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Evolving beyond antiracism: Reflections on the experience of developing a cultural safety curriculum in a tertiary education setting

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Abstract

There is an inextricable link between cultural and clinical safety. In Australia high-profile Aboriginal deaths in custody, publicised institutional racism in health services and the international Black Lives Matter movement have cemented momentum to ensure culturally safe care. However, racism within health professionals and health professional students remains a barrier to increasing the

Positioning Statement

This article describes the collective experience of an Aboriginal and Torres Strait Islander led collaborative process in developing a cultural safety curriculum innovation and initiative. The article reflects on this experience comparing this process to the 'business as usual' approach of developing curricula in higher education nursing programmes. The following discussion and reflections are consciously framed from a deliberate standpoint agreed upon by those involved in the curriculum innovation and initiative. Specifically, curriculum reflections are delineated within the conscious contextualising of history and political factors that influence cultural safety for Aboriginal and Torres Strait Islander peoples in Australia today. In efforts to challenge paternalism within an often highly colonial tertiary context, it has been the collective position of the authors to prioritise an Aboriginal and Torres Strait Islander perspective and voice within these writings. Consequently, these reflections draw significant attention to the importance of an Aboriginal and Torres Strait Islander led process (Rigney, 1999) for the production of an innovative Aboriginal and Torres Strait Islander Health specific cultural safety curriculum initiative. Such a process is a further exemplar of academic allyship in partnership with our fellow non-Indigenous authors involved in this curriculum process.

The terms 'Aboriginal and Torres Strait Islander', 'Indigenous' and 'First Peoples' are used in this document to describe individuals and communities who are, and consider themselves to be, continuous with the First Peoples of the lands now known as Australia. While these terms are certainly problematic due to their homogenising effect, they are used in this article with the utmost respect for the incredibly rich diversity of over 500 First Peoples and communities, each with their own unique culture, language, traditions and history.

number of Aboriginal and Torres Strait Islander Health professionals. The Australian Health Practitioner Regulation Agency's Aboriginal and Torres Strait Islander Health Strategy's objective to 'eliminate racism from the health system', and the recent adoption of the Aboriginal and Torres Strait Islander peoples led cultural safety definition, has instigated systems level reflections on decolonising practice. This article explores cultural safety as the conceptual antithesis to racism, examining its origins, and contemporary evolution led by Aboriginal and Torres Strait Islander peoples in Australia, including its development in curriculum innovation. The application of cultural safety is explored using in-depth reflection, and the crucial development of integrating critical consciousness theory, as a precursor to culturally safe practice, is discussed. Novel approaches to university curriculum development are needed to facilitate culturally safe and decolonised learning and working environments, including the key considerations of non-Indigenous allyship and collaborative curriculum innovations and initiatives.

KEYWORDS
cultural safety, curriculum, nurse education, racism, social justice

1 | INTRODUCTION

1.1 | Situating cultural safety

The concept of antiracism has its foundations with the European spread of racism to the Americas, when clergy, educated in the new values of the Renaissance, questioned the Spanish treatment of American Indians in the early 1500s. This antiracist movement was a deliberate utilisation of privilege and power to influence and instigate change regarding the treatment of those who were being oppressed (de las Casas, 1992; Johansen, 2006). Critically for this process to effect positive change, those in positions of power and privilege must intentionally prioritise privileging the oppressed voices rather than their own, to avoid perpetuating paternalism and the 'management of the other'. Antiracism is not a new term that came into vogue during the 2020 Black Lives Matter movement, and antiracism differs from the concept of the more passive 'nonracism' in that it requires conscious efforts and deliberate actions to make change (King, 2016): 'To be antiracist is a radical choice in the face of history, requiring a radical reorientation of our consciousness' (Kendi, 2019). Such radical choice and change in consciousness is required to challenge the status quo for the majority, a process which necessarily comes at a cost to those driving such change, namely redistribution of privilege and disruption of prevailing popular opinion (Radke et al., 2020; Sumerau et al., 2021). However, a common misstep in the space of antiracism is the failure to engage with the deliberate consciousness that would promote genuine allyship, instead replicating the very dynamics of the oppression this movement seeks to undo. It is therefore argued that the ongoing critical reflection and prioritising of equalised relationships with the oppressed, inherent within critical consciousness theory, is the most effectual pathway to promoting cultural safety for Aboriginal and Torres Strait Islander peoples and genuine allyship.

While racism for Australia's Aboriginal and Torres Strait Islander people is a major determinant of health outcomes for patients, families and communities, the term 'antiracism' has been criticised for not addressing racism for Aboriginal and Torres Strait Islander people (Paradies, 2005). Use of the terms Aboriginal and Torres Strait Islander Health *and* 'cultural safety' may more accurately represent the aspirations of Aboriginal and Torres Strait Islander peoples' perceptions of culturally safe healthcare, and thereby encompass Aboriginal and Torres Strait Islander peoples' unique experience of colonisation and subsequent racism, including pervasive contemporary institutional racism. The unique colonisation experience of Australia's First Peoples, unlike British colonial conquests elsewhere (e.g., Canada; New Zealand), was devoid of a treaty and disregarded Aboriginal and Torres Strait Islander peoples' ongoing connection to Australia until a prominent Australian High Court case, known as the Mabo decision, *just 30 years ago* (Bartlett, 1993). Originally defined by Maori nurse Irihapeti Ramsden, 'cultural safety' was 'developed from the experience of colonisation and recognises that the social, historical, political and economic diversity of a culture impacts on their contemporary health experience' (Ramsden, 2002, p. 112). In her thesis Ramsden (2002) purports:

> In the neocolonial environment this requires a profound understanding of the history and social function of racism and the colonial process. It also requires a critical analysis of existing social, political and cultural structures and the physical, mental, spiritual and social outcomes for people who are different. It is a given that this type of knowledge is

> not taught in a general educational pedagogy which is normally about maintaining the status quo which underpins a conservative economic system based on individual success. (p. 180)

1.2 | Cultural safety in nursing education

Ramsden (2002) revolutionised conceptualisations of care by stating that 'it must be the patient who makes the final statement about the quality of care which they receive' (p. 181) and 'the formation of trust and the components of trust becoming recognisable and tangible to patients and nurses…This often involves the transfer of power from nurse to patient and the renegotiation of traditionally held positions' (p. 179). In renegotiating these positions cultural safety in nursing education, according to Ramsden (2002):

> …aims to identify attitudes that may either consciously or unconsciously exist towards cultural/social differences in the provision of nursing care. Secondly, it attempts to transform those attitudes by tracing them to their origins and enabling students to see their effects on practice through a framework of practice related reflection and action. Cultural safety always seeks to locate its action in the belief systems and behaviours of the caregiver rather than the patient. (p. 121)

1.3 | Cultural safety in Australia

Thirty years on, the concept of cultural safety in Australia has evolved and is contemporarily conceptualised and championed by Aboriginal and Torres Strait Islander scholars in Australia, and by organisations including the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM). Cultural safety has gained traction with a national definition of cultural safety adopted by the Australian Health Practitioner Regulatory Authority (AHPRA). Culturally safe practice is the ongoing critical reflection of health practitioner knowledge, skills, attitudes, practising behaviours and power differentials in delivering safe, accessible and responsive healthcare free of racism. Critically, cultural safety is solely determined by Aboriginal and Torres Strait Islander individuals, families and communities (AHPRA, 2018, 2020; Bin-Sallik, 2003; Phillips, 2015; Wilkes et al., 2002; Williams, 1999).

1.4 | Cultural safety in professional standards

Although the Nursing and Midwifery Board of Australia (NMBA) introduced a new cultural safety standard, for the nursing and midwifery professions in Australia, by way of codes of conduct for nurses and midwives in 2018, the uptake among professions has varied. The NMBA have led the way in articulating and implementing a cultural safety standard in the nursing and midwifery professions (Milligan et al., 2021). There, however, remains a long way to go for the articulated standard to consistently translate to cultural safety as a higher education outcome, thus ensuring appropriate, high quality, healthcare provision by nurses and midwives in Australia (Geia et al., 2020; Mills et al., 2022; Power et al., 2021).

1.5 | Cultural safety in programme accreditation standards

A key factor limiting the application and assessment of cultural safety in accredited health professional programmes is the consciousness and knowledge of non-Indigenous academics. A lack of awareness of cultural safety has negatively impacted non-Indigenous academics' ability, willingness and confidence to elevate Aboriginal and Torres Strait Islander knowledges and inclusive ways of knowing, being and doing in education (Martin & Mirraboopa, 2003; Power et al., 2021; Sherwood & Mohamed, 2020; West et al., 2019).

This article highlights how these critical reflections can be applied in the nursing and midwifery educators' professions, and by all registered health practitioners, reiterating the need to privilege Aboriginal and Torres Strait Islander worldviews in the pursuit of culturally safe education and practice. It should be noted that while the focus of this article is on nursing and midwifery education, critical reflections and their implications are relevant for cultural safety education and practice across the health fields and beyond. Barriers to culturally safe practice are consistent and evident among all health professions, thus applications are imperative for every health profession.

Key insights include essential learnings that non-Indigenous academics can implement to develop cultural safety curricula, which then could be applied to other curriculum development approaches. 'Guideposts' are identified for non-Indigenous academic staff to use in their own personal and professional practice to achieve and be an ally in 'unlocking of the door' for the inclusion and application of Aboriginal and Torres Strait Islander in nursing and midwifery education in Higher Education.

2 | AN ABORIGINAL AND TORRES STRAIT ISLANDER LED CULTURAL SAFETY CURRICULUM DEVELOPMENT PROCESS

An Aboriginal and Torres Strait Islander-led curriculum development process was undertaken, the aim of which was to inform cultural safety curriculum capabilities and learning outcomes (Department of Health, 2014; Rigney, 2006) of a curriculum innovation and initiative. The curriculum development process incorporated the following stages: 'Consultation and collaboration'; 'Policy and framework analysis' and alignment with Aboriginal and Torres Strait Islander conceptualisations of cultural safety in health, as outlined below.

2.1 | Consultation and collaboration

Knowledge holders and representatives of peak national Aboriginal and Torres Strait Islander organisations and leaders were involved in initial discussions about the cultural safety curriculum, including the National Aboriginal Community Controlled Health Organisation (NACHHO), CATSINaM, Aboriginal and Torres Strait Islander Allied Health Australia and the Australian Aboriginal and Torres Strait Islander Doctors Association to gain their feedback and support for the curriculum approach. An informal yarning methodology was conducted with 10 knowledge holders, elders and staff of the key Aboriginal and Torres Strait Islander Health organisations at a national level for consultation and input for curriculum development. Staff of national organisations included the health organisation, managerial and operational staff members and representatives of an Aboriginal and Torres Strait Islander knowledge holder strategy group.

2.2 | Policy and framework analysis

A review of nine policies and frameworks informing the development of the cultural safety curriculum was undertaken and included:

- The AHPRA and National Scheme's Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020–2025 (AHPRA, 2020)
- Aboriginal and Torres Strait Islander Health Curriculum Framework (Department of Health, 2014)
- National Aboriginal and Torres Strait Islander Health Plan (Australian Government, 2013)
- National Aboriginal and Torres Strait Islander Health Workers Association Cultural Safety Standards (National Aboriginal and Torres Strait Islander Health Workers Association, 2016)
- National Aboriginal Community Control Health Organisation Cultural Safety Standards (National Aboriginal Community Controlled Health Organisation, 2011)
- United Nations Declaration on the Rights of Aboriginal and Torres Strait Islander peoples (United Nations General Assembly, 2007)
- National Aboriginal Health Strategy (National Aboriginal Health Strategy Working Party, 1989)
- Racial Discrimination Act 1975 (Australian Commonwealth Government, 1975)
- Aboriginal Community Controlled Health Organisation Sector (National Aboriginal Community Controlled Health Organisation, 2016)

The analysis of these policies and frameworks was conducted through an audit of the occurrence of the key terms of 'cultural safety'. These Aboriginal and Torres Strait Islander Health policies, professional standards, curriculum design, adult learning principles and theories of cultural safety revealed the evolution and strengthening of cultural safety work over time. This analysis also identified a lack of elaboration of the term 'cultural safety' in key policy frameworks, which highlighted the need to update the Aboriginal and Torres Strait Islander Health Curriculum Framework (Department of Health, 2014). Cultural safety was identified as the outcome of the Aboriginal and Torres Strait Islander Health Curriculum Framework only.

The purpose of undertaking this policy and framework analysis was to understand the historical development of the term 'cultural safety' and to identify key frameworks, developed by key Aboriginal and Torres Strait Islander stakeholders and knowledge holders, that would inform the development of the curriculum.

As a result of these initial consultations and literature scoping, 5 capabilities and 24 topics were proposed for the cultural safety curriculum that included key topics such as racism. In January 2020, an audit of the occurrences of these 24 topic terms in the following Aboriginal and Torres Strait Islander strategies, frameworks and seminal research was conducted:

- National Aboriginal Health Strategy (National Aboriginal Health Strategy Working Party, 1989)
- Royal Australian College of General Practitioners Aboriginal Health Training Module (The Royal Australian College of General Practitioners, 1998)
- Cultural safety and nursing education in Aotearoa and Te Waipounamu (Ramsden, 2002)
- National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003–2013 (National Aboriginal and Torres Strait Islander Health Council, 2004)
- 2013–2023 National Aboriginal and Torres Strait Islander Health Plan (Australian Government, 2013)
- Aboriginal and Torres Strait Islander Health Curriculum Framework (Department of Health, 2014)
- Dancing with power: Aboriginal health, cultural safety and medical education (Phillips, 2015)
- National Aboriginal and Torres Strait Islander Health Workers Cultural Safety Framework (National Aboriginal and Torres Strait Islander Health Workers Association, 2016)
- AHPRA Strategy—National Scheme's Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020–2025 (AHPRA, 2020)

The results of the audit and analysis revealed two bodies of research that best encapsulated cultural safety in Australia, discussed below.

2.3 | Aboriginal and Torres Trait Islander conceptualisations of cultural safety—Elevating critical consciousness

The term 'cultural safety' came to prominence in two seminal bodies of research undertaken in Aotearoa/New Zealand by Irihapeti Ramsden in 2002 and in Australia by Professor Gregory Phillips in

2015 (Phillips, 2015; Ramsden, 2002). In this project, the cultural safety principles encapsulated within these two seminal bodies of research were synthesised and mapped to the Aboriginal and Torres Strait Islander Health Curriculum Framework (The Framework) (Department of Health, 2014). The Framework is a seminal work which aimed to guide best practice for Aboriginal and Torres Strait Islander Health curriculum, based on five capabilities: 'Respect', 'Communication', 'Safety and Quality', 'Reflection' and 'Advocacy'. The process of synthesising and mapping revealed that The Framework was lacking in its focus on the development of cultural safety (Department of Health, 2014). Contemporary approaches in cultural safety education require the inclusion of a broader focus on power differentials, institutional racism and 'whiteness' in the delivery of safe, accessible and responsive healthcare free of racism. Although these topics were identified in The Framework they were taught under the capability of 'Reflection' as opposed to the capability of 'Safety and Quality' that links cultural safety practises more strongly to quality standards in clinical practice (AHPRA, 2020; Phillips, 2015; Ramsden, 2002).

In February 2020 partnerships were developed with two leading Aboriginal educational academics who provided expertise in the development of a new cultural safety Curriculum Framework aligned to Ramsden's and Phillips' conceptualisations of cultural safety (Phillips, 2015; Ramsden, 2002). Their expertise identified the need to further develop The Framework with a heightened emphasis on cultural safety 'critical consciousness' as a beginning and an end point to promote cultural safety (Adams, 2007; Glover-Reed et al., 1997; Nicotera & Kang, 2009). Although The Framework included the 'Reflection' capability it was devoid of the specific topic of critical consciousness now central to the 'cultural safety' discourse.

'Reflection' is a capability that encompasses examination of health practitioners' dominant cultural paradigms that influence clinical interactions with Aboriginal and Torres Strait Islander patients. However, a more sophisticated framework was needed to extend individual consciousness, and account for the environment of healthcare organisations and systems (Department of Health, 2014). The new framework required that participants critically reflect on not only the individual but the social, political and environmental factors, which impact upon cultural safety. A revised framework renamed this 'Reflection' capability of The Framework as 'critical consciousness'. Critical consciousness, in contrast to reflection, is a deep part of emancipatory praxis where individuals first critically reflect on their place in society and further act to advance change beyond themselves. This emphasis on critical consciousness or transformative education through dialogue, requires a reflective awareness of, and action upon, societal conditions and inequities emphasising a more active personal self-reflection component (Freire, 1993; Halman et al., 2017).

Considerations were given to critiques of critical consciousness and to the appropriate positioning of the antiracism concept. Jemal (2017) detailed the consequence of sole reliance upon self-reflection as a proponent of change, to counter this the current implementation of critical consciousness theory and pedagogical practice with strongly utilised components of 'transformative potential'. 'Critical consciousness' and 'transformative reflection' were paired with 'transformative action' to guide participants towards the practical application of culturally safe practices. Similarly, analysis of antiracism sentiments identified inherent philosophical challenges, namely the antiracism approach to cultural safety delivers risk of perpetuating a deficit-based approach to behavioural change, further running the risk of victimisation and the privileging of paternalistic approaches by the novice reflective practitioner. Antiracism content was, therefore, relegated to inclusion within the curriculum as a relevant complimentary strategy, in unison with critical consciousness, rather than sole reliance on an antiracism approach to facilitate culturally safe practice. The revised critical consciousness capability, and its integral foundation of ongoing personal reflection, was considered the most efficacious vehicle for culturally safe practice.

In addition to the revised capability 'critical consciousness' it was further found that the 'Safety and Quality' capability of The Framework needed to be extended for better alignment with the insights of Ramsden and Phillips (Phillips, 2015; Ramsden, 2002). The 'Safety and Quality' capability was reorientated to capture how the framing of disease, its' diagnosis, and treatment and the cultural considerations which link to population health trends can be explicitly considered. The changes to the framework, therefore, directly linked cultural safety practices to quality standards in clinical practices as they apply to Aboriginal and Torres Strait Islander peoples. Reorientating the 'Safety and Quality' capability, in this process also subsumed the 'Communication' capability of the Health Curriculum Framework. The importance of applied knowledge of culturally safe health practices and partnerships with professionals, organisations and communities, previously contained in the 'Communication' capability of the Health Curriculum Framework was better aligned with the reorientated 'Safety and Quality' capability of the cultural safety curriculum (Department of Health, 2014). This better demonstrated the inextricable link that has been made between cultural and clinical safety.

2.4 | Cultural safety curriculum capabilities and learning outcomes

The way in which the Framework (Department of Health, 2014) was re-oriented to develop the Cultural Safety Curriculum Framework, capabilities and learning outcomes is summarised in Table 1. This reorientation occurred through an iterative process of developing new learning outcomes aligned to the new framework of 'critical consciousness' and 'Safety and Quality' in addition to the existing 'Respect' and 'Advocacy' capabilities of the framework (Department of Health, 2014). The iterative process also involved an amalgamation of a 'reverse curriculum planning process' whereby the 24 topics (previously identified from the initial consultations and literature scoping) informed the learning outcomes for each capability and the topics that would be included in each capability (Bessarab, 2015; Bin-Sallik, 2003; Martin & Mirraboopa, 2003).

TABLE 1 Conceptual reorientation for cultural safety curriculum learning outcome

Aboriginal and Torres Strait Islander Health Curriculum Framework and capabilities (Department of Health, 2014)	Aboriginal and Torres Strait Islander Health and Cultural Safety Curriculum Framework and capabilities	Cultural safety curriculum learning outcome
Respect	Respect	Reflect on Australia's shared history including the evolution of cultural safety initiatives and analyse its contribution to the current healthcare and health practitioner workforce inequities experienced by Aboriginal and Torres Strait Islander peoples
Advocacy	Advocacy	Propose evidence-based strategies to affirm human rights in Australia's health system
Reflection	Critical consciousness	Critically analyse the causes of everyday inequity and illuminate power structures in Australia's health system
Safety and quality Communication	Safety and quality	Design respectful strategies based on a shared language to design and deliver a health system free of racism

The alignment of learning outcomes to Bloom's Revised Teaching Taxonomy also ensured that the learning outcomes were pitched at the analysis level relevant to the adult learners of the curriculum (Atherton, 2013). The teaching taxonomy describes progressive stages of thinking and skill development. The learning outcomes were aligned with level iii. Entry to practice which requires practical skills and hands on engagement with evaluation in practice. This taxonomy provided a structure for mapping learning in stand-alone modules, aligned to the learning outcomes (Table 1), as well as horizontally (across) and vertically (within) across the modules of the curriculum.

A team of five Aboriginal and Torres Strait Islander multi-disciplinary academic staff and one non-Indigenous academic staff member worked collaboratively to develop curriculum content to meet the learning outcomes for each of the 4 modules, each including 3 topics, 12 topics in total. While a lead team member was allocated to each module, all team members supported each other with resources, links and relevant content for modules. The lead Aboriginal academic oversaw the development process and was responsible for amalgamating the final modules into a coherent final product.

A team of four senior Aboriginal and Torres Strait Islanders and two senior non-Indigenous academic staff members further developed the curriculum content to incorporate more rigour and depth into the curriculum. The pilot curriculum content was undertaken in its entirety by three Aboriginal and Torres Strait Islander academic and one non-Indigenous academic staff members, from a learner perspective, to check for consistency. Specific Aboriginal and Torres Strait Islander knowledge holders were asked to review the relevant components of the curriculum content that were aligned to their expertise and provide feedback. All feedback and suggestions for the final changes were collated and forwarded to the lead Aboriginal academic leader who approved the final changes. The final content was transformed into an online learning environment using the principles of adult learning and universal design (Bernacchio & Mullen, 2007; Rose, 2000).

In the face of a global pandemic, Aboriginal and Torres Strait Islander academics led the facilitation and transition to on-line collaborative sessions to facilitate learning content. Academics were debriefed before and after every collaboration session. To support the cultural safety curriculum, on-line resources were made available to learners on Indigenous HealthInfoNet website, an authoritative site in Aboriginal and Torres Strait Islander Health, has received more than 26,000 page views (Australian Indigenous HealthInfonet, 2020).

3 | REFLECTION ON THE EXPERIENCE OF A UNIQUE APPROACH

In reflecting on our experiences of the cultural safety curriculum development approach we applied, four unique points were highlighted. The following key points emerged as we engaged with the tensions that came with following an Aboriginal and Torres Strait Islander-led pedagogical approach which crucially contrasted with the westernised pedagogical approach:

- Relationality—To people, country and place.
- Critical consciousness preceded by necessary unlearning.
- Rigour of the pedagogical process.
- 'Walking the Talk'—Role modelling cultural safety.
- Intersectionality of Aboriginal Health and Aboriginal Education with mainstream health and education.

3.1 | Relationality—To people, country and place

An Aboriginal and Torres Strait Islander led approach grounds the centrality of 'relationship' in the way curriculum is developed. This relationality assisted in 'mapping the knowledge context' and in 'preparing the spaces' for deep active learning. More specifically, research and published knowledge was mapped in conjunction with

guidance from cultural knowledge holders to identify the origins of cultural safety, through to the current context and ways forward. This process informed content development, as well as ongoing acknowledgement of the efforts of those who 'had come before' regarding research as well as revered cultural knowledge holders who 'paved the way'. Relationality is also reflected in the extensive consultations engaged in with key elders and knowledge holders, peak Aboriginal and Torres Strait Islander organisations, professional bodies and groups. Dedication to a relational approach ensured that all relevant aspects of learning, including those from Aboriginal and Torres Strait Islander community members as patients and recipients of care from the health system, were considered in the development and delivery of learning experiences. The incorporation of historical mapping of Aboriginal and Torres Strait Islander Health and cultural safety education and training in Australia, illustrated in Figure 1, enabled relationality between contemporary learnings on a broader timeline of events, enabling learning from the past, and to propel learning and action into the future.

Consultation through focussed interviews with representatives from learning communities allowed ascertainment of individual, as well as organisational readiness for change, and facilitated a willingness to uphold and honour cultural safety principles. Overall, our focus on relationality and the collegial approach undertaken ensured that all involved were supported and maintained their own cultural safety in the process.

Aboriginal and Torres Strait Islander peoples' ways of knowing, being and doing in curriculum development and delivery paves a culturally safe way of developing and delivering curricula that maintains the cultural safety of academics and participants. In all interactions throughout the process, the Acknowledgement of Country and honouring Elders and ancestors' past, present and emerging is central to grounding the curriculum in the knowledge of place and the many peoples who informed the knowledge shared. In all interactions, the primacy of the curriculum approach also honoured relationships, recognising, respecting and acknowledging those who hold specific knowledge and expertise and emphasising that, rather than the product of a single perspective, cultural safety curriculum content was the culmination of many minds and lived experiences. This approach further upholds the cultural protocol of understanding the diversity of Aboriginal and Torres Strait Islander peoples, their connections to country and kin before the commencement of content delivery to establish lived experience perspectives and denote influences upon these diverse Aboriginal and Torres Strait Islander perspectives.

3.2 | Critical consciousness preceded by necessary unlearning

Critical consciousness is key to developing culturally safe practice in developing culturally safe education, hence cultural safety curriculum design must facilitate the opportunity to grow the critical consciousness of educators and learners. A significant amount of explicit 'unlearning' of dominant assumed knowledge, values and beliefs including conscious and unconscious biases needs to occur before educators and learners can truly 'hear' the messages related to developing culturally safe education, to move

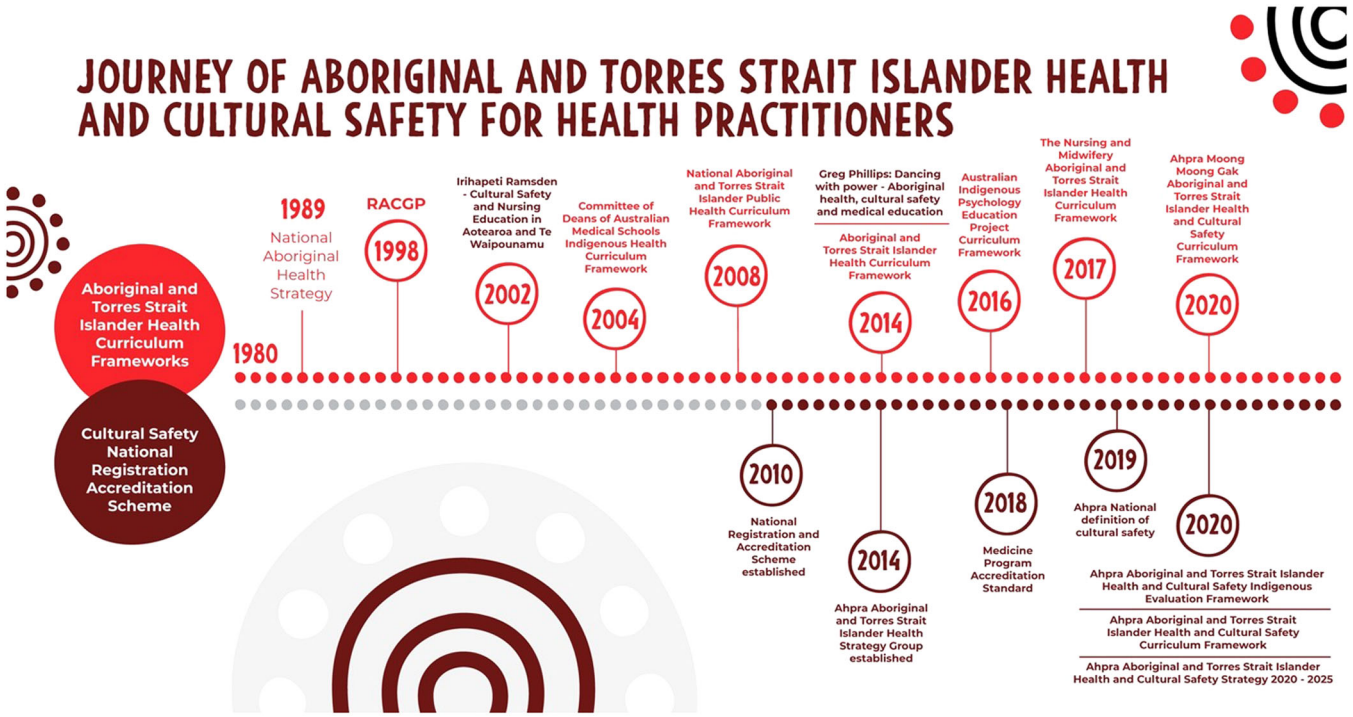

FIGURE 1 Journey of Aboriginal and Torres Strait Islander Health and cultural safety for health practitioners

towards culturally safe education spaces, and eventually to culturally safe practices.

Before participating in cultural safety education, many people may not have critically reflected on the extent to which Australia's dominant culture is dictated by 'white' and western cultural colonial worldviews and ways of knowing being and doing, often termed 'whiteness' (Phillips, 2015). Often, the invitation to make explicit, one's implicit assumptions can be challenging for participants as it may undermine their extant knowledge and concepts that they have founded their entire lives on. This invitation to critically reflect may be the first-time participants have considered that that education and health system have been developed on imperialism (Ramsden, 2002). Similarly understanding the unhelpfulness of often well-intentioned activism regarding Aboriginal and Torres Strait Islander issues is required to facilitate allyship processes between and among academics, with an emphasis on not perpetuating inequitable power dynamics and paternalistic actions. This learning typically arouses many emotions, denial, and defensiveness, also shock, anger, sadness, bewilderment, fear, and guilt for educators and learners. Managing these emotions and tensions at 'the cultural interface' is challenging for the development of cultural safety curriculum and for delivery by academics. However, recognition of the importance of the 'pedagogy of discomfort' is critical to facilitating transformational learning within this context, as well as the relationality which provides the necessary environment in which to transcend these tensions.

3.3 | Rigour of pedagogical process

Following a process of consultation, the number of academic staff and knowledge holders involved in the development, redevelopment and delivery of the updated curriculum included 12 people in addition to a team of 7 people who assisted with the development of online-based version of the curriculum. This number of personnel is indicative of the diversity and depth of expertise, experience and resource requirements, including time, for up to three iterations of the curriculum development, to produce a rigorous Aboriginal and Torres Strait Islander Health and Cultural Safety Framework that aims to increase the critical consciousness of learners. A crucial step in developing the framework was the rigorous process of mapping the term cultural safety in the current learning and teaching frameworks in Aboriginal and Torres Strait Islander Health. In this project, cultural safety was understood as an Aboriginal and Torres Strait Islander defined concept by Ramsden and Phillips, and these lenses were used to guide the development of learning objectives and topics for the cultural safety curriculum (Phillips, 2015; Ramsden, 2002). A critical outcome of this mapping process was the finding that among the 10 learning and teaching frameworks that currently guide the teaching of Aboriginal and Torres Strait Islander Health, cultural safety was not mentioned by a key framework that was previously in use, the Aboriginal and Torres Strait Islander Health Curriculum Framework (Department of Health, 2014).

3.4 | 'Walking the talk'—Role modelling cultural safety

The culturally safe process underpinning the cultural safety curriculum development was also unique to an Aboriginal and Torres Strait Islander led pedagogical approach. Literature reviews were undertaken privileging Aboriginal and Torres Strait Islander authors and Aboriginal and Torres Strait Islander clearinghouses of articles and databases, this is an important process as these sources are often excluded by western research methods (Chambers et al., 2018). Cultural safety of academics was also ensured through supportive relationships and humour through collaborative curriculum development processes. The focus on positive relationships is paramount to culturally safe processes for Aboriginal and Torres Strait Islander peoples.

The uniqueness of an Aboriginal and Torres Strait Islander led cultural safety curriculum development approach lies in its rigour, the experience and calibre of Aboriginal and Torres Strait Islander knowledge holders, and attention to the safety of the process for all collaborators. Cultural safety, or lack thereof, in health and other systems has real consequences for the lives of real people evident in across a range of sectors and outcomes published in the health literature (Awofeso, 2011; Bourke et al., 2018; Jennings et al., 2018; Marrie, 2017; Paradies, 2016). Applying Aboriginal and Torres Strait Islander knowledges and cultural safety in higher education including nursing and midwifery degree programmes can have a significant impact. Nurses are poised to be 'agents of disruption' however an Aboriginal and Torres Strait Islander led cultural safety curriculum development approach is required. This research highlights key considerations in this process including delivery approach necessitating specific Aboriginal and Torres Strait Islander knowledge, expertise, experience, leadership, more time and more resources are required in comparison with the traditional 'linear' curriculum development and delivery approach used within a singular often western worldview. All these considerations highlight contrasts between an Aboriginal and Torres Strait Islander worldview and the prevailing domain of most tertiary settings (Horrill et al., 2021).

It is also important in this approach that non-Indigenous academics are open to embrace an Aboriginal and Torres Strait Islander-led curriculum development approach, developing cultural humility together and understanding the magnitude and limits of each other's expertise. The non-Indigenous academic working with cultural humility is able to offer their expertise, and to share power in intentionally making space for Aboriginal and Torres Strait Islander knowledges and expertise, to act as a true ally, based on the needs and priorities of Aboriginal and Torres Strait Islander Health as defined by Aboriginal and Torres Strait Islander peoples for Aboriginal and Torres Strait Islander peoples.

4 | OPPORTUNITIES FOR ALLYSHIP

Strong relationships between academics are key to culturally safe practice for academics facilitating curriculum at the coalface of the cultural interface. Specifically, engagement with ongoing relational

check points to ensure shared objectives and clarity on curriculum standpoints are essential to allyship between Aboriginal and Torres Strait Islander and non-Indigenous academics. Prioritisation of timelines over strong relationships appears to be a common misstep in cross cultural partnerships of this nature that facilitate cultural unsafety for Aboriginal and Torres Strait Islander academics in the space.

A partnership approach between Aboriginal and Torres Strait Islander and non-Indigenous academics is pivotal in counteracting the power imbalances inherent in higher education to facilitate the inclusion and application of cultural safety education. Such partnerships empower Aboriginal and Torres Strait Islander and non-Indigenous academics to traverse through and role model the same process that they seek to facilitate with students.

To facilitate authentic allyship non-Indigenous academics must critically reflect, to challenge their own notions of privilege and 'whiteness', their identity as an academic, vested interests, reputation and career risks. There is much to be gained from working through these challenges, by taking the opportunity to contribute to a larger body of knowledge of how non-Indigenous academics can work collaboratively within an Aboriginal and Torres Strait Islander led approach that genuinely impacts on, and benefits, the lives of Aboriginal and Torres Strait Islander people.

The opportunity for non-Indigenous academics to also learn how to work and live by the principles of Aboriginal and Torres Strait Islander ways of knowing, being and doing, of the oldest continuous cultures in the world, is unparalleled. Ongoing processes of non-Indigenous academic staff continuously challenging their conscious and unconscious assumptions and biases and continually seeking these out in others and in the systems within which we work are necessary to the ongoing collaboration in this area and importantly role modelling for students and the broader nursing community of practice. Engaging in this process also provides the authenticity of a 'lived experience' that academics are then able to share with students and others. Maintaining and building trust, a critical element of cultural aafety, while continually paying attention to the relationships between Aboriginal and Torres Strait Islander and non-Indigenous academics is also of primary importance, including engaging in the necessary 'repair work' in the navigation of tensions and discomfort that are characteristics of the cultural interface (Ramsden, 2002).

5 | KEY LEARNINGS AND FUTURE DIRECTIONS

We highlight how these critical reflections can be applied in the nursing and midwifery profession. There have been several calls to action to address racism in healthcare by Aboriginal and Torres Strait Islander nursing and midwifery organisations, and more recently by Aboriginal and Torres Strait Islander nursing and midwifery leaders as in other health professions, calls for academics to 'step up' (Burnett et al., 2020; Doran et al., 2019; Geia et al., 2020; Power et al., 2021; Sherwood & Mohamed, 2020; West et al., 2017, 2019). Current arguments that there is 'not enough time', 'not enough resources', 'not enough professional development' to include and apply Aboriginal and Torres Strait Islander knowledges in cultural safety and into nursing and midwifery tertiary programmes are insufficient to address the disparities in health professions, disparities in education outcomes, and disparities in health outcomes. The existence of racism in healthcare points to a lack of professional integrity—and the need to acknowledge personal and institutional racism within nursing and midwifery (Geia et al., 2020; Marrie, 2017; Power et al., 2021).

The time to act is now and all nurses and midwives have a role. Given the increasing presence of Aboriginal and Torres Strait Islander nurses and midwives in the health workforce, non-Indigenous nursing and midwifery academics have a critical role to play in influencing change. Acknowledging how our cultural backgrounds influence health outcomes for people of cultural backgrounds other than our own is a life-long learning journey, that will involve making mistakes and critically reflecting upon and learning from these mistakes. The collective responsibility that comes with making a commitment to culturally safe care lies in continually challenging our own assumptions, values, and biases, conscious and unconscious. Continually challenging our privileges, and as academics and practitioners is about being aware of the inherent whiteness in our higher education and health systems that benefit non-Indigenous people. These benefits come from working and living on unceded Aboriginal and Torres Strait Islander lands.

In aligning ourselves as allies living and working on Aboriginal and Torres Strait Islander lands, and in taking responsibility for our own lifelong learning journeys we commit to using our own time to learn, to research, to read and privilege research by Aboriginal and Torres Strait Islander authors, to attend community events, to reach out to Aboriginal and Torres Strait Islander colleagues. This may also include supporting a different idea from Aboriginal and Torres Strait Islander colleagues, that may be perceived as 'risky', to foster culturally safer learning environments for Aboriginal and Torres Strait Islander students and culturally safer healthcare for Aboriginal and Torres Strait Islander people, and therefore for all Australians. We call for others to make this commitment too. This is what it means to be a true ally in our shared efforts to address racism in the higher education and healthcare systems and truly begin addressing Aboriginal and Torres Strait Islander educational, workforce and health inequities.

6 | CONCLUSION

Cultural Safety is more than 'antiracism'. Grounded in the sovereignty of Aboriginal and Torres Strait Islander people, cultural safety recognises the historical, political and contemporary oppression uniquely experienced by Aboriginal and Torres Strait Islander peoples. Frameworks of consultation, collaboration, policy and analysis aligned with Aboriginal and Torres Strait Islander conceptualisations of cultural safety in health, are key to Aboriginal and

Torres Strait Islander led curriculum development processes (Rigney, 2006). This Aboriginal and Torres Strait Islander-led curriculum development process, of applying a culturally safe approach highlights the necessity to address the foundations of racism experienced by Aboriginal and Torres Strait Islander peoples. As identified by many Aboriginal and Torres Strait Islander scholars—if we can get this right for Aboriginal and Torres Strait Islander people, we can get this right for everyone (Phillips, 2015).

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CONFLICT OF INTEREST

The authors declare no conflict of interest.

DATA AVAILABILITY STATEMENT

Data sharing is not applicable to this article as no data sets were generated or analysed during the current study.

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