor analysis) by Ryder et al. (2017) renders Australia’s First Peoples’ community voice mute in the cacophony of statistics that Mick Dodson famously stated ‘we die silently under these statistics’.¹⁸⁷ That would not have been the intent of Ryder et al. (2017) but it is an effect that culturally safe knowledge production processes would balance out through in-depth Aboriginal community engagement and mixed methodology (e.g. Fleming et al. 2017). The use of mathematical modelling in cultural safety research by Ryder et al. (2017) and Fleming et al. 2018b is technically justifiable but it needs to be contextualised to the social, political, and colonial use of statistics in power relationships¹⁸⁸⁻¹⁹⁰ so that Australia’s First Peoples see that research academics demonstrate reflexivity about the politics and power of research.

The points above refer to aspects of research knowledge production that need to be assessed through a cultural safety lens: governance (which includes transparency and accountability), reflexivity, research profession, expert power, methodology (including literature and mathematical modelling), and research process. The importance of research profession governance is that researchers and academics cannot operate free from the social and cultural norms of the society in which their education, training, and employment takes place. They are culturally immersed and so it is difficult to justify measures of attitude change for students and staff when the owners of that questionnaire are not subject to accreditation standards.

Criterion 32 – Develop Researcher Accreditation Standards

The challenge is to determine and describe accreditation standards for the research profession because the knowledge that they generate feeds into an Australian healthcare system that is culturally dangerous.

Criterion

Do the producers of knowledge (e.g. researcher, academic, etc.) demonstrate culturally safe and secure accreditation standards?

Relevance (on the concept 'standards')

Corporate Governance and Accountability Compendium for NSW Health (2012). Standard 5: Maintain high **standards** of professional and ethical conduct, where [inter alia] 'Models of good practice are implemented that provide culturally safe work environments and health services through a continuous quality improvement model.' (2.05, December 2016).⁵²

National Safety and Quality Health Service Standards - 2nd Ed (2017). The NSQHS Standards 'provide a quality assurance mechanism that tests whether relevant systems are in place to ensure that expected standards of safety and quality are met' (p. 1).⁴⁰

National Safety and Quality Health Service **Standards** user guide for Aboriginal and Torres Strait Islander Health (2017). Purpose of this guide. Health service organisations can achieve the greatest impact when they [inter alia] 'value the knowledge and experiences of Aboriginal and Torres Strait Islander peoples' (p. 22).¹⁶

One of the interesting facets of the research of Ryder et al. (2017) is the focus on 'attitudes', which reflects the experience of Sjoberg and McDermott (2016) (see 'language power imbalance', above), because it highlights the complexity of influences on attitudes that need to be addressed in training and education programs. This is reflected in the next article.

Labyrinthine Learning

33. [S. McGough](#), [D. Wynaden](#), and [M. Wright](#) published *Experience of Providing Cultural Safety in Mental Health to Aboriginal patients: A Grounded Theory Study* (2018, Western Australia) as a research article about the perspectives of 25 non-Aboriginal mental health professionals providing care for Aboriginal patients.¹⁹¹

This article is unique because it presents the first substantive **model** about cultural safety based on empirical research in McGough's thesis.¹⁹² It also occurs within an explicit location of Perth where mental health services are provided to the Nyoongar people, thus, it does not make the implied claim to generalise to Australia compared to Kendall and Marshall (2004) and Truasheim (2014). As for other articles in this critique, for example Johnstone and Kanitsaki (2007a), there is recognition of the lack of research about cultural safety, McGough et al. (2018) state, 'There remains a chasm between policy and practice with many mainstream services failing to provide cultural safety' (p.204). This echoes the sentiment of Williams (1999) about the lack of 'discourse' about cultural safety and Wilkes et al. (2002) 'lack of operational guidance as to what precisely a culturally secure service would look like' (p.13).

While McGough et al. (2018) provide a ‘substantive theory of seeking solutions by navigating the labyrinth to overcome being unprepared’ (p. 210) it excluded First Peoples’ voices as did the methodology of the study, there was no validation of the clinicians’ experiences by First Peoples patients, and the ‘literature’ only included McGough (2016, self-reference)¹⁹³ and Taylor and Guerin (2010),¹⁵² which demonstrates a very limited engagement with relevant literature. There are no citations to any Australian cultural safety literature in the journal article, which is also the case for Dr McGough’s [dissertation](#) that relies on New Zealand and Canadian literature.¹⁹² These methodological flaws limit the credibility of the findings to being applied in Australian healthcare organisations.

However, the strength of the ‘substantive theory’ (which means that the model is based on empirical research with practitioners rather than on solely on good ideas and literature reviews) lies in understanding Williams’s (1999) ethos about ‘shared learning’ because in the dual relationship between a non-First Peoples clinician and First Peoples’ patient, both sides need to be understood. Thus, state McGough et al., ‘The experience of providing cultural safety has not been adequately addressed by organizations, health services, governments, educational providers and policy makers’ (p. 211). Indeed, this article shows just how difficult it is for mainstream health professionals to find a clear pathway to learn about, understand, and practice culturally safe healthcare.

Given the labyrinthine nature referred to by McGough et al. (2018) it is perhaps no surprise that mainstream health professionals would revert to the value of ‘we treat everyone the same way’,¹⁹⁴ which is also a sentiment reported in the work of Brown et al. (2016), because there is so little knowledge about what is, and is not, culturally safety in general or in the specific context of each profession.

Criterion 33 – Aim for Clear Pathways

The challenge is to determine and describe what is culturally safe care for each health profession. Health professionals need clear guidance on complex and challenging topics bound to cultural safety including racism and institutional racism, white privilege, decolonisation, ethnocentrism, othering, and power.

Criterion

Does the knowledge base provide clarity on the points and pathways required for enabling cultural safety and security?

Relevance (on the concept ‘clear’)

[Corporate Governance and Accountability Compendium for NSW Health \(2012\)](#). NSW Health Performance Framework ‘provides a **clear** and transparent outline of how performance is assessed and how responses to performance concerns are structured’ (7.06, July 2014).⁵²

National Safety and Quality Health Service Standards - 2nd Ed (2017). Clinical Governance Standard. Criteria, [inter alia]: safe environment for the delivery of care. Action 1.31 'The health service organisation facilitates access to services and facilities by using signage and directions that are **clear** and fit for purpose' (p. 12).⁴⁰

National Safety and Quality Health Service Standards user guide for Aboriginal and Torres Strait Islander Health (2017). Action 1.21: Improving cultural competency by 'providing a supportive environment and **clear** processes for the workforce to explore the cultural needs of Aboriginal and Torres Strait Islander patients' (p. 22).¹⁶

McGough et al. (2018) note 'More research is needed to understand the expectations of Aboriginal patients in mental health settings and the experience cultural safety' and the next article by Jennings et al. (2018) privileges Indigenous voices.

Privileging Indigenous Voices

34. [Warren Jennings](#), [Chelsea Bond](#) and [Peter Hill](#) published *The Power of Talk and Power in Talk: a Systematic Review of Indigenous Narratives of Culturally Safe Healthcare Communication* (2018, Queensland) as a research article 'to explore Indigenous narrative accounts of healthcare access within qualitative research papers, to better understand Indigenous views on culturally safe healthcare and health communication represented in that literature.'¹⁰⁸

Very culturally sensitive research, explicitly directed by Ramsden's (2002) view of cultural safety especially where 'safety is a subjective word deliberately chosen to give power to the consumer' (Ramsden 2002) and 'diminish, demeaned, and disempowered' (citing Eckermann et al. 2010). This narrative synthesis is the first to privilege the voices of Indigenous peoples, in contrast to most of the papers in this critique where their perspectives were excluded. However, the only paper referred to was that of Kendall and Marshall (2004), and no other literature of this critique was referred to by Jennings et al. (2018), showing a very limited engagement with the Australian discourse about cultural safety.

Criterion 34 – Highlight Cultural Voice

There is scant reference to the perspectives of Australia's First Peoples in academic research about cultural safety and security which limits their cultural validity for being used to drive reforms in healthcare practice.

Criterion

Does the knowledge base highlight the cultural voice of Australia's First Peoples?

Relevance (on the concept ‘cultural needs’)

[Corporate Governance and Accountability Compendium for NSW Health \(2012\)](#).

References Respecting the Difference: An Aboriginal Cultural Training Framework for NSW Health, ‘By **providing** appropriate Aboriginal cultural training, organisations will become more culturally safe, providing better health services and improved health outcomes to the Aboriginal community’ (p. 8.03, July 2014).⁵²

[National Safety and Quality Health Service Standards - 2nd Ed \(2017\)](#). Clinical Governance Standard. Criteria, [inter alia]: clinical performance and effectiveness. Item: safety and quality training, action 1.21 ‘The health service organisation has strategies to improve the cultural awareness and cultural competency of the workforce to meet the **needs** of its Aboriginal and Torres Strait Islander patients (p. 10).⁴⁰

[National Safety and Quality Health Service Standards user guide for Aboriginal and Torres Strait Islander Health \(2017\)](#). Action 2.13: Working in partnership, by following cultural principles including ‘Aboriginal and Torres Strait Islander communities are diverse, and this diversity **needs** to be adequately represented’ (p. 7).¹⁶

The need for academics and researchers to improve their engagement with Australia’s First Peoples is a standard principle in the ethics of health research,¹⁹⁵ but this is clearly not the practice of research as evident in the articles of this critique. Instead, literature reviews form the philosophical basis for research strategy.

Privileging Literature Reviews

35. [Tania Fleming, Debra K. Creedy, and Roianne West](#) published *Cultural Safety Continuing Professional Development for Midwifery Academics: an Integrative Literature Review* (2018a, Queensland) to report on the their research to ‘conduct an integrative review of the literature with respect to the scope and efficacy of professional development interventions that aim to increase awareness of cultural safety by midwifery academics’.¹⁹⁶

The scope of the literature review covered the years 2005–2017 during which were found just **two** (Gladman et al. 2015, and Fleming et al. 2017) publications specific to cultural safety. This article covers much the same literature as the Fleming et al.’s (2017) ‘intervention study’ (see ‘high standard intervention study’, above), and they found a gap between the rhetoric for cultural safety and the lack of published evidence for continuing professional development activities.

It could be argued that privileging literature reviews is a way to valorise Western modes of knowledge over modes that respect oral knowledge traditions, but such a line of reasoning would ignore the standard healthcare industry practice of ‘doing’ work with Australia’s First Peoples that is not captured into writing – a practice to literature gap.

Nevertheless, the literature review is the first step in research processes (e.g. see Ryder et al. 2017) while engagement with First Peoples occurs as further along the research pathway. Could it be inverted so that engagement occurs first – before the literature review – so that cultural voice informs the philosophy of the research from the beginning?

A key part of the literature review process is to assess the relevance of the articles. Fleming et al. (2018a) used the Critical Appraisals Skills Program ([CASP](#)) checklist for use by researchers to assess quality according to the study design. Other checklists are also available, and it is relevant to ask if they are culturally safe by design? For example, the [CREATE Critical Appraisal Tool](#) (personal communication 2018, article submitted to a journal for assessment)¹⁹⁷ developed by the [Centre of Research Excellence in Aboriginal Chronic Disease Knowledge Translation and Exchange \(CREATE\)](#), *but this was not available for use in 2018*. The point is that CASP and other appraisal tools were developed without a consideration of cultural voice and the social and cultural construction of knowledge. As Marston and Watts ([2003](#)) point out about researchers that their ‘personal and social values inevitably inform the research discourse’¹⁹⁸ and thereby are implicated in the development of appraisal tools that are blind to the social, political, historical, and cultural power of scientific knowledge.

For example, one aspect of this critique is to detect the cultural voice of Australia’s First Peoples and that could be a criterion in literature appraisal tools about cultural safety because it is common for researchers to assume cultural fit between First Nations peoples from different countries (see ‘assumptions of cultural fit’, above). Fleming et al. (2018a) combined the knowledge from Australia on cultural safety – Gladman et al. (2015), Milne et al. (2016), and Fleming et al. (2017) – with knowledge about cultural competence from the United States of America, and knowledge about cultural safety based on Ramsden (2002) from New Zealand. This ‘cultural mash’ approach to knowledge production could be seen to demean the numerous cultures of Australia’s First Peoples, especially when the trajectory of Fleming’s work on the Aboriginal Cultural Safety Scale began (see Milne et al. 2016) by excluding the Williams and Bin-Sallik Australian definition of cultural safety (although that is normal Australian policy practice).

One obvious reason to look to the literature from other cultures is that so little work on Australian cultural safety and security in health has been undertaken since 1999 (36 articles in this critique in the health domain) compared to New Zealand where hundreds of publications were compiled between 1988–2012.¹⁹⁹ As many authors have noted, there is lack of research on cultural safety and cultural security in Australia (Wilkes et al. 2002, Kruske et al. 2006, Johnstone and Kanitsaki, 2007b, Phiri et al. 2010, Fleming et al. 2017, McGough et al. 2018, and Fleming et al. 2018a,b) that should stimulate Australian research agencies (the National Health and Medical Research Council and the Australian Research Council) to develop a specific funding priority to address the numerous knowledge gaps noted in this critique.

An important knowledge gap is noted by Fleming et al. (2018a) ‘there is currently no agreed best practice framework to support awareness of cultural safety for midwifery academics’ which is stunning because cultural awareness is the first step towards cultural sensitivity and thereafter of cultural safety, and to not have a best practice framework for cultural awareness – after decades of cultural training programs in Australia^{88, 132, 200, 201} – says something about the absence of strategic thought and effort to that end. Thankfully, Fleming et al. (2018a, b) have started down that pathway through an empirical, transparent, and published approach to their research.

The thematic results of the integrative literature review (cultural terms, knowledge of culture, cultural education, cultural aspirations, and culture in curricula) were discussed through three New Zealand (from Ramsden 2002) principles of cultural safety: partnership, participation, and protection. The use of these principles in Australia is an example of academic policy naivete because partnerships with Australia’s First Peoples are not legislated in Australia²⁰² compared to Māori people and the Crown in New Zealand,²⁰³ participation is more complex in Australia’s federal system,^{204, 205} the term ‘protection’ raises the spectre of protectionist policies²⁰⁶⁻²⁰⁸ which have a devastating impact on Australia’s First Peoples (e.g. Stolen Generations),²⁰⁹ and another ‘p’ word to come to mind is ‘paternalism’ (as mentioned by van den Berg, 2010).²¹⁰ Therefore, the combination of the ‘integrative’ literature discussed through the ‘p’ words from another cultural context renders this article to be of low philosophical, intellectual, and empirical value.

Criterion 35 – Strategic Awareness in Knowledge Production

Knowledge production is not separate from the historical development of social, cultural, and political values of distinct societies. Therefore, knowledge governance should encourage a genuine and meaningful understanding of the uniqueness of Australia’s history with its First Peoples.

Criterion

Does the knowledge base reflect the uniqueness of Australia’s history with its First Peoples?

Relevance (on the concepts of ‘genuine’ and ‘meaningful’)

Corporate Governance and Accountability Compendium for NSW Health (2012). ‘Effective and **meaningful** stakeholder engagement is fundamental to achieving the public health organisations objectives in the planning, development and delivery of improved outcomes to our stakeholders’(p. 10.02, May 2013).⁵²

National Safety and Quality Health Service Standards - 2nd Ed (2017). Comprehensive Care. **‘Meaningful** implementation of this standard requires attention to the processes for

partnering with patients in their own care, and for safely managing transitions between episodes of care.’ (p. 39).⁴⁰

National Safety and Quality Health Service Standards user guide for Aboriginal and Torres Strait Islander Health (2017). ‘**Meaningful**, lasting relationships with the Aboriginal and Torres Strait Islander community are integral to redressing past wrongs and moving towards an equitable healthcare system for all Australians.’ (p. 4).¹⁶

The idea of a ‘best practice framework’ by Fleming et al. (2018a) should be pursued within every health profession given the current ‘cultural policy’ context in Australia wherein cultural safety is to be integrated through health profession accreditation standards,¹³ healthcare organisation accreditation,¹⁶ and the Australian health system.¹⁵ A key strategy within that agenda would be the development of a system for measurement, monitoring, and evaluation.

Cultural Safety Measurement

36. [Tania Fleming, Debra K. Creedy, and Roianne West](#) published *Evaluating Awareness of Cultural Safety in the Australian Midwifery Workforce: a Snapshot* ([2018b](#), Queensland) to report on their research to ‘adapt and evaluate the Awareness of Cultural Safety Scale with the midwifery workforce’.²¹¹

This article represents the most significant and ongoing research project about cultural safety and is led by Tania Fleming (nee Milne): Milne et al. (2016), West et al. (2016), Fleming et al. (2017), Fleming et al. (2018a), and Fleming et al. (2018b). The basis of the research is the Aboriginal Cultural Safety Scale (ACSS) that was first reported in Milne et al. (2016) and critiqued under the heading of ‘absence of theoretical merit’ (above). The aim of the ACSS was ‘to develop and validate a self-report tool that aims to measure nursing and midwifery academics’ awareness of cultural safety’ in order to improve Indigenous student success in higher education organisations.¹⁵⁹

The work of Fleming et al. (2018b) is important because it not only reflects the need for the measurement of cultural safety and cultural security, but it also is the first published research to show a ‘snapshot’ (2% of the midwifery workforce) of awareness of cultural safety in a health profession. The item ‘knowledge and understanding of the concept of cultural safety’ received a self-rated mean of 3.10 (n=92, 5 novice/beginner, 24 advanced/beginner, 28 competent, 27 proficient, and 8 expert). This is in a profession at the forefront of cultural safety discussions in Australia and signals that the marketing and communication of cultural safety needs to be substantially improved through the midwifery accreditation standards. However, it also points to significant problems in Australia with measuring ‘cultural concepts’ because there is no specific and systematic effort to do so.

That is, whilst cultural concepts and cultural training are touted in policy as ‘critical’ or ‘essential’ to improving health outcomes of Australia’s First Peoples, there is no substantive funding to establish data collection and monitoring systems specifically about cultural concepts. For example, the [Aboriginal and Torres Strait Islander Health Performance Framework 2017 Report \(2017\)](#) notes that there are ‘key gaps in the evidence on the cultural competency of health services’ and, in order to gain a sense of cultural competency then information is drawn from a range of data collections.²¹² That is, information is cobbled together from different data sources, whose underlying premises and purposes are not about cultural concepts, but reflect what Foucault (1983) terms “bio-power” as the tactics of control of people and populations through their bodies - or biopolitics.²¹³

For example, the [Aboriginal and Torres Strait Islander Health Performance Framework 2017 Report \(2017\)](#) emphasises ‘Tier 1 Health Status and Outcomes’ statistics of health conditions, human function, life expectancy and wellbeing, and deaths’ to which all data collection systems and resources are geared to measuring, but the ‘Tier 3 – cultural competency’ receives no dedicated resources. I suggest that the differential emphasis given to measuring health conditions versus cultural competency is indicative of the cultural safety distinction between the health professional and the patient. Therefore, data collection systems should be restructured to emphasise more the cultural needs of the patient over the data needs of health epidemiologists. And that’s why the work of Fleming is pivotal as a cultural wedge to crack the biopolitical dominance within Australian healthcare.

Additionally, Fleming et al. (2018b) use of the phrase ‘implicit bias’ - which is also heavily mentioned by Ryder et al. (2017) - and adds another difficult to understand concept into the Australian discourse about cultural safety. It is challenge to the proponents of cultural concepts to provide clear understanding about not only the various cultural concepts (culture, awareness, sensitivity, safety, competence, humility, capability, inclusiveness, and respect) but how other concepts relate to them (racism, institutional racism, white privilege, decolonisation, ethnocentrism, ‘othering’, implicit bias, and various forms of power). Achieving clarity between all these confusing concepts is important because legislators, health professions, health executives, and health stewards require simple and unambiguous statements to support the political case for change throughout complex healthcare organisations.

Along with achieving conceptual clarity is the goal to achieve measurement clarity – just what are relevant, valid, and reliable indicators for all these concepts? Constructing questionnaires and using complicated mathematical analysis is a valuable route pursued by Fleming and off-sets the usual health and wellbeing statistics. However, some fundamental philosophical considerations cannot be measured through self-assessed questions. For example, implicit bias, institutional racism, white privilege, and biopolitics operate within society but are not explicitly in the deliberate conscious thoughts of people that are able to be recalled and described in language and speech. Therefore, a challenge to academics is to develop and describe a measurement framework for cultural safety and security that encompasses a number of different levels – such as Awofeso’s (2011) ‘conceptual framework highlighting racism as a structural determinant of health inequity’²¹⁴ or Paradies’s (2006) ‘conceptualising privilege/oppression as a determinant of health’.²¹⁵

With the development of frameworks comes the need to be explicit about principles of cultural safety and security. For example, Fleming et al. (2018a), in the concluding remarks of the paper, 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.^{14, 20, 48, 162} 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’.²¹⁶

Indeed, the ‘conflict of principles’ is perpetuated in the previous article by the Fleming et al. (2018a) – see ‘privileging literature reviews’, above – which references the principles of: respect, communication, safety and quality, reflection, and advocacy (from the [Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2016-2026](#)). Then, Fleming et al. (2018a) 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 concept of ‘principles’ is thus another that needs careful consideration in future Australian cultural safety and security discourse.

Criterion 36 – Measure Cultural Safety and Security

Knowledge production governance needs to be geared to producing information about cultural safety and security in accord with a culturally and empirically rigorous framework.

Criterion

Does the knowledge base contain information relevant to a framework for measuring cultural safety and security?

Relevance (on the concept ‘framework’)

Corporate Governance and Accountability Compendium for NSW Health (2012). ‘As well as setting out requirements in legislation and Government policy it provides a governance **framework** to underpin local decision making and the CORE values of the NSW Health’(p. iii, July 2014).⁵²

National Safety and Quality Health Service Standards - 2nd Ed (2017). Clinical Governance Standard. Intention of this Standard ‘To implement a clinical governance **framework** that ensures that patients and consumers receive safe and high-quality health care.’ (p. 4).⁴⁰

National Safety and Quality Health Service Standards user guide for Aboriginal and Torres Strait Islander Health (2017). Action 1.4: Implementing and monitoring targeted strategies. Suggested strategies, [inter alia], ‘Develop or adopt an indicator set to measure change in

include Australia's First Peoples in knowledge services, culturally safe literature reviews, assess progress using Coffin's cultural security scale, examine the potential for cultural appropriation, value local cultural provenance, critically evaluate exotic experiences, critically reflexive writing practice, practice critical reflexivity in publication practice, address white



privilege in knowledge governance, promote culturally safe textmarks, peer review commissioned articles, decolonise knowledge governance, critically reflect on 'othering' exotic cultures, promote culturally rigorous research methodology, organisational responsibility for culturally safe knowledge, consider white anti-racist privilege, engage with decolonisation theorists, identify junk research, detect tokenism in the use of cultural concepts, consider the power imbalance in health curriculum governance, uncover cherry picking bias, ensure culturally rigorous research governance process, external evaluation of academic programs, assess the cultural fit of knowledge, include a theory of change, assess the relevance of the research focus, connect with healthcare executives, aim for high quality knowledge, develop researcher accreditation standards, aim for clear pathways, highlight cultural voice, strategic awareness of knowledge production, and measure cultural safety and security.

The themes underscore the **main finding** that examining the Australian cultural safety and security literature would leave any healthcare steward confounded as to how to translate the ideas from them into meaningful points for integration and diffusion into healthcare governance.



Discussion – Governance, Cultural Policy, and Knowledge

Australian healthcare leaders and stewards are faced with the push to provide culturally safe and secure healthcare services, but there is a low quality knowledge base from which they can learn from and apply to their organisational governance. Therefore, an aim of this critique was to provide criteria for the assessment of the cultural safety and security of evidence to be used healthcare governance reforms. And a second aim was to promote knowledge governance that produces a culturally safe and secure healthcare knowledge economy.

Professor Ian Anderson ([2008](#)), in his Dean's Lecture 'The Knowledge Economy and Aboriginal Health Development', stated that 'knowledge is a significant resource (other than financing, infrastructure) that includes the elements of ideas, information, and people resources'.³⁶ However, knowledge is neither value-free or culturally neutral in relationships between Australia and its First Peoples.¹²⁶ Therefore, careful attention needs to be paid to the knowledge production process so that the lessons gained from it contribute to a culturally safe and secure knowledge base.

I established a link between healthcare governance, cultural policy, and knowledge production and found the evidence-based governance and evidence based cultural policy do not exist. Specifically, that formal published knowledge produced by academics and researchers have no relevance for either healthcare governance or cultural policy. Therefore, the 36 criteria are meant to push the knowledge user (healthcare leaders and stewards) and the knowledge producer (academics and researchers) into a co-design space to produced shared knowledge. A key barrier is that neither healthcare governance nor cultural policy consider formal published knowledge in their formulations.

The ultimate message from this critique is that Australian healthcare governance lacks standards about formal knowledge governance. The governance documents included in this critique (see 'culturally unsafe and insecure by design', above): [Building Better Governance](#),⁵¹ [Corporate Governance and Accountability Compendium for NSW Health](#),⁵² [Corporate Governance Principles and Recommendations \(3rd Edition\)](#),⁴² [Public Sector Governance - Strengthening Performance through Good Governance. Better Practice Guide](#),⁴⁴ [Governance Lighthouse - Strategic Early Warning System](#),⁵³ and the [National Safety and Quality Health Service Standards \(Second edition\)](#),⁴⁰ do not have standards for the quality and safety of 'knowledge' (which appears to be implicitly included in 'resources'). They could learn from 'Domain 6 – Data, Planning, Research and Evaluation' in the [Cultural Respect Framework for Aboriginal and Torres Strait Islander Health, 2016-2026](#),¹⁵ where cultural values and principles inform the evidence-base used in health services.

A great deal of effort is directed toward the production of high-quality clinical knowledge for use in evidence-based healthcare - hence Ms Mohi's words about 'safe knowledge'. The knowledge production system is geared to that end so that healthcare professionals deliver quality and safe clinical services by, for example, using evidence-based guidelines. In contrast, neither the mainstream corporate governance documents nor Australian cultural policy documents refer to any formal published knowledge. The contradiction is healthcare

leaders and stewards require health professionals to deliver care based on best evidence, but healthcare governance does not reflect that standard.

How, then, are healthcare leaders and stewards meant to develop evidence-based healthcare governance when knowledge production is not geared to that purpose? The development of each criterion, with reference to healthcare governance policy documents, is an attempt to bridge the formal knowledge gap between researchers and healthcare leaders and stewards. This preliminary set of 36 criteria are a standard for culturally safe and secure knowledge governance. I argue that genuine and meaningful engagement with these criteria are in the spirit of Ms Mohi's words 'what about cultural safety?'

– The End –

Criteria for Culturally Safe and Secure Knowledge Governance

Criterion 1 – Culturally Safe Knowledge Governance

Does the knowledge base explicitly attribute the intellectual contribution of Australia's First Peoples?

Criterion 2 – Culturally Secure Knowledge Governance

Is cultural safety and security considered in and through knowledge production processes?

Criterion 3 – Consider the Moral Obligations of Knowledge Governance

Are the moral obligations of knowledge production of an about Australia's First Peoples reflected in the information?

Criterion 4 – Include Australia's First Peoples in Knowledge Services

Are Australia's First Peoples included in the knowledge production process?

Criterion 5 – Culturally Safe Literature Reviews

Do literature reviews explicitly include Australia's First Peoples?

Criterion 6 – Assess Progress using Coffin's Cultural Security Scale

Is a consideration of cultural security evident in the knowledge base?

Criterion 7 - Examine the Potential for Cultural Appropriation

Could the proposition for the use of a cultural concept reflect academic political appropriation?

Criterion 8 – Value Local Cultural Provenance

Are local language terms from Australia's First Peoples used for cultural concepts in the knowledge base?

Criterion 9 – Critically Evaluate Exotic Experiences

Is the uniqueness and diversity of local cultures reflected in knowledge base?

Criterion 10 – Critically Reflexive Writing Practice

Is the writing practice of authors evaluated for their objectivity, reflexivity, methodology, sense of politics, and moral, cultural, and ethical dimensions?

Criterion 11 – Practice Critical Reflexivity in Publication Practice

Does the publication process reflect an understanding of the social and political construction of knowledge about Australia's First Peoples?

Criterion 12 – Address White Privilege in Knowledge Governance

How is white privilege reflected in knowledge governance?

Criterion 13 – Promote Culturally Safe Textmarks

Does the text contain markers of cultural safety?

Criterion 14 – Peer Review Commissioned Articles

Are commissioned articles peer-reviewed?

Criterion 15 – Decolonise Knowledge Governance

Does the knowledge base reflect an ethic of decolonisation?

Criterion 16 – Critically reflect on 'othering' exotic cultures

Do Australia's First Peoples writers critically reflect on their cultural assumptions when travelling abroad to **view** other cultures and bring their lessons to Australian practice?

Criterion 17 – Promote Culturally Rigorous Research Methodology

Does the methodology of the knowledge base reflect considerations of cultural safety and security?

Criterion 18 – Organisational Responsibility for Culturally Safe Knowledge Governance

Does an organisation have a cultural safety review process of all its publications?

Criterion 19 – Consider White Anti-Racist Privilege

Does the knowledge base privilege the cultural lens and reflexivity of white anti-racist academics?

Criterion 20 – Engage with Decolonisation Theorists

Does the knowledge base refer decolonisation theories?

Criterion 21 – Identify Junk Research

Does the knowledge base display an acceptable level of rigour?

Criterion 22 – Detect Tokenism in the use of Cultural Concepts

Does the knowledge base demonstrate justification for the choice of ‘cultural’ concepts?

Criterion 23 – Consider the Power Imbalance in Health Curriculum Governance

Do education and training programs for cultural safety and security demonstrate the Australia’s First Peoples are included in the control of their curriculum governance?

Criterion 24 – Uncover Cherry Picking Bias

Does the knowledge base provide a rationale to justify the selection and use of the ‘cultural safety’ and ‘cultural security’ concepts?

Criterion 25 – Ensure Culturally Rigorous Research Governance Process

Does the knowledge base demonstrate high ethical and moral qualities?

Criterion 26 – External Evaluation of Academic Programs

Is positive report bias reduced through external critique of academic programs?

Criterion 27 – Assess the Cultural Fit of Knowledge

Does the knowledge base reflect the voice of Australia’s First Peoples?

Principle 28 – Include a Theory of Change

Are theoretical reasoning and argumentation clearly provided to explain the arguments and propositions in academic research?

Criteria 29 – Assess the Relevance of the Research Focus

Is the relevance of the knowledge base argued for against the principles of cultural safety and security?

Criterion 30 – Connect with Healthcare Executives

Does the knowledge base reflect the views of non-patients?

Criterion 31 – Aim for High Quality Knowledge

Is the knowledge produced of high quality?

Criterion 32 – Develop Researcher Accreditation Standards

Do the producers of knowledge (e.g. researcher, academic, etc.) demonstrate culturally safe and secure accreditation standards?

Criterion 33 – Aim for Clear Pathways

Does the knowledge base provide clarity on the points and pathways for enabling cultural safety and security?

Criterion 34 – Highlight Cultural Voice

Does the knowledge base highlight the cultural voice of Australia's First Peoples?

Criterion 35 – Strategic Awareness in Knowledge Production

Does the knowledge base reflect the uniqueness of Australia's history with its First Peoples?

Criterion 36 – Measure Cultural Safety and Security

Does the knowledge base contain information relevant to a framework for measuring cultural safety and security?



References

1. 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.
2. Bennington L., (2010). Review of the Corporate and Healthcare Governance Literature. *Journal of Management and Organization*. Vol.16(2):314-333. Available: <https://doi.org/10.1017/S1833367200002200>. Accessed: 31 July 2018.
3. Philippon D.J., Braithwaite J., (2008). Health System Organization and Governance in Canada and Australia: A Comparison of Historical Developments, Recent Policy Changes and Future Implications. *Healthcare Policy*. Vol.4(1):e168. Available: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2645208/pdf/policy-04-e168.pdf>. Accessed: 8 August 2018.
4. Edwards M., (2002). Public Sector Governance - Future Issues for Australia. *Australian Journal of Public Administration*. Vol.61(2):51-61. Available: <https://onlinelibrary.wiley.com/doi/abs/10.1111/1467-8500.00272>. Accessed: 8 August 2018.
5. Barbazza E., Tello J.E., (2014). A Review of Health Governance: Definitions, Dimensions and Tools to Govern. *Health Policy*. Vol.116(1):1-11. Available: <https://doi.org/10.1016/j.healthpol.2014.01.007>. Accessed: 11 July 2018.
6. 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.
7. Brigg M., Curth-Bibb J., (2017). Recalibrating Intercultural Governance in Australian Indigenous Organisations: The Case of Aboriginal Community Controlled Health. *Australian Journal of Political Science*. Vol.52(2):199-217. Available: <http://dx.doi.org/10.1080/10361146.2017.1281379>. Accessed: 15 October 2018.
8. Hunt J., Smith D., Garling S., Sanders W. (2008). Contested Governance: Culture, Power and Institutions in Indigenous Australia. Centre for Aboriginal Economic Policy Research, Research Monograph No.29. Canberra: Australian National University. Available: http://press.anu.edu.au/titles/centre-for-aboriginal-economic-policy-research-caepr/c29_citation/. Accessed: 8 August 2018.
9. Hermanson D.R., Rittenberg L.E. (2003). Chapter 2 Internal Audit and Organizational Governance. In Bailey A.D., Gramling A.A., Ramamoorti S., (Eds). *Research Opportunities in Internal Auditing*. Altamonte Springs, Florida: The Insitute of Internal Auditors Research Foundation. Available: <https://na.theiia.org/iia/PDF/Public%20Documents/Chapter%202%20Internal%20Audit%20and%20Organizational%20Governance.pdf>. Accessed: 13 October 2017.
10. Congress of Aboriginal and Torres Strait Islander Nurses and Midwives, (2014). Cultural Safety Position Statement. Canberra: CATSINaM. Available: <http://catsinam.org.au/policy/position-statements>. Accessed: 11 October 2017.
11. Congress of Aboriginal and Torres Strait Islander Nurses and Midwives, (2017). Position Statement: Embedding Cultural Safety across Australian Nursing and Midwifery. Canberra: CATSINaM. Available: <http://catsinam.org.au/static/uploads/files/aboriginal-and-torres-strait-islander-health-curriculum-framework-wfgioxngfdbn.pdf>. Accessed: 23 November 2017.

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. 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.
14. 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.csheitec.org.au/wp-content/uploads/2015/11/CSTStandardsBackgroundPaper-NACCHO.pdf>. Accessed: 15 October 2018.
15. Australian Health Ministers' Advisory Council, (2016). Cultural Respect Framework for Aboriginal and Torres Strait Islander Health, 2016-2026. Canberra: AHMAC. Available: http://www.coaghealthcouncil.gov.au/Portals/0/Cultural%20Respect%20Framework%20for%20ATSI%20Health%202016%20-%202026_1.pdf. Accessed: 8 August 2018.
16. 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: Australian Commission on Safety and Quality in Health Care. Available: <https://www.safetyandquality.gov.au/publications/national-safety-and-quality-health-service-standards-user-guide-for-aboriginal-and-torres-strait-islander-health/>. Accessed: 2 February 2018.
17. Keast K. (2017). Push for Cultural Safety into Legislation. Available: <https://healthtimes.com.au/hub/aboriginal-health/32/news/kk1/push-for-cultural-safety-into-legislation/2662/>. Accessed: 11 October 2017.
18. Congress of Aboriginal and Torres Strait Islander Nurses, (2013). Towards a Shared Understanding of Terms and Concepts: Strengthening Nursing and Midwifery Care of Aboriginal and Torres Strait Islander Peoples. Canberra: CATSIN. Available: <https://www.anmac.org.au/sites/default/files/documents/Definitive%20CATSIN%20Paper%20-%20Towards%20a%20shared%20understanding%20of%20terms%20and%20concepts..pdf>. Accessed: 29 September 2017.
19. Congress of Aboriginal and Torres Strait Islander Nurses and Midwives, (2016). Cultural Safety in Policy and Practice Seminar: Summary and Implications. Canberra: CATSINaM. Available: <http://catsinam.org.au/static/uploads/files/cultural-safety-in-policy-and-practice-seminar-27-april-2016-report-wfwxsnrkyzyh.pdf>. Accessed: 28 November 2018.
20. 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.
21. Congress of Aboriginal and Torres Strait Islander Nurses and Midwives. (2017). CATSINaM Definition of Cultural Safety. Available: <http://catsinam.org.au/policy/cultural-safety>. Accessed: 26 February 2018.
22. Congress of Aboriginal and Torres Strait Islander Nurses and Midwives, (2015). External Evaluation of the Catsinam 2013-2018 Strategic Plan: Interim Evaluation Report. Canberra:

- CATSINaM. Available: <https://www.catsinam.org.au/static/uploads/files/evaluation-report-catsinam-strategic-plan-final-wfpfhraxewzd.pdf>. Accessed: 5 November 2018.
23. Congress of Aboriginal and Torres Strait Islander Nurses and Midwives, (2017). A Framework for Promoting Cultural Safety in the Australian Healthcare System. Canberra: CATSINaM. Available: Not Online.
 24. Mohamed J., (2014). CATSINaM Submission to the Review of the NRAS. Online: COAG Health Council. Available: <https://www.coaghealthcouncil.gov.au/Portals/0/HealthPACT/NRAS%20Documents/Searchable/Congress%20of%20Aboriginal%20and%20Torres%20Strait%20Islander%20Nurses%20and%20Midwives/Congress%20of%20Aboriginal%20and%20Torres%20Strait%20Islander%20Nurses%20and%20Midwives.pdf>. Accessed: 10 April 2018.
 25. Mohamed J. (2018). Janine Mohamed: Cultural Safety Matters – the Conversation We Need to Keep Having. Available: https://indigenoux.com.au/janine-mohamed-cultural-safety-matters/#.W_5skWgzZD8. Accessed: 28 November 2018.
 26. Northern Territory Health, (2016). Aboriginal Cultural Security Framework 2016-2026. Darwin: Northern Territory Government. Available: <https://health.nt.gov.au/professionals/aboriginal-and-torres-strait-islander-health/aboriginal-health-policy>. Accessed: 13 August 2018.
 27. Australian Public Service Commission, (2015). Aboriginal and Torres Strait Islander Cultural Capability: A Framework for Commonwealth Agencies. Canberra: APSC. Available: <http://www.apsc.gov.au/publications-and-media/current-publications/cultural-capability-framework>. Accessed: 15 October 2018.
 28. Australian Capital Territory Government, Multicultural Co-Ordinating Framework - Towards Culturally Appropriate and Inclusive Services 2014-2018. Canberra: ACT Government. Available: http://www.health.act.gov.au/sites/default/files/Policy_and_Plan/Multicultural%20Co-ordinating%20Framework%20-%20Towards%20Culturally%20Appropriate%20and%20Inclusive%20Services%202014-2018.pdf. Accessed: 15 June 2017.
 29. Western Australia Department of Health, (2012). WA Health Aboriginal Cultural Learning Framework. Perth: Government of Western Australia. Available: https://ww2.health.wa.gov.au/~/_media/Files/Corporate/general%20documents/Multicultural/PDF/Cultural_Learning_Framework.ashx. Accessed: 15 October 2018.
 30. NSW Government, (2011). Respecting the Difference: An Aboriginal Cultural Training Framework for NSW Health. Sydney: NSW Department of Health. Available: <https://www.health.nsw.gov.au/workforce/aboriginal/Pages/respecting-the-difference.aspx>. Accessed: 12 September 2018.
 31. Queensland Health, (2010). Aboriginal and Torres Strait Islander Cultural Capability Framework 2010-2033. Brisbane: Queensland Government. Available: https://www.health.qld.gov.au/atsihealth/cultural_capability.asp. Accessed: 15 October 2018.
 32. Victorian Aboriginal Child Care Agency, Victorian Government Department of Human Services, (2008). Aboriginal Cultural Competence Framework. Melbourne: Victorian Government Department of Human Services. Available: <https://www.childabuseroyalcommission.gov.au/sites/default/files/VAC.0001.002.0001.pdf>. Accessed: 18 May 2018.

33. Victorian Government Department of Human Services, Victorian Aboriginal Child Care Agency, (2008). Aboriginal Cultural Competence Matrix. Melbourne: Victorian Government Department of Human Services. Available: <https://www.childabuseroyalcommission.gov.au/sites/default/files/VAC.0001.002.0001.pdf>. Accessed: 28 November 2018.
34. State Government of Victoria, (2011). Victorian Government Aboriginal Inclusion Framework. Melbourne: Victorian Government. Available: http://www.vic.gov.au/system/user_files/Documents/av/Aboriginal-Inclusion-Framework-2011.pdf. Accessed: 28 July 2017.
35. South Australian Department of Health, (2008). Aboriginal Cultural Respect Framework 2007-2012. Adelaide: Government of South Australia. Available: http://www.sahealth.sa.gov.au/wps/wcm/connect/c18de20043cab5c9292d326a3df42b9/directive_aboriginal_cultural_respect_framework_dec2007_final.pdf?MOD=AJPERES&CACHEID=c18de20043cab5c9292d326a3df42b9&CACHE=NONE. Accessed: 15 October 2018.
36. Anderson I.P.S., (2008). The Knowledge Economy and Aboriginal Health Development: Dean's Lecture, Faculty of Medicine, Dentistry & Health Sciences, 13 May 2008. Melbourne: Onemda VicHealth Koori Health Unit T.U.o.M. Available: <http://onemda.unimelb.edu.au/sites/default/files/docs/deanslecturefinal.pdf>. Accessed: 22 November 2017.
37. 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.
38. 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.
39. 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.
40. 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.
41. ACT Government Health, (2015). ACT Health Quality and Clinical Governance Framework 2015-2018. Canberra: Australian Capital Territory Government.
42. 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.
43. 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.
44. 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.
45. Johnstone M.-J., Kanitsaki O., (2007a). An Exploration of the Notion and Nature of the Construct of Cultural Safety and Its Applicability to the Australian Health Care Context. *Journal of Transcultural Nursing*. Vol.18(3):247-256. Available: <https://www.ncbi.nlm.nih.gov/pubmed/17607062>. Accessed: 15 October 2018.
 46. Johnstone M.-J., Kanitsaki O., (2007b). Health Care Provider and Consumer Understandings of Cultural Safety and Cultural Competency in Health Care: An Australian Study. *Journal of Cultural Diversity*. Vol.14(2):96-105. Available: <https://www.ncbi.nlm.nih.gov/pubmed/19175250>. Accessed: 15 October 2018.
 47. 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.
 48. 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.
 49. 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.
 50. 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.
 51. Australian Public Service Commission, (2007). Building Better Governance. Canberra: Commonwealth of Australia. Available: <https://www.apsc.gov.au/building-better-governance>. Accessed: 13 August 2018.
 52. NSW Ministry of Health, (2012). Corporate Governance and Accountability Compendium for NSW Health. North Sydney: NSW Ministry of Health. Available: <http://www.health.nsw.gov.au/policies/manuals/Pages/corporate-governance-compendium.aspx>. Accessed: 10 September 2008.
 53. New South Wales Auditor-General. (2015). Appendix One - Governance Lighthouse - Strategic Early Warning System. In: New South Auditor-General's Report to Parliament Volume One 2015. Sydney: Audit Office of New South Wales:36-45. Available: <http://www.audit.nsw.gov.au/publications/governance-framework>. Accessed: 13 August 2018.
 54. 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%20%20Cultural%20Safety_Full.pdf. Accessed: 15 August 2008.
 55. Ramsden I.M., (1990). Cultural Safety. *New Zealand Nursing Journal*. Vol.December:18-19. Not available online.
 56. 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.

57. Eckermann A.-K. (1992). Binan Goonj : Bridging Cultures in Aboriginal Health. Armidale, NSW: University of New England Press, in association with the Dept. of Aboriginal and Multicultural Studies, University of New England, and the Council of Remote Area Nurses of Australia.
58. Wilkes T., Houston S., Mooney G., (2002). Cultural Security: Some Cost Estimates from Derbarl Yerrigan Health Service. *New Doctor*. Vol.77:13-15. Available: <https://search.informit.com.au/documentSummary;dn=774167782773332;res=IELAPA>. Accessed: 11 May 2018.
59. Australian Rural Health Education Network. (2008). A Textbook of Australian Rural Health. Canberra: ARHEN. Available: http://arhen.org.au/wp-content/uploads/2015/06/Text_Book_of_Australian_Rural_Health.pdf. Accessed: 20 March 2018.
60. Perth Co-occurring Disorders Capacity Building Project Consortium, (2013). Aboriginal Cultural Security Guide for Human Service Organisations – First Edition. Palmerston: Palmerston Association Inc. Available: <http://palmerston.org.au/publications.htm>. Accessed: 19 September 2015.
61. Casey W. (2014). Strong Spirit Strong Mind Model - Informing Policy and Practice. In Dudgeon P., Milroy H., Walker R., (Eds). Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice (2nd Edition). Perth: Australian Government:448-457. Available: <https://www.telethonkids.org.au/our-research/early-environment/developmental-origins-of-child-health/aboriginal-maternal-health-and-child-development/working-together-second-edition/>. Accessed: 23 June 2018.
62. Thackrah R.D., (2016). Culturally Secure Practice in Midwifery Education and Service Provision for Aboriginal Women. Unpublished: Publisher. Available: http://research-repository.uwa.edu.au/files/10908691/THESIS_DOCTOR_OF_PHILOSOPHY_THACKRAH_Rosalie_Dawn_2016.pdf. Accessed: 20 March 2018.
63. Thackrah R.D., Thompson S.C., Durey A., (2015). Exploring Undergraduate Midwifery Students' Readiness to Deliver Culturally Secure Care for Pregnant and Birthing Aboriginal Women. *BMC Med Educ*. Vol.15:77. Available: <http://www.ncbi.nlm.nih.gov/pubmed/25885286>. Accessed: 28 November 2018.
64. Australian Health Ministers' Advisory Council, Standing Committee on Aboriginal and Torres Strait Islander Health Working Party, (2004). AHMAC Cultural Respect Framework for Aboriginal and Torres Strait Islander Health, 2004-2009. Adelaide: Department of Health South Australia. Available: http://iaha.com.au/wp-content/uploads/2013/03/000211_culturalrespectframework.pdf. Accessed: 4 September 2014.
65. 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.
66. Lutschini M., (2005). Engaging with Holism in Australian Aboriginal Health Policy--a Review. *Aust New Zealand Health Policy*. Vol.2:15. Available: <http://www.ncbi.nlm.nih.gov/pubmed/16014165>.

67. 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.
68. Pechenkina E., Anderson I., (2011). Background Paper on Indigenous Australian Higher Education: Trends, Initiatives and Policy Implications. Commissioned Research Paper #1. Canberra: Australian Government Department of Education E.a.W.R. Available: http://sydney.edu.au/documents/about/higher_education/2011/20110930%20IndigenousHigherEducationReview-ReseachPaper.pdf. Accessed: 13 October 2017.
69. Moran M. (2016). Serious Whitefella Stuff: When Solutions Became the Problem in Indigenous Affairs. Melbourne: Melbourne University Press. Available: <https://www.mup.com.au/books/serious-whitefella-stuff-paperback-softback>. Accessed: 5 November 2018.
70. Steering Committee for the Review of Government Service Provision, (2016). Overcoming Indigenous Disadvantage: Key Indicators 2016. Canberra: Productivity Commission. Available: <http://www.pc.gov.au/research/ongoing/overcoming-indigenous-disadvantage/2016#thereport>. Accessed: 18 August 2016.
71. Achterstraat P., (2013). The Corporate Governance Lighthouse -- an Integrated Governance Framework for Public Sector Organisations. *Keeping Good Companies (14447614)*. Vol.65(8):452-456. Available: <https://search.informit.com.au/documentSummary;dn=566314451465348;res=IELAPA>. Accessed: 25 May 2018.
72. Audit Office of NSW. (2011). Corporate Governance-Strategic Early Warning System. In: Audit Office of NSW (Ed). Auditor-General's Report to Parliament Volume Two 2011 Focus on Universities. Sydney: Audit Office of NSW. Available: <http://www.audit.nsw.gov.au/publications/financial-audit-reports/2011-reports/volume-two-2011/volume-two-2011>. Accessed: 2 September 2016.
73. Australian National Audit Office, (1999). Corporate Governance in Commonwealth Authorities and Companies - Discussion Paper. Barton, ACT: ANAO. Available: <https://www.vta.vic.edu.au/document-manager/governance/links/121-corporate-governance-in-commonwealth-authorities-a-companies/file>. Accessed: 13 September 2018.
74. Braithwaite J., Travaglia J.F., (2008). An Overview of Clinical Governance Policies, Practices and Initiatives. *Australian Health Review*. Vol.32(1):10-22. Available: <http://www.publish.csiro.au/ah/AH080010>. Accessed: 15 October 2018.
75. Edwards M., Halligan J., Horrigan B., Nicoll G. (2012). Public Sector Governance in Australia. Canberra: ANU E Press. Available: <https://press.anu.edu.au/publications/series/australia-and-new-zealand-school-government-anzsog/public-sector-governance>. Accessed: 19 February.
76. Kendall E., Marshall C.A., (2004). Factors That Prevent Equitable Access to Rehabilitation for Aboriginal Australians with Disabilities: The Need for Culturally Safe Rehabilitation. *Rehabilitation Psychology*. Vol.49(1):5-13. Available: <https://www.scopus.com/inward/record.uri?eid=2-s2.0-0842349463&partnerID=40&md5=8eea1fa3a82abced5489f1ab547a561b>. Accessed: 30 November 2018.
77. Productivity Commission, (2011). Disability within the Indigenous Community. Canberra: Productivity Commission. Available: <http://www.healthinfonet.ecu.edu.au/related-issues/disability/reviews/disability-within-the-indigenous-community>. Accessed: 4 October 2017.

78. Disability Services Commission, (2014). National Standards for Disability Services - Implementation for Aboriginal People with Disability. Perth: Government of Western Australia. Available: <https://www.dss.gov.au/our-responsibilities/disability-and-carers/standards-and-quality-assurance/national-standards-for-disability-services>. Accessed: 4 October 2017.
79. Council of Australian Governments, (2011). National Disability Strategy 2010-2020. Canberra: Commonwealth of Australia. Available: <https://www.dss.gov.au/our-responsibilities/disability-and-carers/publications-articles/policy-research/national-disability-strategy-2010-2020>. Accessed: 4 October 2017.
80. Morgan D.L., Slade M.D., Morgan C.M., (1997). Aboriginal Philosophy and Its Impact on Health Care Outcomes. *Aust N Z J Public Health*. Vol.21(6):597-601. Available: <https://onlinelibrary.wiley.com/doi/abs/10.1111/j.1467-842X.1997.tb01762.x>. Accessed: 30 November 2018.
81. National People with Disabilities and Carer Council, (2009). Shut Out: The Experience of People with Disabilities and Their Families in Australia. Canberra: Australian Government. Available: <https://www.dss.gov.au/our-responsibilities/disability-and-carers/publications-articles/policy-research/shut-out-the-experience-of-people-with-disabilities-and-their-families-in-australia?HTML>. Accessed: 4 October 2017.
82. 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.
83. Nursing and Midwifery Board of Australia, (2006). National Competency Standards for the Midwife. Melbourne: NMBA. Available: <http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards.aspx>. Accessed: 29 September 2017.
84. Australian Psychological Society. (2016). Australian Psychological Society Apologises to Aboriginal and Torres Strait Islander People. Available: https://www.psychology.org.au/news/media_releases/15September2016/. Accessed: 8 November 2018.
85. Panaretto K.S., Mitchell M.R., Anderson L., Larkins S.L., Manassis V., Buettner P.G., Watson D., (2007). Sustainable Antenatal Care Services in an Urban Indigenous Community: The Townsville Experience. *MJA*. Vol.187(1-2 July):18-22. Available: <https://www.mja.com.au/journal/2007/187/1/sustainable-antenatal-care-services-urban-indigenous-community-townsville>. Accessed: 18 September 2017.
86. Coffin J., (2007). Rising to the Challenge in Aboriginal Health by Creating Cultural Security. *Aboriginal and Islander Health Worker Journal*. Vol.31(3):22. Available: <http://search.informit.com.au/documentSummary;dn=955665869609324;res=IELFSC>. Accessed: 8 August 2018.
87. Western Australia Department of Health, (2001). Aboriginal Cultural Security - a Background Paper. Perth: Department of Health, Government of Western Australia. Available: [https://healthinonet.ecu.edu.au/uploads/resources/4230_cultural_security_discussion_document\[1\].pdf](https://healthinonet.ecu.edu.au/uploads/resources/4230_cultural_security_discussion_document[1].pdf). Accessed: 13 August 2018.
88. Truong M., Paradies Y., Priest N., (2014). Interventions to Improve Cultural Competency in Healthcare: A Systematic Review of Reviews. *BMC Health Serv Res*. Vol.14(1):99. Available: <https://www.ncbi.nlm.nih.gov/pubmed/24589335>. Accessed: 15 October 2018.
89. Maslow A.H., (1943). A Theory of Human Motivation. *Psychological Review*. Vol.50(4):370-396. Available: <http://psycnet.apa.org/record/1943-03751-001>. Accessed: 19 May 2018.

90. Wahba M.A., Bridwell L.G., (1976). Maslow Reconsidered: A Review of Research on the Need Hierarchy Theory. *Organizational Behavior and Human Performance*. Vol.15(2):212-240. Available: <http://www.sciencedirect.com/science/article/pii/0030507376900386>. Accessed: 23 February 2018.
91. Hofstede G.J., (1984). The Cultural Relativity of the Quality of Life Concept. *The Academy of Management Review*. Vol.9(3):389-398. Available: <https://web.archive.org/web/20141112000247/http://myweb.usf.edu/~jldorio/Articles/The%20cultural%20relativity%20of%20the%20quality%20of%20life%20concept.pdf>. Accessed: 25 April 2018.
92. Willis J., Wilson G., Renhard R., Chong A., Clarke A., (2010). Improving the Culture of Hospitals Project - Final Report. Melbourne: Australian Institute for Primary Care. Available: <http://www.lowitja.org.au/improving-culture-hospitals>. Accessed: 30 November 2018.
93. Dennis S., Hasan I., Pulver L.J., Wilson I., Zwar N., (2015). Experiences and Views of a Brokerage Model for Primary Care for Aboriginal People. *Aust Health Rev*. Vol.39(1):26-32. Available: <http://www.ncbi.nlm.nih.gov/pubmed/25318845>. Accessed: 15 October 2018.
94. McKenna B., Fernbacher S., Furness T., Hannon M., (2015). "Cultural Brokerage" and Beyond: Piloting the Role of an Urban Aboriginal Mental Health Liaison Officer. *BMC Public Health*. Vol.15:881. Available: <http://www.ncbi.nlm.nih.gov/pubmed/26358718>. Accessed: 15 October 2018.
95. The Royal Australian College of General Practitioners, (2012). An Introduction to Aboriginal and Torres Strait Islander Health Cultural Protocols and Perspectives. South Melbourne: RACGP. Available: <http://www.racgp.org.au/yourracgp/faculties/aboriginal/guides/cultural-protocols/>. Accessed: 15 October 2018.
96. Hurley A., (2003). Respect, Acknowledge, Listen: Practical Protocols for Working with the Indigenous Community of Western Sydney. Liverpool: City of Bankstown. Available: <https://www.cbcity.nsw.gov.au/community/cultural-services/aboriginal-torres-strait-islanders/respect-acknowledge-listen>. Accessed: 15 October 2018.
97. Thomson A.M., Perry J.L., (2006). Collaboration Processes: Inside the Black Box *Public Administration Review*. 20-32. Available: <http://www.jstor.org/stable/4096567>. Accessed: 15 October 2018.
98. Papps E.H. (2015). Cultural Safety: Daring to Be Different. In Wepa D., (Ed). *Cultural Safety in Aotearoa New Zealand: Second Edition*. Melbourne: Cambridge University Press:36-48. Available: <http://www.cambridge.org/im/academic/subjects/medicine/nursing/cultural-safety-aotearoa-new-zealand-2nd-edition#ESrT7XemGW0tfhmm.97>. Accessed: 25 April 2018.
99. Williams M., (2018). Ngaa-Bi-Nya Aboriginal and Torres Strait Islander Program Evaluation Framework. *Evaluation Journal of Australasia*. Vol.18(1):6-20. Available: <http://journals.sagepub.com/doi/pdf/10.1177/1035719X18760141>. Accessed: 7 May 2018.
100. Belfrage M., (2007). Why "Culturally Safe" Health Care? *Medical Journal of Australia*. Vol.186(20):537-538. Available: https://www.mja.com.au/system/files/issues/186_10_210507/bel10498_fm.pdf. Accessed: 4 September 2017.
101. Dodson M., (1994). The Wentworth Lecture the End in the Beginning: Re (De) Finding Aboriginality. *Australian Aboriginal Studies*. (1):2. Available: <http://www.columbia.edu/itc/polisci/juviler/pdfs/dodson.pdf>. Accessed: 4 October 2017.
102. 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.
103. Phiri J., Dietsch E., Bonner A., (2010). Cultural Safety and Its Importance for Australian Midwifery Practice. *Collegian*. Vol.17(3):105-111. Available: <http://www.sciencedirect.com/science/article/pii/S1322769609001115>. Accessed: 15 October 2018.
 104. van Nes F., Abma T., Jonsson H., Deeg D., (2010). Language Differences in Qualitative Research: Is Meaning Lost in Translation? *European Journal of Ageing*. Vol.7(4):313-316. Available: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2995873/>. Accessed: 15 October 2018.
 105. Nursing and Midwifery Board of Australia, (2006). National Competency Standards for the Registered Nurse. Melbourne: NMB. Available: <http://www.nursingmidwiferyboard.gov.au/Search.aspx?q=National+competency+standard+for++++Registered+Nurse.+>. Accessed: 4 October 2017.
 106. Department of Health, (2018). Clinical Practice Guidelines: Pregnancy Care. Canberra: Australian Government Department of Health. Available: <https://beta.health.gov.au/resources/publications/pregnancy-care-guidelines-and-related-documents>. Accessed: 9 November 2018.
 107. van den Berg R., (2010). Cultural Safety in Health for Aboriginal People: Will It Work in Australia? *Med J Aust*. Vol.193(3):136-137. Available: <http://www.ncbi.nlm.nih.gov/pubmed/20678038>. Accessed: 15 October 2018.
 108. Jennings W., Bond C., Hill P.S., (2018). The Power of Talk and Power in Talk: A Systematic Review of Indigenous Narratives of Culturally Safe Healthcare Communication. *Aust J Prim Health*. Vol.24:109-115. Available: <https://doi.org/10.1071/PY17082>. Accessed: 28 April 2018.
 109. Rigby W., Duffy E., Manners J., Latham H., Lyons L., Crawford L., Eldridge R., (2011). Closing the Gap: Cultural Safety in Indigenous Health Education. *Contemp Nurse*. Vol.37(1):21-30. Available: <http://www.tandfonline.com/doi/pdf/10.5172/conu.2011.37.1.021>. Accessed: 15 October 2018.
 110. Australian Pharmacy Council Ltd, (2012). Accreditation Standards for Pharmacy Programs in Australia and New Zealand. Canberra: APC. Available: <https://www.pharmacycouncil.org.au/policies-procedures/standards/>. Accessed: 8 May 2018.
 111. Pharmaceutical Society of Australia, (2014). Guide to Providing Pharmacy Services to Aboriginal and Torres Strait Islander People. Deakin: PSA. Available: <http://6cpa.com.au/factsheets/>. Accessed: 12 October 2018.
 112. Indigenous Allied Health Australia, (2013). Position Paper: Culturally Responsive Health Care. Canberra: IAHA. Available: http://iaha.com.au/wp-content/uploads/2013/09/Position_Paper_Culturally_Responsive_Health_Care.pdf. Accessed: 8 May 2018.
 113. Funston L., (2013). Aboriginal and Torres Strait Islander Worldviews and Cultural Safety Transforming Sexual Assault Service Provision for Children and Young People. *Int J Environ Res Public Health*. Vol.10(9):3818-3833. Available: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3799501/>. Accessed: 3 May 2018.
 114. Gerlach A.J., (2012). A Critical Reflection on the Concept of Cultural Safety. *Canadian Journal of Occupational Therapy*. Vol.79(3):151-158. Available: <http://dx.doi.org/10.2182/cjot.2012.79.3.4>. Accessed: 14 August 2017.

115. Milroy H.M., (2013). Beyond Cultural Security; Towards Sanctuary. *Med J Aust*. Vol.199(1):14. Available: <https://www.ncbi.nlm.nih.gov/pubmed/23829243>. Accessed: 20 March 2018.
116. Nelson J., Ryan K., Rotumah D., Bennett-Levy J., Budden W., Stirling J., Wilson S., Beale D., (2014). Aboriginal Practitioners Offer Culturally Safe and Responsive Cbt: Response to Commentaries. *Australian Psychologist*. Vol.49(1):22-27. Available: https://www.researchgate.net/profile/James_Bennett-Levy/publication/259547001_Aboriginal_Practitioners_Offer_Culturally_Safe_and_Responsive_CBT_Response_to_Commentaries/links/0046352ce8512da8ff000000.pdf. Accessed: 15 October 2018.
117. Bennett-Levy J., Wilson S., Nelson J., Stirling J., Ryan K., Rotumah D., Budden W., Beale D., (2014). Can Cbt Be Effective for Aboriginal Australians? Perspectives of Aboriginal Practitioners Trained in Cbt. *Australian Psychologist*. Vol.49(1):1-7. Available: <http://dx.doi.org/10.1111/ap.12025>. Accessed: 15 October 2018.
118. Graham J.R., Sorenson S., Hayes-Skelton S.A., (2013). Enhancing the Cultural Sensitivity of Cognitive Behavioral Interventions for Anxiety in Diverse Populations. *The Behavior therapist / AABT*. Vol.36(5):101-108. Available: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4225557/>. Accessed: 15 October 2018.
119. Clifford A.C., Doran C.M., Tsey K., (2013). A Systematic Review of Suicide Prevention Interventions Targeting Indigenous Peoples in Australia, United States, Canada and New Zealand. *BMC Public Health*. Vol.13(1):463. Available: <https://doi.org/10.1186/1471-2458-13-463>. Accessed: 15 October 2018.
120. Truasheim S., (2014). Cultural Safety for Aboriginal and Torres Strait Islander Adults within Australian Music Therapy Practices. *Australian Journal of Music Therapy*. Vol.25:135-147. Available: <https://www.austmta.org.au/journal/article/cultural-safety-aboriginal-and-torres-strait-islander-adults-within-australian-music>. Accessed: 15 October 2018.
121. Humphery K., (2001). Dirty Questions: Indigenous Health and 'Western Research'. *Aust N Z J Public Health*. Vol.25(3):197-202. Available: <https://www.ncbi.nlm.nih.gov/pubmed/11494986>. Accessed: 15 October 2018.
122. Wilson A., (2014). Addressing Uncomfortable Issues: Reflexivity as a Tool for Culturally Safe Practice in Aboriginal and Torres Strait Islander Health. *Australian Journal of Indigenous Education*. Vol.43(2):218-230. Available: <https://www.cambridge.org/core/journals/australian-journal-of-indigenous-education/article/addressing-uncomfortable-issues-reflexivity-as-a-tool-for-culturally-safe-practice-in-aboriginal-and-torres-strait-islander-health/361EFC239359D129266EE39BA99D1B3A>. Accessed: 15 October 2018.
123. Kowal E., (2012). Stigma and Suffering: White Anti-Racist Identities in Northern Australia. *Postcolonial Studies*. Vol.15(1):5-21. Available: <https://www.tandfonline.com/doi/abs/10.1080/13688790.2012.658743>. Accessed: 15 October 2018.
124. Wilson A.M., Magarey A.M., Jones M., O'Donnell K., Kelly J., (2015). Attitudes and Characteristics of Health Professionals Working in Aboriginal Health. *Rural and Remote Health*. Vol.15(1):2739. Available: <http://www.ncbi.nlm.nih.gov/pubmed/25818832>.
125. Moreton-Robinson A. (2004). Whiteness, Epistemology and Indigenous Representation. In Moreton-Robinson A., (Ed). *Whitening Race Essays in Social and Cultural Criticism*. Canberra, ACT: Australian Studies Press:75-88. Available: <https://eprints.qut.edu.au/28312/>.

126. Attwood B., Arnold J. (1992). Power, Knowledge and Aborigines. Bundoora, VIC: La Trobe University Press in association with the National Centre for Australian Studies. Available: <http://trove.nla.gov.au/work/22387238?selectedversion=NBD9483071>. Accessed: 11 October 2017.
127. Dietitians Association of Australia, (2015). National Competency Standards for Dietitians in Australia (with Guide). Deakin: DAA. Available: <https://daa.asn.au/maintaining-professional-standards/ncs/>. Accessed: 27 November 2018.
128. Anderson I., (2001). Aboriginal Society and Health: Critical Issues Demand What from Sociologists? *Health Sociology Review*. Vol.10(2):5-20. Available: <https://www.tandfonline.com/doi/abs/10.5172/hesr.2001.10.2.5>. Accessed: 23 July 2018.
129. Dietitians Association of Australia, (2017). Reflect Reconciliation Action Plan Feb 2017-Feb 2018. Deakin. Available: https://daa.asn.au/wp-content/uploads/2016/09/DAA_Reconciliation_Action_Plan_RAP.pdf. Accessed: 11 October 2017.
130. Molloy L., Grootjans J., (2014). The Ideas of Frantz Fanon and Culturally Safe Practices for Aboriginal and Torres Strait Islander People in Australia. *Issues Ment Health Nurs*. Vol.35(3):207-211. Available: <http://www.ncbi.nlm.nih.gov/pubmed/24597586>. Accessed: 15 October 2018.
131. Gladman J., Ryder C., Walters L.K., (2015). Measuring Organisational-Level Aboriginal Cultural Climate to Tailor Cultural Safety Strategies. *Rural and Remote Health*. Vol.15(4):3050. Available: <http://www.ncbi.nlm.nih.gov/pubmed/26446197>. Accessed: 15 October 2018.
132. Westwood B., Westwood G., (2010). Aboriginal Cultural Awareness Training: Policy v. Accountability - Failure in Reality. *Aust Health Rev*. Vol.34(4):423-429. Available: <http://www.ncbi.nlm.nih.gov/pubmed/21108902>; <https://www.questia.com/read/1P3-2259856791/aboriginal-cultural-awareness-training-policy-v>. Accessed: 15 October 2018.
133. Maher P., (1999). A Review of 'Traditional' Aboriginal Health Beliefs. *Aust J Rural Health*. Vol.7(4):229-236. Available: <http://www.ncbi.nlm.nih.gov/pubmed/10732513>. Accessed: 15 October 2018.
134. Parkinson M. (2017). The Promise of 1967: Commonwealth Public Administration of Indigenous Affairs 50 Years On. Available: <https://www.pmc.gov.au/news-centre/pmc/wentworth-lecture-full-transcript-promise-1967-commonwealth-public-administration-indigenous-affairs-50-years>. Accessed: 1 October 2017.
135. National Health and Medical Research Council, (2003). Values and Ethics: Guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander Health Research. Canberra: NHMRC. Available: <https://www.nhmrc.gov.au/guidelines-publications/e52>. Accessed: 1 July 2007.
136. Australian Institute of Aboriginal and Torres Strait Islander Studies and The Lowitja Institute,(2013). Evaluation of the National Health and Medical Research Council Documents - Values and Ethics: Guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander Health Research 2003 and Keeping Research on Track: A Guide for Aboriginal and Torres Strait Islander Peoples About Health Research Ethics 2005. Canberra: National Health and Medical Research Council. Available: <https://www.lowitja.org.au/ethics/nhmrc-research-ethics>. Accessed: 11 May 2018.
137. Australian Institute of Aboriginal and Torres Strait Islander Studies, The Lowitja Institute, (2013). Researching Right Way. Aboriginal and Torres Strait Islander Health Research Ethics: A Domestic and International Review. Melbourne: AIATSIS and The Lowitja Institute.

- Available: <https://nhmrc.gov.au/research-policy/ethics/ethical-guidelines-research-aboriginal-and-torres-strait-islander-peoples>. Accessed: 12 October 2018.
138. Fenton C., Jones L.K., (2015). Achieving Cultural Safety in Australian Indigenous Maternity Care. *International Journal of Health Sciences*. Vol.3(1):23-38. Available: http://ijhsnet.com/journals/ijhs/Vol_3_No_1_March_2015/2.pdf. Accessed: 15 October 2018.
 139. Woods M., (2017). Australia's Health Workforce: Strengthening the Education Foundation. Independent Review of Accreditation Systems within the National Registration and Accreditation Scheme for Health Professions. Draft Report September 2017. Canberra: Australian Health Ministers' Advisory Council. Available: https://www.coaghealthcouncil.gov.au/Portals/0/Accreditation%20Review%20Draft%20Report_U.pdf. Accessed: 30 March 2018.
 140. Phillips G., (2004). Cdams Indigenous Health Curriculum Framework. Melbourne: Medical Deans Australia and New Zealand. Available: <https://medicaldeans.org.au/priorities/indigenous-health/teaching-indigenous-health-and-culturally-safe-care/>. Accessed: 10 September 2018.
 141. Australian Government Department of Health, (2014). Aboriginal and Torres Strait Islander Health Curriculum Framework. Canberra: Australian Government. Available: <http://www.health.gov.au/internet/main/publishing.nsf/Content/aboriginal-torres-strait-islander-health-curriculum-framework>. Accessed: 15 October 2018.
 142. Woods M., (2017). Australia's Health Workforce: Strengthening the Education Foundation. Independent Review of Accreditation Systems within the National Registration and Accreditation Scheme for Health Professions. Final Report. Canberra: Australian Health Ministers' Advisory Council. Available: <http://www.coaghealthcouncil.gov.au/Projects/Accreditation-Systems-Review>. Accessed: 16 November 2018.
 143. Tertiary Education and Quality Standards Agency, (2017). Guidance Note: Academic Governance (Version 2.3). Online: Australian Government. Available: <https://www.teqsa.gov.au/latest-news/publications/guidance-note-academic-governance>. Accessed: 16 November 2018.
 144. McLennan V., Taylor N., Rachow A., South G., Chapman K., (2016). Creating Culturally Safe Vocational Rehabilitation Services for Indigenous Australians: A Brief Review of the Literature. *Australian Journal of Rehabilitation Counselling*.1-11. Available: <https://www.cambridge.org/core/journals/australian-journal-of-rehabilitation-counselling/article/creating-culturally-safe-vocational-rehabilitation-services-for-indigenous-australians-a-brief-review-of-the-literature/4B2C8C5B3EB8420AED98FB510B6C3238>. Accessed: 30 November 2018.
 145. Lock M.J., (2007). Aboriginal Holistic Health: A Critical Review. Darwin: CRAH. Available: <https://www.lowitja.org.au/lowitja-publishing/C002>. Accessed: 15 October 2018.
 146. Indigenous Education and Employment Committee, (2015). Recommended Guidelines for Aboriginal and Torres Strait Islander Terminology. Brisbane: Queensland University of Technology. Available: https://cms.qut.edu.au/_data/assets/pdf_file/0008/477143/qut-guidelines-for-aboriginal-torres-strait-islander-terminology.pdf. Accessed: 12 October 2017.
 147. Tervalon M., Murray-Garcia J., (1998). Cultural Humility Versus Cultural Competence: A Critical Distinction in Defining Physician Training Outcomes in Multicultural Education. *J Health Care Poor Underserved*. Vol.9(2):117-125. Available: <http://www.nrchmh.org/ResourcesMHAdminsLeaders/Cultural%20Humility%20vs%20Cultu>

[ral%20Competence%20a%20Critical%20Distinction%20in%20Defining%20Physician%20Training%20Outcomes%20.pdf](#). Accessed: 12 October 2017.

148. Indigenous Allied Health Australia, (2015). Cultural Responsiveness in Action: An IAHA Framework. Deakin West, ACT: IAHA. Available: <http://iaha.com.au/media-release-national-indigenous-organisation-launches-cultural-responsiveness-framework/>. Accessed: 27 July 2017.
149. Thomas D., (2000). The Beginnings of Aboriginal Health Research in Australia. Melbourne: VicHealth Koori Health Research & Community Development Unit, Centre for the Study of Health & Society, University of Melbourne. Available: <http://onemda.unimelb.edu.au/sites/default/files/docs/DP3.pdf>. Accessed: 14 November 2018.
150. Sjoberg D., McDermott D., (2016). The Deconstruction Exercise: An Assessment Tool for Enhancing Critical Thinking in Cultural Safety Education. *International Journal of Critical Indigenous Studies*. Vol.9(1):28-48. Available: http://www.isrn.qut.edu.au/publications/internationaljournal/documents/volume9_number1_16-3-sjoberg.pdf. Accessed: 12 October 2017.
151. 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.
152. Taylor K., Guerin P. (2010). Health Care and Indigenous Australians: Cultural Safety in Practice. South Yarra: Palgrave Macmillan. Available: <https://trove.nla.gov.au/work/28373091>. Accessed: 15 October 2018.
153. Brown A.E., Middleton P.F., Fereday J.A., Pincombe J.I., (2016). Cultural Safety and Midwifery Care for Aboriginal Women - a Phenomenological Study. *Women Birth*. Vol.29(2):196-202. Available: <https://www.sciencedirect.com/science/article/pii/S1871519215003339>. Accessed: 30 November 2018.
154. Willis J., Chong A., Clarke A., Wilson G., Lawrence M., (2010). Aboriginal and Torres Strait Islander Patient Quality Improvement Toolkit for Hospital Staff. Improving the Culture of Hospitals Project. Melbourne: Australian Institute of Primary Care, La Trobe University. Available: http://healthwest.org.au/wp-content/uploads/2015/02/aboriginal_pt_quality_improvement_toolkit_hospitals_oct2010.pdf. Accessed: 25 May 2018.
155. Renhard R., Chong A., Willis J., Wilson G., Clarke A., (2014). Aboriginal Quality Improvement Framework and Toolkit for Hospital Staff (Aqifths). Melbourne: St Vincent's Hospital. Available: <https://healthinonet.ecu.edu.au/key-resources/publications/?id=28995>. Accessed: 15 October 2018.
156. Laverty M., McDermott D.R., Calma T., (2017). Embedding Cultural Safety in Australia's Main Health Care Standards. *Med J Aust*. Vol.207(1):15-16. Available: <https://www.ncbi.nlm.nih.gov/pubmed/28659104>. Accessed: 11 October 2017.
157. Chong A., Renhard R., Wilson G., Willis J., Clarke A., (2011). Improving Cultural Sensitivity to Indigenous People in Australian Hospitals a Continuous Quality Improvement Approach. *Focus on Health Professional Education: A Multi-disciplinary Journal*. Vol.13(1):84. Available: <https://search.informit.com.au/documentSummary;dn=348953581147456;res=IELHEA>. Accessed: 15 October 2018.

158. Rothman J. (2014). Is Heidegger Contaminated by Nazism? Available: <https://www.newyorker.com/books/page-turner/is-heidegger-contaminated-by-nazism>. Accessed: 29 September.
159. Milne T., Creedy D.K., West R., (2016). Development of the Awareness of Cultural Safety Scale: A Pilot Study with Midwifery and Nursing Academics. *Nurse Education Today*. Vol.44:20-25. Available: <http://dx.doi.org/10.1016/j.nedt.2016.05.012>. Accessed: 14 August 2017.
160. West R., Gamble J., Kelly J., Milne T., Duffy E., Sidebotham M., (2016). Culturally Capable and Culturally Safe: Caseload Care for Indigenous Women by Indigenous Midwifery Students. *Women and Birth*. Vol.29(6):524-530. Available: <http://www.sciencedirect.com/science/article/pii/S1871519216300257>. Accessed: 28 November 2018.
161. Kelly J., West R., Gamble J., Sidebotham M., Carson V., Duffy E., (2014). 'She Knows How We Feel': Australian Aboriginal and Torres Strait Islander Childbearing Women's Experience of Continuity of Care with an Australian Aboriginal and Torres Strait Islander Midwifery Student. *Women Birth*. Vol.27(3):157-162. Available: <http://www.ncbi.nlm.nih.gov/pubmed/24997119>. Accessed: 16 November 2018.
162. 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.
163. West R., Mills K., Rowland D., Creedy D.K., (2018). Validation of the First Peoples Cultural Capability Measurement Tool with Undergraduate Health Students: A Descriptive Cohort Study. *Nurse Education Today*. Vol.64:166-171. Available: <http://www.sciencedirect.com/science/article/pii/S0260691718300947>. Accessed: 15 October 2018.
164. West R., Wrigley S., Mills K., Taylor K., Rowland D., Creedy D.K., (2017). Development of a First Peoples-Led Cultural Capability Measurement Tool: A Pilot Study with Midwifery Students. *Women and Birth*. Vol.30(3):236-244. Available: <http://www.sciencedirect.com/science/article/pii/S1871519217300094>.
165. De Souza R. (2015). Navigating the Ethics of Cultural Safety. In Wepa D., (Ed). *Cultural Safety in Aotearoa New Zealand*. Port Melbourne: Cambridge University Press:111-124. Available: https://www.academia.edu/12680400/Navigating_the_ethics_in_cultural_safety. Accessed: 24 October 2018.
166. International Confederation of Midwives. (2018). Who We Are. Available: <https://www.internationalmidwives.org/about-us/international-confederation-of-midwives/>. Accessed: 16 November 2018.
167. Australian Commission on Safety and Quality in Health Care, (2012). National Safety and Quality Health Service Standards. Sydney: ACSQHC. Available: <http://www.safetyandquality.gov.au/wp-content/uploads/2011/09/NSQHS-Standards-Sept-2012.pdf>. Accessed: 28 September 2017.
168. Australian Commission on Safety and Quality in Health Care. (2015). Improving Care for Aboriginal and Torres Strait Islanders. Available: <http://www.safetyandquality.gov.au/our-work/accreditation-and-the-nsqhs-standards/improving-care-for-aboriginal-and-torres-strait-islanders/>. Accessed: 31 July.
169. Australian Commission on Safety and Quality in Health Care, (2016). Overview: Guide to Better Care for Aboriginal and Torres Strait Islander Communities. Online: ACSQHC.

Available: <https://www.safetyandquality.gov.au/our-work/assessment-to-the-nsqhs-standards/improving-care-for-aboriginal-and-torres-strait-islander-people/>. Accessed: 15 October 2018.

170. Australian Commission on Safety and Quality in Health Care, (2016). 1. Setting Safety and Quality Goals for Aboriginal and Torres Strait Islander People in Health Service Organisations. Online: ACSQHC. Available: <https://www.safetyandquality.gov.au/our-work/assessment-to-the-nsqhs-standards/improving-care-for-aboriginal-and-torres-strait-islander-people/>. Accessed: 2 February 2018.
171. Australian Commission on Safety and Quality in Health Care, (2016). 2. Cultural Competence in Caring for Aboriginal and Torres Strait Islander Consumers. Online: ACSQHC. Available: <https://www.safetyandquality.gov.au/our-work/assessment-to-the-nsqhs-standards/improving-care-for-aboriginal-and-torres-strait-islander-people/>. Accessed: 2 February 2018.
172. Australian Commission on Safety and Quality in Health Care, (2016). 3. Improving Identification Rates of Aboriginal and Torres Strait Islander Consumers. Online: ACSQHC. Available: <https://www.safetyandquality.gov.au/our-work/assessment-to-the-nsqhs-standards/improving-care-for-aboriginal-and-torres-strait-islander-people/>. Accessed: 2 February 2018.
173. Australian Commission on Safety and Quality in Health Care, (2016). 4. Creating Safe and Welcoming Environments for Aboriginal and Torres Strait Islander Consumers. Online. Available: <https://www.safetyandquality.gov.au/our-work/assessment-to-the-nsqhs-standards/improving-care-for-aboriginal-and-torres-strait-islander-people/>. Accessed: 2 February 2018.
174. Australian Commission on Safety and Quality in Health Care, (2016). 5. Effective and Safe Communication with Aboriginal and Torres Strait Islander Consumers. Online: ACSQHC. Available: <https://www.safetyandquality.gov.au/our-work/assessment-to-the-nsqhs-standards/improving-care-for-aboriginal-and-torres-strait-islander-people/>. Accessed: 2 February 2018.
175. Australian Commission on Safety and Quality in Health Care, (2016). 6. Comprehensive Care for Aboriginal and Torres Strait Islander Consumers. Online: ACSQHC. Available: <https://www.safetyandquality.gov.au/our-work/assessment-to-the-nsqhs-standards/improving-care-for-aboriginal-and-torres-strait-islander-people/>. Accessed: 2 February 2018.
176. Australian Commission on Safety and Quality in Health Care, (2017). National Safety and Quality Health Service Standards (Second Edition) User Guide for Aboriginal and Torres Strait Islander Health. Sydney: ACSQHC. Available: <https://www.safetyandquality.gov.au/our-work/assessment-to-the-nsqhs-standards/national-standards-program-updates-and-consultations/>.
177. Fleming T., Creedy D.K., West R., (2017). Impact of a Continuing Professional Development Intervention on Midwifery Academics' Awareness of Cultural Safety. *Women and Birth*. Vol.30(3):245-252. Available: <http://www.sciencedirect.com/science/article/pii/S1871519217300719>. Accessed: 28 November 2018.
178. Holland C., (2018). A Ten-Year Review: The Closing the Gap Strategy and Recommendations for Reset. Melbourne: The Close the Gap Campaign Steering Committee. Available: <http://apo.org.au/system/files/131816/apo-nid131816-584181.pdf>. Accessed: 16 February 2018.

179. Universities Australia, (2011). National Best Practice Framework for Indigenous Cultural Competency in Australian Universities. Canberra: Universities Australia. Available: <https://www.universitiesaustralia.edu.au/uni-participation-quality/Indigenous-Higher-Education/Indigenous-Cultural-Compet#.VbrxN7OqpBc>. Accessed: 6 April 2018.
180. Australian Health Ministers' Advisory Council, (2014). Aboriginal and Torres Strait Islander Health Performance Framework 2014 Report. Canberra: AHMAC. Available: <http://www.health.gov.au/indigenous-hpf>. Accessed: 30 November 2018.
181. 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.
182. Medical School Accreditation Committee, (2017). Procedures for Assessment and Accreditation of Medical Schools by the Australian Medical Council 2018. Kingston: Australian Medical Council Ltd. Available: <https://www.amc.org.au/accreditation/primary-medical-education>. Accessed: 27 November 2018.
183. Medical School Accreditation Committee, (2012). Standards for Assessment and Accreditation of Primary Medical Programs by the Australian Medical Council 2012 Kingston: Australian Medical Council Ltd. Available: <https://www.amc.org.au/accreditation/primary-medical-education>. Accessed: 27 November 2018.
184. Australian Nursing and Midwifery Accreditation Council, (2012). Registered Nurse Accreditation Standards 2012. Canberra: ANMAC. Available: <https://www.anmac.org.au/program-accreditation/program-accreditation>. Accessed: 27 November 2018.
185. Occupational Therapy Council (Australia & New Zealand) Ltd, (2013). Accreditation Standards for Entry-Level Occupational Therapy Education Programs. South Perth: OTC. Available: <https://www.occupationaltherapyboard.gov.au/accreditation.aspx>. Accessed: 27 November 2018.
186. South Australian Aboriginal Education and Training Consultative Body. (2011). About Us - Aboriginal Voices in Education and Training. Available: <http://saaetcb.demo.webez.biz/about-us/>. Accessed: 27 November 2018.
187. Aboriginal and Torres Strait Islander Social Justice Commissioner. (1994). Aboriginal and Torres Strait Islander Social Justice Commission: Second Report 1994. Available: <http://www.austlii.edu.au/au/other/IndigLRes/1994/2.html>. Accessed: 27 November 2018.
188. Anderson I. (1997). The Ethics of the Allocation of Health Resources. Race Matters: Indigenous Australians and 'Our' Society. Canberra: Aboriginal Studies Press:191-208. Available: <http://search.informit.com.au/documentSummary;dn=302170302107395;res=IELIND>. Accessed: 15 October 2018.
189. Pholi K., Black D., Richards C., (2009). Is 'Close the Gap' a Useful Approach to Improving the Health and Wellbeing of Indigenous Australians? *Australian Review of Public Affairs*. Vol.9(2):1-13. Available: http://www.australianreview.net/journal/v9/n2/pholi_etal.html. Accessed: 27 November 2018.

190. Lea T., (2001). A Benign Arithmetic: Taking up Facts About Indigenous Health. *The UTS Review: Cultural Studies and New Writing*. Vol.7(1):59-73. Available: Unavailable online.
191. 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.
192. McGough S.-A., (2015). Facilitating Equity in Mental Health Outcomes for Aboriginal People within Mainstream Mental Health Services in Western Australia: A Grounded Theory Study. Unpublished thesis. Available: <https://espace.curtin.edu.au/handle/20.500.11937/1275>. Accessed: 26 January 2018.
193. McGough S., (2016). Culturally Safe Mental Healthcare. *Australian Nursing and Midwifery Journal*. Vol.23(8):45. Available: <https://espace.curtin.edu.au/handle/20.500.11937/20188>. Accessed: 26 January 2018.
194. McBain-Rigg K.E., Veitch C., (2011). Cultural Barriers to Health Care for Aboriginal and Torres Strait Islanders in Mount Isa. *Aust J Rural Health*. Vol.19(2):70-74. Available: <https://onlinelibrary.wiley.com/doi/abs/10.1111/j.1440-1584.2011.01186.x>. Accessed: 30 November 2018.
195. National Health and Medical Research Council, (2018). Ethical Conduct in Research with Aboriginal and Torres Strait Islander Peoples and Communities: Guidelines for Researchers and Stakeholders. Canberra: Commonwealth of Australia. Available: <https://www.nhmrc.gov.au/guidelines-publications/ind2>. Accessed: 10 August 2018.
196. 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.
197. Harfield S., Gibson O., Morey K., Kite E., Canuto K., Glover K., Streak Gomersall J., Davy C., Carter D., Aromataris E., Braunack-Mayer A., (2017). The Create Critical Appraisal Tool: A Tool to Appraise Research from Aboriginal and Torres Strait Islander Perspectives. Cochrane Colloquium Abstracts - 2017 Cape Town Global Evidence Summit. Online: Cochrane.org. Available: <https://abstracts.cochrane.org/2017-global-evidence-summit/create-critical-appraisal-tool-tool-appraise-research-aboriginal-and>. Accessed: 6 November 2018.
198. Marston G., Watts R., (2003). Tampering with the Evidence: A Critical Appraisal of Evidence-Based Policy-Making. *The Drawing Board: an Australian Review of Public Affairs*. Vol.3(3):143-163. Available: <https://researchbank.rmit.edu.au/view/rmit:7593>. Accessed: 21 November 2018.
199. Nursing Council of New Zealand, (2013). Bibliographic Timeline of the Introduction of Cultural Safety into Nursing Education in New Zealand 1988-2012. Wellington: NCNZ. Available: <http://www.nursingcouncil.org.nz/News/Bibliographic-Timeline-of-the-Introduction-of-Cultural-Safety-into-Nursing-Education-in-New-Zealand-1988-2012>. Accessed: 22 May 2018.
200. Williamson M., Harrison L., (2010). Providing Culturally Appropriate Care: A Literature Review. *International Journal of Nursing Studies*. Vol.47(6):761-769. Available: <http://www.sciencedirect.com/science/article/pii/S0020748909004040>. Accessed: 23 March 2018.
201. McLennan V., Khavarpour F., (2004). Culturally Appropriate Health Promotion: Its Meaning and Application in Aboriginal Communities. *Health Promotion Journal of Australia*. Vol.15(3):237-239. Available: <https://doi.org/10.1071/HE04237>.

202. 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.
203. 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](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(06)68773-4/fulltext). Accessed: 30 November 2018.
204. 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.
205. Anderson I., Sanders W. (1996). Aboriginal Health and Institutional Reform within Australian Federalism: Australian National University, Centre for Aboriginal Economic Policy Research. Available: <http://caepr.cass.anu.edu.au/research/publications/aboriginal-health-and-institutional-reform-within-australian-federalism>. Accessed: 15 October 2018.
206. 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.
207. Gardiner-Garden J., (1999). From Dispossession to Reconciliation. Canberra: Department 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.
208. 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.
209. 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.
210. Altman J.C. (2007). The Howard Government's Northern Territory Intervention: Are Neo-Paternalism and Indigenous Development Compatible?: Australian National University, Centre for Aboriginal Economic Policy Research,. Available: <http://caepr.cass.anu.edu.au/research/publications/howard-government-s-northern-territory-intervention-are-neo-paternalism-and>. Accessed: 30 November 2018.
211. 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.
212. Australian Health Ministers' Advisory Council, (2017). Aboriginal and Torres Strait Islander Health Performance Framework 2017 Report. Canberra: Commonwealth of Australia. Available: <https://www.pmc.gov.au/resource-centre/indigenous-affairs/health-performance-framework-2017-report>. Accessed: 28 November 2018.
213. Morgensen S.L., (2011). The Biopolitics of Settler Colonialism: Right Here, Right Now. *Settler Colonial Studies*. Vol.1(1):52-76. Available:

<https://www.tandfonline.com/doi/pdf/10.1080/2201473X.2011.10648801>. Accessed: 28 November 2018.

214. Awofeso N., (2011). Racism: A Major Impediment to Optimal Indigenous Health and Health Care in Australia. *Australian Indigenous Health Bulletin*. Vol.11(3):1-8. Available: http://healthbulletin.org.au/wp-content/uploads/2011/07/bulletin_review_awofeso_2011.pdf. Accessed: 22 November 2018.
215. Paradies Y.C., (2006). Defining, Conceptualizing and Characterizing Racism in Health Research. *Critical Public Health*. Vol.16(2):143-157.
216. 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.

COMMITTIX

Committee Analytics

