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Discussion

Cultural Safety and clinical safety: A symbiotic relationship for improving Aboriginal and Torres Strait Islander Peoples and Communities' health outcomes

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In Australia, it is widely acknowledged that Indigenous Australians have been significantly traumatised by invasion, ongoing colonisation and the impact of previous racist government policies, creating cycles of disadvantage and inequality. Racism remains a major determinant of poor health, impacting daily life and wellbeing - central to the national 'Closing the Gap' initiative. Health administrators and researchers often misinterpret these issues, viewing Indigenous health through a deficit-based lens.

Discussion: While the link between Cultural Safety and patient outcomes is clear, consistent application in practice is lacking. Cultural Safety is equally vital as clinical safety in ensuring quality care, particularly for Indigenous Australians affected by culturally unsafe practices.

Recommendations: In healthcare delivery Indigenous Australians health and the 'Closing the Gap' agenda is everybody's business, it is not the responsibility of the patient, their family or their Community. The authors propose a reconceptualisation of the way health and wellbeing is perceived by health professionals, in which providing culturally safe care is symbiotic with providing clinically safe care. As an integrated foundation for quality and safety in health care, this strategy brings together the social determinants of culturally safe care with competent, evidence-based, equitable and non-bias care for all, and could help advance the Closing the Gap agenda.

Keywords: Australian Indigenous Peoples; Cultural Safety; clinical safety; Closing the Gap; quality and safety; Aboriginal and Torres Strait Islander Peoples; nursing and midwifery; racism

Impact statement

In healthcare, Aboriginal and Torres Strait Islander Peoples health is everybody's business, and so is The Closing the Gap agenda, and neither are the responsibility of the patient, the family or their Community. Cultural Safety is symbiotic with the providing clinically safe care. An integration and acknowledgement of all healthcare professionals regarding Cultural Safety and clinical safety will improve quality and safety in healthcare for all.

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Throughout this paper 'Indigenous Australians' will be used to represent Aboriginal and Torres Strait Islander Peoples of Australia.

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Plain language summary

Every registered healthcare professional has an accountability to quality and safety mechanisms and frameworks that can be measured and determined, yet much of the delivery of culturally safe care is not aligned to guidelines, procedures, or frameworks. It relies on the practitioner considering Cultural Safety practice as important and an essential component of care in every patient interaction.

Due to ongoing health outcomes of Indigenous Australians, there is urgency in ensuring that both the safety and quality related to patient care needs are addressed. The urgency lies in the need to have healthcare services practice in culturally safe ways to begin to address the Closing the Gap agenda. Indigenous Australians' health is often discussed in negative ways, which only further impacts health and wellbeing. Systemic and inherent racism further contribute to poorer health outcomes. The impact of invasion and past racist policies have further contributed to poor health outcomes and ongoing inequality in health and wellbeing.

This paper provides recommendations for educational and industry implementation to further strengthen quality and safety in healthcare delivery for Indigenous Australians. Operationalising the implementation of both Cultural Safety and clinical safety would ensure that all Indigenous Australians and their families would be much more likely to receive care that sheds factors such as systemic racism and discrimination and focuses on holistic and safe care.

Background

In Australia, the historical and ongoing impacts of invasion, colonisation, and racist government policies towards Indigenous Australians have caused profound trauma, contributing to current health and wellbeing inequalities (Kairuz et al. 2021). These conditions result in a higher disease burden and poorer health outcomes, including reduced life expectancy, further compounded by loss of connection to Country, family, language, identity and culture (Cox et al. 2021; Nolan-Isles et al. 2021). Racism is a key health determinant and significantly affects Indigenous People's daily lives and capacity to live well (Australian Institute of Health and Welfare [AIHW] 2024). For many, not living well is tied to experiences of racism, chronic illness, and exposure to culturally unsafe healthcare (Blow 2019; Geia et al. 2020; The Lamp 2018). Indigenous health data is often framed through a deficit lens, reinforcing stigma, discrimination, and racism (Nolan-Isles et al. 2021). When healthcare providers fail to sensitively address these issues, patient safety and care quality are compromised. This paper argues that implementing both Cultural Safety and clinical safety are essential to improving health outcomes for Indigenous Australians. It also contends that without integrating Cultural Safety with clinical safety, efforts to meet Closing the Gap (CTG) targets will remain ineffective for Indigenous Australians, their families, and Communities. This notion is further supported by the seminal work of Ramsden (2002) who espoused that both Cultural Safety and *all* aspects of patient safety are the responsibility of the nurse.

The predicament

Due to the poor health outcomes of Indigenous Australians, there is an urgent need to ensure that both the safety and quality related to patient care needs are addressed for this population, which must undoubtedly be inclusive of Cultural Safety (Australian Health Practitioner Regulation Authority [Ahpra] 2020; McGough et al. 2022). The urgency lies in the need to have healthcare services that are culturally safe for Indigenous Australians to receive optimal care for their health conditions (De Zilva et al. 2022; Mohamed et al. 2024). Current health status of Indigenous

Australians indicates that there are many existing barriers preventing them from actively engaging in a good life, with two examples of chronic diseases being the higher incidence of respiratory diseases, and the increasing prevalence of kidney disease and failure requiring dialysis (AIHW 2024). The CTG targets highlight additional health disadvantages specifically prevalent in this population that also need to be addressed urgently.

Culturally safe healthcare has the potential to improve health and life expectancy outcomes for Indigenous Australians (Hall et al. 2023). Current data shows Indigenous Australians live significantly shorter lives than non-Indigenous Australians, with a gap of 8.8 years for males and 8.1 years for females (Australian Bureau of Statistics 2023a). To address this disparity, the National Agreement on CTG was introduced in 2007. The first baseline statistics were reported in 2008, yet as of 2025, many of these health gaps remain unresolved (National Indigenous Australians Agency 2025).

Racism and stereotyping continue to undermine health professionals' ability to deliver culturally safe care due to entrenched racial biases (Best et al. 2025; Hall et al. 2023). One such stereotype "Aboriginal patients are under the influence of alcohol or other drugs" exposes the systemic and structural nature of racism in healthcare, resulting in unfair, unequal, and insensitive care. These examples of racial bias were identified by Health Service Providers, key senior Western Australian Health Staff, primary health and mental health staff within Western Australia in the consultative process of "Take own Leave" (Aboriginal Health Policy Directorate 2018; Phillips 2015). Such behaviours significantly affect patients, contributing to poorer outcomes and increased rates of discharge against medical advice (DAMA) among Indigenous Australians, and are driven by a lack of both clinical and Cultural Safety (Curtis et al. 2019). This results in unacceptable levels of unsafe care, including preventable deaths (Yoorook Justice Commission 2024) and higher rates of mortality and morbidity (Orbin et al. 2024). Greater efforts are needed to ensure quality and safety frameworks actively address racism, and that policies for reporting racism are enforced to ensure the provision of Cultural Safety to Indigenous Peoples, in all healthcare settings.

Cultural Safety is a healthcare approach that recognises, respects, and supports the patient's cultural identity whilst challenging power imbalances, institutional discrimination, racism, and historical disadvantage (Curtis et al. 2019; Ramsden 2002). It extends beyond cultural awareness and sensitivity by requiring health professionals to reflect on their own cultural identity and its influence on their practice (Curtis et al. 2019). Crucially, Cultural Safety is defined by the person receiving the care, not the provider (Ramsden 2002). To emphasise its significance, Māori nurse Irihapeti Ramsden (2002) capitalised 'Cultural Safety' to position it as a nursing theory requiring integration into all healthcare education, hence its consistent use in this paper. Ultimately, good clinical outcomes cannot be achieved without culturally safe care, as it ensures communication remains open and effective (McGough et al. 2022).

Clinical safety involves minimising and managing risks to prevent harm and ensure high-quality healthcare. It requires identifying, analysing, and addressing clinical risks to improve patient outcomes (Australian Commission on Safety and Quality in Health Care [ACSQHC] 2021a). It also includes delivering the right care, in the right place, at the right time, which helps reduce patient harm. Clinical safety cannot exist without Cultural Safety, as both are essential to keeping patients safe (Hall et al. 2023; McGough et al. 2022).

An evaluation by the ACSQHC (2023) of three National Safety and Quality Health Service (NSQHS) Standards; (Antimicrobial Stewardship, Delirium, and Hip Fracture Care) found that more consumers received high-quality, appropriate care; improving overall wellbeing. Though limited to three standards, the findings highlight the positive impact of clinical safety on care outcomes, inclusive of patient-centred care. Clinical safety is a core element of the NSQHS Standards, which guide providers in delivering person-centred care (ACSQHC 2021a). Supporting

its global importance, the World Health Organization (WHO 2021) launched the Global Patient Safety Action Plan 2021–2030 to raise awareness and reduce harm from unsafe care, which affects one in 10 patients worldwide and costs over one trillion dollars annually.

Clinical safety, including Cultural Safety, is a key factor in achieving CTG targets, such as increasing life expectancy, improving social and emotional wellbeing, and ensuring babies are born healthy and strong (AIHW 2022). As of 2025, 17 years after the first CTG, only five of the 19 targets are on track (Productivity Commission 2025). Despite nearly two decades of government-led efforts, the lifespan disparity for Indigenous Australians persists. This is concerning, as Cultural Safety has been shown to improve health outcomes, reduce DAMA, and help heal the ‘wounds of colonisation’ (Moloney et al. 2023; Taylor et al. 2021).

While clinical safety is well addressed in quality and safety frameworks (ACSQHC 2021a), it is ineffective without Cultural Safety (Berg et al. 2019; Sherwood et al. 2020). Cultural Safety is the ‘antidote’ to poor health outcomes and racism in healthcare, yet health disparities persist because many professionals have not undertaken or adopted it as best practice (Power et al. 2021). Therefore, Cultural Safety education must be embedded at all levels of healthcare and evident in all interactions with Indigenous Australian patients and caregivers.

The solutions

While Cultural Safety is recognised as essential in healthcare in Australia, it has not been fully implemented (Geia, Deravin, and West 2023). The Australian Quality and Safety Framework outlines three elements of care: it must be consumer-centred, informed by data, and organised for safety. It further states that Australians should expect high-quality, consumer-centred care that is appropriate for both patients and their families. This includes care that respects patient needs, values, and choices, highlighting the importance of both clinical and Cultural Safety in delivering quality healthcare (ACSQHC 2021b, 2022).

Some progress has been made in healthcare professions, notably with the Australian Psychological Society’s (APS) 2016 Apology, which acknowledged the failure to respect Indigenous cultural beliefs and worldviews (APS 2016). The Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM) has long sought a formal apology for past wrongs from peak professional bodies (McInerney 2021), but this was not delivered until 2022, by the Council of Deans of Nursing and Midwifery (CDNM) six years after the APS Apology.

Ahead of the CDNM Apology, Geia et al. (2020) led a unified call to action urging nursing and midwifery leaders to confront racism and acknowledge its impact on Black lives. Geia et al. (2020) emphasised that non-Indigenous nurses and midwives have a professional duty to help dismantle oppression by partnering with Indigenous colleagues. Two years later, following sustained advocacy from CATSINaM, CDNM issued a formal Apology (Croakey Professional Services 2022). Since then, further research has highlighted ongoing racism targeting Indigenous Australian nurses and midwives and revealed serious breaches in healthcare quality and safety (Best et al. 2025).

In 2025, the CDNM released a statement declaring zero tolerance for racism in nursing and midwifery, affirming healthcare as a human right. It emphasised regulatory processes to address breaches of conduct, particularly regarding racism in the professions (CDNM 2025). When racism in healthcare goes unaddressed, it causes harm and deepens disparities, including higher rates of DAMA, chronic and complex conditions, and reduced rates of healthcare services due to fear, disengagement, and feeling unheard, often dismissed with a ‘shut up’ pill like Paracetamol (Power et al. 2022). As a result, many Indigenous Australians continue to feel unsafe accessing mainstream health services, receiving inferior care that may shorten or end their

lives. This reflects how systemic racism persists in healthcare due to nurses and midwives failing to practice Cultural Safety or engage in truth-telling. These behaviours reinforce colonial attitudes in interactions with Indigenous Peoples (Mackay et al. 2025). Despite this, health professionals who breach Cultural Safety protocols rarely face consequences (Curtis et al. 2019).

In 2002, ‘getting em n keeping em’ (GENKE) report was an early call to action for nursing and midwifery schools to improve workforce competency in delivering safe, appropriate care to Indigenous Australians. It emphasised the need for more Indigenous nurses and midwives to create a safer healthcare system for both patients and staff, recommending population parity as a goal (Indigenous Nursing Education Working Group 2002). The report called for accountability from educational institutions, intersectoral collaboration, and curriculum inclusion. It also stressed the importance of embedding Cultural Safety in all nursing and midwifery curricula to ensure Indigenous history, health, and culture are taught through a strengths-based, truth-telling lens (Indigenous Nursing Education Working Group 2002). These implementations will assist in the decolonising of health, through nurses and midwives learning about the impact of colonisation (Moloney et al. 2023; Ramsden 2002). Had these recommendations been implemented 20 years ago, Australia might be closer to meeting CTG targets and achieving a culturally safe health workforce. Workforce parity could also have led to improved quality and safety outcomes across healthcare systems.

Due to the poor uptake of the CATSINaM (2022) report, a follow-up – ‘gettin em n keepin em n growin em’ (GENKE II) was released in 2022. It reinforced the need for Cultural Safety and highlighted the importance of expanding the Indigenous nursing and midwifery workforce to achieve population parity (CATSINaM 2022). An additional 2.4% of Aboriginal and Torres Strait Islander nurses and midwives are needed to reach this goal (ABS 2023b). While parity remains distant, it may be attainable through consistent implementation of GENKE II. Currently, tracking progress relies on the number of Indigenous nurses and midwives who identify during NMBA registration, but full adoption of GENKE II by education providers could help achieve parity.

The formal Apology from the CDNM (2022), alongside the release of GENKE II (2022) and support from other nursing and midwifery bodies, has set a precedent for all organisations to enhance Cultural Safety education and address institutional and professional racism. The professions must examine behaviours that harm Indigenous Australians and recognise how racism and the lack of Cultural Safety have affected the Indigenous Australian workforce (Geia, Deravin, and West 2023). Despite these efforts, evidence shows that racist and oppressive behaviours persist in healthcare (Best et al. 2025). Health professionals often attribute poor Indigenous health to culture rather than structural, political, and historical causes (McMurray and Param 2008). Nurses and midwives must integrate these understandings into their everyday practice and teaching.

When Cultural and clinical safety are lacking, the health consequences for Indigenous Australians are severe. In recent years, preventable deaths have occurred due to the absence of Cultural Safety, clinical care, and the continuation of systemic and inherent racism by healthcare professionals (Moloney et al. 2023). One such case was in 2016, when 27-year-old Wiradjuri woman Naomi Williams, 22 weeks pregnant, presented at a regional New South Wales hospital 18 times within a seven-month period with nausea, vomiting, and abdominal pain. The coronial investigation found her care was dismissed, with nursing, midwifery and medical staff stereotyping her as a ‘drug user’. Naomi died of sepsis – a preventable death – along with her unborn child (Grahame 2019; Pezet and Hayter 2019). Many similar cases reflect ongoing racist attitudes amongst healthcare professionals, yet the system rarely addresses this behaviour. As a result, such incidents continue, with discussion often limited to sentinel events, while preventable deaths persist (Watego, Singh, and Macoun 2021).

Discussion

The authors argue that within Australia, Indigenous Peoples experiences of disparity and poor health outcomes, are not *because* of Indigenous People's culture, but rather *because of non-Indigenous people* and imposed institutional cultures (Cox and Best 2022). With this in the forefront of all clinical interactions, there should be a heightened awareness of the need for both *Cultural Safety* and *clinical safety* for all patients; and that this relationship is symbiotic. It cannot continue to be ignored that the Australian healthcare system is systemically and societally failing Indigenous Peoples on all levels (Mackay et al. 2025). Furthermore, there is an urgent professional need for the integration of Cultural Safety to be included in all quality and safety frameworks to ensure that a professional level of healthcare remains at a high standard.

Closing the Gap, is everybody's business, therefore, Indigenous Australian health outcomes are *everybody's business*, not the responsibility of the patient or their family (Geia et al. 2020). This means a holistic approach for all patient care that is inclusive of Cultural Safety and clinical safety, which has beginnings in policy within the National Registration Boards (Ahpra) and is inclusive of frameworks such as the NSQHS. Cultural Safety and clinical safety are not unique nor separate entities, in fact, they are interdependent, in that one cannot exist without the other, because they are components of holistic patient care (Ahpra, 2020). When safe care, in every aspect is not provided, clinical risks increase and the potential for harm to the patient increases.

The Australian Nursing and Midwifery Accreditation Council (ANMAC) through accreditation processes is strongly positioned to advance rapid change by ensuring that schools of nursing and midwifery meet the GENKE II recommendations (CATSINaM 2022, 8). Within the current Strategic Plan (2024–2027) ANMAC has elements that relate directly to Cultural Safety (ANMAC 2024). This inclusion within nursing and midwifery programme accreditation requirements aligned with staff education, and a strengths-based curriculum, has the potential to expedite results in the application of recommendations from GENKE II, resulting, in directly impacting the clinical and Cultural Safety of Indigenous Australians (Gatwiri, Rotumah, and Rix 2021; Laccos-Barrett et al. 2022). Despite these guidelines and the recommendations current practices remain insufficient, further hindering progress in improving health outcomes for Indigenous Australians. However, the authors are anticipating rapid change.

Australian nurses and midwives are entering a new era that mandates the teaching and practice of Cultural Safety, and as the largest group professionally within healthcare, the potential to create social change is great (Best et al. 2022). The practice of Cultural Safety requires historical literacy and acknowledgement, and a contextualised social justice approach to understand culture, society, wellness, and inequity (Best et al. 2022). Whilst there is some groundswell with the release of GENKE II, it is only close monitoring and implementation that will determine if these concepts are enacted.

Health disparities among Indigenous Australians are well documented, but the full impact of combining Cultural Safety with clinically safe care on health and wellbeing outcomes remains unclear. If culturally safe practice were prioritised, and nurses and midwives held accountable for documenting and reflecting on instances where Cultural Safety was provided, the potential improvements in wellbeing and quality of life for Indigenous Australians could be significant. Ultimately, accountability for delivering culturally safe care must lie with the healthcare professional, including the application of Ramsden's 5 Principles of Cultural Safety. Without these implementations, clinical nor Cultural safety can be achieved.

Recommendations

The authors assert that there are two areas that are highlighted in the application of both Cultural Safety and clinical safety. (1), Educational settings (higher education providers such as

universities, inclusive of academics and researchers and vocational providers such as Technical and Further Education (TAFE) and (2), Industry settings (all modes of healthcare within Australia delivered by nurses and midwives) (Best et al. 2025; CATSINaM 2018; Hall et al. 2023; Laccos-Barrett et al. 2022). From these two areas, the authors support the following recommendations drawn from literature as being crucial in improving the health and wellbeing for Indigenous Australians:

Educational recommendations

1. Nursing and midwifery academics to undertake Cultural Safety education, focused on Ramsden's (2002) 5 Principles of Cultural Safety prior to educating students and maintaining currency.
2. Inclusion of Cultural Safety within in all nursing and midwifery courses, which is reviewed and updated in such a manner as clinical guidelines or procedures are, such is the importance of Cultural Safety.
3. Embedding Cultural Safety *across and within* every subject/course, just as clinically crucial aspects such as effective communication or safe patient assessment are.
4. Embedding healthcare as a human right, therefore ensuring no place for racism in education or healthcare delivery.
5. Development of a professional framework that highlights professional growth in the delivery of Cultural Safety.
6. Accountability within nursing and midwifery standards and national annual licensure renewal to provide contemporaneous and reflective evidence of the implementation and provision of Cultural Safety where impact/s are measurable.

Industry recommendations

1. Inclusion of Cultural Safety within Quality and Safety Frameworks, such as the NSQHS.
2. Monitoring and reporting of clinical safety outcomes such as DAMA in relation to provision of culturally safe care.
3. Appropriate and ongoing education that is focused on place-based truth-telling; re-establishing and refreshing healthcare professionals' understanding and knowledge of invasion, social and cultural determinants of health, health disparities, and the significant and unique cultural needs for Indigenous Australians. This education needs to be in collaboration with Community.
4. Maintenance of accountability of culturally safe practice by all registered healthcare practitioners.
5. Cultural Safety considerations to be included in all staff education.
6. Monitoring, evaluation, and consistent reporting of racism within the workplace.
7. Increase Indigenous identified positions across all levels of nursing and midwifery to support leadership.

The authors are optimistic that if the above recommendations are implemented, coupled with regulatory requirements from peak bodies such as ANMAC and stronger accountability in curriculum development, design, and implementation from educational providers, there will be sustainable change in nurses and midwives implementing Cultural Safety in all aspects of care. These actions may therefore see nurses and midwives being invested in culturally safe patient outcomes. Operationalising the implementation of both Cultural Safety and clinical safety

would ensure that all Indigenous Australians would be much more likely to receive care that sheds factors such as systemic racism and discrimination and focuses on holistic and safe care. Finally, the authors are hopeful that reading this paper will create disruption and discourse and facilitate change for the reader so that they can also review their own practices.

Author contributions

CRedit: **Ali Moloney**: Conceptualization, Writing – original draft, Writing – review & editing; **Lynne Stuart**: Conceptualization, Writing – original draft, Writing – review & editing.

Disclosure statement

No potential conflict of interest was reported by the author(s).

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