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Paramedics' understandings and perceptions of cultural safety and the provision of culturally safe care

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Abstract

Background Aboriginal and Torres Strait Islander peoples experience persistent disadvantage and health inequity in today's society. It is widely accepted that this is resultant of Australia's colonial history. Current literature suggests that an increase in culturally safe care may assist in bettering the health outcomes of Aboriginal and Torres Strait Islander recipients of care. Research in nursing has suggested that cultural safety is largely misunderstood, however, there is no research into paramedic understanding of this approach.

Methods A qualitative descriptive design was adopted for this pilot study. Semi-structured interviews were held with six paramedics from December 2022 – February 2023. Interviews were transcribed verbatim, and data was analysed using reflexive thematic analysis. Findings were then critiqued against the cultural safety framework and the democratic racism framework.

Results Data identified four major themes; characteristics of being culturally safe, approaches to clinical practice, inferiority stereotyping and education.

Conclusions Limited understanding of cultural safety was identified in participant voices. Participants did not display critical cultural reflection, and instead discourses within a democratic racism framework were present. This suggests that for this small qualitative study, paramedic practice is not underpinned by the principles of cultural safety, thus questioning the provision of culturally safe care.

Keywords Cultural safety, Aboriginal and Torres Strait Islander peoples, Paramedicine

Background

Aboriginal and Torres Strait Islander peoples[1] have inhabited Australia for over 65,000 years [2]. Colonisation saw the destruction and fragmentation of family and community, traditional lands and cultural practices and the intergenerational trauma is reflected in the high rates of unemployment, incarceration, poor housing, and rates of chronic disease of Aboriginal and Torres Strait Islander peoples [3–5]. Although complex societies with holistic understandings of health and wellbeing including mental, physical, cultural, and spiritual health [2], the ongoing impact of colonisation on Aboriginal and Torres Strait Islander peoples' health is reflected in their disproportionately high rates of morbidity and mortality [5]. Today's society sees the perpetuation of a dominant story

[1] It is accepted preferred terminology varies and individuals and communities should be consulted to identify local preferred terminology. For transparency and to acknowledge the diversity and presence of distinct identities the term Aboriginal and Torres Strait Islander peoples has been used throughout this article [1].

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based upon western truths, encouraging deficit discourse and enabling the continuation of colonial approaches [3, 4, 6]. Best and Fredericks emphasise the importance of examining colonial practices through an historical lens and challenging the biomedical model that has seen Aboriginal and Torres Strait Islander peoples actively excluded from education throughout most of history [6].

Review of current literature shows many frameworks have been developed in an attempt to address and improve these health disparities, including cultural awareness, cultural sensitivity and cultural competency [7]. These approaches have been criticised for promoting narrow understandings of culture which sees the development of deficit-based views, normalisation of stereotyping, othering of racialized communities and the minimisation of the influence of socio-political structures [7]. These have also failed to address inequality rooted in systems of oppression, and Aboriginal and Torres Strait Islander peoples' morbidity and mortality remains disproportionately high [5].

Research suggests that application of a cultural safety framework would see improvement in Aboriginal and Torres Strait Islander peoples' health outcomes [3]. Originating in New Zealand, cultural safety was developed by Māori nurse-scholar Dr Irihapeti Ramsden [8]. Rooted in critical social theory, cultural safety is conceptualised in a postcolonial context [9]. The foundation of cultural safety is the recognition of the socio-political power structures that exist, and the acknowledgement that Aboriginal and Torres Strait Islander peoples receive care in the context of colonialism and systemic racism [4]. Whether a paradigm shift or an extension of previous concepts, cultural safety seeks to achieve better health care through decolonising, being aware of power relationships and implementing reflective practices [3].

Cultural Safety is being increasingly embedded into professional standards throughout Australia. Both the Nursing and Midwifery Board of Australia (NMBA) standards of practice [10] and the Paramedicine Board of Australia professional capabilities [11] dictate that practitioners must provide culturally safe care. The Paramedicine Board of Australia professional capabilities [11] state that practitioners must acknowledge colonialisation, be aware of their own biases, recognise the importance of self-determination and foster a safe environment through leadership to support Aboriginal and Torres Strait Islander peoples. Despite governing bodies for both paramedics and nurses articulating the importance of the provision of culturally safe care, research into cultural safety continues to grow in nursing, whilst remaining minimal in paramedicine.

Current literature into cultural safety in nursing demonstrates varying levels of understanding and application. For example, Marriott et al. [12] identified an inability to distinguish cultural safety from other cultural concepts, such as competency and sensitivity. They also found that although some participants were able to define cultural safety correctly, many demonstrated a lack of critical reflection, articulating racial assumptions and denying the presence of racism in the Australian maternal care system. Pirhofer et al.'s [13] exploration of cultural safety in advanced practice nurses found that of ten participants, nine answered *no* when asked 'do you provide culturally safe care?' Withall et al. [14] found that of the participants who identified an inability to provide culturally safe care, many were quick to divulge the barriers they believed were at fault for this, promoting the idea that these barriers were too significant to change.

These findings demonstrate that although varying levels of understanding and application exist in nursing practice, cultural safety is largely misunderstood and inadequately applied. Further, little published evidence was identified of research into cultural safety in paramedicine. With research suggesting that an increase in culturally safe practice would improve health outcomes for Aboriginal and Torres Strait Islander peoples [3], it is crucial to evaluate how this is being understood and implemented in the field of paramedicine.

Methods

Aim

This pilot study aimed to explore paramedics' understandings and perceptions of cultural safety and the provision of culturally safe care in the prehospital setting. Gaining insight into paramedics' knowledge of cultural safety and the provision of culturally safe care could aid in the improvement of Aboriginal and Torres Strait Islander peoples' health outcomes in the prehospital setting.

Methodology

This study adopted a qualitative descriptive design with an inductive approach to data analysis. This approach was employed to create a rich description of an experience depicted by information provided directly by those who have experienced the phenomena [15]. The use of a qualitative descriptive design was suitable as this research aimed to create a comprehensive summarisation of a concept and related experiences with limited time and resources [16, 17]. The study design enabled the researchers to directly address the research aim of exploring paramedics' understandings and perceptions of cultural safety, whilst remaining within the parameters and constraints of a pilot project. The COREQ criteria was applied to ensure the research process was rigorously and transparently reported [18].

Study design

Following ethics approval (H22311), participants were recruited using both consecutive and snowball sampling. To be eligible for participation, participants were required to have at least one year experience working as a paramedic within Australia. Project and participant information were detailed on a website shared on the University [redacted for anonymity] Alumni Facebook page and shared via email to potential participants. Minimal uptake was seen from the isolated use of the website, or from snowballing on participant social media or station email distribution lists. The inclusion of email and continued encouragement of snowballing identified nine possible participants, with three resulting in non-participation. A rolling recruitment phase was used, however slow uptake and the restricted timing of the associated study period meant that recruitment concluded with six participants. Of the six participants interviewed, experience ranged from five to seventeen years of clinical practice. Five participants were from a metropolitan zone, while one was from a rural zone. Five participants identified as female, and one identified as male. When asked if they identified with a cultural background, one participant identified as an Aboriginal person, while the other five said they did not identify with a cultural background. All six participants stated they had experience responding to Aboriginal and Torres Strait Islander recipients of care.

The method of data collection utilised for this study was semi-structured interviews. Data collection occurred between December 2022 and March 2023 via the online platform Zoom. Participants were emailed a consent form to be signed and returned to the primary author. Once this was received, a mutually agreeable date and time were set for an interview. Verbal assent, in addition to the original written consent provided, was also confirmed at the beginning of the interviews. Data was collected individually by the primary researcher, and both video and audio of the interviews were recorded. The duration of interviews ranged from 17 to 41 min, with no repeat interviews conducted. Interviews commenced with a description of the research purpose and aims, followed by the collection of participant demographics. Interviews were conducted using an interview guide (see Additional file 1) developed solely for this study and pilot tested with the first interview. The interview guide was developed based on current literature suggesting cultural safety is poorly understood and a disconnect between theoretical knowledge and practice exists [12–14]. Using the interview guide, participants were asked to draw on their lived experiences and discuss how they; responded to Aboriginal and Torres Strait Islander peoples, conceptualised cultural safety, provided culturally safe care and any perceived barriers & facilitators to the provision of culturally safe care. While themes had begun to saturate, the restricted timing of this project meant data collection was ceased after six interviews.

Upon the completion of each interview, audio transcription provided by the platform Zoom was reviewed by the primary researcher and any transcription errors were identified and corrected. Names were removed and replaced with numeric pseudonyms to ensure anonymity. All identifying information was removed from the data, such as station assignments and names of local medical centres. All participants were provided with their interview transcript and had a two-week period to make any desired changes, however, no requests for changes were made.

As this study aimed to explore culturally safe practice, in-depth interviews enabled broad yet thorough discussion about the paramedics' experiences. The flexible structure of the semi-structured interviews also enabled follow up questions and clarification, reduction of non-response and resulted in a granularity of data that was rich and fine in detail [19]. This approach promoted a relatively close relationship between the interviewer and interviewee, which potentially increased the credibility of the data by reduction of response biases such as acquiescence, satisfice and distortion of data due to what was deemed socially acceptable [19]. Furthermore, the emic perspective of the primary researcher, as a paramedic student, provided opportunity for a closer and more open relationship with the participants.

Analysis

The interview data was analysed using reflexive thematic analysis [20]. The research team followed the proposed 6-step process to analyse the data [20]. In the first stage, familiarisation, all interview transcripts were read by the primary author and initial annotations were made. In phase 2, all transcripts were imported into NVivo 12 and coded by the primary researcher. Following the first interview, preliminary coding was reviewed by all members of the research team with discussion resulting in increased descriptive NVivo coding and a focus on the inductive process [21]. In phase 3, the first author reviewed the existing codes for commonalities to build the themes. The broader research team then reviewed the themes in phase 4. The resultant coding framework was discussed, and in phase 5, the agreed-upon themes were defined and named (Table 1).

An extension of Braun and Clarke's [22] earlier approach, reflexive thematic analysis required the research team to be critically aware of their own

Table 1 Example of coding the theme *characteristics of culturally safe care*

Primary Theme	Subthemes	Example of NVivo Coding
Characteristics of Cultural Safety	Respect	*'So to me, cultural safety would be being respectful towards all cultures.'* (P3)
	Non-maleficence	*'Some of it's just out of not wanting to offend people by asking those questions.'* (P4)
	Responding to Individual Needs	*'Because you know although people may identify with some culture doesn't mean they carry all of those same ideas.'* (P5)

emotions, experiences, preconceived biases and how these impacted the research. As reflexivity is a core principle of the cultural safety framework [6], reflexive thematic analysis was a highly appropriate method of choice [6].

Upon completion of thematic analysis, resultant themes were critiqued against two frameworks. Initially, themes were searched for the incorporation of the key principles of the cultural safety framework [6]. Then, due to the emergence of conflicting notions, the broader sociocultural framework of democratic racism was applied to the findings [23].

As previously defined, cultural safety was conceptualised in a postcolonial context and aimed to address health disparity through the application of a biosocial-cultural framework [6]. Its core principles have been defined as decolonisation, power imbalances, reflexivity, dialogue and regardful care [6]. Application of the cultural safety framework allowed for comprehensible analysis of how participant understandings and perceptions converged and diverged from a correct conceptualisation.

The development of the democratic racism framework described the way in which individuals ignored the persistent implications of racist ideologies against the oppressed group in a democratic liberal nation by society being viewed as fair and just [24]. It contended that with overtly racist sentiments less common present-day, individuals often demonstrated ambivalent and contradictory discourses that attempted to conceal or justify such sentiments and resulted in discrimination normalised and prejudice denied [25–27]. The introduction of a democratic racism lens enabled further analysis of participant discourse and provided further insight into their perceptions of cultural safety [24].

Findings

Themes

Four general themes emerged from the data: *characteristics of culturally safe care*, *approaches to clinical practice*, *inferiority stereotyping* and *education*. The first theme portrays participant understandings of cultural safety and has three subthemes. The second theme outlines participant approaches to clinical practice within the context of cultural safety and has four subthemes. The third relates to the presence and cause of negative stereotyping in paramedic practice and has three subthemes. The fourth and final general theme depicts participants' belief in a need for education and has three subthemes.

Characteristics of culturally safe care

Participant references to the *characteristics of culturally safe care* were clustered into the subthemes *respect*, *non-maleficence* and *responding to individual needs*.

Respect Three participants felt that respect was a core characteristic of cultural safety. They spoke of the importance of respecting Aboriginal and Torres Strait Islander peoples and their beliefs, culture and communities. For example, P2 said:

> *being I guess, respectful of the community and their beliefs and their cultural differences.*

However, some participants noted that respect is not unique to culturally safe care, but instead is present and equally significant throughout all patient care. For example, P3 stated:

> *I always just respected everyone the same way. I didn't really change my approach to anything.*

Non-maleficence The second subtheme that emerged as a characteristic of culturally safe care was *non-maleficence*. Four participants recognised the importance of not harming Aboriginal and Torres Strait Islander peoples through causing offence or acting without consent. P1 for example stated:

> *trying to not harm or cause distress or offence to their individual culture through the way that you treat or speak to them.*

Moreover, emphasis was placed on creating an environment that fostered feelings of generic safety, with P6 referring to the importance of:

> *allowing them to feel safe in the environment that they're in.*

Responding to individual needs The third subtheme that emerged was *responding to individual needs*. Three participants spoke to the importance of adapting patient treatment to each individual and acknowledged that needs

may vary amongst Aboriginal and Torres Strait Islander peoples. P4 referred to this, stating:

> *It's just tailoring your needs to your patient for every patient.*

One participant felt that despite this importance, the pre-hospital environment does not offer Aboriginal and Torres Strait Islander peoples:

> *opportunities that are in line with their values and needs. (P5)*

Approaches to clinical practice

Participants' perceptions of the provision of culturally safe care and its presence or absence in paramedicine emerged as the subthemes of *clinical priorities*, *not front of mind*, *caution* and *treating everybody the same*.

Clinical priorities Two participants identified that clinical components of care are prioritised in paramedic practice. P1 stated:

> *It sounds quite harsh, but I find the sicker a person is, the more critical a patient is the less they get treated like an individual.*

Participants spoke to this prioritisation in time-critical instances, promoting the belief that medical intervention is viewed as of higher importance than cultural considerations. This is highlighted by P5, who stated:

> *We think from a clinical point of view.*

Not front of mind Two participants disclosed that cultural identity and its impact on treatment is not regularly front of mind throughout treatment. When asked to discuss how participants determined whether they were responding to an Aboriginal and Torres Strait Islander recipient of care, many stated they waited for:

> *visual clues (P4)*

to prompt their attention. For example, P4 stated:

> *just listening for those different clues looking for things like that, and then that will prompt me to ask. But it's never usually something that I lead with.*

Caution Four participants described feelings of caution and wariness, as well as displaying an apparent hesitation throughout data collection. This hesitation was closely linked to the fear of misspeaking, evident throughout discourse as P5 for example stated:

> *how do I say it?*

before continuing in their discussion. The sense of caution and wariness was in reference to avoiding causing offense. P4 highlighted this wariness, stating:

> *I think some of it's not even out of ignorance. Some of its just out of not wanting to offend people by asking those questions.*

Another participant described feelings of wariness regarding their personal safety. P3 stated:

> *so, we're always sort of a bit wary of going into the community.*

Treating everybody the same Two participants concluded that their treatment remains the same between Aboriginal and Torres Strait Islander recipients of care and those of the wider community. An example of this, P2 stated:

> *I don't think I treat them differently because I guess I always ask my patients before I do anything, like cannulate or do anything.*

Similarly, P3 stated:

> *I didn't really change my approach to anything.*

Both statements reflect the belief that participants provide the same, high standard quality of care for all patients without specific consideration of culture.

Inferiority stereotyping

The theme *inferiority stereotyping* was formed by the subthemes of *bias or judgement*, *skewed perceptions*, and *negative stereotypes.*

Bias or judgement Three participants recognised biases and judgements as factors that hinder the provision of cultural safety yet continue to exist in paramedic practice. These were identified as preconceived ideas, underlying prejudices, judgements passed covertly, and opinions formulated elsewhere. P4 stated:

> *I know there are some paramedics that will go into that job looking for those symptoms and misdiagnoses, "poor woman", who's probably got something critically wrong with her, based on this; on their preconceived idea about what they were going to.*

Skewed perceptions Two participants felt that these biases and negative stereotypes were caused or impacted by the skewed perceptions of Aboriginal and Torres Strait Islander peoples' culture resulting from the nature of paramedic practice. For example, P3 stated:

Yeah, it is hard in a role that you are called only to emergencies, and a lot of emergencies happen to be violent in nature. Yeah. You can see how people's perception gets skewed.

Negative stereotyping Two participants felt that negative stereotyping is still present in the pre-hospital setting, with P4 stating

absolutely there's stereotypes.

Some provided examples of negative stereotypes towards Aboriginal and Torres Strait Islander peoples, such as P3:

I've seen lots of paramedics hold on to that one bit like maybe they'll hold on to the D [domestic] and V [violence] that occasionally we see and hold on to that one bit and then play off that stereotyping.

Others recognised stereotyping as present but provided examples unrelated to Aboriginal and Torres Strait Islander peoples. P3 perpetuated a negative stereotype, stating:

and alcohol was always involved, like drug and alcohol with these particular people.

Education

The theme *education* was formed by the subthemes of *lack of education*, *specific education* and *need for education.*

Lack of education Four participants perceived there to have been a lack of education throughout their experience as a paramedic. This scarcity was identified as limited tertiary education prior to employment, reduced placement hours and mentorship opportunities, and finite training once within the service.

Specific education Of the limited education identified as being received, two participants felt this education was not specific enough to paramedicine. Instead, tertiary education courses were designed for healthcare in general, omitting the nuances of the pre-hospital environment. P5 stated:

so it wasn't specific to paramedics. But we did do an Indigenous health unit in that.

Need for education Associated with the belief of a lack of education, three participants felt that further education is a necessity in increasing the provision of culturally safe care. For example, when asked what could help facilitate culturally safe care, P1 stated:

just more general education.

Application of frameworks

Cultural safety framework

Once thematic analysis was completed, the emerged themes were searched for the incorporation of the key principles of the cultural safety framework; being decolonisation, power imbalances, reflexivity, dialogue and regardful care [6] (Table 2).

Analysis of the resultant themes against the five key principles of the cultural safety framework depicted clear omission of the principles of decolonisation, power imbalances and reflexivity. No reference to Australia's colonial history or its subsequent effect on Australia's socio-political context or recipients of care were made by participants. Acknowledgement of power imbalances was also absent throughout participant voices, with deficit-based views identified in lieu. This was particularly evident within the theme *inferiority stereotyping*, as participants made reference to Aboriginal and Torres Strait Islander peoples and low socio-economic status. In conjunction with its termed omission by participants, a lack of reflexivity was identified within the theme *inferiority stereotyping*. *Inferiority stereotyping* and its subthemes saw participants identify the presence of biases in paramedicine, albeit with no acknowledgement or provision of their own. Although participants identified such biases and proposed reasons for their developments, there was an apparent lack of reflection into how these could influence interactions with Aboriginal and Torres Strait Islander recipients of care. The subthemes *not front of mind* and *treating everybody the same* saw participants express that their provision of treatment was not impacted nor altered by the cultural identity of the recipient of care. Likewise, there was no acknowledgement of how participants' own cultural identity could influence interactions within care; both considerations which must be present in reflexive practice. Contrarily to the aforementioned principles, dialogue and regardful care were identified in some capacity throughout themes.

The principle of dialogue was alluded to in the subthemes *caution* and *non-maleficence*. In both, participants identified the importance of not causing distress or offence through communication. In reference to the principle of regardful care, themes highlighted a contradiction between theory and actual provision of care. The theme *characteristics of culturally safe care* demonstrated that participants believed respect to be a core component in culturally safe care, speaking of the importance of respecting Aboriginal and Torres Strait Islander peoples and their beliefs, culture and communities. This was furthered with discussions of ensuring treatment is adapted to meet the needs of individual patients, as seen in the subtheme *responding to individual needs*. Despite this, the subtheme *treating everybody the same*, demonstrated

Table 2 Application of the cultural safety framework to themes

Themes	Subthemes	Key Quotes	Cultural Safety Framework
Characteristics of Culturally Safe Care	Respect	*'being I guess, respectful of the community and their beliefs and their cultural differences.'* (P2)	The foundation of cultural safety is the acknowledgment that Aboriginal and Torres Strait Islander peoples receive care in the context of colonialism and systemic racism. The key principles of the cultural safety framework are decolonisation, power imbalances, reflexivity, dialogue and regardful care.
	Non-maleficence	*'trying to not harm or cause distress or offence to their individual culture through the way that you treat or speak to them.'* (P1)	
	Responding to Individual Needs	*'it's just tailoring your needs to your patient for every patient.'* (P4)	
Approaches to Clinical Practice	Clinical priorities	*'we think from a clinical point of view.'* (P5)	Cultural safety requires the application of reflexivity in practice to consider and address power imbalances that are both inherent to healthcare and exist in Australia's post-colonial context. Cultural safety encourages open and respectful dialogue that aids in creating a safe environment for Aboriginal and Torres Strait Islander peoples to receive care.
	Not Front of Mind	*'Yeah, just listening for those different clues looking for things like that, and then that will prompt me to ask. But it's never usually something that I lead with.'* (P4)	
	Caution	*'I think some of it's not even out of ignorance. Some of its just out of not wanting to offend people by asking those questions.'* (P4)	
	Treating Everybody the Same	*'I didn't really change my approach to anything.'* (P3)	
Inferiority Stereotyping	Bias or Judgement	*'I know there are some paramedics that will go into that job looking for those symptoms and misdiagnose… based on this; on their preconceived idea about what they were going to.'* (P4)	The cultural safety framework challenges discursive practices associated with deficit approaches to care. It places emphasis on the influence of socio-political power structures and postcolonial context upon Aboriginal and Torres Strait Islander peoples' health outcomes. It opposes beliefs perpetuated by the deficit model of care that places responsibility for issues on the affected group and sees blame moved away from systems of oppression.
	Skewed Perceptions	*'Yeah, it is hard in a role that you are called only to emergencies, and a lot of emergencies happen to be violent in nature. Yeah. You can see how people's perception gets skewed.'* (P3)	
	Negative Stereotyping	*'… and alcohol was always involved, like drug and alcohol with these particular people.'* (P3)	
Education	Lack of Education		Cultural safety aims to move away from an emphasis on education often seen in other cultural frameworks such as awareness and competency, and instead focuses on decolonising approaches to care through reflexivity and awareness of systems of oppression.
	Specific Education	*'so it wasn't specific to paramedics. But we did do an Indigenous health unit in that.'* (P5)	
	Need for Education	*'just more general education.'* (P1)	

that treatment is rarely altered when providing care to Aboriginal and Torres Strait Islander recipients of care.

Democratic racism framework

Through the application of the democratic racism lens, associated notions and discursive practices were identified throughout participant voices (Table 3).

Throughout themes use of othering and deficit-based language was identified. Both were seen clearly in a quote made by P3:

> *and alcohol was always involved, like drug and alcohol with these particular people.*

The discourse of denial was identified throughout patient voices through the lack of reference to colonialism and the minimisation of its impact in healthcare. Denial discourse and its attempt to justify racist ideologies was particularly evident in the subtheme *not front of mind*, whereby P1 stated:

> *Most people are good people trying to do the right thing. But if they just haven't heard of something, or are unaware of it, unaware that maybe a certain culture holds a certain belief, then they're not going to think of asking about it.*

The discourse of culturalism was evident in the theme *education*; whereby ethnocentric views were promoted as participants stated they felt further education would be a core facilitator in the provision of culturally safe care. The discourse of political correctness was evident in the subtheme *caution* where participants were seen speaking with hesitation and an apparent fear of misspeaking. For example, P5 stated:

> *how do I say it?*

in an attempt to restrict and filter their language to avoid saying something deemed politically incorrect. Strong notions of egalitarianism were seen with the subtheme *treat everyone the same* as participants reported that their patient approach and treatment tend not to differ when with Aboriginal and Torres Strait Islander recipients of care.

Table 3 Application of the democratic racism framework to themes

Themes	Subthemes	Key Quotes	Democratic Racism Framework
Characteristics of Culturally Safe Care	Respect	*'I always just respected everyone the same way. I didn't really change my approach to anything.'*(P3)	Associated with the democratic racism framework are notions of egalitarianism. Unlike equity-oriented care, an egalitarian approach describes a provision of care that does not vary amongst recipients of care. This ideology ignores the inequalities that exist throughout those positioned differently in the social hierarchy, nor does it acknowledge the impact of colonialism on these socio-political structures.
	Non-maleficence	*'trying to not harm or cause distress or offence to their individual culture through the way that you treat or speak to them.'* (P1)	
	Responding to Individual Needs	*'it's just tailoring your needs to your patient for every patient.'*(P4)	
Approaches to Clinical Practice	Clinical Priorities	*'we think from a clinical point of view.'* (P5)	Othering language sees construction of the Other and creates a normative perception of the Us and positions groups as incompatible. The discourse of political correctness associated with democratic racism is considered an aversive form of racism whereby discussions of race and racism are restricted by fear of dialogue that may be deemed politically incorrect.
	Not Front of Mind	*'Yeah, just listening for those different clues looking for things like that, and then that will prompt me to ask. But it's never usually something that I lead with.'* (P4)	
	Caution	*'how do I say it?'*(P5)	
	Treating Everybody the Same	*'I don't think I treat them differently because I guess I always ask my patients before I do anything, like cannulate or do anything.'* (P2)	
Inferiority Stereotyping	Bias or Judgement	*'I know there are some paramedics that will go into that job looking for those symptoms and misdiagnose… based on this; on their preconceived idea about what they were going to.'* (P4)	The foundation of the democratic racism framework is the ideology that racism is a rarity in liberal democratic societies such as Australia. Denial of such racism upholds systems of oppression and enables systemic racism to persist. Within the democratic racism framework, deficit discourse places responsibility for issue on the affected group, positioning them at fault and incompatible with western structures of healthcare. This again averts criticism away from socio-economic structures and their influences on Aboriginal and Torres Strait Islander peoples' healthcare outcomes.
	Skewed Perceptions	*'Yeah, it is hard in a role that you are called only to emergencies, and a lot of emergencies happen to be violent in nature. Yeah. You can see how people's perception gets skewed.'* (P3)	
	Negative Stereotyping	*'… and alcohol was always involved, like drug and alcohol with these particular people.'* (P3)	
Education	Lack of Education		Sentiments such as a lack of education regarding Aboriginal and Torres Strait Islander peoples' culture being at fault for provision of culturally unsafe care is strongly associated with democratic racism and is often perpetuated through the discourse of culturalism. Discourse such as that of culturalism enables racism to be reduced to ethnocentrism, directing focus towards understanding diverse cultures and averted from structural and ideological influences on health.
	Specific Education	*'so it wasn't specific to paramedics. But we did do an Indigenous health unit in that.'* (P5)	
	Need for Education	*'just more general education.'* (P1)	

Discussion

With research suggesting that application of a cultural safety framework would see improvement in Aboriginal and Torres Strait Islander peoples' health outcomes [3], this study sought to explore the understandings and perceptions of cultural safety and the provision of culturally safe care amongst paramedics. Critique of the four general themes; *characteristics of culturally safe care*, *approaches to clinical practice*, *inferiority stereotyping* and *education* and the presence of discursive practices associated with the democratic racism framework suggest cultural safety is poorly understood and implemented. With reference to such discourse throughout, the core principles of cultural safety; decolonisation, power imbalances, reflexivity, dialogue and regardful care provide a framework to facilitate articulation of participant perceptions and understandings.

Decolonisation

Cultural safety is unique in its focus on decolonising healthcare through acknowledging the colonial context in which Aboriginal and Torres Strait Islander peoples receive care. This foundational element acts to oppose the fundament of democratic racism that averts focus from systems of oppression and places responsibility onto the affected group. There was an apparent omission of any reference to colonialism throughout themes, instead participant voices exhibited discourses of denial, culturalism, political correctness, egalitarianism and the deficit model.

The discourse of denial is argued to be the fundamental rhetorical strategy of democratic racism [24]. In a liberal democratic society such as Australia, racism is deemed antithetical and therefore rendered a rarity [28]. The essentialist conceptualisation of 'culture' exists within the discourse of denial, acting to avoid terms of race and racism. Similarly, the discourse of political correctness is understood to be a form of aversive racism whereby

discussions of race are controlled and restricted by the fear of expressions that may be deemed politically incorrect. This phenomenon paradoxically averts discussions from racism and health inequity to enable racialisation through other forms [28].

The culturalism discourse enables racism to be reduced to ethnocentrism, with the focus directed toward understanding diverse cultures and averted from structural and ideological influences on health inequities [29]. Cultural safety aims to move away from an emphasis on education and instead focuses on decolonising through reflexivity and awareness of systems of oppression [3].

The strong notions of egalitarianism present in participant voices highlight a fallacious understanding of the provision of culturally safe care. The egalitarian approach to care described by participants imply that Aboriginal and Torres Strait Islander peoples receive the same high standard of care as their non-identifying counterparts [30]. For an egalitarian sentiment such as this to be warranted is the assumption that all individuals have equal opportunity and freedom. Within the larger discursive and socio-political contexts of Australian society today, persistent inequalities exist throughout those positioned differently in the social hierarchy, rendering an egalitarianist approach grossly inappropriate [30]. Current literature argues that equity-oriented care produces improved health outcomes for Aboriginal and Torres Strait Islander peoples, rather than the equality focused approach seen in egalitarianism [30]. The implication of the egalitarian approaches to healthcare detailed by participants is again the denial of the influence of the socio-political context and the furthering of its impact on Aboriginal and Torres Strait Islander peoples' health outcomes.

Deficit discourse places responsibility for issues on the affected group, moving blame away from the healthcare system and broader socio-economic structures and instead supporting the perception of Aboriginal and Torres Strait Islander peoples as problematic to the wider population, and that they require attempts to be 'fixed' [31–34]. It also perpetuates the interpretative repertoire of culture as a burden whereby the stereotypical perceptions of Aboriginal and Torres Strait Islander peoples are positioned at fault and incompatible with the western design and structure of healthcare [31, 35, 36]. Alongside the absence of the principle of decolonisation within themes, the use of such rhetoric in participant voices acts to further minimise the impact of systemic racism in healthcare delivery and demonstrates poor understanding of the cultural safety framework [28].

Power imbalances

Acknowledgement of power imbalances was absent from participant voices, instead a high incidence of othering language was noted. Othering language creates an asymmetric dichotomy [37] leading to dynamic power imbalances and its use further perpetuates those inherent in healthcare. The construction of the Other subsequently creates a normative perception of the Us and categorises groups as incompatible [37]. In conjunction with the discourse of denial, participant use of deficit discourse such as othering furthers inherent power imbalances and subsequently perpetuates social exclusion, reinforces disparity and can be detrimental in access to health care [37].

Reflexivity

In conjunction with recognition of colonialism and power imbalances, provision of culturally safe care requires reflexivity to be applied to practice. Reflexivity is vital in the provision of culturally safe care as consideration of the influence of one's own cultural identity within the context of colonialism, current socio-political structures and the power imbalances inherent to healthcare must occur to ensure cessation of colonial approaches to care. With no acknowledgement or demonstration of reflexivity by participants, it can be assumed that their provision of care is not culturally safe.

Dialogue

Minimal reference to dialogue was seen within the themes that emerged from the data. Despite identifying the need for respectful communication without the infliction of harm upon Aboriginal and Torres Strait Islander recipients of care, participants appeared unable to provide further explanation or examples of dialogue within the context of the cultural safety framework.

Regardful care

Although the principle of regardful care was identified within the themes that emerged from the data, there was notable contradiction between participant perception of regardful care as an element of cultural safety and the description of how similar notions manifest in practice. Despite depicting a perceived importance of respecting Aboriginal and Torres Strait Islander peoples' culture and providing care in accordance with individual needs, participants went on to admit that in practice there is rarely consideration of the recipient of care's cultural identity, nor any subsequent altering of approach to treatment. This disparity is supported by current literature that reports a disconnect between theoretical knowledge and practice.

It is important to note that although the two cultural safety principles of dialogue and regardful care were identified within themes, both elements converge with aspects seen in formerly utilised cultural frameworks. Previous research into the understandings of cultural safety found it to be poorly distinguished from other

cultural concepts, such as competency and sensitivity [12]. The cultural safety framework differentiates itself from preceding approaches to addressing health disparities with its acknowledgement and emphasis on the context of colonialism and systemic racism in which Aboriginal and Torres Strait Islander peoples receive care [3, 4]. The identification of the principles of dialogue and regardful care with the omission of decolonising, power imbalances and reflexivity suggest in alignment with current literature that participants have a fallacious conceptualisation of cultural safety and one that is more alike preceding frameworks. These formally utilised cultural frameworks, with the inclusion of cultural awareness, have been criticised for their promotion and development of deficit-based views, normalisation of stereotyping, othering of racialized communities and the minimisation of the influence of socio-political structures. These critiques were present throughout patient voices and resultant themes, again supporting current literature and suggesting participants lack the understanding of the core elements of cultural safety that differentiate it from earlier frameworks. Further, the presence of such deficit-based views and minimisation of the impact of systems of oppressions highlight the importance of accurate conceptualisation and implementation of the cultural safety framework.

Despite the provision of culturally safe care being identified as a professional capability by The Paramedicine Board of Australia [11], the findings of this study suggest that such care is not being provided. With participants unable to define cultural safety or identify its distinguishing fundaments, deficit-based views and the minimisation of the influence of socio-political structures continue to underlie the provision of care and enable the perpetual and disproportional rates of morbidity and mortality for Aboriginal and Torres Strait Islander peoples. This suggests prehospital care in Australia is another structural vulnerability for Aboriginal and Torres Strait Islander peoples.

With research suggesting that the successful application of a cultural safety framework would see improvement in Aboriginal and Torres Strait Islander peoples' health outcomes, there is significant need for such framework in paramedicine with an accurate understanding of it as a concept and how it translates into the provision of care. The erroneous understanding of cultural safety demonstrated suggests a need for the implementation of cultural safety discussions into pedagogy and praxis for paramedics, with pre-service and practicing education focused on improving the health disparities experienced Aboriginal and Torres Strait Islander peoples. The evidence from this pilot study suggests the need for undertaking a similar study at scale and working towards co-designing and trialling creative approaches to embedding cultural safety into education and practice driven by discussions with Aboriginal and Torres Strait Islander cultural advisory groups.

Conclusion

Aboriginal and Torres Strait Islander peoples receive healthcare in a colonised context resulting in persistent health inequalities [3, 4]. Previous research has suggested that an increased emphasis on culturally safe care could aid to improve health outcomes for Aboriginal and Torres Strait Islander peoples and decrease health inequity [3]. This study aimed to explore paramedics' understandings and perceptions of cultural safety and the provision of the culturally safe care. The results demonstrate that participants' have an erroneous understanding of cultural safety as the conceptualisations expressed do not reflect the core principles of decolonising, power imbalances, reflexivity, dialogue and regardful care and the provision of care described displays similarity with deficit approaches associated with the democratic racism framework. This apparent misconception suggests a need for the implementation of cultural safety discussions into pedagogy and praxis for paramedics with education focused on improving the health disparities experienced by Aboriginal and Torres Strait Islander peoples. The evidence from this pilot study suggests need for similar research to be undertaken at scale, working towards co-designing and trialling approaches to embedding cultural safety into education and practice.

Limitations

As a small qualitative pilot study, this research is limited by the participant size, and the closeness in geographical proximity. The time constraints of this project meant that data collection was unable to continue until saturation was reached. The findings of this study are not generalisable but lay a foundation for the need for more investigation into cultural safety in paramedic practice.

Supplementary Information

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Supplementary Material 1.

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Authors' contributions

G.L created the study design, completed the data collection and primary analysis. J.G and B.S, responsible for primary supervision and secondary supervision respectively, provided guidance regarding data collection and data analysis. All authors prepared and reviewed the manuscript.

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Data availability
The datasets generated and/or analysed during the current study are not publicly available as to protect participant privacy but are available from the corresponding author on reasonable request.

Declarations

Ethics approval and consent to participate
This research project was performed in accordance with the Declaration of Helsinki and approved by the Charles Sturt University Human Research Ethics Committee. The provided reference number is H22311.
Written informed consent was gained by all participants prior to data collection through consent waivers and confirmed again verbally at the commencement of all interviews.

Consent for publication
Not applicable.

Competing interests
The authors declare no competing interests.

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