AMA TASMANIA
ABN 11 009 484 931

15 May 2019

rap@ahpra.gov.au

To whom it may concern,

Re: consultation on the proposed definition of "Cultural Safety"

AMA Tasmania believes that the definition of "Cultural Safety" as proposed, is inappropriate. Not because the definition as formulated is without merit, but because the definition does not appropriately relate the concept of "safety" (which is used clinically in a specific context) to "culture". In the clinical setting the word "safety" has specific connotations and implications related to physical or psychological well-being of an individual or group of individual's, so the proposed use in the term "safety" in the context of "culture" is confusing and ill-describes the intent of the proposed definition which more appropriately relates to the concept of "cultural sensitivity".

The proposed definition is:

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

AMA Tasmania contends that use of the word "safety" is highly inappropriate in this context and will argue that the appropriate words for what is being described in the definition is "Cultural Sensitivity".

In any clinical environment "safety" relates to an individual or group of individual's physical or psychological well-being.

It is therefore anomalous and erroneous to link safety to a "culture" in this way, as a culture does not represent an entity or entities that can suffer harm of a physical or psychological nature. Conversely, the concept and word formulation of "safety culture" is perfectly meaningful and a critical part of all good clinical practice.

While we are fully aware of the NZ origin and context of "cultural safety", neither in Australia nor in this consultantion document can its use as a term be readily justified as their is neither common definition with NZ or commonality in relation to the original context.

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Consequently, our recommendation is that we define first what we wish to achieve, namely sensitivity, compassion and empathy in relation to delivering culturally "optimal health care for Aboriginal and Torres Strait Islander Peoples as determined by Aboriginal and Torres Strait Islander individuals, families and communities."

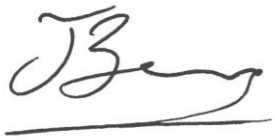
As much as any culture can represents a meaningful and positive force for a person or people, elements of any culture can also represent negative forces that adversely impact good health and the adoption of positive public health messages.

In the setting of health and health care regulation our goal should always be to use words precisely and with clear definitional relevance to the intended purpose. In this sense the conjunction of the words "culture" and "safety" is ambiguous for a health care context where "patient safety" relates to the well-being of the patient, "clinical safety" relates to ensuring clinical practice is safe for patients, "hospital safety" relates to ensuring the hospital is safe for patients, and "workplace safety" relates to ensuring the workplace is safe for those entering a workplace. Even the common usage in terms of "food safety" and "road safety" place a requirement for safety on the "food" and "road" as things which must be rendered safe to protect people.

Hence "cultural safety" would a priori suggest that there is an onus on a culture to be safe, made safe if unsafe or used safely to protect people who adopt a particular culture. This is not what the proposed definition of cultural safety intends and it also lacks the ability for objective external scrutiny or a requirement for modification should negative consequences for elements of a culture be identified that require modification to improve the health and well being of cultural adherents.

Thank you for the opportunity to participate in the consultation process. Please do not hesitate to contact me through AMA Tasmania, should you wish to understand our position further.

Yours sincerely



Prof. Dr John Burgess
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Submission to the Australian Health Practitioner Regulation Agency

Consultation on the Definition of Cultural Safety

May 2019

The Australasian College for Emergency Medicine (ACEM; the College) is the peak body for emergency medicine and has a vital interest in ensuring the highest standards of emergency medical care for all patients. ACEM is responsible for the training and ongoing education of emergency physicians and the advancement of professional standards in emergency medicine in Australia and New Zealand.

ACEM welcomes a single definition of cultural safety developed by Aboriginal and Torres Strait Islander Peoples. The definition proposed by the Australian Health Practitioner Regulation Agency (AHPRA) is useful as it is specific to the First Nations Peoples of Australia, and encapsulates the essential element that cultural safety can only be determined by those who are receiving the care, not by the person or institution delivering the care.

ACEM will review its current policies, standards and other education material to ensure that the term cultural safety is used appropriately and consistently once the definition is endorsed.

ACEM is committed to improving the care and conditions for all culturally and linguistically diverse people who present to and work in emergency departments in Australia and Aotearoa New Zealand. ACEM chose to adopt the term "cultural competency" in 2013 to reflect terminology used by the Australian Medical Council at that time. In 2018, ACEM took the step to make cultural competency training a mandated part of Continuing Professional Development for Fellows. ACEM's health equity strategy for Aboriginal and Torres Strait Islander peoples is articulated through our Reconciliation Action Plan, established in 2017 and in the process of being refreshed for the next two years.

AHPRA may be aware that cultural safety was first developed in Aotearoa New Zealand by Irihapeti Ramsden (*Ngai Tahupōtiki* and *Rangitane*), with the publication of *Kawa Whakaruruhau - Cultural Safety in Nursing* Education in 1988. Cultural safety has been incorporated in the New Zealand nursing and midwifery curriculum since 1992.

As a bi-national medical college, working across Australia and New Zealand, ACEM acknowledges Māori as tangata whenua and Treaty of Waitangi partners in Aotearoa New Zealand, and is committed to equitable care for Māori through our strategy, *Manaaki Mana: Excellence in Emergency Care for Māori.* ACEM encourages AHPRA to acknowledge the ground breaking work of Irihipati Ramsden and the Māori nursing community once the definition for First Nations Australians is endorsed and promoted.

The introduction of the proposed definition for cultural safety will allow ACEM to further articulate the need for emergency physicians working in Australia to embed cultural safety for Aboriginal and Torres Strait Islander Peoples in their individual work practice, and for inclusion in ACEM Accreditation Standards for Australian emergency departments. ACEM will also need to define a separate term for the knowledge, skills

and attitudes necessary to provide optimal care for other culturally and linguistically diverse peoples, and would welcome the development of further standard definitions for health organisations in the future.

Thank you again for the opportunity to provide feedback to this consultation. If you require further information, please do not hesitate to contact the ACEM Policy Manager, Helena Maher (t: (03) 9320 0444, e: helena.maher@acem.org.au).

Yours sincerely,

Dr Simon Judkins
President

Dr Elizabeth Mowatt
Chair, Indigenous Health Committee

Associate Professor Gregory Phillips and Ms Julie Brayshaw
Co-Chairs
National Registration and Accreditation Scheme's Aboriginal and Torres Strait Islander Health Strategy Group

By email: rap@ahpra.gov.au

Dear Associate Professor Phillips and Ms Brayshaw

Re: Feedback on the consultation on the definition of 'cultural safety'

The Australian College of Nursing (ACN) would like to thank you for the opportunity to provide feedback on the consultation on the definition of 'cultural safety'.

ACN has read the consultation document and would make a general comment that through the definition it isn't clear what the organisational responsibility is to ensure that staff have access to appropriate resources and training to ensure that care provided is culturally appropriate and aligns to the definition of culturally safe care as outlined by Aboriginal and Torres Strait Islander peoples and their families.

ACN consulted its Fellows and Members for their input into our submission and our responses are aligned with the questions in the consultation below.

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

ACN believes it would be advantageous to have a single definition because it enables a common understanding of the concept and helps guide development of education around knowledge, skills, attitudes and competencies to deliver optimal care within the construct of cultural safety. It will be helpful to have a foundational definition of the concept to ensure a common understanding for health professionals.

Other considerations put forward by the ACN membership include the importance of cultural safety across all cultures within our diverse and multicultural society to include all people from culturally and linguistically diverse backgrounds. It is imperative that everyone is entitled to cultural safety. Future work could explore expanding the definition, or having a separate definition, which acknowledges the diversity of Australian society and addresses the needs of multiculturalism.

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

ACN agrees that the definition captures the elements underpinning the concept of cultural safety and the acknowledgement that it is determined by Aboriginal and Torres Strait Islander individuals, families and communities. ACN member feedback suggests using the term 'practice behaviours' instead of competencies because competencies are determined by assessment at a particular point in time compared to practice behaviours that are established, understood and developed. It was also suggested to ACN to change the word, 'attitudes' to belief or value instead as it commits an organisation or institution at a deeper level such that lapses in cultural safety are less easily explained away with 'must do better' statements. If it is expressed as a belief or value, then lapses would cause a moment of (hopefully) authentic reflection. Other member feedback described the benefit of clarifying what is meant by the term individual. Is the individual a health professional or other person? Furthermore, the word institution may cause confusion which could be eliminated by substituting the word with organisation.

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

ACN supports the proposed draft definition and it is important to have cultural safety defined to allow or enable a common understanding. However, it is worth noting that each patient/consumer/resident will have a unique interpretation of cultural safety and their own cultural safety space. This is important for the health professional to be aware of in order to establish the boundary and connect with the individual through the building of trust. Care must also be taken to ensure the definition is not too 'academic' in nature by enabling the notion of learnings rather than skills so that it is not interpreted as too clinical an approach but rather acknowledges the importance of interacting and supporting people in need of care. Again, ACN would stress that it is important that everyone is entitled to cultural safety not only Aboriginal and Torres Strait Islander people.

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

ACN suggests that in addition to codes of conduct the definition of cultural safety should also be included in professional standards for practice. A clear definition of the roles and responsibilities between the patient/consumer/resident and the health professional would be useful. This could be a sequence or stepped approach to do the following: 1. Ask permission to discuss the cultural safety boundary. 2. Wait for the direction of meaning from the patient/consumer/resident. 3. Establish the culturally safe space and boundary. 4. Document the care directive. 5. Respond when the safe space is at risk and have a support for both health professional and patient/consumer/resident.

ACN is the pre-eminent and national leader of the nursing profession and a community of dynamic and passionate nurses. We are committed to our intent of advancing nurse leadership to enhance

the health care of all Australians. Leadership skills in any occupation drive change, but in the nursing profession, leadership skills are vital to patient care and advocacy, regardless of your title or position. Nurses with leadership skills are change makers, taking a holistic, patient-centred approach to care.

Please contact ACN's Policy and Advocacy Manager, Dr Carolyn Stapleton FACN, at carolyn.stapleton@acn.edu.au if you have any questions.

Yours sincerely

Ms Marina Buchanan-Grey MACN, MSc (Nursing), FCHSM
Executive Director - Professional
Australian College of Nursing

20 May 2019

Australian Council of Deans of Health Sciences submission regarding the AHPRA Consultation on the definition of 'cultural safety'.

The Australian Council of Deans of Health Sciences (ACDHS) welcomes the opportunity to provide comment on the AHPRA Consultation on the definition of 'cultural safety'. ACDHS is the peak representative body of the Australian universities that provide pre-professional education in the allied health sciences. The Council adopts a whole of health system perspective and considers the development of an innovative and sustainable health workforce will best position Australia to address present and emerging health care demands.

ACDHS member universities include:

Central Queensland University
Charles Sturt University
Curtin University
Deakin University
Edith Cowan University
Flinders University
Griffith University
James Cook University
La Trobe University
Monash University
Queensland University of Technology
University of Canberra
University of Melbourne
University of Newcastle
University of Queensland
University of South Australia
University of Sydney
Western Sydney University

While it is noted that many of our members teach a broader range of health programs, the following professions fall within the remit of our Council:

Clinical exercise physiology/sport and exercise science
Medical laboratory science
Nutrition and dietetics
Occupational therapy
Optometry
Orthoptics
Pharmacy
Physiotherapy
Podiatry
Prosthetics and orthotics
Medical radiation science
Speech pathology

Comments from the Australian Council of Deans of Health Sciences (ACDHS) therefore cover a number of the professions of allied health regulated by AHPRA. ACDHS members recognise and respect that defining cultural safety is a matter for Aboriginal and Torres Strait Islander Peoples and appreciate the opportunity to contribute to the consultation. In providing this response, ACDHS notes that responding Council members sought advice and input from Aboriginal and Torres Strait Islander colleagues in their respective universities.

The proposed Definition

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

Questions

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

ACDHS members support the notion of a single definition, yet provide the following qualifying comments that draw upon the works of Dr Irihapeti Merenia Ramsden, Professor Juli Coffin and the 2016 Aboriginal and Torres Strait Islander Health Curriculum Framework. Comments received include:

- A single definition would be useful provided that it is an accurate reflection of the true intention of Dr Ramsden's[1] work
    - definitions of cultural safety that do not engage with the original work have potential to mislead health care practitioners and impede the effective delivery of culturally safe health care services
- There are implications for the different terms that may be lost if a single definition is adopted.
    - For example, Professor Juli Coffin (Coffin 2007)[2] uses a three stage concept:
        - i) *cultural awareness* (awareness of history, cultural practices …),
        - ii) *cultural safety* (ensuring that the Aboriginal person's values, culture and worldview are respected in interactions, treatment in health environments …), and
        - iii) *cultural security* (cultural safety at an institutional level where culturally safe processes are in place across an institution that happen regardless of individual practitioner knowledge, awareness and safety)
    - Trying to combine these into one term may lose these important distinctions.

However, members note a single definition will be helpful to provide standardised nomenclature to underpin education and practice, enabling consistency across applications.

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

While acknowledging that many of these issues have no doubt been well debated, comments received include:

- That the proposed definition fails to capture the core elements of cultural safety and, as currently written, demonstrates a lack of engagement with the theory of cultural safety. As such the proposed definition does not reflect the true intentions of cultural safety as specified by the original author and theorist, Dr Ramsden.
  Amending the proposed definition to reflect the following core ideas has been suggested:
    - The proposed definition conflates cultural safety with Aboriginal and Torres Strait Islander people. Cultural safety is not about the ethnicity or cultural characteristics of the service user. When defined and practiced as originally intended, cultural safety extends into a wide range of contexts and views culture in its broadest sense to apply to any individual(s) who differ from the practitioner due to socio-economic status, age, gender, sexual orientation, ethnic origin, migrant/refugee status, religious belief or disability.
    - One interpretation of the definition provided by AHPRA is that it reverses the true intention of Ramsden by placing the onus of cultural safety on service users. While service users are important to the determination of culturally safe care, the primary responsibility of cultural safety is on health care systems and practitioners.
    - Cultural safety is concerned with the values, beliefs and assumptions of health care practitioners and health institutions and the influence these factors have on the equitable delivery of health care. Cultural safety is about the practitioner, their own culture, and the way they provide safe and respectful care.
    - Cultural safety has been developed to prepare health care practitioners to negotiate and address power and privilege imbalances, all forms of racism and the various social processes which have a detrimental impact on practice and on health outcomes for service users. Individual and organisational self-reflection is critical to this process.

[1] Ramsden, I. (2002). Cultural safety and nursing education in Aotearoa and TeWaipounamu. Wellington: University of Wellington.

[2] Coffin, J. (2007). Rising to the challenge in Aboriginal health by creating cultural security. Aboriginal and Islander Health Worker Journal, 31, 22-24.

- The proposed definition does not include other critical elements of cultural safety, these being cultural awareness and cultural sensitivity.
    - Noting that the terms are not interchangeable, but were considered by Ramsden as a step wise process to Cultural Safety[3]
    - The definition seems to focus on the practitioners' skills rather than the product of what these skills can hopefully create for the clients
    - The concept of cultural safety should not focus on someone's skill, but a state of being where the client/person 'feels' culturally safe. It would see that cultural safety can't ultimately be judged by ticking off someone's knowledge, skills and competencies.

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

The comments received indicate refinement is required in relation to the areas noted above.

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

Noting again that these frameworks are widely known, members offered the following for consideration:

- The Aboriginal and Torres Strait Islander Health Curriculum Framework[4] :

    - "*The concept of cultural safety in health service delivery focuses on the subjective experience of the health service user, whereby they experience an environment that does not challenge, assault or deny their cultural identity. Cultural safety is enabled if the people who work there show respect and sensitivity for the different cultural needs of Aboriginal and Torres Strait Islander peoples and are aware of how their own cultural values may have an impact. A culturally safe setting allows for shared learning, shared meaning and genuine listening with full acceptance of Aboriginal and Torres Strait Islander diversity*."

- Examples of cultural safety that meet internationally recognised definitions and standards of cultural safety practice which engage with the original work of Ramsden that AHPRA could draw upon to refine the definition include:

    - The Nursing Council of New Zealand Guidelines define cultural safety accurately and provides clear and practical guidelines to delivering culturally safe care. The Nursing council of New Zealand Guidelines define cultural safety as:

        "*The effective nursing practice of a person or family/wh-anau from another culture, and is determined by that person or family. Culture includes, but is not restricted to, age or generation; gender; sexual orientation; occupation and socioeconomic status; ethnic origin or migrant experience; religious or spiritual beliefs; and disability. The nurse delivering the nursing care will have undertaken a process of reflection on their own cultural identity and will recognise the impact their personal culture has on their professional practice. Unsafe cultural practice comprises any action which diminishes, demeans or disempowers the cultural identity and well-being of an individual.*" (Code of Conduct, p.13)[5].

    - The Nursing and Midwifery Board of Australia (NMBA) Codes of Conduct define cultural safety accurately and outline the application of cultural safety in a variety of patient

[3] Ramsden, I. (2002). Cultural safety and nursing education in Aotearoa and TeWaipounamu. Wellington: University of Wellington.p117

[4] Commonwealth Department of Health 2016 Aboriginal and Torres Strait Islander Health Curriculum Framework: http://www.health gov.au/internet/main/publishing.nsf/Content/aboriginal-torres-strait-islander-health-curriculum-framework

[5] The Nursing council of New Zealand guidelines http://www.nursingcouncil.org.nz/Publications/Standards-and-guidelines-for-nurses

contexts. The NMBA's definition of cultural safety draws on the work of the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM). The Nursing and Midwifery Board of Australia (NMBA) defines cultural safety as:

> *"Cultural safety is a philosophy of practice that is about how a health professional does something, not just what they do. It is about how people are treated in society, not about their diversity as such, so its focus is on systemic and structural issues and on the social determinants of health. Cultural safety represents a key philosophical shift from providing care regardless of difference, to care that takes account of peoples' unique needs. It requires nurses and midwives to undertake an ongoing process of self-reflection and cultural self-awareness, and an acknowledgement of how a nurse's/midwife's personal culture impacts on care. In relation to Aboriginal and Torres Strait Islander health, cultural safety provides a de-colonising model of practice based on dialogue, communication, power sharing and negotiation, and the acknowledgment of white privilege. These actions are a means to challenge racism at personal and institutional levels, and to establish trust in healthcare encounters. In focusing on clinical interactions, particularly power inequity between patient and health professional, cultural safety calls for a genuine partnership where power is shared between the individuals and cultural groups involved in healthcare. Cultural safety is also relevant to Aboriginal and Torres Strait Islander health professionals. Non-Indigenous nurses and midwives must address how they create a culturally safe work environment that is free of racism for their Aboriginal and Torres Strait Islander colleagues."* (Code of Conduct for Midwives and Nurses, p.16)[6].

- While these definitions and guidelines have been developed in the context of nursing, it has been suggested that they are highly applicable across all health care contexts and could be adapted to fit the needs and contexts of all health care practitioners in Australia.

Once there is an agreed definition, policies, frameworks and curricula should be reviewed to align with the new definition.

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

Concepts of cultural awareness and cultural sensitivity, as components of a stepwise progression to Cultural Safety, should be included in accompanying documentation- if not in the definition itself.

Thank you once again for the opportunity to provide comment

ACDHS AUSTRALIAN COUNCIL OF DEANS OF HEALTH SCIENCES

[6] Nursing and Midwifery Board of Australia (NMBA) Codes of Conduct https://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards.aspx

15th May 2019

Ms Jayde Fuller
Program Manager
Aboriginal and Torres Strait Islander Health Strategy
Australia Health Practitioner Regulation Agency

Dear Ms Fuller

Re: AHPRA Public Consultation – Cultural Safety Definition

Thank you for your invitation to provide feedback on the definition of cultural safety. The Australian Indigenous Psychologists Association (AIPA) views are currently represented on the National Registration and Accreditation Scheme's Aboriginal and Torres Strait Islander Health Strategy Group. AIPA supports the current work towards the shared goal of embedding cultural safety across all functions and health disciplines in the National Scheme. The AIPA Steering Committee through collaborative consensus support an agreed national baseline definition that will be used as a foundation for embedding cultural safety.

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

Feedback

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

AIPA unreservedly supports the proposal for a single definition for the National Scheme and for the NHLF. AIPA feels that this is a positive step towards optimal health and wellbeing care for Aboriginal and Torres Strait Islander people and by extension, communities.

A single definition will be helpful for Indigenous and non-Indigenous people, communities and institutions. Currently there are a variety of terms that are used interchangeably and there is confusion within the health profession around definitions. A single definition may reduce confusion and ambiguity across the various health professions.

The unintended consequences of the single definition may include an administrative burden, time involved and associated costs for institutions, organisations and health systems to modify their curriculum, training and policies to incorporate the single definition. Another unintended

consequence may involve unfavourable reactions and responses from organisations, health practitioners and the media.

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

AIPA understands and believes that the concept of health incorporates holistic health which includes social and emotional wellbeing. Whilst most of the general population understands this, this may not be reflected clearly within the current definition. Optimal holistic health care for Aboriginal and Torres Strait Islander people include specific attention towards social and emotional wellbeing.

AIPA strongly suggests AHPRA consider including the words 'health and wellbeing,' within the current definition.

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

As mentioned above, AIPA in principle supports the proposed draft definition with the inclusion of 'health and wellbeing.'

AIPA further supports that the definition is reviewed after a period of time, especially noting any unintended consequences. An evaluation framework should be considered with the communication strategies and implementation processes going forward.

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

AIPA asserts broad consultations will be required to ensure that the definition of cultural safety is embedded within current and future frameworks and policies. The Concordance document which highlights the interconnectdess of Aboriginal and Torres Strait Islander social and emotional wellbeing, mental health and suicide prevention details 8 policies, plans and frameworks that would need to consider the single definition. https://natsilmh.org.au/sites/default/files/NATSILMH%20Health%20in%20Culture%20Policy%20Concordance.pdf

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

AIPA strongly supports consultation with Elders. Elders are the wisdom keepers for Aboriginal and Torres Strait Islander people and we strongly recommend that an attempt to ensure their knowledge is incorporated as part or as an oversight of this consultative process.

In closing, AIPA looks forward to a time where, Aboriginal and Torres Strait Islander peoples receive optimal standard of culturally safe care at every health and wellbeing interaction. We are happy to be contacted if needed for further consultations. We wish you well with this process.

Kind regards

_____

Tania Dalton
Chair
Australian Indigenous Psychologists Association

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AMA submission to the Australian Health Practitioner Regulation Agency – Consultation on the definition of cultural safety

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The Australian Medical Association (AMA) is pleased to provide a submission to the Australian Health Practitioner Regulation Agency (AHPRA) consultation on the following proposed definition of cultural safety for use across all functions of the National Registration and Accreditation Scheme and members of the National Health Leadership Forum (NHLF):

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

The AMA is the peak medical organisation in Australia representing doctors across all specialties of medicine and is strongly committed to advocating for improved health and life outcomes for Aboriginal and Torres Strait Islander people through the provision of culturally safe care.

Aboriginal and Torres Strait Islander people have the right to feel safe in accessing health care services across Australia and feel confident that the health system will respond positively and appropriately to their needs. The concept of cultural safety emerged in the late 1980s as a basis for delivering more appropriate health services for Maori people in New Zealand, and today, there are many different existing definitions of cultural safety. One such definition states cultural safety as being "an environment that is spiritually, socially and emotionally safe, as well as physically safe for people; where there is no assault challenge or denial of their identity, of who they are and what they need".[1]

Some peak Aboriginal and Torres Strait Islander health organisations in Australia view cultural safety as a concept that is comprised of different interrelating factors, such as community and country, collaboration, and individual and systemic reflection as outlined in the National Aboriginal and Torres Strait Islander Health Workers Association's *Cultural Safety Framework*[2],

[1] Williams, R. 1999. Cultural Safety – What Does It Mean for Our Work Practice? *Australian and New Zealand Journal of Public Health*, 23(2), pp. 213-214.
[2] National Aboriginal and Torres Strait Islander Health Workers' Association, 2016. *Cultural Safety Framework*, https://www.natsihwa.org.au/sites/default/files/natsihwa-cultural_safety-framework_summary.pdf (accessed 2 May 2019)

or as the final step on a continuum of care, as viewed by the Australian Indigenous Doctors' Association[3] and the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives[4].

Despite the variations in the meaning of cultural safety to different people and organisations, the AMA believes that the intent of cultural safety is to provide care to Aboriginal and Torres Strait Islander people that is respectful, acknowledges differences in attitudes and culture, high-quality and free of discrimination.

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

As previously mentioned, there are many existing definitions of cultural safety. The AMA considers it difficult to have only a single definition of cultural safety, as this concept has slightly different meanings to different people and organisations. However, if only one definition of cultural safety is to be adopted by AHPRA, the AMA considers that the definition should, include references to the following:

- reflecting on one's own culture, attitudes and beliefs and the impact this has on the provision of care to Aboriginal and Torres Strait Islander people;
- recognition of and respect for the cultural identities of Aboriginal and Torres Strait Islander people, and being open-minded and flexible;
- being prepared to engage with Aboriginal and Torres Strait Islander people in a two-way dialogue where knowledge is shared and respected;
- practising clear, open and respectful communication with Aboriginal and Torres Strait Islander people;
- developing trust; and
- recognising and avoiding stereotypes.

The AMA acknowledges that cultural safety is determined by the recipient of care – not by the provider of care, and that a genuine partnership must be established between patients and health professionals to ensure a balance of power.

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

An important principle of cultural safety is that it is about examining our own cultural identities and attitudes, and how this can impact on engagement with Aboriginal and Torres Strait Islander people. The AMA considers that the proposed definition of cultural safety captures the basic principle of cultural safety, however it could be strengthened by incorporating references to what Aboriginal and Torres Strait Islander people, organisations and communities consider as essential components of culturally safe care (as outlined in the previous section).

[3] Australian Indigenous Doctors' Association, *Cultural Safety for Aboriginal and Torres Strait Islander Doctors, Medical Students and Patients,* Position Paper, https://www.aida.org.au/wp-content/uploads/2017/06/Cultural_Safety.pdf (accessed 2 May 2019).
[4] Congress of Aboriginal and Torres Strait Islander Nurses and Midwives, Cultural Safety Position Statement, https://www.catsinam.org.au/static/uploads/files/cultural-safety-endorsed-march-2014-wfginzphsxbz.pdf

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

The AMA considers that the proposed definition captures the basic principle of cultural safety, however it could be strengthened, as referred to in previous sections.

What other definitions, frameworks or policies should the National Registration and Accreditation Scheme and NHLF definition of cultural safety support?

The AMA recommends that the cultural safety definitions, frameworks or policies developed by national peak Aboriginal and Torres Strait Islander health organisations should definitely be supported as they are the leaders in providing appropriate health care to Aboriginal and Torres Strait Islander people.

14 MAY 2019

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15 May, 2019

Mr. Martin Fletcher

Chief Executive Officer

Australian Health Practitioners Regulation Agency

Dear Mr. Fletcher,

Public consultation on the definition of 'cultural safety'

Thank you for the opportunity to provide a submission to this consultation on the consistent use and definition of 'cultural safety' within the health care professions.

Established in 1924, the Australian Nursing and Midwifery Federation (ANMF) is the largest professional and industrial organisation in Australia for nurses and midwives, with Branches in each State and Territory of Australia. The core business of the ANMF is the professional and industrial representation of our members, the professions of nursing and midwifery, and promoting the health and wellbeing of our communities.

Our response represents the views of our membership of 275,000 nurses, midwives and assistants in nursing employed in a wide range of enterprises in urban, rural and remote locations in both the public and private health and aged care sectors.

We applaud the decision to create and implement a definition of 'cultural safety' that is agreed to and made in collaboration with Aboriginal and Torres Strait Islander health leaders. This collaboration will promote consistency in meaning and terminology across Australia's health professional groups. ANMF notes the extensive consultation already undertaken by the Nursing and Midwifery Board of Australia (NMBA) in collaboration with Congress of Aboriginal Torres Strait Islander Nurses and Midwives (CATSINaM) to create the definition of cultural safety included in the *Nursing and Midwifery Board of Australia Code of conduct for nurses*, as below.

Proposed definition

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

Questions

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

   The advantage of a single definition means that different health practitioner disciplines working in Australia's health care system will be using a common, and commonly understood, concept, facilitating communication, and shared documentation, and the provision of best practice care.

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

   The ANMF believes the proposed definition falls short of encompassing the most useful and necessary components of cultural safety. Specifically, the proposed definition makes no reference to the traumatic, enduring, multigenerational effects of colonisation, including the introduction and continuation of racist policies (within and outside health care) that continue to significantly contribute to the gap between non-Indigenous and Aboriginal and Torres Strait Islander people's health care and health care outcomes.

   Accordingly, ANMF submits that the definition of cultural safety contained within the *Nursing and Midwifery Board of Australia Code of conduct for nurses* be adopted.

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

   No. The proposed definition does not adequately characterise the totality of cultural safety, which is critical. The ANMF fully supports and endorses the comprehensive definition of cultural safety that was developed and adopted by the Nursing and Midwifery Board of Australia (NMBA) in conjunction with the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM). The ANMF believes this should be adopted by the Australian Health Practitioners Regulating Agency, as it is inclusive of all cultural elements of cultural safety, and demonstrates strong commitment to cultural safety in clinical practice.

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

   Please see below.

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

   The ANMF supports the NMBA's 2018 decision to set expectations of the provision of culturally safe care within the nursing and midwifery Codes of Conduct, with the expectation that these professions will deliver care within a larger culturally safe, competent, and collaborative health care framework.

The ANMF, on behalf of our nurse and midwife members, has been a driver for acknowledging the need for recognition of the concept of cultural safety, particularly in relation to health care provision for and with Aboriginal and Torres Strait Islander people, and of embedding in nursing and midwifery education information that ensures health care delivery incorporates cultural safe practices, including understandings of the multigenerational impact of colonisation on these populations' health and health care outcomes. We note that it was our Māori nursing colleagues who first identified and advocated for this concept of care, over thirty years ago.

We request you refer to the NMBA and CATSINaM joint statement on culturally safe care, which contextualises the NMBA definition, and describes how using this understanding contributes to better patient care and outcomes.

We appreciate the opportunity to participate in this consultation process and provide our feedback on behalf of our membership. Should you require further information on this matter, please contact Julianne Bryce, Senior Federal Professional Officer, ANMF Federal Office, Melbourne on 03 9602 8500 or julianne@anmf.org.au.

Yours sincerely

Annie Butler
Federal Secretary

13 May 2019

Aboriginal and Torres Strait Islander Health Strategy Group &
National Health Leadership Forum (NHLF)
Australian Health Practitioner Regulation Agency
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Reference: Public consultation on the definition of 'cultural safety"

The Australian Pharmacy Council (APC) is pleased to provide feedback on the definition of cultural safety. We commend and support efforts to seek a definition that can be used in the context of the National Scheme and for the purposes of the NHLF and its members.

The APC is the independent accrediting authority for pharmacy education and training in Australia. APC accreditation helps to protect the health and safety of the Australian community by establishing and maintaining high-quality standards for pharmacy education, training and assessment.

This consultation is timely as we are in the final stages of the Review of Accreditation Standards and Performance Outcomes for Pharmacy Programs in Australia and New Zealand. The revised program standards are underpinned by the promotion and maintenance of safe and socially accountable practice with a strong emphasis on cultural safety. The APC is committed to the inculcation of cultural safety in pharmacist training programs by embedding the National Scheme's definition of cultural safety in pharmacy program accreditation standards.

Our response to the consultation questions follows:

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

APC supports a single definition for cultural safety to enable uniformity in the understanding, implementation and adoption of nationally consistent practice amongst members of the NHLF. This will enable ongoing accumulation and application of knowledge of Aboriginal and Torres Strait Islander values, principles and norms[1] in providing optimal health services.

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

A culturally safe environment allows healthcare decisions and actions to align with the beliefs and wishes of the patient, to empower them to actively participate in interactions[2]. The APC understands that a measure of cultural safety is the experience of the recipient of care, and that a culturally safe environment enables the care recipient the ability to participate in healthcare decisions. APC suggests that the term "as determined by…."may not adequately convey this message. It may be understood to mean that Aboriginal and Torres Strait Islander individuals, families and communities are the sole factor in making decisions about optimal service delivery which could conflict with the principles of collaborative care.

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[1] *Australian Indigenous Doctor's Association Ltd. Cultural Safety Factsheet.* https://www.aida.org.au/our-work/cultural-safety/. *Accessed 17 April 2019.*
[2] *Dementia Learning Resource for Aboriginal and Torres Strait Islander Communities. NATSIDA Facilitators guide. Section 7 – cultural safety. https://www.dementia.org.au. Accessed 2 May 2019.*

While the meaning of "knowledge, skills, attitudes and competencies" as it applies to individuals is clear, the interpretation of this terminology at an institutional level could create difficulties and significant variation in the way institutions become culturally safe. The risk is that we may see an increase in individual health care provider's awareness and use of cultural competency and safety concepts, and yet have poor implementation of cultural safety at organisation level as experienced in Canada[3].

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

Yes. APC supports the proposed draft definition. It provides impetus for National Scheme members to begin to work together to embed consistent approaches to cultural safety in health provider programs.

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

a). Principles of shared respect, shared meaning, shared knowledge and working together as first described by the Maori nursing fraternity in New Zealand[4]

> *"An environment that is safe for people: where there is no assault, challenge or denial of their identity, of who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience, of learning, living and working together with dignity and truly listening."*

b).The principles of ongoing accumulation and application of knowledge of Aboriginal and Torres Strait Islander value, principles and norms in order to contribute to their health as described by the Australian Indigenous Doctors Association (AIDA)[5].

> *Cultural safety refers to the accumulation and application of knowledge of Aboriginal and Torres Strait Islander values, principles and norms. Cultural safety is about overcoming the cultural power imbalances of places, people and policies to contribute to improvements in Aboriginal and Torres Strait Islander health.*

c). Cultural competency framework by the Centre for Culture, Ethnicity and Health[6].

d). The LIME Network - CDAMS Indigenous Curriculum Framework[7]. Ensuring that those individuals and systems delivering health care are aware of the impact of their own culture and cultural values on the delivery of services, and that they have some knowledge of, respect. for and sensitivity towards the cultural needs of others.

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[3] *Guerra O, Kurtz D. Building Collaboration: A Scoping Review of Cultural Competency and Safety Education and Training for Healthcare Students and Professionals in Canada. Teach Learn Med. 2017 Apr-Jun;29(2):129-142.*

[4] *Williams, Robyn (2008). Cultural safety: what does it mean for our work practice? Australian and New Zealand Journal of Public Health. 23(2): 213-214.*

[5] *. Australian Indigenous Doctor's Association Ltd. https://www.aida.org.au/our-work/cultural-safety/. Accessed 17 April 2019.*

[6] *A framework for cultural competency. Centre for Culture, Ethnicity and Health. https://www.ceh.org.au/framework-cultural-competence/. Accessed 17 April 2019.*

[7] THELIMENETWORK. CDAMS Indigenous Health Curriculum Framework. https://www.limenetwork.net.au/resources-lime-publications/curriculum-framework/. Accessed 17 April 2019.

australian pharmacy council

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

- It would be useful to develop a knowledge repository and prospectively gather empirical evidence on best practice.
- A Nationally recognised self-assessment tool would be useful in assisting organisations improve their own performance on cultural safety.

Thank you for the opportunity to provide feedback on this important national agenda. The APC submission may be published in its entirety.

Yours sincerely

Bronwyn Clark
Chief Executive Officer

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AUSTRALIAN PHYSIOTHERAPY ASSOCIATION

AUSTRALIAN PHYSIOTHERAPY COUNCIL

Australian Health Practitioner Regulation Agency

Have your say: Consultation on the definition of 'cultural safety'

May 2019

Authorised by:

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Executive Summary

On behalf of the physiotherapy profession the Australian Physiotherapy Association (APA) and Australian Physiotherapy Council (APC) welcomes the opportunity to provide a joint submission in response to the consultation paper, *Have your say: Consultation on the definition of 'cultural safety'*. We welcome the opportunity to comment on the proposed definition of cultural safety to ensure Aboriginal and Torres Strait Islander people(s) receive safe accessible care. Together, we support the National Registration and Accreditation Scheme's (National Scheme) decision to apply cultural safety into the National Scheme.

We believe a consistent definition across all National Boards will promote ongoing improvements in Aboriginal and Torres Strait Islander health outcomes through improved professional development opportunities and minimum standards of care.

We support a single definition of cultural safety to ensure consistent implementation and regulation of cultural safety across the National Scheme.

Although we agree with a single definition across the National Scheme, we consider the proposed definition doesn't satisfactorily incorporate the key components of cultural safety.

The definition of cultural safety differs widely among health organisations however cultural safety is based on the following principals:

- *Culturally safe practice requires an understanding of cultural differences between the health care provider and the person receiving care*[1,4]*,*
- *Culturally safe practice requires an understanding and acknowledgement of any power imbalance which may be present between the health care provider and the person receiving care*[1,2,4]*, and*
- *Culturally safe practice is defined by the person receiving care, not the health practitioner*[2,5]*.*

The APA and APC consider that the proposed definition of cultural safety fails to capture these fundamental components.

We suggest that the definition should more definitively recognise and describe the cultural differences between provider and person receiving care, and the power imbalance that exists between a health care provider and the person receiving care.

Across the sector many consider cultural safety to be on continuum, starting with cultural awareness.[2,4,5] Although we recognise the lack of consistency of the different stages along this continuum, we consider it important that the NRAS reach a consistent definition of this continuum. This anticipate this will be of particular importance when addressing the requirements of cultural safety training.

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Introduction

The health disparities between Aboriginal and Torres Strait Islander people(s) and Non-Indigenous Australians is well documented, with numerous social and cultural factors being attributed to poor health outcomes.[1,3] Cultural differences between health service providers and Aboriginal and Torres Strait Islander people(s) has created a well recognised gap which acts as a barrier to health care access[1]. A major component of this disparity is the discrimination faced by Aboriginal and Torres Strait Islander people(s) when accessing health care services.[2]

Improving the cultural awareness of health workers is a common step toward addressing the discrimination faced in the health care setting, however there is little evidence to suggest this improves health outcomes.[1,2] It has been suggested this is because the emphasis is on 'other' rather than focusing on individual practitioner attitudes and behaviors[1].

Cultural safety as a concept has been increasingly utilised in New Zealand, Canada and Australia, and has been shown to have positive effects on health outcomes of Aboriginal and Torres Strait Islander people(s).[3] Changing the notion of learning from 'other' to a focus on self-reflection, allows health professionals to better understand their inherent professional and personal cultural biases and existing power imbalances.

The professions registered under the National Scheme are diverse and work across a range of healthcare of health care settings. As such there are multiple situations and settings where health care providers provide care for Aboriginal and Torres Strait Islander people(s). Building cultural safety into the registration requirements of health professionals ensures cultural safety is built into educational and professional development frameworks across all professions registered under the National Scheme.

Question 1

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

The following definition of cultural safety is proposed by the National Registration and Accreditation Scheme:

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

We support a single definition of cultural safety for the National Scheme and consider consistency across the Scheme an important determinant of successful implementation.

Culturally unsafe care has been shown as a major barrier to accessing health care for Aboriginal and Torres Strait Islander peoples[1,2,3] and we support NRAS's decision to apply a single definition of cultural safety into the National Scheme.

We recognise that in order for this to be effective there needs to be an accepted definition of cultural safety to facilitate consistent implementation across all National Boards. This ensures the Scheme can begin to build and support a health workforce that meets the minimum standard for cultural competency. In the absence of a single definition there is no consistent minimum standard, leaving considerable variation in way in which cultural safety is embedded across the workforce.

It is widely acknowledged that the process toward developing a culturally safe workforce will require upskilling of health professionals across each National Board. A uniform definition will allow the National Boards to implement and regulate an agreed minimum training requirement.

The APA and APC are unable to comment on the application of a single definition for the National Health Leadership Forum (NHLF) on the basis that we are not an indigenous member organization. We consider this to be solely the purview of the NHLF.

Question 2

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

The term cultural safety has been defined differently by various health bodies and organisations, however each definition is based on the following key components:

- Culturally safe practice requires an understanding of cultural differences between the health care provider and the person receiving care[1,4],
- Culturally safe practice requires an understanding and acknowledgement of any power imbalance which may be present between the health care provider and the person receiving care[1,2,4], and
- Culturally safe practice is defined by the person receiving care, not the health practitioner[2,5].

The APA and APC consider that the proposed definition of cultural safety fails to capture these fundamental components. We suggest that the definition should more definitively recognise and describe the cultural differences between provider and person receiving care, and the power imbalance that exists between a health care provider and the person receiving care.

We also suggest a stronger emphasis on cultural safety being defined by the *individual* recipient of care. The proposed definition states cultural safety is *'determined by Aboriginal and Torres Strait Islander individuals, families and communities.*' This could be interpreted as meaning there has been consultation on a single definition of cultural safety for all Aboriginal and Torres Strait Islander peoples rather than how each individual interprets the safety of their care.

Question 3

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

The APA and APC strongly support a definition that reflects the observations and suggestions identified in Question 2. This includes a definition that reflects the inherent power imbalance and recognises the fundamental cultural differences between practitioner and client.

Other peak indigenous bodies including CATSINaM and AIDA endorse a definition of cultural safety that reflects these important defining components. We support a definition that aligns with the indigenous peaks and would anticipate the National Scheme to similarly endorse a definition that is reflective of contemporary cultural safety.

As the purpose of this consultation is to establish a baseline definition in the National Scheme for *individual* providers it is unclear to us why the definition includes cultural safety at the institutional level.

The APA and APC have developed a joint definition based on our research and understanding of the term cultural safety:

> *"Cultural safety is a health care provider's knowledge, skills, attitudes and competencies when providing care to Aboriginal and Torres Strait Islander People(s). It is Aboriginal and Torres Strait Islander recipients of care, their families and community who determine whether the treatment provided was culturally safe".*

Question 4

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

Many position statements and frameworks consider cultural safety to be on a continuum, starting with cultural awareness.[2,4,5] There is however a lack of consistency on the different stages along this continuum. For example, CATSINaM view cultural safety as the endpoint on a continuum that includes cultural sensitivity, cultural knowledge, cultural respect and cultural competence. The Cultural Respect Framework (2016-2026)[6] define cultural respect as the end of a continuum with cultural safety sitting at a midpoint.

Although we recognise the lack of consistency and agreement of the different stages along this continuum, we consider it important that the NRAS reach a consistent definition of this continuum. This will be of particular importance when addressing the requirements of cultural safety training.

Australian Physiotherapy Association

The APA is the peak body representing the interests of Australian physiotherapists and their patients.

It is a national organisation with state and territory branches and specialty subgroups.

The APA represents more than 26,000 members who conduct more than 23 million consultations each year.

To find a physiotherapist in your area, visit www.choose.physio

Australian Physiotherapy Council

The Australian Physiotherapy Council (Council) is the only accreditation authority guaranteeing the highest standards for physiotherapy in Australia, thus ensuring Australia has the safest, most ethical physiotherapy practitioners. Additionally, the Council assesses the qualifications, skills and key competencies of overseas qualified physiotherapists for registration and migration purposes.

www.physiocouncil.com.au

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4. Australian Indigenous Doctors Association. Cultural Safety Factsheet. 2013. Accessed 2019.
5. Congress of Aboriginal and Torres Strait Islander Nurses and Midwives. Cultural Safety Position Statement. 2014. Accessed 2019.
6. Australian Health Ministers' Advisory Council's National Aboriginal and Torres Strait Islander Health Standing Committee. Cultural Respect Framework (2016-2026) for Aboriginal and Torres Strait Islander health. Australian Health Ministers' Advisory Council. 2016.

CATSINaM

24 May 2019

Mr. Martin Fletcher
Chief Executive Officer
Australian Health Practitioners Regulation Agency

Dear Mr Fletcher

Public Consultation on the definition of 'cultural safety'

Thank you for the opportunity to provide a submission to this consultation on the consistent use and definition of 'cultural safety' within the health care professions.

CATSINaM advocates and supports the embedding of *cultural safety* into the National Law. The term *cultural safety* represents taking further steps, than other terms, in delivering culturally appropriate healthcare. Unlike *cultural competence* or *cultural respect*, *cultural safety* has a trust component (Brascoupe, 2009). To ensure Indigenous patients feel safe, a level of acceptance and trust needs to be reached between them and the health practitioner. *Cultural safety* embeds opportunity for healing as it requires health professionals to be more than competent and respectful, but requires a relational approach (Brascoupe, 2009). A study by Marlene Brant Castellano found that a perquisite to the path to recovering from inter-generational trauma is establishing trust between Indigenous patients and non-Indigenous professionals (Brascoupe, 2009).

Cultural safety is more than an understanding of Indigenous culture and requires an understanding of complex race relations (Brascoupe, 2009). *Cultural safety* recognises the need for the non-Indigenous medical practitioner and the Indigenous patients to have a 'negotiated and equal partnership' (Brascoupe, 2009). Building this relationship and aligns with the principle of self-determination as it ensures the non-Indigenous health professional does not have power over the Indigenous patient (Brascoupe, 2009). The position of authority the health professional is in does not allow them to make decisions for the Indigenous patient; rather decisions are made in partnership (Brascoupe, 2009). The fact the amendments to the National Law propose use of the term *cultural safety* indicates the amendments have a significant likelihood of providing positive long-term outcomes for Australia's Indigenous community.

AHPRA Proposed definition

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

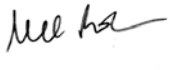
CATSINaM's Position

A single definition for cultural safety within Australia will mean that health professionals across the disciplines working in Australia's health care system will be working within a common framework to provide best practice care. However, CATSINaM believes that any definition of cultural safety to be used as a baseline across the National Scheme must include the principles of self-reflection and challenging systemic discrimination and racism, as was communicated in the codes of Conduct for Nurses and Midwives. Without clear communication of these principles, it is our view that practitioners will not be able to fulfil their obligations for culturally safe practice.

Cultural safety is about recognising the traumatic, enduring, multigenerational effects of colonisation, including the introduction and continuation of racist policies (within and outside health care) that continue to significantly contribute to the gap between non-Indigenous and Aboriginal and Torres Strait Islander people's health care and health care outcomes. Not recognising racism and its impact on health care delivery is a fundamental flaw within the proposed definition.

CATSINaM would also like to acknowledge the contribution of our nursing and midwifery colleagues in furthering the cause of embedding cultural safety into our health care system. Particularly after the negative backlash from certain elements within the media towards nurses and midwives upon the release of the Codes of Conduct. Given this backlash but also the positive response by an overwhelming number of nurses and midwives and their respective nursing and midwifery organisations (of which there are over 50), it is disappointing that all that hard work has not been harnessed in the proposed definition.

Yours Sincerely



Melanie Robinson
Chief Executive Officer
CATSINaM

Please find below the response from Danila Dilba CEO, Olga Haven to the AHPRA Consultation on the proposed definition of Cultural Safety.

RESPONSE TO AHPRA CONSULTATION ON DEFINITION OF CULTURAL SAFETY
DANILA DILBA Health Service, Darwin

Proposed definition:

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

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

As noted in the discussion paper, a wide variety of terms are used to describe development of culturally appropriate skills and behaviour to improve Aboriginal and Torres Strait Islander health delivery. It would be valuable to have a clear definition of cultural safety and how it differs from other widely used terms that are often taken to mean the same thing, however as this definition is in a sense 'single purpose' definition, an unintended consequence may be that it could add to the confusion surrounding the terminologies, or alternatively, would provide a narrow and prescriptive definition of cultural safety as existing only in a health or Indigenous context.
2. Does this definition capture the elements of what cultural safety is? If not, what would you change?

Although the purpose of defining the term here is in the context of the vision of the National Registration and Accreditation scheme, the definition seems too narrow and should be broadened to take account of the key concepts of the cultural safety model that has evolved over time from its origins in New Zealand and in developing practice in Australia.
A stronger definition of Cultural Safety would:

- encompass awareness of health inequities and social justice, rather than focus solely on cultural differences and acquiring competencies that in effect only aspire to provide more culturally sensitive services,
- acknowledge power imbalances in the delivery of services and the need for patient autonomy and self-management – that is, a context of power sharing in which clients are able to negotiate health services and systems in culturally (and clinically) safe ways,
- challenge institutional and systemic racism and mainstream cultural dominance in health systems and health education

Although much of the work in cultural safety is being developed in Aboriginal and Torres Strait Islander health organisations and representative bodies, the definition is over-restrictive in concentrating so specifically on Aboriginal and Torres Strait Islander clients. It should reflect the diversity of cultures in Australia and the needs of other groups.
3. Do you support the proposed draft definition? Why or why not?

Not in the current form, for the reasons outlined above.

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

There are a number of other definitions and frameworks either existing or in development, including IAHA (Cultural Responsiveness), CATSINaM, AIDA, Rural Health Alliance, amongst health providers'

peak bodies, and in government departments (e.g. NT Health, Territory Families). Those that should be supported would reflect the model/concepts discussed briefly in response to question 2.

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

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15 May 2019

Australian Health Practitioner Regulation Agency
GPO Box 9958
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Australia

Consultation feedback on proposed cultural safety definition

Thank you for the opportunity to submit our feedback on the proposed cultural safety definition.

The Dental Council (the Council) is the regulatory authority tasked under the Health Practitioners Competence Assurance Act 2003 to regulate oral health practitioners in New Zealand. The Council regulates approximately 4800 oral health practitioners. This includes dentists, dental specialists, oral health therapists, dental hygienists, dental therapists, clinical dental technicians, dental technicians and orthodontic auxiliaries.

Our response to your consultation questions follow.

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

The Council commends AHPRA for taking the first steps in defining the delivery of optimal healthcare through a cultural lens. We further applaud AHPRA for prioritising and working alongside the indigenous peoples of Australia to develop the cultural safety definition.

The Council supports a single definition for cultural safety be adopted across the National Scheme. This allows other health agencies, including those delivering services on behalf of AHPRA (such as accreditation and examination agencies), to all adopt and use the same definition.

Common standards and resources across health professions can be developed, including professional competencies and attributes. The definition can form the foundation for a common understanding by health practitioners in Australia of what is meant by cultural safety, and AHPRA's expectation of practitioners' behaviour related to this aspect of patient care can be clearly articulated. Consistency in approach also makes it clear for Aboriginal and Torres Strait Islander patients to know what behaviour to expect from their health practitioner.

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

The proposed definition recognises and respects the fact that the specific health care needs for Aboriginal and Torres Strait Islander Peoples should be determined by their own people and communities.

Two areas are highlighted for your consideration.

Cultural safety versus cultural awareness

The experience and debate in New Zealand around cultural safety versus cultural awareness has led to the development of two broad schools of thought about delivering healthcare through a cultural lens.

Cultural safety is usually viewed from the point of view of the patient and their family/community - ie, what was their experience of the service received and was it delivered in a way that acknowledged and encompassed cultural considerations.

Cultural awareness is usually viewed from the point of view of the practitioner/institution - ie, how do their personal experiences/values/behaviours influence and impact their interaction with and delivery of healthcare to patients who have different experiences/values/behaviours from their own.

Based on our interpretation, the proposed AHPRA definition appears to be reaching for an amalgam of the two schools of thoughts but may not be encompassing both aspects in a balanced way.

Partnership between the health practitioner and patient

The delivery of optimal healthcare requires the establishment of an intentional and deliberate partnership between the patient (and their family and community) and the practitioner (and their practice environment or institution).

The definition refers to two parties (patient and practitioner) involved in the partnership, but somewhat isolates their roles rather than connecting the two parties.

The proposed definition places the responsibility for institutional knowledge, skills, attitudes and competencies to deliver healthcare solely on the health practitioner. Aboriginal and Torres Strait Islanders have the autonomy to determine their health and wellbeing, including the way they receive healthcare. The integral partnership between the two parties are not highlighted in the proposed definition.

It should also be recognised that cultural safety is only one aspect contributing towards achieving optimal health care.

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

The Council supports the proposed definition in principle.

We are unsure about the use of *competencies* in the proposed definition. We consider that knowledge, skills, attributes and attitudes are components of competencies. Consideration may be given to the use of *competence.* In particular, professional competence.

The following definition of professional competence supports the principles covered by the proposed AHPRA definition:

> "Professional competence is the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and the community being served." Epstein and Hundert (2002)

The proposed definition is solely focused on the delivery of optimal healthcare to Australia's indigenous peoples. This was also emphasised in the consultation document.

The Council acknowledges the special place that indigenous peoples of Australia have, and the current inequity of health care within this group. However, the contemporary construct of "culture/cultural" is broader than what is currently reflected in the proposed definition. The proposed definition focuses on ethnicity only, whereas religious, social and other beliefs usually form part of the definition of culture.

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

Covered in our earlier responses.

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

We are looking forward to the outcome of this significant piece of work and further developments in this space. We remain committed to ongoing collaboration with the Dental Board of Australia on any dental specific aspects.

Please do not hesitate to contact me for any further information.

Yours sincerely

Marie Warner

Chief Executive

To whom it may concern,

The Federation of State Medical Boards would like to thank AHPRA for the opportunity to participate in its consultation on the definition of "Cultural Safety." We reviewed the consultation materials with great interest and while we are not in a position to provide specific feedback on the proposed definition based on similar definitions or experiences in our jurisdiction, we wish to commend AHPRA for addressing this issue of great importance for patients and practitioners alike.

We would also like to support the fact that within its definition, AHPRA acknowledges that Aboriginal and Torres Strait Islander individuals, families and communities are best-suited for determining the knowledge, skills, attitudes and competencies required for delivering culturally safe care. This is in line with accepted best practices from across the United States for culturally appropriate decision-making in health care as well.

Thank you once again for the opportunity to participate in AHPRA's consultation. We look forward to continued collaboration between our organizations.

Mark Staz, MA
Director, Continuing Professional Development

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7 May 2019

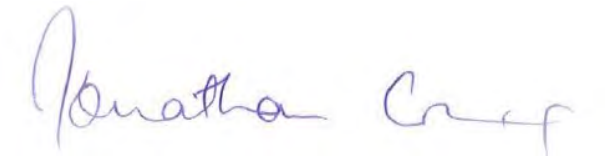
Australian Health Practitioner Regulation Agency
for the National Registration and Accreditation Scheme's Aboriginal and Torres Strait Islander Health Strategy Group in partnership with the National Health Leadership Forum
GPO Box 9958
ADELAIDE SA 5000
Via Email: rap@ahpra.gov.au

Dear Sir/Madam

Re: Consultation around the proposed definition of 'cultural safety'

Please find enclosed collated Flinders University College of Medicine and Public Health (CMPH) submissions for the current public consultation on the National Scheme and NHLF definition of 'cultural safety'. Indigenous Health staff from the CMPH have responded in line with the five key feedback questions. We trust that you will take this feedback into account in your final deliberations and look forward to viewing the outcomes.

Yours faithfully



Professor Jonathan Craig
Vice President and Executive Dean
College of Medicine and Public Health

INSPIRING ACHIEVEMENT

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Consultation with Flinders University Indigenous Heath Staff re the proposed definition of Cultural Safety

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

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

I believe a single definition will be helpful in regards to providing a baseline for cultural safety but this baseline has to be adaptable to recognise the cultural differences and diversity found within Aboriginal and Torres Strait Islander communities and the individual needs of the people within these communities.

I think a single definition used across all health professions registered under the National Scheme is useful, because as noted in the Public Consultation document, there are already a wide variety of terms in use (e.g. cultural awareness, competency, etc.). The broader literature in this area suggests that there is already some confusion amongst health practitioners as to which is more appropriate, and what they mean. Multiple (profession-specific) definitions would potentially add to that confusion, particularly if we are expecting health professionals to work in multi- or inter-disciplinary teams. Having a single definition used by all health professions would, I suspect, help to reduce that level of confusion.

Given that this definition would also inform accreditation processes, some thought would need to be given to what constitutes adequate learning of cultural safety, and what type of profession-specific knowledge may be necessary. At the individual level (i.e. the way that a health practitioner conducts themselves), there would be substantial similarities between professions. However at the institutional level this would need to be tailored – a core element of cultural safety is the critical reflection on both personal and *professional* culture. This means that (future) health professionals need to be aware of the culture of their chosen profession, and what impact this may have on delivery of care. This does not necessarily mean that a single definition would not work, just that there would need to be clarity about what constitutes culturally safe practice at the institutional level for each of the health professions.

I personally think that having multiple organisations coming up with their own definitions for cultural safety will continue to fuel the argument about what cultural safety actually is. I think for the statement of intent there needs to be a definition for how the national scheme defines it though.

Cultural safety is about two way engagement. This should be stated clearly within the definition or as part of the key points. We agree, however there would need to be other core element for inclusion.

Caution is needed with a single definition. However, the definition is broad enough to interpret differences. Also, there may need to be some mechanisms or an evaluation to track and understand those consequences with clear parameters. Attitudes and institutions change overtime, so I think there needs to be a review of the definition every 5-10years.

A single definition will be helpful for Indigenous and non-Indigenous people, communities and institutions. The unintended consequences of the single definition will be some organisations rewriting what they may already have in place or modifying their work/training to fit under the single definition. For example, the definition is different from the one proposed in the Australian Human Rights Commission – Social Justice Report. There would be a need to have a transition period whilst this takes place.

In Aboriginal Culture we show respect to all living creatures and the environment. In practising Traditional Aboriginal Culture we are bound by a set of "cultural rules and instructions" that are taught to Aboriginal people since birth.

Once you receive this knowledge you are automatically underpinned by a set of "cultural protocols" which are already being practised within your immediate community. Aboriginal culture is based on having a respectful relationship and attitude towards your elders and to everything that you have been taught.

The definition of "Cultural Respect" incorporates everything above and below the ground that has a cultural connection. This is reflected in our stories, ceremonies and song-lines on country, which also includes our neighbouring Aboriginal groups across the country.

In order to receive this knowledge you are automatically bound by a set of "cultural protocols" which is underpinned by a respectful attitude to every thing that you have been taught.

In our cultural practises the word "Cultural Safety" is a sub-section of the title "Cultural Respect." The word Cultural Respect as previously mentioned is the making of maintaining a strong culture. It is the essence of our total spiritual well-being. "Cultural Safety" is how we and others conduct our activities within the parameters of this cultural respectful boundary. How to be respectful and sensitive in our activities towards culture and to each other.

Examples of Aboriginal Cultural protocols

- Respect
- Awareness
- Knowledge
- Understanding
- Safety

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

No, the cultural and holistic values of traditional healing that provides social and emotional well-being to Aboriginal and Torres Strait Islander people also needs to be recognised to provide optimal health care.

It captures some of the core elements of cultural safety, in that it recognises both individual and institutional responsibility, and it highlights that care can only be deemed culturally safe by the person (or people) receiving care.

I think one of the issues I have with this definition is that the reference to "knowledge, skills, attitudes and competencies" is very close to the definition of cultural competency (which could cause some confusion for health practitioners, given my response above). They're also very broad terms – what sort of "knowledge, skills, attitudes and competencies" constitute cultural safety and culturally safe care? Going back to the first question (about potential unintended consequences of a single definition), if these four aspects are not defined in some way, it leaves them open to interpretation by health educators and practitioners. While there would need to be some flexibility in how they are implemented according to health profession, it seems like this very broad definition leaves a lot of flexibility and room for interpretation.

It may be necessary to give some definition to these terms, to ensure they are interpreted and applied with at least some consistency across tertiary and health care institutions.

Cultural safety for any individual means that they are valued for who they are and they are never made to feel inferior individually or as a community because of the way they look, feel or behave. That all cultures are equitably valued and respected and inform the basis of policy and delivery of services.

In regard to the whole statement of intent for the National Scheme, the proposed definition of cultural safety in respect to Aboriginal and Torres Strait Islander Peoples seems inadequate in that it implies the ability for acquisition of skills attitudes and competencies. Cultural safety is more than this. I think its needs a slightly more holistic approach in terms of valuing, respecting and incorporating diversity. Moving towards a whole of Australia cultural shift in terms of equity and equitable access to services, especially health and education,

The proposed definition would need to include specific key points. For example, local contexts, gender, locality, language etc. as per consideration upon addressing patient and incorporate a Two-Way engagement.

Yes. It is broad.

I would need to consult more with my peers, but it might include, "it is about shared respect meaning and shared knowledge of learnings."

In Aboriginal Culture:
"Cultural Safety" would mean that we would have a clear understanding how we conduct our behaviour and activities in a culturally appropriate manner. There is this "CULTURAL LINE" between certain people in the community. This line sets the parameters of showing RESPECT and CULTURAL SAFETY in our community. It is a reciprocal process, in English the interpretation is "if you look after me, then I will look after you." You are providing a favour which in turn will be responded in a similar fashion. This is the making of CULTURAL SAFETY. We show respect towards our elders and our community. This is instilled into our community and we know, that as young adults (male and female), there are cultural and family boundaries. These boundaries determine "what you can and can't do." Being respectful of senior cultural men and women in the community. Being aware of the cultural constraint and practises that is around us every day. Knowing your physical and cultural boundaries, showing your respect and knowing your limitations. Having this knowledge provides direction as to your own capabilities. Knowing what is the appropriate course of action to take, in order to progress or move forward. These issues are the making of a culturally safe environment. As long as we follow these cultural protocols, we know that we will have the respect of our elders and our community.

Knowing that your subject material that you are teaching is culturally safe and is not embarrassing or even confronting, showing respect is commonly used in our community in everything that we do. We don't tell stupid

jokes because we are sensitive about what happens to our people and our community. These type of activities are the making of our people. We know the strength of our culture and the spiritual connect to country and how the country responds back to our community. Our people have a strong spiritual connection to our lands we are part and parcel as one, not separate.

In a Western concept:
Cultural Safety could be seen as an interpretation of the above. Being respectful of who we are. Knowing that we have a very strong culture that is based on an old, old, spiritual system. This system is not about personal gain, but is about a better community and environment. Looking after country and family, maintaining that spiritual connection. Being sensitive about how to look after the well-being of all our people and the environment.

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

Yes I do support the proposal and feel it is a positive step towards optimal health care, but it needs to recognise the cultural and traditional needs and differences for holistic health of Aboriginal and Torres Strait Islander people.

I support it to an extent. As noted above, it captures some of the core aspects of cultural safety, but is also potentially open to interpretation which may render the single definition useless (if there is such wide variation in interpretation that learning or usage in one context is not applicable or relevant in a different context). I think if there was more information about what constitutes "knowledge, skills, attitudes and competencies" then I would feel more comfortable supporting this definition.

Another potential issue I can foresee with this definition is that it's applied *only* to Aboriginal and Torres Strait Islander people. I understand entirely the reasons for this, and wholeheartedly support the focus on improving care delivery and outcomes for Aboriginal and Torres Strait Islander Australians. However, there are two issues here. The first is that arguably, this usage of the term 'cultural safety' reinforces the narrow definition of culture as ethnicity (and specifically in this case, Aboriginal and Torres Strait Islander cultures). A primary aspect of cultural safety is the recognition that 'culture' is far more than ethnicity; as demonstrated by the Nursing Council of New Zealand's definition of cultural safety:

> *"…Culture includes, but is not restricted to, age or generation; gender; sexual orientation; occupation and socioeconomic status; ethnic origin or migrant experience; religious or spiritual belief; and disability."* (NCNZ, 2011, p. 7).

The potential is that future and current health practitioners will see this as only applicable to Aboriginal and Torres Strait Islander people, rather than an approach to health care that can benefit all (and potentially transform the health care system). Further, because the connection is made specifically to Aboriginal and Torres Strait Islander Australians (and by extension, Indigenous cultures), my worry is that this may unintentionally homogenise a diverse population – local ethnicities (cultures) may be recognised (e.g. Kaurna, Larrakia, etc.), but other aspects of culture may not be recognised (e.g. age, gender, sexual orientation, disability, etc.), all of which are important factors that impact health care delivery.

Further to this, the other worry I have is the potential for pushback from health practitioners, the general population, and specifically the media. By making cultural safety only applicable to Aboriginal and Torres Strait Islander Australians, I can foresee the Bolts of the world crying about 'special treatment' and 'reverse racism'. Given the recent furore over the inclusion of cultural safety into Nursing codes of practice, there is the potential for this to be a highly contentious issue (I'm not arguing that we should not specifically target health care delivery standards for Aboriginal and Torres Strait Islander Australians, as there is ample evidence and reason to support this approach. My worry is the potential consequences of this on individuals and communities, given some of the rhetoric that gets thrown about by mainstream media – similar to the damaging rhetoric surrounding the Referendum on same-sex marriage).

I have no strong inclination either way. I think it is adequate in the context of the whole statement of intent without having a nationally agreed definition in Australia. But if it could be made more holistic as above that would be better.

In principle, but I believe the definition will need to be reviewed over a period time, especially if unintended consequences go un-checked. Hence, having a form of evaluation and monitoring attached within the implementation.

I do support a single definition. There are now so many cultural definitions, we need to be clear with this as an overarching definition.

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

If you are providing one definition within a medical and health related field then all other frameworks and policies within this sector should be the same, to provide consistency and collusion across the sector.

The Nursing Council of New Zealand has a useful definition that may be provide a good basis for an expanded understanding of 'culture':

> *The effective nursing practice of a person or family from another culture, and is determined by that person or family. Culture includes, but is not restricted to, age or generation; gender; sexual orientation; occupation and socioeconomic status; ethnic origin or migrant experience; religious or spiritual belief; and disability.*
>
> *The nurse delivering the nursing services will have undertaken a process of reflection on his or her own cultural identity and will recognise the impact that his or her own personal culture has on his or her own professional practice. Unsafe cultural practice comprises any action which diminishes, demeans or disempowers the cultural identity and well being of an individual.*
> (NCNZ, 2011, p. 7: NCNZ Guidelines for Cultural Safety, the Treaty of Waitangi and Maori Health in Nursing Education and Practice)

This would obviously need to be adapted to be more broadly applicable rather than focussed on nursing practice, but it does take a more inclusive approach to 'culture' and recognises the central and important role of self-reflection. However it's also not an ideal definition, as it does not recognise institutional roles or responsibilities in the delivery of culturally safe care, and places the burden of responsibility on individual nurses. The recognition of institutional responsibility is definitely a point of strength in the AHPRA definition.

Other organisations to support:

- Australian Indigenous Doctors Association (AIDA)
- CATSINAM
- Australian indigenous Psychologists Association
- NACCHO
- Indigenous Allied Health Association
- Lowitja Institute
- RACGP- Aboriginal and Torres Strait Islander Health Council
- Aboriginal and Torres Strait Islander Health Practitioners
- PRIDOC- Pacific Region Indigenous Doctors Congress
- Indigenous Dentists Association

I have always been guided by the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM) statement which reads:

> "In relation to Aboriginal and Torres Strait Islander health, cultural safety provides a decolonising model of practice based on dialogue, communication, power sharing and negotiation, and the acknowledgement of white privilege. These actions are means to challenge racism at personal institutional levels, ant to establish trust in health care encounters (CATSINaM, 2017,p.11)".
>
> "In focusing on clinical interactions, particularly power inequity between patient and health professional, cultural safety calls for a genuine partnership where power is shared between the individuals and cultural groups involved in health care. Cultural safety is also relevant to Aboriginal and Torres Strait Islander health professionals. Non-Indigenous nurses and midwives must address how they create a culturally safe work environment that is free of racism for their Aboriginal and Torres Strait Islander colleagues (CATSINaM, 2017a)".

While I am guided by the above statement "Cultural Safety" is about respect and to understand what is "Cultural Protocols".

I am respectful of boundaries and by acknowledging the custodians of the lands that I am visiting/and or those that are visiting my country.

As an Aboriginal academic I am mindful of language and that I do not offend anyone from different Aboriginal and Torres Strait Islander cultural backgrounds and communities.

Examples of Aboriginal Cultural protocols include and not limited to:

- Gender balance
- Respect
- Understanding
- Awareness
- Spirituality
- Understanding and
- Non-judgmental

Cultural safety is about working in partnership and building a stronger relationship between Aboriginal and Torres Strait Islander people and non-Indigenous Australians.

I am quite sensitive about our culture and past welfare injustices, however I am trying to educate those to understand that as one of the world's oldest living cultures that 'our stories' need and should be told and hopefully this will create a better understanding amongst the wider population so that we can work better as a whole and to stay stronger. Aboriginal and Torres Strait Islander people have a strong connection to country and this should be acknowledged in order to move forward.

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

I believe that by providing a cultural safety definition that is the same across all frameworks and policies as suggested would provide a uniformity that will streamline a system that often clogs up and causes confusion with the many definitions of cultural safety within each sector. The ability to have the draft and final consultation undertaken by Aboriginal and Torres Strait Islander people will lead to providing the requirements you endeavour. Incorporating the recognition of traditional and cultural health will lead to greater understanding of their contribution towards Aboriginal and Torres Strait Islander holistic, social and emotional wellbeing views, providing optimal health care to the people and their communities.

Consideration for two (male and female) Community Representatives to be included on National schemes Aboriginal and Torres Strait Islander Health Strategy Group.

The definition will need to be monitored through the implementation phase. Also, there will need to be clear guidelines or a Board that oversees adverse effects or consequences of the definition.

It would be good to have an Elders Council to also provide advice and that this is part of this consultation. If AHPRA had not received any information from Elders or Healers, that there is an attempt to do so.

General Practice Training Tasmania
Submission to NRAS Consultation
Feedback on the proposed definition of cultural safety

This is the proposed definition we are seeking your feedback on:
Cultural safety is the individual and institutional knowledge, skills, attitudes and competencies needed to deliver optimal health care for Aboriginal and Torres Strait Islander Peoples as determined by Aboriginal and Torres Strait Islander individuals, families and communities.

Q1: Will having a single definition for the National Scheme and NHLF be helpful? Why or why not?

GPTT supports having a single definition for the National Scheme and National Health Leadership Forum.

Q2: Does this definition capture the elements of what cultural safety is? If not, what would you change?

GPTT believes the definition captures the elements of cultural safety, however is aware that this is stated as an end point and therefore does not fully capture the continuum of learning required to provide a culturally safe environment. AIDA's 2017 Position Paper on Cultural Safety for Aboriginal and Torres Strait Islander Doctors, Medical Students and Patients refers to cultural safety as the accumulation and application of knowledge of Aboriginal and Torres Strait Islander values, principles and norms. Supporting this viewpoint GPTT believes that cultural safety is best viewed on a continuum of care with cultural awareness being the first step in the learning process (which involves understanding difference), cultural sensitivity being a next step (where self-exploration occurs) and cultural safety being the final outcome of this process.

Q3: Do you support the proposed draft definition? Why or why not?

GPTT supports the proposed draft definition with a caveat that acknowledges the need for flexibility in training options to recognise the journey to providing culturally safe health care including development of cultural awareness and respect of Indigenous values, principles and

norms. This requires ongoing commitment and accumulation of knowledge.

Q4: What other definitions, frameworks or policies should NRAS and NHLF's definition of cultural safety support?

The National Scheme should look at frameworks and policies from the United Nationals Declaration on Rights of Indigenous Peoples; Reconciliation Australia; the National Aboriginal Community Controlled Health Organisation and the Australian Indigenous Doctors Association.

Q5: Is there anything else you'd like to tell us about the draft definition?

GPTT believes a non-judgemental and respectful approach to Aboriginal health care is important to 'Closing the Gap' and is committed to embedding cultural safety into health care through its training program. As such GPTT has developed cultural training programs that recognise the differing stages of learner experience and development. Building on this work, GPTT has worked in collaboration with the Tasmanian Aboriginal Centre to develop a Reconciliation Action Plan and we would recommend this approach for all organisations. We look forward to receiving the outcomes from this consultation.

Reference:
AIDA Position Paper – Cultural Safety for Aboriginal and Torres Strait Islander Doctors, Medical Students and Patients, 2017,
https://www.aida.org.au/wp-content/uploads/2017/06/Cultural_Safety.pdf

Indigenous Allied Health Australia

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Australian Health Practitioner Regulation Agency
Aboriginal and Torres Strait Islander Health Strategy Group
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Re: Public consultation on the definition of 'cultural safety'

Indigenous Allied Health Australia (IAHA) is a national not for profit, member based Aboriginal and Torres Strait Islander allied health organisation and a member of the National Health Leadership Forum (NHLF). IAHA support the intention to embed an informed understanding of culturally safety, and to promote translation to culturally safe practise, across both the regulatory environment and the work of the Australian Health Practitioner Regulation Agency (AHPRA), through the National Scheme. IAHA provides the following comments on the consultation definition below:

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

We note that the definition above is not proposed to be a singular definition for cultural safety in all contexts, but rather is designed to be a definition which can be applied consistently within the regulatory environment and with a primary focus on the provision of - and access to - care for Aboriginal and Torres Strait Islander peoples. To do so, we encourage AHPRA to support – for example through the development of guidelines – the correct utilisation of existing definitions.

IAHA, through our work and public positions, utilise the definition of cultural safety as *"a philosophy of practice that is about how a person does something, not what they do, in order to not engage in unsafe cultural practice that '… diminishes, demeans or disempowers the cultural identity and wellbeing of an individual".*[1]

This definition is based on that of the New Zealand Council of Nursing[2] that *'the effective nursing practice of a person or family from another culture, and is determined by that person or family. Culture includes, but is not restricted to, age or generation; gender; sexual orientation; occupation and socioeconomic status; ethnic origin or migrant experience; religious or spiritual belief; and disability.*

[1] Williams, R. (1999) *'Cultural Safety – what does it mean for our work practice?'*, Australian and New Zealand Journal of Public Health https://doi.org/10.1111/j.1467-842X.1999.tb01240.x
[2] Nursing Council of New Zealand (2011) Guidelines for Cultural Safety, the Treaty of Waitangi and Maori Health in Nursing Education and Practice: Regulating nursing practice to protect public safety

The nurse delivering the nursing service will have undertaken a process of reflection on his or her own cultural identity and will recognise the impact that his or her personal culture has on his or her professional practice. Unsafe cultural practice comprises any action which diminishes, demeans or disempowers the cultural identity and well being of an individual.'

These definitions are founded in Indigenous knowledge and informed directly by the work of Māori nurses led by Dr Irihapeti Ramsden. The strengths of cultural safety as defined in these works include that cultural safety:

- Places the responsibility for action on the part of the person or system (i.e. it is about how they do something);
- Recognises unequal distribution of power both between cultures (the role of dominant culture) and power imbalance between, for example, practitioner and patient and systems and individuals;
- Recognises that cultural safety requires understanding and awareness of one's own culture and how this influences action. This is distinctly different from concepts such as cultural awareness which is othering and places the focus on learning aspects of (an)other culture;
- Requires lifelong reflection and learning;
- Recognises that whether cultural safety is achieved is determined by the experience of the recipient of services/care;
- Is applicable across populations - including Aboriginal and Torres Strait Islander peoples - to the benefit of all Australians. Cultural safety is another example of Indigenous knowledges and approaches informing improvements in mainstream services along with, for example, community-controlled services approach to care coordination and holistic care; and
- Is applicable across settings which contribute to access to quality health care including provision of clinical services, education and research.

IAHA work to promote cultural safety and cultural responsiveness in health, education and associated sectors. Cultural responsiveness is the action required to implement cultural safety and to transform systems, incorporating knowing, being and doing. IAHA note that this emphasis on action (doing) is absent in the consultation definition. It is important, therefore, that the definition itself accurately reflects the components of cultural safety listed above and provides an entry to further understanding cultural safety and responsiveness. The utilisation of a concise, common definition must evoke and/or facilitate access to a body of knowledge that strengthens the collective and practical understanding of cultural safety.

In addition to the feedback provided through this consultation phase, IAHA would encourage AHPRA to consider the following in applying any definition of cultural safety within the National Scheme:

- A communication strategy to ensure that all stakeholders are informed of *how* the definition of cultural safety will be incorporated within the scheme. This should include public communication and messaging to ensure that the public discourse is informed and not unduly influenced by vested interests, as experienced with the inclusion of cultural safety within the nursing and midwifery codes of conduct.
- Clear direction and guidance from AHPRA - informed by Aboriginal and Torres Strait Islander expertise - for how stakeholders utilise the definition. This is essential to

ensure that the definition is not incorrectly used or contextualised, which may result in further examples of cultural safety being incorrectly conflated with related - but distinct - terminology such as 'cultural awareness' and 'cultural competence'.

- Clear and well communicated mechanisms and support for individuals, families and communities to identify and respond to culturally unsafe care, services and institutions through AHPRA.

IAHA support the inclusion of strong and clear references to cultural safety within the National Scheme as one mechanism to achieve systemic, transformational change toward a more culturally safe system. It should also be emphasised that cultural safety is not a separate and additional component of quality healthcare, but is intrinsically linked to health care access, clinical safety and capability, and to the health impact and outcomes people experience. IAHA look forward to continuing to work with AHPRA, the National Registration and Accreditation Scheme's Aboriginal and Torres Strait Islander Health Strategy Group and the National Health Leadership Forum to improve access to culturally safe and responsive health care.

Indigenous Dentists' Association Australia

Cultural safety – IDAA submission to Australian Health Practitioner Regulation Agency

Background:

The Australian Health Practitioner Regulation Agency (AHPRA) has called for feedback from all interested persons and organisations, particularly Aboriginal and Torres Strait Islander individuals, organisations and health experts on the definition of 'cultural safety'. The public consultation is being undertaken by the National Registration and Accreditation Scheme's Aboriginal and Torres Strait Islander Health Strategy Group (Strategy Group) in partnership with the National Health Leadership Forum (NHLF).

The final definition will be applied in the context of the National Registration and Accreditation Scheme (National Scheme), and by NHLF member organisations, as a foundation for embedding cultural safety across the National Scheme. This includes the opportunity for using the final, agreed definition in documents such as future Codes of conduct for the professions regulated in the National Scheme and/or registration standards and guidelines.

The proposed definition that AHPRA is seeking feedback is:

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

Indigenous Dentists' Association Australia:

Indigenous Dentists' Association Australia (IDAA) is the national member-based organisation for Aboriginal and Torres Strait Islander dentists and dental students. IDAA was founded in 2004 with the purpose of improving Indigenous oral health in Australia. IDAA is a member of the NHLF and the Campaign for Indigenous Health Equality (Close the Gap).

Introduction:

The terminology 'cultural safety' was first described within the Maori health setting in Aotearoa/New Zealand nearly 30 years ago. The concept has been translated from these bicultural origins into the multicultural context of Aboriginal and Torres Strait Islander peoples in Australia. This translation has produced both variation and commonalities. The understanding of the concept is continuing to be developed by Aboriginal and Torres Strait Islander people within their organisations, academies and health professions.

Fundamentally cultural safety is a philosophy for the health practitioner; it is not about what care is provided but how care is provided. At the core of cultural safety is the recognition by the health practitioner of the power differential within each encounter with a patient. Cultural safety has been described as a decolonising method of practice, reliant upon negotiation and power-sharing through discussion and effective communication, and requires health practitioners to acknowledge their own culture, including white privilege.

The presence, or absence, of cultural safety must be defined by the Aboriginal and Torres Strait Islander peoples receiving the care.

This is a developing policy area where the theory and definitions have not been clarified. There is still debate as to whether cultural safety applies to the workplace experiences of Aboriginal and Torres Strait Islander health professionals.

Proposed definition of cultural safety:

The proposed definition describes cultural safety as the attributes of a healthcare organisation or health individual health practitioner. This perspective does not align with current understanding which defines cultural safety in term of the patient experience of Aboriginal and Torres Strait Islander people. The proposed definition retains a power imbalance because it centres the definition around organisational or individual attributes.

A way forward could be to place Aboriginal and Torres Strait Islander patient experience at the core of a definition and then acknowledge the individual health practitioner attributes necessary for delivery.

For example:

'Cultural safety is the Aboriginal and Torres Strait Islander patient experience of the provision of optimal health care, as determined by Aboriginal and Torres Strait Islander patients, that requires individual health practitioner knowledge, skills, attitudes and competencies to deliver.'

Because cultural safety theory continues to develop within the unique Aboriginal and Torres Strait Islander milieu in Australia it would be sensible for AHPRA to regularly review the definition.

AHPRA should seek an alternative terminology, such as institutional racism, to describe the role of healthcare organisations in delivering sub-optimal care for Aboriginal and Torres Strait Islander people.

Dr Gari Watson

President

13 May 2019

Cairns
Singapore
Townsville

JAMES COOK UNIVERSITY
AUSTRALIA

Response to the AHPRA Consultation paper on the definition of 'cultural safety'

Associate Professor Rebecca Sealey, Dr Lynore Geia, Dr John Smithson, Dr Kerry Anne McBain, and Mr Donald Whaleboat; on behalf of the Division of Tropical Health and Medicine, James Cook University. May 2019.

Introduction – JCU Context

James Cook University (JCU) is a regional University that has a significant proportion of domestic students identifying as Australian Aboriginal and/or Torres Strait Islander. JCU's Strategic Intent is to create a brighter future for life in the tropics world-wide, through graduates and discoveries that make a difference. JCU takes pride in training health professionals for future practice in the regional, rural and remote communities, with a particular focus on Aboriginal and Torres Strait Islander Peoples health, to make a sustained and meaningful contribution to the Australian Government's Close the Gap strategy. JCUs commitment to Aboriginal and Torres Strait Islander Peoples education, health and wellbeing is evidenced through our enactment of the JCU Reconciliation Action Plan. JCU provides training for entry to the following AHPRA registered professions: Dentistry, Medicine, Midwifery, Nursing, Occupational Therapy, Physiotherapy, Pharmacy, and Psychology.

Proposed Definition as provided by AHPRA

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

JCU feedback regarding the proposed definition of 'cultural safety'

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

Yes, a single definition will be helpful as it provides standardised nomenclature to underpin education and practice, enabling consistency across applications. A single definition may assist with driving policy and practice change. An unintended consequence of the application of a single definition will be the need to recalibrate and realign existing definitions/applications with the new standard to avoid the loss of existing work/knowledge if current terms are not subsumed by the term 'cultural safety'.

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

The proposed definition is missing articulation of the other critical elements of cultural safety, these being cultural awareness and cultural sensitivity (Ramsden, 2002). We recommend explicitly including the terms 'awareness' and 'sensitivity' in the definition (proposed alternate wording provided in response to Question 4).

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

We do not support the proposed draft definition. We recommend modification with respect to the following items/concepts:

- Include the critical elements of 'awareness' and 'sensitivity' along with 'safety'
- Remove 'skills' and 'competencies' and focus on the concepts of application and practice.
- Remove reference to 'individual' and 'institutional' from the first statement to ensure that the practice remains the responsibility of all.

We propose the following alternate definition:

Cultural safety is the knowledge, awareness and sensitivity of issues and cultural differences that impact the health of Aboriginal and Torres Strait Islander Peoples; that when applied, will deliver optimal health care for Aboriginal and Torres Strait Islander Peoples, as determined by Aboriginal and Torres Strait Islander individuals, families and communities.

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

Existing terminologies within frameworks, policies and white papers should be realigned with the new definition to avoid inadvertent loss of existing knowledge.

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

JCU recognises that people progress through the continuum of understanding and practice from novice to highly competent; and that peoples' understanding and capabilities will evolve at different rates, based on different experiences. Implementation of a standardized definition into practice should also consider these concepts.

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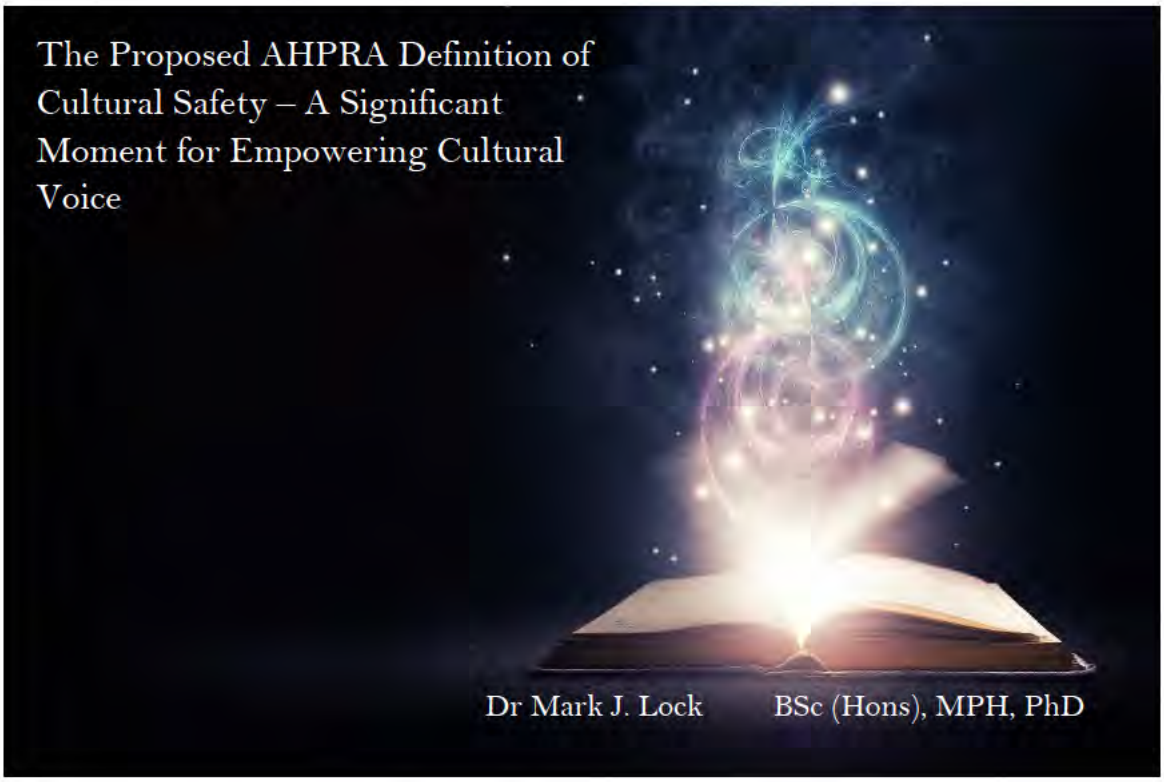
Reference

Ramsden, I. (2002). *Cultural safety and nursing education in Aotearoa and TeWaipounamu*. Wellington: University of Wellington.



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

Contents

Introduction

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

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

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

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

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

Statement of Reflexivity

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

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

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

Cultural Validity

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

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

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

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

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

Understanding the 'National Scheme'

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

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

Australian Cultural Safety Ecosystem

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

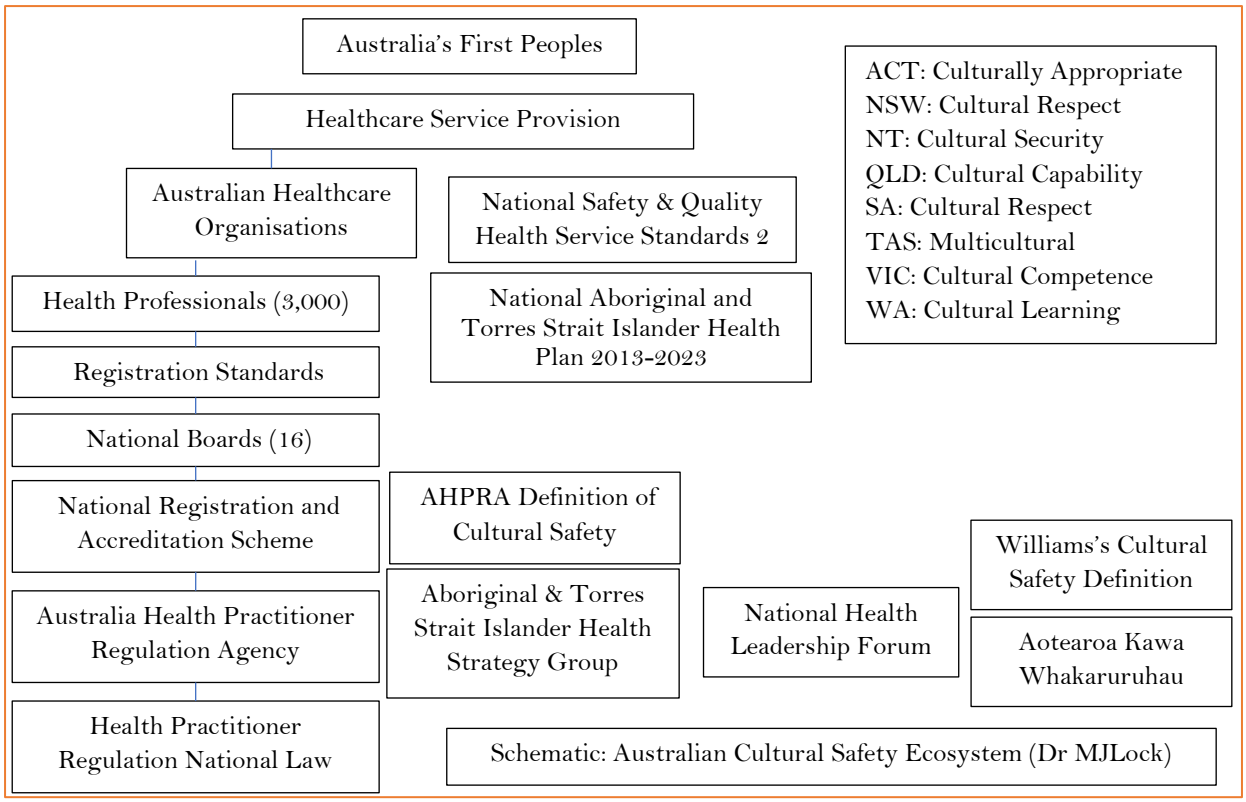


Figure 1: Australian Cultural Safety Ecosystem (Dr MJLock)

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

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

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

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

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

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

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

Theory of Change

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

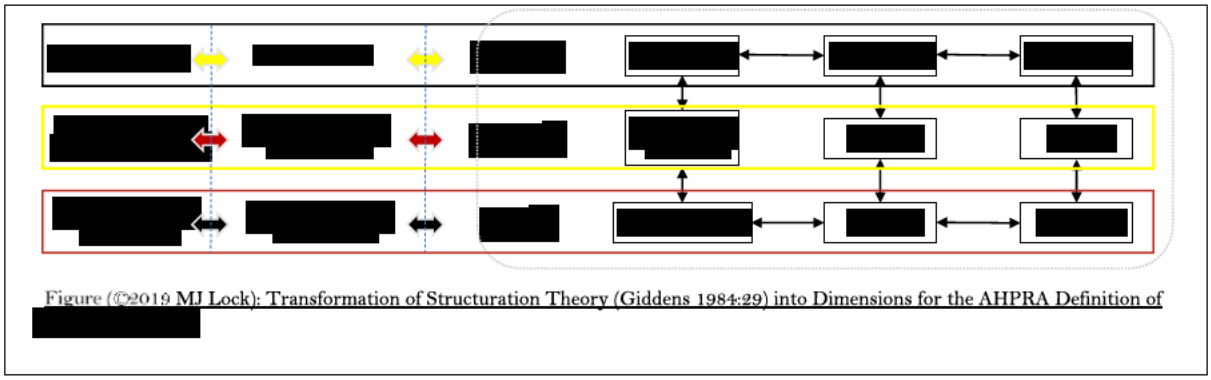


Figure 2: Structuration Theory for the AHPRA Definition of Cultural Safety

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

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

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

Feedback questions

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

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

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

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

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

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

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

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

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

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

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

Vital cultures and amorphous attitudes allow for redefinition

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

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

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

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

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

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

The ethic of cultural safety is about power and culture

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

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

Clearly emphasising culture as human interactions

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

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

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

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

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

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

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

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

A strife of principles

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

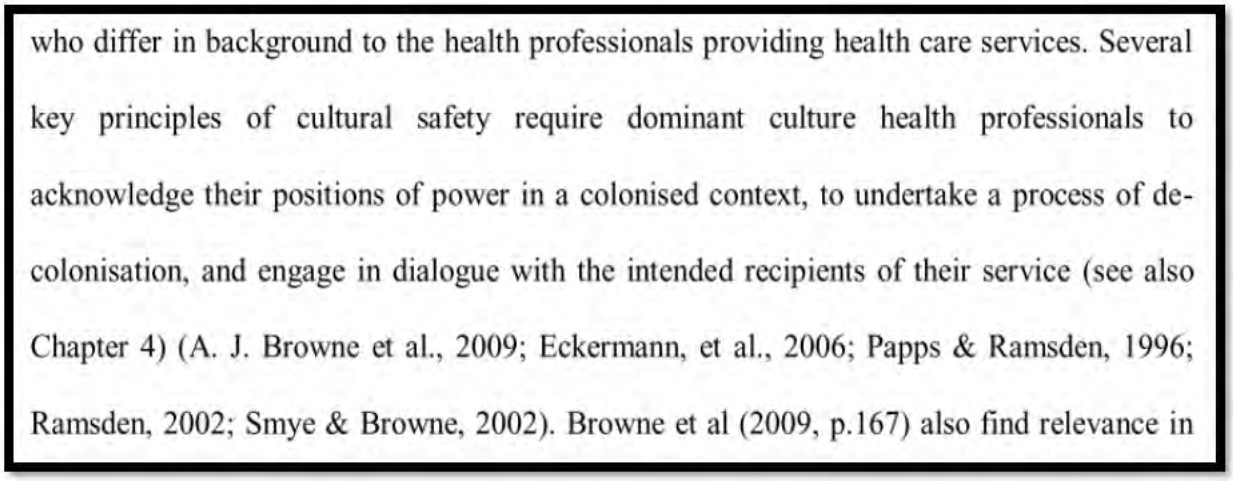
Ramsden (2002), citing Mason Durie (1989) notes that extracting principles and applying them to contemporary health situations assists people to translate treaty (of Waitangi) guarantees into possibilities for action.[40] This translational process is where the translators biases are carried into the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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Figure 4: AHPRA Proforma for Cultural Safety

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

Conclusion

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

Table 1: Australian Usage of Cultural Safety

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

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

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

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

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

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

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

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

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

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

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20 May 2019

Shae Bradshaw
Board Services Officer
Medical Board of Australia

Via email rap@ahpra.gov.au

Tēnā koe

Consultation on the definition of 'cultural safety'

Thank you for providing the Medical Council of New Zealand (Council) the opportunity to give feedback to AHPRA on the definition of 'cultural safety' released by the National Registration and Accreditation Scheme's Aboriginal and Torres Strait Islander Health Strategy Group (Strategy Group) in partnership with the National Health Leadership Forum (NHLF).

We acknowledge the leadership you have demonstrated in undertaking this work, which is being led appropriately, by Aboriginal and Torres Strait Islander health leaders.

As the medical regulator in New Zealand, one of Council's responsibilities is to set standards of cultural competence that will enable effective and respectful interaction with Māori. Council sees it has an important role to play and to this end, one of our key strategic directions is focused on how we can support doctors in the further development of a culturally competent workforce. Our view is that by further improving the cultural competence of the workforce, to ensure the delivery of culturally-safe care, it will lead to better health outcomes for Māori and create greater health equity.

We are working in partnership with Te Ohu Rata o Aotearoa (Te ORA) Māori Medical Practitioners Association in this work. Council documents, including standards for doctors, are being reviewed and updated to reflect the evolution of cultural competence with an increasing recognition of cultural safety. Essentially, we are seeking to highlight the power relationships and inequities that exist within health care and to focus on patients' experience to define and improve the quality of care provided.

In New Zealand, we have yet to establish a universally-accepted definition of 'cultural safety'. Therefore, we are not presently in a position to comment on your proposed definition. That said, Council would welcome the opportunity for discussion in the future as our work progresses in this important area.

Council will be consulting on its draft cultural competence standards this month and would welcome your input. We will send you a copy of our consultation documents when they are available. Subject to consultation feedback, Council and Te ORA have chosen to use the term cultural competence, in recognition of New Zealand's statutory use of the term with respect to the regulators' role. However, our proposed definition of cultural competence is well aligned with your proposed cultural safety approach.

We are also hosting a symposium in late June focused on this important topic. We look forward to welcoming the two AHPRA representatives who have registered to attend.

If you have any questions in the meantime, you are welcome to contact Senior Policy Adviser and Researcher, Kanny Ooi on kooi@mcnz.org.nz.

Nāku iti noa, nā

Joan Simeon
Chief Executive

Dr Curtis Walker
Council Chair

Dear Shae,

Just to confirm that Medical Deans Australia and New Zealand endorses this response, developed by the Indigenous medical education leaders in our member medical schools.

Regards

Helen Craig
Chief Executive Officer | Medical Deans Australia and New Zealand

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Medical Deans acknowledges the traditional custodians of the lands, seas and waters where we live and work and their connection to community. We pay our respects to their Elders past, present and emerging.

From: Caitlin Ryan [mailto:ryanc@unimelb.edu.au]
Sent: Wednesday, 15 May 2019 9:16 AM
To: Shae.Bradshaw@ahpra.gov.au; rap@ahpra.gov.au
Cc: Odette Mazel <omazel@unimelb.edu.au>; A/Prof. Lilon Bandler <lbandler@unimelb.edu.au>; Helen Craig <hcraig@medicaldeans.org.au>; Shaun Ewen <shaun.ewen@unimelb.edu.au>
Subject: Re: Consultation on cultural safety definitions

Dear Shae,
Please find attached a response to the *Consultation on cultural safety definitions* from the Leaders in Indigenous Medical Education (LIME) Network.
Please contact me if you have any questions.
All the best,
Caitlin Ryan

Caitlin Ryan | Project Manager
Leaders in Indigenous Medical Education (LIME) Network
Faculty of Medicine, Dentistry and Health Sciences
141 Barry Street, Carlton | The University of Melbourne
I am in the office Mondays, Tuesdays and Wednesdays.
Ph. +61 3 90358294 | www.limenetwork.net.au |Sign up as a member today!

The LIME Network is a Program of Medical Deans Australia and New Zealand funded by the Australian Government Department of Health.

National Health Practitioner
Ombudsman and
Privacy Commissioner

15 May 2019

Aboriginal and Torres Strait Islander Health Strategy Group
(Strategy Group)

National Health Leadership Forum (NHLF)

By email: rap@ahpra.gov.au

Dear Strategy Group and NHLF

I refer to the public consultation on the joint review of a draft definition of cultural safety to be used in the context of the National Registration and Accreditation Scheme (National Scheme) and for the purposes of the NHLF and their members.

The National Health Practitioner Ombudsman and Privacy Commissioner (NHPOPC) **supports** the proposed definition, particularly as the NHPOPC recognises that what constitutes culturally safe practice should be determined by Aboriginal and Torres Strait Islander individuals, families and communities themselves. The NHPOPC also agrees with the definition being led by Aboriginal and Torres Strait Islander health leaders.

Role of the NHPOPC

The role of the NHPOPC is to provide ombudsman, privacy and freedom of information oversight of the Australian Health Practitioner Regulation Agency (AHPRA) and the 15 National Boards.

We handle complaints and, where appropriate, conduct investigations into the administrative processes of AHPRA and the National Boards in order to assist people (both members of the public and health practitioners) who are dissatisfied with the way a matter has been handled. We also work with AHPRA and the National Boards to address systemic issues which have been identified during the course of our complaint handling activities.

Overview of NHPOPC complaints data

The NHPOPC recorded 794 approaches during the 2017–18 financial year. This was the NHPOPC's busiest year to date, with 24% more approaches in comparison with 2016–17. After assessment, 444 of the approaches were recorded as complaints about AHPRA and/or one of the National Boards.

The overwhelming majority of complaints received by the NHPOPC (65% in 2017–18) concerned the administrative processes of AHPRA and the National Boards in relation to handling notifications about the health, conduct or performance of health practitioners. The second largest category was complaints about registration, which represented 28% of all complaints in 2017–18. It is noted that we currently have minimal relevant complaint data in relation to how AHPRA and the National Boards handle matters associated with cultural safety.

Definition of cultural safety

Notwithstanding our limited complaint data, the NHPOPC supports the proposed definition as well as the need for a single definition across the National Scheme and NHLF. Aligning the definition across the regulated health professions and NHLF should:

- foster a consistent approach to cultural safety
- provide a baseline to underpin the work that AHPRA, the National Boards and Accreditation Authorities are doing to include specific mention of cultural safety in standards, codes and guidelines
- support the goals of the Strategy Group, which the NHPOPC strongly endorses, to:
  - embed cultural safety in how practitioners work
  - increase access to culturally safe health services for Aboriginal and Torres Strait Islander Peoples
  - ultimately promote health equity for Aboriginal and Torres Strait Islander Peoples.

In relation to the consultation questions, the NHPOPC:

- does not foresee any unintended consequences to the single definition, as it allows for the rich diversity of Aboriginal and Torres Strait Islander cultures across Australia in its wording
- has no suggested changes, as the definition captures the elements of cultural safety, and in particular its need to be defined by Aboriginal and Torres Strait Islander Peoples receiving the health care, their families and communities.

It is clear from the consultation documentation that the Strategy Group and the NHLF have put significant work into the proposed definition. The NHPOPC has no further comments but applauds the efforts of the Strategy Group and the NHLF to create a national definition of cultural safety to lead to improved health equity for Aboriginal and Torres Strait Islander Peoples.

Thank you for the opportunity to comment.

You are welcome to contact this office on 1300 795 265 or by email via complaints@nhpopc.gov.au if you require any further information.

Yours sincerely

Richelle McCausland
National Health Practitioner Ombudsman and Privacy Commissioner

AHPRA defining cultural safety

(Submitted electronically: Wednesday 15 May 2019, 2.30pm)

Proposed definition

The National Scheme and NHLF have agreed on a draft definition of cultural safety to be used in the context of the National Scheme and for the purposes of the NHLF and their members.

Please note, **we are not seeking feedback on a national definition** of cultural safety for all governments/jurisdictions and purposes across Australia.

Rather, we seek feedback for the purpose of the National Scheme's and NHLF's core business. The intention is for the new, agreed definition to provide a consistent baseline definition for use in the National Scheme.

> **This is the proposed definition we are seeking your feedback on:**
>
> *Cultural safety is the individual and institutional knowledge, skills, attitudes and competencies needed to deliver optimal health care for Aboriginal and Torres Strait Islander Peoples as determined by Aboriginal and Torres Strait Islander individuals, families and communities.*

Feedback questions

We invite your feedback on the proposed draft, and specifically your views on these questions:

1. Will having a single definition for the National Scheme and NHLF be helpful?

   YES

   Why or why not?

   It ensures that all practitioners have a common understanding of what cultural safety is.

2. Are there unintended consequences of a single definition?

   YES. Many peak bodies are embracing the philosophy of cultural safety. Therefore AHPRA's definition may not necessarily match those of the organisations where practitioners are based. This may lead to some practitioners getting confused messages about cultural safety. Listed below in Point 5 are examples from a no. of peak bodies.

3. Does this definition capture the elements of what cultural safety is?

   NO

   If not, what would you change?

   Need to have a section *Why is there a need for cultural safety?*

   Provide examples of what cultural safety is in practical terms.

4. Do you support the proposed draft definition?

NO.

Why or why not?

- No clear definition provided. **What does cultural safety look like / feel like in practice?**

- If cultural safety focuses only on Aboriginal/Torres Strait Islander peoples, there is the tendency for it to be seen as another form of *special treatment just for them.*[i] This could lead to resentment/resistance by practitioners to provide service in a culturally safe manner. Therefore, the concept of cultural safety should be for all peoples accessing services and for all staff working in these services.

- On the other hand, it is important to note the specific requirements of Aboriginal and Torres Strait Islander people given the impacts of colonisation, the significant disparity in health status and recognition as First Peoples.

- Needs to be in plain English

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

Many peak agencies (government / non-government) acknowledge the importance of cultural safety in their work practices. Whilst some definitions focus only on the Aboriginal/Torres Strait Islander experience, other definitions are broader to reflect a change in population demographics. Below is a small selection of other definitions.

Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM)[ii]

Cultural safety is the recipient's own experience and cannot be defined by the caregiver …. by promoting a framework of cultural safety to inform attitudes and behaviours in the provision of care by health professionals to Aboriginal and Torres Strait Islander individuals and communities, so individuals and their families feel culturally secure, safe and respected.

It is also important to emphasise that cultural safety is as important to quality care as clinical safety.[iii]

Nursing and Midwifery Board of Australia[iv]

Culturally safe and respectful practice requires having knowledge of how a midwife's own culture, values, attitudes, assumptions and beliefs influence their interactions with women and families, the community and colleagues.

Committee of Deans of Australian Medical Schools[v]

Ensuring that those individuals and systems delivering health care are aware of the impact of their own culture and cultural values on the delivery of services, and that they have some knowledge of, respect for and sensitivity towards the cultural needs of others.

Royal Australian College of General Practitioners[vi]

Cultural safety training requires an awareness of how the practitioner's own values can influence their practice, but it has a focus on outcomes for health services and their patients.

Cultural safety is defined as 'an outcome of health practice and education that enables safe services to be defined by those who receive the service'. Strategies aim to create an

environment that is 'safe for people: where there is no assault, challenge or denial of their identity, of who they are and what they need; where there is a shared respect, shared meaning, shared knowledge and experience of learning, living and working together with dignity and truly listening'. Cultural safety training is more in-depth and aims to result in behavioural change.

Royal Australian and New Zealand College of Obstetricians and Gynaecologists[vii]

Cultural competency strives to underpin a reciprocal relationship between service provision and the meeting of cultural needs. It is widely accepted that cultural competency needs to occur at an organisational, systemic and individual level.

The principles that guide cultural competency are based on:

- recognition of the importance of reciprocal trust between health care provider and patient;

- recognition that a patient's cultural background may influence their understanding, assimilation and acceptance of health information and behaviour; and similarly that the health care provider's cultural background can also influence the interaction;

- recognition that giving all patients the ability to make informed choices will result in better outcomes for the patient, the health care provider, and the health service, irrespective of the cultural background of any person involved. The College encourages all Fellows, Members, and Affiliates to embrace and develop cultural competency in their work.

Australian Indigenous Doctors' Association[viii]

Cultural safety refers to the accumulation and application of knowledge of Aboriginal and Torres Strait Islander values, principles and norms. It is about overcoming the cultural power imbalances of places, people and policies to contribute to improvements in Aboriginal and Torres Strait Islander health and increasing numbers within, and support for, the Aboriginal and Torres Strait Islander medical workforce. AIDA views cultural safety on a continuum of care with cultural awareness being the first step in the learning process and cultural safety being the final outcome. This is a dynamic and multi-dimensional process where an individual's place in the continuum of care can change depending on the setting.

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

Whatever the words AHPRA use in their final version of this definition, it needs to be in plain English

Need to reflect on who is the target audience for this definition and will they be able to translate AHPRA's definition into their day-to-day practice.

The definition needs to have context:

- why is there a need for cultural safety and

- what are the potential impacts if cultural safety is not practised

The definition needs to be broader to reflect the changing demographics of the Australian society, but also reflecting the changing landscape of identity relating to sexuality and religious beliefs.

If the cultural safety definition focuses only on the experiences of Aboriginal/Torres Strait Islander peoples, it negates the experiences of many other people who experience discrimination based on their race, class, gender, sexuality, religious beliefs and so on.

If people experience any form of discrimination or unconscious bias because of their difference, it sets the tone for the rest of the experience in the service.

Cultural safety is a 2 way process – clients should feel culturally safe when accessing services; staff should be able to work in a culturally safe environment.

Cultural safety is about *how we make people feel, and treating people the way that they would like to be treated but taking into account any cultural factors if we need to.*

In closing, culturally safety means that

… all people can access health care and health workers can come to work without fear of discrimination or bias based on their nationality, beliefs or sexuality. To achieve this, the reciprocal relationship between the health practitioner and the health care recipient should be viewed as one of mutual respect and understanding and be seen as an opportunity to learn from each other - building a trusting relationship for optimum health outcomes.

REFERENCES

[i] ***Speaking Out*** with Larissa Behrendt, 11 March 2019. Audio of panel discussion. Duration: 21 mins; 53 secs. *Quote from Associate Professor Chelsea Bond, Poche Centre for Indigenous Health, University of Queensland* https://www.abc.net.au/radio/programs/speakingout/coronial-panel-pt-1/10884192 (Site accessed 30 April 2019)

[ii] **Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM)** *Cultural Safety Position Statement* https://www.catsinam.org.au/static/uploads/files/cultural-safety-endorsed-march-2014-wfginzphsxbz.pdf Site accessed Tuesday 30 April 2019.

[iii] **Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM)** *CATSINaM definition of Cultural Safety* https://www.catsinam.org.au/policy/cultural-safety Site accessed Tuesday 30 April 2019.

[iv] **Nursing and Midwifery Board of Australia** *Code of conduct for midwives*: *Principle 3.2 Cultural safe and respectful practice* (page 9). https://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards.aspx Site accessed Tuesday 30 April 2019

[v] **Committee of Deans of Australian Medical Schools (CDAMS) (August 2004). *CDAMS Indigenous Health Curriculum Framework (page 8),* published by VicHealth Koori Health Research and Community Development Unit on behalf of CDAMS.**
https://medicaldeans.org.au/md/2018/07/CDAMS-Indigenous-Health-Curriculum-Framework.pdf Site accessed Tuesday 30 April 2019

[vi] **Royal Australian College of General Practitioners (RACGP)** *Cultural awareness and cultural safety training,* pages 1-2.
https://www.racgp.org.au/FSDEDEV/media/documents/Faculties/ATSI/NFATSIH-Cultural-awareness-and-safety-training.PDF Site accessed Tuesday 30 April 2019

[vii] **Royal Australian and New Zealand College of Obstetricians and Gynaecologists** (RANZCOG) (2018) *Cultural competency* https://www.ranzcog.edu.au/RANZCOG_SITE/media/RANZCOG-MEDIA/Women%27s%20Health/Statement%20and%20guidelines/Workforce%20and%20Practice%20Issues/Cultural-Competency-(WPI-20)-March-2018.pdf?ext=.pdf Site accessed Thursday 9 May 2019

[viii] **Australian Indigenous Doctors' Association** *Cultural Safety Factsheet*
https://www.aida.org.au/wp-content/uploads/2018/07/Cultural-Safety-Factsheet_08092015.docx.pdf
Site accessed Thursday 9 May 2019

Submission to the Australian Health Practitioners Regulatory Authority.

Definition of Cultural Safety.

Prepared by Nunkuwarrin Yunti of South Australia Inc.

May 2019.

Introduction

Nunkuwarrin Yunti of South Australia Inc. welcomes the opportunity to provide a submission to the Australian Health Practitioners Regulatory Authority (AHPRA) on the proposed definition of 'Cultural Safety'.

As an Aboriginal Community Controlled Health Service has over 45 years of experience in leading the way in the design and delivery of contemporary culturally based health and social & emotional wellbeing services to build a healthy Aboriginal and Torres Strait Islander community.

As a key Aboriginal organisation that employs Aboriginal and non-Aboriginal Health Practitioners as a key strategy in addressing the significant comparative gaps in health outcomes for Aboriginal people, the focus on cultural safety at both the individual and institutional level is welcomed.

Nunkuwarrin Yunti also has nearly 15 years of experience as a Registered Training Organisation that delivers qualifications and skill sets in the area of Aboriginal Social and Emotional Well Being, of which cultural safety is a core element of the design and delivery of these training products.

The scope of this submission has been designed to respond to the questions posed for the purpose of the consultations:

1. Will having a single definition for the National Scheme and National Health Leadership Forum (NHLF) be helpful? Why or why not? Are there unintended consequences of a single definition?
2. Does this definition capture the elements of what cultural safety is? If not, what would you change?
3. Do you support the proposed draft definition? Why or why not?
4. What other definitions, frameworks or policies should NRAS and NHLF's definition of cultural safety support?
5. Is there anything else you'd like to tell us about the draft definition?

Our overarching Strategic Theme

Aboriginal Culture and Community is at the Core of Everything We Do.

Our Core Strategic Directions

1. Responsive and flexible service design that promotes choice and responds to individual, family and community needs and hopes
2. Enhancing partnerships and teamwork inside and outside the organisation
3. Building on the strong foundation of Nunkuwarrin Yunti governance, corporate services and infrastructure
4. Exploring new directions
5. Workforce Development & Growth in Aboriginal Health

Cultural Safety Defined

The AHPRA *Aboriginal and Torres Strait Islander Health Strategy – Statement of Intent*[1] states 'we acknowledge that there is currently no nationally agreed definition of cultural safety'. However, this is not the case.

AHPRA proposes to define 'cultural safety' as: … the individual and institutional knowledge, skills, attitudes and competencies needed to deliver optimal health care for Aboriginal and Torres Strait Islander Peoples as determined by Aboriginal and Torres Strait Islander individuals, families and communities.

In relation to the question will having a single definition for the National Scheme and National Health Leadership Forum (NHLF) be helpful, broadly this is accepted as the optimal strategy to enable consistency and a shared commitment to operationalising the essential elements of cultural safety across the various health professional groupings.

Cultural safety is already defined within the *Cultural Respect Framework: 2016 – 2026*[2]. Under this definition, cultural safety is the:

> *"Recognition, protection and continued advancement of the inherent rights, cultures and traditions of Aboriginal and Torres Strait Islander people***."**

This Framework also notes that 'Cultural respect is achieved when the health system is safe, accessible and responsive for Aboriginal and Torres Strait Islander people and cultural values, strengths and differences are respected'.

In assessing the question of does the proposed AHPRA definition capture the elements of what cultural safety is? If not, what would you change, it is the view of Nunkuwarrin Yunti that rather than constructing a specific alternative definition, the existing definition should be utilised and reinforced.

The definition of Cultural Safety within the *Cultural Respect Framework: 2016 – 2026*[3] identifies that health consumers are safest when health professionals have considered power relations, cultural differences and patients' rights. Part of this process requires health professionals to examine their own realities, beliefs and attitudes.

Cultural safety is not defined by the health professional, but is defined by the health consumer's experience—the individual's experience of care they are given, ability to access services and to raise concerns.

The essential features of cultural safety are:

a) An understanding of one's culture

b) An acknowledgment of difference, and a requirement that caregivers are actively mindful and respectful of difference(s)

c) It is informed by the theory of power relations; any attempt to depoliticise cultural safety is to miss the point

[1] Available online at https://www.ahpra.gov.au/about-ahpra/aboriginal-and-torres-strait-islander-health-strategy/statement-of-intent.aspx
[2] https://nacchocommunique.files.wordpress.com/2016/12/cultural_respect_framework_1december2016_1.pdf
[3] Available online at http://www.coaghealthcouncil.gov.au/Portals/0/National%20Cultural%20Respect%20Framework%20for%20Aboriginal%20and%20Torres%20Strait%20Islander%20Health%202016_2026_2.pdf

d) An appreciation of the historical context of colonisation, the practices of racism at individual and institutional levels, and their impact on First Nations people's living and wellbeing, both in the present and past

e) Its presence or absence is determined by the experience of the recipient of care and not defined by the caregiver

If a single definition of cultural safety is sought, then this definition should be adopted given that the *Cultural Respect Framework* was developed under COAG's Australian Health Ministers Advisory Council (AHMAC).

Whilst the proposed AHPRA definition is not inconsistent with the AHMAC definition, it is too imprecise and makes no mention of the central themes of power relations, cultural differences and patients' rights.

Cultural Learning Continuum

The consultations are premised on a view that terms such as cultural awareness, cultural competence, cultural capability, cultural proficiency, cultural respect, cultural security, cultural appropriateness, cultural understanding, cultural responsiveness, and cultural safety are often used almost interchangeably.[4]

These terms may well be used interchangeably by some, or even many people, however this is not due to a lack of definition.

Cultural safety is but one element of the *Cultural Respect Framework* that sits within a continuum, as illustrated in the figure to the right.

Cultural awareness is the entry point of cultural learning, which is aimed at those with little or no cultural understanding of Aboriginal and Torres Strait Islander culture. Someone who is culturally aware:

> '*Demonstrates a basic understanding of Aboriginal and Torres Strait Islander histories, peoples and cultures. There is no common accepted practice, and the actions taken depend upon the individual and their knowledge of Aboriginal and Torres Strait Islander culture. Generally accepted as a necessary first step and a foundation for further development, but not sufficient for sustained behaviour change'*.

Achieving cultural respect is the ultimate goal for people working to improve Aboriginal health.

[4] Public consultation paper, pp.1-2.

Cultural respect is about shared respect. It is achieved when the health system is a safe environment for Aboriginal and Torres Strait Islander peoples and where cultural differences are respected. It is a commitment to the principle that the construct and provision of services offered by the Australian health care system will not knowingly compromise the legitimate cultural rights, practices, values and expectations of Aboriginal and Torres Strait Islander peoples.

The goal of cultural respect is to uphold the rights of Aboriginal and Torres Strait Islander peoples to maintain, protect and develop their culture and achieve equitable health outcomes.

Cultural safety falls within this spectrum and is clearly defined and distinguished from other popularly used cultural learning terms.

Cultural Safety Unit of Competency

Cultural safety has also attained some definition through the development of the unit of competency 'CHCDIV002 - Promote Aboriginal and/or Torres Strait Islander cultural safety'.[5] The elements of this unit of competency are presented in Appendix 1.

Consistent with the AHMAC definition of cultural safety, the elements include a focus on power relations, cultural differences and patients' rights.

Among other things, the assessment requirements for this unit distinguish cultural safety from cultural awareness and cultural competence. It also requires knowledge evidence in relation to past and present power relations.

Importantly, the unit is reflective of the holistic view of Aboriginal health as defined since the 1989 *National Aboriginal Health Strategy*, viz:

"Aboriginal health" means not just the physical well-being of an individual but refers to the social, emotional and cultural well-being of the whole Community in which each individual is able to achieve their full potential as a human being, thereby bringing about the total well-being of their Community. It is a whole-of-life view and includes the cyclical concept of life-death-life.[6]

The same can be said for the definition of cultural safety that is found within the *Cultural Respect Framework: 2016 – 2026*.

In response to the question on support for the proposed draft definition, Nunkuwarrin Yunti would prefer use of the existing definition due to it being more comprehensive in recognising of the role of cultural safety in achieving cultural respect in the Australian health system, and the associated professional workforce within this system.

Nunkuwarrin Yunti welcomes the opportunity to make this submission and looks forward to the outcome of this process to better align the working definition of cultural safety as it relates to the important work of the various Health Practitioner Boards.

[5] Available online at https://training.gov.au/Training/Details/CHCDIV002

[6] National Aboriginal Community Controlled Health Organisation, no date, *Definitions: Aboriginal health*, viewed May 10, 2019, https://www.naccho.org.au/about/aboriginal-health/definitions/

Appendix 1: *CHCDIV002 Promote Aboriginal and/or Torres Strait Islander cultural safety* unit of competency elements:

Elements define the essential outcomes	***Performance criteria describe the performance needed to demonstrate achievement of the element***
1. Identify cultural safety issues in the workplace	1.1 Identify the potential impact of cultural factors on service delivery to Aboriginal and/or Torres Strait Islander clients
	1.2 Identify critical issues that influence relationships and communication with Aboriginal and/or Torres Strait Islander people
2. Model cultural safety in own work	2.1 Ensure work practices are grounded in awareness of one's own cultural bias
	2.2 Reflect awareness of own and other cultures in work practices
	2.3 Use communication techniques and work practices that show respect for the cultural differences of Aboriginal and/or Torres Strait Islander people
	2.4 Engage with Aboriginal and/or Torres Strait Islander interpreters and colleagues as cultural brokers, according to situation needs
3. Develop strategies for improved cultural safety	3.1 Support the development of effective partnerships between staff, Aboriginal and/or Torres Strait Islander people and their communities
	3.2 Identify and utilise resources to promote partnerships
	3.3 Devise and document ways to support the delivery of services and programs that are culturally safe and encourage increased participation
	3.4 Integrate strategies that encourage self-determination and community control in services and programs
4. Evaluate cultural safety strategies	4.1 Agree outcomes against which cultural safety strategies can be measured
	4.2 Involve Aboriginal and/or Torres Strait Islander people in evaluations
	4.3 Evaluate programs and services against desired outcomes
	4.4 Revise strategies based on evaluation with appropriate engagement of Aboriginal and/or Torres Strait Islander people

Occupational Therapy Board of New Zealand
TE POARI WHAKAORA NGANGAHAU O AOTEAROA
FOSTERING FAITH AND CONFIDENCE IN THE PROFESSION

13 May 2019

Australian Health Practitioner Regulation Agency
Aboriginal and Torres Strait Islander Health Strategy Group
National Health Leadership Forum

Via email: rap@ahpra.gov.au

Consultation on the definition of cultural safety

Thank you for the opportunity to make a submission on this important aspect of practice for health professionals, health organisations and health regulators.

We understand that you are seeking feedback on the following definition:

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

Our submission responds to the feedback questions you have posed in the consultation.

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

Response

We understand that this definition has been defined by the Aboriginal and Torres Strait Islander Peoples and we support this approach. A single definition will be helpful so all health practitioners and the organisations in which they work are moving towards the same end point. However, a single definition may close off other experiences or understanding of cultural safety. As individual perceptions, experiences, time, national events and exposure to cultures vary the definition may also be interpreted in very different ways.

Issues of promotion, education and enforcement of the definition will need to be accommodated. It would be interesting to understand whether any outcome measures have been, or will be identified. Answering the question - “we know practitioners are culturally safe because…?” Or how are you going to evidence safe cultural practice?

A clear understanding of appropriate cultural practice within other cultures may also need to be articulated, so that the differences between indigenous cultural safety and working with non-indigenous cultures are clarified. The growing

multicultural nature of our communities does present challenges for health practitioners. Although the definition is directed at Aboriginal and Torres Strait Islander Peoples there will be questions from practitioners and the community about the cultural safety of other cultures. It is therefore important to be clear on the foundation on which cultural safety of Aboriginal and Torres Strait Islander Peoples is being made. And as mentioned above evidencing outcome measures will help deepen the practice of cultural safety.

As the definition is intended for such a vast array of institutions this may lead to misinterpretation and inappropriate application. This in turn could have significant "downstream" effects that may not be noticed for some time. Providing support for how to adopt culturally safe practice in all the different contexts and levels of implementation will be essential for consistent and effective adoption of culturally safe practice. Monitoring will be an important aspect in signaling any issues. Key to having a definition is how it is then operationalised. We note that the definition talks about individuals and institutions. While this is important we would suggest that bringing this definition to life will require support across the health professions and institutions in which they work.

The consultation identifies that once agreed, the definition will be applied to a number of documents, such as the Code of Conduct and registration standards and guidelines. Will this also include Competencies for Practice which we understand are part of the registration standards?

Question 2

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

Response

The definition places a significant burden on the Aboriginal and Torres Strait Island Peoples. The resources to support this definition may not be adequate for the widespread application that is required. For example applying cultural safety in the operationalisation of regulation requires detailed examination at the micro level of forms, processes, wording and other such operational processes. To do this appropriately will require in-depth engagement with Aboriginal and Torres Strait Island Peoples at levels as mundane as re-writing these documents and carrying out these processes. From our experience practitioners who identify as Māori are often targeted for their knowledge and experience and can over time feel weighed down or burdened with the responsibility of providing advice on cultural matters. Appropriately resourcing cultural safety is key to its sustainability and ultimate change in practice that can impact on lasting health outcomes.

Question 3

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

Response

Yes, as it clearly positions Aboriginal and Torres Strait Island Peoples as the authority and rightful people to decide what is safe for their lives.

Question 4

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

Response

A clear framework and advice for implementing such a definition for the regulators, educators and other stakeholders who operationalise national policy needs to be provided.

We note your document – Reflect, Reconciliation Action Plan for AHPRA. This document appears to identify organisational changes that AHPRA is starting to consider. We commend the identification of the pillars of reconciliation and the action plan connected with these. We think that having such a document provides the vehicle to bring about change. It would appear that the whole country is aware of reconciliation and that you are on a journey of change.

Operationalising such a definition will be difficult. For any likelihood of success significant resources need to be invested in supporting the stakeholder organisations to employ Aboriginal and Torres Strait Island Peoples. Upskilling the current staff in how to enact a foundational concept such as this will be essential as all the active policy, procedures and administrative processes will need to be re-written.

From a governance perspective will there be a change in the membership of the national boards? Cultural advice and safety will need to be available and applied at a governance level if it is to find its way into health practice. Again your reconciliation action plan has some considerable deliverables and we commend you for identifying such an array of actions.

Question 5

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

Response

The concept and underlying requirement of sharing power may be useful to insert into any major guiding documents. Without the willingness of institutions to truly share power it will be difficult for any actual downstream effects to occur because

of the highly powerful place the stakeholders have in health practitioners and health consumers' lives.

The degree of change that some organisations will need to make to accommodate cultural safety should not be underestimated. As we know, organisational change can take time.

From a regulatory perspective we are very aware of the question "so what happens when people are not culturally safe?" Answering the question is potentially outside the remit of your consultation but we feel it is an important factor that will need further discussion. This will be particularly important if cultural safety is identified in Codes of Ethics and Competencies for Practice. Remember that regulators may not be experts in cultural safety but they are in regulation - in which cultural safety sits.

Thank you for allowing us to comment on this important consultation and we look forward to watching how your journey progresses.

Yours faithfully

Andrew Charnock
CEO/Registrar
Occupational Therapy Board of New Zealand

Pharmaceutical Society of Australia

Cultural Safety Consultation

Pharmaceutical Society of Australia

May 2019

About PSA

PSA is the only Australian Government-recognised peak national professional pharmacy organisation representing all of Australia's 31,000 pharmacists working in all sectors and across all locations.
PSA is committed to supporting pharmacists in helping Australians to access quality, safe, equitable, efficient and effective healthcare. PSA believes the expertise of pharmacists can be better utilised to address the health care needs of all Australians.
PSA works to identify, unlock and advance opportunities for pharmacists to realise their full potential, and to be appropriately recognised and fairly remunerated.
PSA has a strong and engaged membership base that provides high-quality health care and are the custodians for safe and effective medicine use by the Australian community.
PSA leads and supports the delivery of innovative and evidence-based healthcare service by pharmacists. PSA provides high-quality practitioner development and practice support to pharmacists and is the custodian of the professional practice standards and guidelines to ensure quality and integrity in the practice of pharmacy.

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

While a single definition is intended to instil clarity, cultural safety is defined by the recipient and therefore will always be subject to interpretation by individuals and by communities. There may be unintended consequences that do not become apparent until the definition is used in practice. One such unintended consequence is concern that the definition should highlight the need for cultural safety to define interaction for all cultures not specifically Aboriginal and Torres Strait Islander people.

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

The proposed definition is framed around the person delivering the care rather than the person accessing the care. It misses reference to the environment in which care is received to ensure that this is respectful of the spiritual, emotional & social wellbeing of the recipient.

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

PSA supports the intent of a single definition with the caveat that we cannot speak on behalf of Aboriginal and Torres Strait Islander people who are the recipients of health care.

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

In the context of pharmacy and the Pharmaceutical Society of Australia, this definition of cultural safety can support:

Australian Commission on Safety and Quality in Health Care: National Safety and Quality Health Service Standards, User Guide for Aboriginal and Torres Strait Islander Health Nov 2017

National Competency Standards Framework for Pharmacists in Australia, 2016 Pharmaceutical Society of Australia

Professional Practice Standards Version 5 2017, Pharmaceutical Society of Australia

Code of Ethics for Pharmacists 2017, Pharmaceutical Society of Australia;

Clinical Governance Principles for Pharmacy services 2018, Pharmaceutical Society of Australia;

And can inform undergraduate cultural awareness learning for pharmacy students.

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

To support the wider adoption of a single definition, some guidance and support regarding the practical application of the definition could be useful. In simple terms, how one person can make another person feel safe in the context of their health in their community or setting. It needs to support the creation of an environment to support cultural safety – the application of knowledge and skills beyond the acquisition of knowledge and skills.

Given the range of terminology in use, some public education on the differentiation of the meaning and use of the terms would be beneficial through the National Boards (AHPRA), whose role it is to protect public safety.

Public consultation

April 2019

Have your say: Consultation on the definition of 'cultural safety'

Overview

We welcome you to provide feedback on the definition of 'cultural safety'.

This public consultation is released by the National Registration and Accreditation Scheme's Aboriginal and Torres Strait Islander Health Strategy Group (Strategy Group) in partnership with the National Health Leadership Forum (NHLF) – see membership below.

We invite feedback from all interested persons and organisations, particularly Aboriginal and Torres Strait Islander individuals, organisations and health experts.

The Strategy Group and NHLF, as well as the organisations they represent, recognise and respect that cultural safety must be defined by Aboriginal and Torres Strait Islander Peoples.

The final definition will be applied in the context of the National Registration and Accreditation Scheme (National Scheme), and by NHLF member organisations, as a foundation for embedding cultural safety across the National Scheme. This includes the opportunity for using the final, agreed definition in documents such as future *Codes of conduct* for the professions regulated in the National Scheme and/or registration standards and guidelines.

To find out more about the Strategy Group and NHLF, please see the 'About us' section on page 4.

This consultation is open until 5pm Wednesday 15 May.

Background

Various terminology is used in Australia to refer to making health organisations and systems more effective for Aboriginal and Torres Strait Islander Peoples. These include, but are not limited, to:

- cultural awareness
- cultural competence
- cultural capability
- cultural proficiency
- cultural respect
- cultural security
- cultural appropriateness
- cultural understanding
- cultural responsiveness, and
- cultural safety.

These terms are often used interchangeably, used differently in various policies and strategies, and taken to mean different things to different people, organisations and jurisdictions.

The National Scheme and the NHLF have settled on the term cultural safety (see *Statement of Intent* at https://www.ahpra.gov.au/about-ahpra/aboriginal-and-torres-strait-islander-health-strategy/statement-of-intent.aspx).

The National Scheme has agreed that the vision is:

'Patient safety for Aboriginal and Torres Strait Islander Peoples is the norm, and that:

- Patient safety includes the inextricably linked elements of clinical and cultural safety, and
- This link must be defined by Aboriginal and Torres Strait Islander Peoples.'

Proposed definition

The National Scheme and NHLF have agreed on a draft definition of cultural safety to be used in the context of the National Scheme and for the purposes of the NHLF and their members.

Please note, **we are not seeking feedback on a national definition** of cultural safety for all governments/jurisdictions and purposes across Australia.

Rather, we seek feedback for the purpose of the National Scheme's and NHLF's core business. The intention is for the new, agreed definition to provide a consistent baseline definition for use in the National Scheme.

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

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

Feedback questions

We invite your feedback on the proposed draft, and specifically your views on these questions:

1. Will having a single definition for the National Scheme and NHLF be helpful? Why or why not? Are there unintended consequences of a single definition?
2. Does this definition capture the elements of what cultural safety is? If not, what would you change?
3. Do you support the proposed draft definition? Why or why not?
4. What other definitions, frameworks or policies should NRAS and NHLF's definition of cultural safety support?
5. Is there anything else you'd like to tell us about the draft definition?

Commented [TS1]: A single definition is useful to ensure consistency in approach.

Commented [TS2]: Slight change to incorporate behaviour????
Skills, attitudes, competencies and **behaviours** .

Commented [TS3]: yes

Aboriginal and Torres Strait Islander Health Practice
Chinese Medicine
Chiropractic
Dental
Medical
Medical Radiation Practice
Nursing and Midwifery
Occupational Therapy
Optometry
Osteopathy
Pharmacy
Physiotherapy
Podiatry
Psychology

AHPRA

Australian Health Practitioner Regulation Agency

Public consultation

April 2019

Have your say: Consultation on the definition of 'cultural safety'

Overview

We welcome you to provide feedback on the definition of 'cultural safety'.

This public consultation is released by the National Registration and Accreditation Scheme's Aboriginal and Torres Strait Islander Health Strategy Group (Strategy Group) in partnership with the National Health Leadership Forum (NHLF) – see membership below.

We invite feedback from all interested persons and organisations, particularly Aboriginal and Torres Strait Islander individuals, organisations and health experts.

The Strategy Group and NHLF, as well as the organisations they represent, recognise and respect that cultural safety must be defined by Aboriginal and Torres Strait Islander Peoples.

The final definition will be applied in the context of the National Registration and Accreditation Scheme (National Scheme), and by NHLF member organisations, as a foundation for embedding cultural safety across the National Scheme. This includes the opportunity for using the final, agreed definition in documents such as future *Codes of conduct* for the professions regulated in the National Scheme and/or registration standards and guidelines.

To find out more about the Strategy Group and NHLF, please see the 'About us' section on page 4.

This consultation is open until 5pm Wednesday 15 May.

Background

Various terminology is used in Australia to refer to refer to making health organisations and systems more effective for Aboriginal and Torres Strait Islander Peoples. These include, but are not limited, to:

- cultural awareness
- cultural competence
- cultural capability
- cultural proficiency
- cultural respect
- cultural security
- cultural appropriateness
- cultural understanding
- cultural responsiveness, and
- cultural safety.

These terms are often used interchangeably, used differently in various policies and strategies, and taken to mean different things to different people, organisations and jurisdictions.

The National Scheme and the NHLF have settled on the term cultural safety (see *Statement of Intent* at https://www.ahpra.gov.au/about-ahpra/aboriginal-and-torres-strait-islander-health-strategy/statement-of-intent.aspx).

The National Scheme has agreed that the vision is:

'Patient safety for Aboriginal and Torres Strait Islander Peoples is the norm, and that:

- Patient safety includes the inextricably linked elements of clinical and cultural safety, and
- This link must be defined by Aboriginal and Torres Strait Islander Peoples.'

Proposed definition

The National Scheme and NHLF have agreed on a draft definition of cultural safety to be used in the context of the National Scheme and for the purposes of the NHLF and their members.

Please note, **we are not seeking feedback on a national definition** of cultural safety for all governments/jurisdictions and purposes across Australia.

Rather, we seek feedback for the purpose of the National Scheme's and NHLF's core business. The intention is for the new, agreed definition to provide a consistent baseline definition for use in the National Scheme.

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

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

Feedback questions

We invite your feedback on the proposed draft, and specifically your views on these questions:

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

   I believe the 'single' definition has had zero effect in being an enabler of 'cultural' change within organisation and systems that are supposedly focused on improving health outcomes for 'Aboriginal people'. I make this comment based on the little impact we have had with the 'multiple' terminologies applied over many years as listed on the previous page. This should tell us that we have to do better.

   Unfortunately a 'definition' does not influence practice, attitudes or behaviours.

   I would suggest a 'Cultural Safety Plan', similar to a Reconciliation Action Plan be developed by individual organisations and agencies who are currently funded to provide services to Aboriginal people and communities or those who are considering entering into this space. This Plan would need to be measurable and evaluated to ensure ongoing 'cultural safety' practices are being exercised.

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

   No. It is not a 'strength based' position and allows for individual interpretation and application.

This is what I would suggest.

"Cultural Safety is a continual process that ensures institutional and individual knowledge, skills, and behaviours are visible and practiced to deliver optimal health care and outcomes for Aboriginal and Torres Strait Islander Peoples".

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

   No. See previous comment.

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

   It should be aligned with and or compliment a Reconciliation Action Plan. Once again definitions do not influence or ensure practice change.

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

   No.

[redacted]

15th May 2019

Australian Health Practitioner Regulation Agency (AHPRA)
Via e-mail: rap@ahpra.gov.au

Dear Sir/Madam,

Consultation on the definition of 'Cultural Safety'

I am pleased to be able to contribute my opinions on the definition of 'Cultural Safety', as detailed in the AHPRA document published in April 2019. I have no objections to this submission being published online, but I request that my identifying details are first redacted.

I am a medical practitioner with over 13 years of post-graduate experience, of which over 10 have been in Central Australia, where 80-90% of my patients have been Aboriginal. I arrived here as a final year medical student and subsequently I worked for both my fellowships in rural and remote medicine, as well as in public health medicine. Furthermore, I believe I may be the only doctor in the region for many years who can speak an Aboriginal language (not simply say a few sentences, but able to converse), namely Pitjantjatjara, and I am privileged to have family connections to Pitjantjatjara and other Aboriginal language groups in Central Australia. In addition, I have lived, received education and/or worked in 7 countries and many different cultures since early childhood, and I speak several other languages aside from English and Pitjantjatjara. Hence I believe I have a broad perspective on the issue of 'cultural safety.'

First and foremost, I am uncomfortable with the notion that 'cultural safety' in relation to AHPRA (and hence presumably all the health professions) is restricted to Aboriginal and Torres Strait Islanders. Australia's residents represent many different cultural backgrounds, not simply a homogenous minority 'indigenous' and a homogenous majority 'non-indigenous', however the current proposed definition gives the impression that there is a simple duality. I therefore strongly suggest that the concept of 'cultural safety' is applied to all cultural groups in Australia, and not just to one group.

Hence, I disagree with the proposal that "cultural safety must be defined by Aboriginal and Torres Strait Islander Peoples." Presuming that just one group can define 'cultural safety' seems very problematic to me, when different groups in society have different cultures, all of which deserve respect and whose members deserve to feel safe in the cultural sphere.

I agree, in principle, with the list that cultural awareness, security, understanding, responsiveness, safety, etc., however, I believe one term is missing, namely 'cultural humility'. The term 'cultural humility' has been increasingly used in the last two decades, and in fact many scholars and practitioners internationally are of the opinion that 'cultural humility' is a more appropriate term than 'cultural competence' when describing desired attitudes towards another culture.[1]

[1] For example, a recent article on the topic: Campinha-Bacote, J., (December 4, 2018) "Cultural Competemility: A Paradigm Shift in the Cultural Competence versus Cultural Humility Debate – Part I" *OJIN: The Online Journal of Issues in Nursing* Vol. 24, No. 1. DOI: 10.3912/OJIN.Vol24No01

Indeed, from my experience in Australia, starting as a medical student, 'cultural competence' seemed to have been instilled through several hours of a workshop about Aboriginal history and stereotypes. I have found that a grossly inadequate introduction to a culture, and in fact, having had close professional and social interactions with Aboriginal people in Central Australia for over a decade, I would describe myself as not yet fully competent in navigating the cultures.

Given my reasoning above, instead of the current proposed definition of 'cultural safety,' I propose that the definition is changed to something broader, for example: "Because Australia is a multi-cultural country, people of all cultures must feel safe when interacting with the health system in Australia. Furthermore, given that Aboriginal and Torres Strait Islanders are the indigenous people of Australia and face significant health inequity, particular care must be given when delivering healthcare to Aboriginal and Torres Strait Islanders. Hence, all individuals and institutions must strive to attain maximal knowledge, skills, attitudes and competencies to deliver optimal healthcare to all, in order to attain health equity in Australia." If it is in a context that is specific to the health of indigenous Australians, then additional specific comments can then be made, without implying that one group dictates what 'cultural safety' means for all.

I submit my opinions respectfully for your consideration.

Yours sincerely,

Queensland Nurses & Midwives' Union

Submission to

Australian Health Practitioner Regulation Agency

Consultation on the definition of 'cultural safety'

May, 2019

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Contents

Introduction

The Queensland Nurses and Midwives' Union (QNMU) thanks the Australian Health Practitioner Regulation Agency (AHPRA) for the opportunity to comment on the *consultation of the definition of 'cultural safety'.*

Nursing and midwifery is the largest occupational group in Queensland Health and one of the largest across the Queensland government. The QNMU is the principal health union in Queensland covering all classifications of workers that make up the nursing workforce including registered nurses (RN), registered midwives (RM), nurse practitioners (NP), enrolled nurses (EN) and assistants in nursing (AIN) who are employed in the public, private and not-for-profit health sectors including aged care.

Our more than 60,000 members work across a variety of settings from single person operations to large health and non-health institutions, and in a full range of classifications from entry level trainees to senior management. The vast majority of nurses and midwives in Queensland are members of the QNMU.

The QNMU supports the intention of a national and consistent baseline definition for cultural safety to ensure there is health equity for Aboriginal and Torres Strait Islander Peoples. We believe AHPRA's proposed definition provides a solid positional statement on cultural safety. Embedding cultural safety in how health practitioners work and increasing access to culturally safe health services for Aboriginal and Torres Strait Islander Peoples is of national importance.

However, we believe the proposed definition is taking a cautious and conciliatory approach to the principal of cultural safety. The QNMU feels that rather than '*standing on the shoulders of giants*' AHPRA has taken a step back with their proposed definition. We believe the definition formed by the Nursing and Midwifery Board of Australia (NMBA) for the *Code of conduct for nurses* and the *Code of conduct for midwives* (the Codes) encompasses all the necessary components of cultural safety (Nursing and Midwifery Board of Australia, 2018).

The QNMU supports the submission of our federal body, the Australian Nursing and Midwifery Federation (ANMF).

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

The QNMU agrees there should be a single definition for the National Registration and Accreditation Scheme (National Scheme) and the National Health Leadership Forum (NHLF). Working to one definition of cultural safety for all health practitioners ensures safe healthcare is provided as defined by Aboriginal and Torres Strait Islander Peoples.

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

The QNMU acknowledges the proposed cultural safety definition is a strong foundational position. We agree with the statement that cultural safety is determined by Aboriginal and Torres Strait Islander individuals, families and communities. This aligns with the *Closing the gap* campaign where Aboriginal and Torres Strait Islander people are at the forefront of decision making and driving outcomes in their choices to healthcare (Australian Government, 2018).

We believe the cultural safety definition could be strengthened by incorporating key elements of cultural safety such as the principles stated in the Codes (NMBA, 2018b). The definition provided in the Codes views cultural safety as an integral part of ethical and competent professional practice and it provides common-sense guidance on how to work in partnership with Aboriginal and Torres Strait Islander Peoples (NMBA, 2018a). We believe the exclusion of any background or guidance for practice as part of the proposed definition, oversimplifies the principal and philosophy of cultural safety.

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

No, the QNMU does not support the proposed cultural safety definition. We believe it does not adequately encompass all aspects of cultural safety. We view this proposed definition from AHPRA as a missed opportunity in providing a strong and deliberate direction in what constitutes cultural safety and how and why it should be practiced.

The QNMU supports the definition of cultural safety that was developed and adopted by the NMBA (2018b) in the code of conducts for nurses and midwives.

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

Please see our response to question 5.

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

While the QNMU believes the proposed definition of cultural safety is a solid positional statement it fails to provide strong leadership on a principal and philosophy that is crucial to the health of Aboriginal and Torres Strait Islander Peoples. The proposed definition falls short of providing guidance to healthcare practitioners and organisations.

We ask AHPRA to consider for their proposed definition the cultural safety principals discussed in the NMBA's Codes. The Codes were released in March 2018 by the NMBA after much consultation with the professions of nursing and midwifery, other peak bodies, key stakeholders and a comprehensive and evidenced-based review of literature. The QNMU and our national body the ANMF were active participants in these consultations. While we acknowledge the proposed definition is a solid positional statement, the QNMU supports the NMBA's definition as it incorporates the necessary components for culturally safe healthcare for Aboriginal and Torres Strait Islander Peoples.

References

Australian Government. (2018). *Closing the gap. Prime Minister's report 2018*. Retrieved from https://www.pmc.gov.au/sites/default/files/reports/closing-the-gap-2018/sites/default/files/ctg-report-20183872.pdf?a=1

Nursing and Midwifery Board of Australia. (2018a). *Joint statement: Cultural safety: nurses and midwives leading the way for safer healthcare*.

Nursing and Midwifery Board of Australia. (2018b). *Professional standards*. Retrieved from https://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards.aspx

Royal Australasian College of Dental Surgeons

15 May 2019

By email rap@ahpra.gov.au

The Royal Australasian College of Dental Surgeons is supportive of the proposed definition on cultural safety.

The College believes that a single definition will provide a good framework and will encourage conversations around respectful and inclusive practices, with reflection and self-awareness of behaviours to break down barriers and reduce inequalities. The College would like optimal health care to reference both physical and mental health. The definition could be expanded to include a holistic approach to care with references to an environment that is spiritually, emotionally, socially and physically safe.

The Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM) definition of Cultural Safety references “care that takes account of peoples’ unique needs” and likewise The National Aboriginal and Torres Strait Islander Health Workers Association (NATSIHWA) refer to cultural safety being based on the experience of the recipient of care, and the effective care of a person from another culture by a healthcare professional who has undertaken a process of reflection on their own cultural identity to recognise the impact their culture has on their own practice.

This definition has been developed with the support of individuals from Aboriginal and Torres Strait Islander peak organisations who provide advice on health, so the definition should capture key elements of what cultural safety is and not have any unintended consequences from a single definition.

Other frameworks and policies that link to cultural safety are the Australian Indigenous Doctors’ Association 2013 Position paper Cultural safety for Aboriginal and Torres Strait islander Doctors Medical Students and Patients, and The Gayaa Dhuwi (Proud Spirit) Declaration.

The College looks forward to being involved in any future work on cultural safety and engaging with the indigenous health sector. Presently the College is working to strengthen the engagement and the participation of Aboriginal and Torres Strait Islander peoples of Australia and Maori of New Zealand within the College programs including the Oral Maxillofacial Surgery program.

Yours faithfully,

Dr Karen Luxford
Chief Executive Officer

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abn 39 004 688 215

15 May 2019

Attention to:

Australian Health Practitioner regulation Agency (AHPRA)

Response to: Consultation on the definition of 'cultural safety'

The Royal Australasian College of Medical Administrators (RACMA) is a specialist medical college accredited by the Australian Medical Council (AMC) and is dedicated to the education, training and professional development of medical practitioners in senior leadership, management and administrative roles, in clinical and non-clinical settings, throughout the world.

This constantly evolving fellowship and professional development program responds and pre-empts the ever changing landscape of medical administration both in Australasia and beyond. RACMA's involvement in education, policy formulation and decision-making enables it to help contribute to the Australian and New Zealand Health systems.

In considering cultural safety definition we provide the following commentary:

Q1: Will having a single definition for the National Scheme and NHLF be helpful? Why or why not? Are there unintended consequences of a single definition?

Having a single definition for the National Scheme and NHLF would be helpful, as it is a statement of the meaning of the term cultural safety. However, we would expect that it would be difficult in its undertaking, as cultural safety is a total framework for the delivery of more appropriate health services. The concept lends itself to be quite broad in its interpretation as cultural safety can be used interchangeably and taken to mean different things to different people (including within a cultural cohort), organisations and jurisdictions. There could be unintended consequences within the Aboriginal and Torres Strait Islanders communities, where different clans, could have differing views as to a definition of cultural safety which would impact the definitions intent.

Q2: Does this definition capture the elements of what cultural safety is? If not, what would you change?

RACMA members were concerned that although the definition has a purpose to reflect the NHLF's core business and not a national definition of cultural safety for all governments/jurisdictions and purposes across Australia, having the inclusion of the National scheme, presents the aesthetic that the definition is one of a national approach and not in the context for Aboriginal and Torres Strait Islanders. This would then present a problem as its definition excludes the cultural identities of others.

In addition, within the Statement of Intent, the definition for cultural safety acknowledges that there is currently no "nationally" agreed definition of cultural safety. This language is confusing and conflates the definition as being a national definition, not one contextualised for Aboriginal and Torres Strait Islanders. In this sense, the definition presents the aesthetic that cultural safety only includes Aboriginal and Torres Strait Islanders and does not respect the cultural identities of others and safely meet their needs, expectations and rights.

We recommend that the language of the definition be tidied up to read specifically as being in the context of Aboriginal and Torres Strait Islanders. Wording should read along the lines of…. *"Cultural Safety for Aboriginal and Torres Strait Islanders is defined as meaning…."*.

Q3: Do you support the proposed draft definition? Why or why not?

RACMA does not support the proposed definition because:

Firstly, the definition gives an impression that it is a national definition and not one which specifically reflects the purpose of the National Scheme's and NHLF's core business. This conflation reads that non-Indigenous cohorts have not been recognised and respected. We recommend that the language better reflects the purpose.

Secondly, Members were not comfortable with *"as determined by Aboriginal and Torres Strait Islander individuals, families and communities*." as it could be construed that only this identified group can qualify what is appropriate and safe medical care.

RACMA's position on what is appropriate and safe medical care should be based on experience-based co-design. As our health system becomes more patient centric, we see that it is critical that we use tools and approaches to design the system to meet the needs of our population. Experience based co-design offers a methodology that brings health workers and consumers together in an authentic and equal partnership to co-design care and deliver an improved experience. This approach not only improves the experience of patients but also of the workforce and the combined benefit is an overall improvement in quality of care.

Q4: What other definitions, frameworks or policies should NRAS and NHLF's definition of cultural safety support?

A commonly used definition of cultural safety is that of Williams (1999) [1] who defined cultural safety as:

> an environment that is spiritually, socially and emotionally safe, as well as physically safe for people; where there is no assault challenge or denial of their identity, of who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience of learning together (p.213).

Culturally safe practices include actions which recognize and respect the cultural identities of others, and safely meet their needs, expectations and rights. We recommend that strategies around the ability to be culturally safe, should include:

- reflecting on one's own culture, attitudes and beliefs about 'others'
- clear, value free, open and respectful communication
- developing trust
- recognising and avoiding stereotypical barriers
- being prepared to engage with others in a two-way dialogue where knowledge is shared
- understanding the influence of culture shock

In defining culture consideration should include but is not be restricted to, age or generation; gender; occupation and socioeconomic status; ethnic origin or migrant experience; religious or spiritual belief; and disability.

Q5: Is there anything else you'd like to tell us about the draft definition?

Nothing further to add regarding the draft definition.

RACMA provides this feedback with the aim of promoting and advancing high standards of safe and effective healthcare. We strongly support cultural safety and see that any culturally unsafe practices would diminish and demean the cultural identity and well-being of individuals in the healthcare system.

Yours faithfully

Associate Professor Alan S C Sandford AM
President, RACMA

[1] Williams, R. (1999). Cultural safety – what does it mean for our work practice? Australian and New Zealand Journal of Public Health, 23(2), 213-214.

RACP
Specialists. Together
EDUCATE ADVOCATE INNOVATE

Submission

Consultation on the definition of "cultural safety"

May 2019

About The Royal Australasian College of Physicians (RACP)

The RACP trains, educates and advocates on behalf of over 17,000 physicians and 8,000 trainee physicians, across Australia and New Zealand. The College represents a broad range of medical specialties including general medicine, paediatrics and child health, cardiology, respiratory medicine, neurology, oncology, public health medicine, occupational and environmental medicine, palliative medicine, sexual health medicine, rehabilitation medicine, geriatric medicine, and addiction medicine. Beyond the drive for medical excellence, the RACP is committed to developing health and social policies which bring vital improvements to the wellbeing of patients.

Introduction

Thank you for the opportunity to comment on the development of a single national definition of cultural safety for the purposes of the National Registration and Accreditation Scheme (the National Scheme). We consent to this submission being published.

We commend the National Registration and Accreditation Scheme's Aboriginal and Torres Strait Islander Health Strategy Group (Strategy Group), the National Health Leadership Forum (NHLF), and the Australian Health Practitioner Regulation Agency (AHPRA) for the important work embedding cultural safety across all functions of the National Scheme.

We support the consultation's approach of seeking input from a broad range of people and organisations, while being led by Aboriginal and Torres Strait Islander health leaders and peak organisations.

It is important for us to note at the outset that while we appreciate the consultation is being conducted for dual purposes—the National Scheme's purposes, and the NHLF's core business—our feedback is limited to the former. We defer to the NHLF and its members to consider and determine the proposed definition's suitability for the purposes of the NHLF and its members' business.

That caveat having been noted, we offer the following responses to four of the consultation questions.

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

Yes, a single definition for the National Scheme will be helpful.

One strength of the definition is that it clearly implies that cultural safety is not a single specific codifiable collection of knowledge and skills, but a dynamic and flexible approach to health care. Cultural safety cannot be learned by rote and cannot be taught by exhortation. Rather, it involves (but is not defined by) open mindedness, respect, and empathy—qualities that are the cornerstones of patient centred care. As the definition states, this state of cultural safety is then determined by the "...*Aboriginal and Torres Strait Islander individuals, families and communities.*" that are impacted by the health service provision.

Another strength of the definition is that it points to the need for other definitions of cultural safety for other purposes. We note here that the proposed definition is an intentionally clinical one, oriented around patients, families, and communities, i.e. the recipients of health care.

While it does include "individual *and institutional* knowledge, skills, attitudes and competencies" (emphasis added), the definition does not necessarily cover cultural safety within organisations that do not provide clinical services. Moreover, the definition is not intended to cover cultural safety of institutions from the perspective of Indigenous doctors (as distinct from Indigenous patients). This is not a flaw in the definition but an important element for organisations like the RACP to be mindful of. This is clear from the discussion paper, which indicates that it is "not seeking feedback on a national definition of cultural safety for all […] purposes across Australia.").

Accordingly, we envisage that the definition:

- will apply to the RACP's primary purpose, training medical specialists, since that activity (training) is provided in part via supervised clinical practice in accredited training locations which must themselves be culturally safe.

- will apply when the RACP carries out its functions assessing overseas trained physicians and paediatricians under delegation from the Medical Board of Australia, because we are assessing their knowledge, skills, attitudes, and competencies in the course of practising specialist medicine.

Being a trans-Tasman college adds a layer of nuance and complexity we share with some other specialist colleges. (We note that while the Australian Medical Council's (AMC) definition of cultural safety draws on

the RACGP's definition, its definition of cultural competence draws on the Medical Council of New Zealand's definition.[1])

Many hospitals and health services currently use definitions that should yield to this one when it is finalised. Similarly, some health practitioners' understanding of cultural safety and their regulatory compliance in relation to it will be effectively rendered obsolete by this new definition. For this reason, we recommend AHPRA develops appropriate communications and educational resources for all registered health practitioners, with specifically tailored resources on the subject. The RACP can incorporate the new definition into the training we provide, but 70% of our members are Fellows whose specialist training has been completed.

The development of educational resources for medical specialists would be desirable given that the definition is for the purpose of "optimal care." It would also be desirable for overall quality improvement reasons, i.e. in order to maximise awareness of the new definition, the implications for specialists' practice, and AHPRA's regulation of that practice.

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

We are comfortable with the advice of the organisations and people who have had input into the Strategy Group's work on the proposed definition.

While the RACP has (appropriately) not had a representative on the Strategy Group, we note it includes Professor Ngiare Brown, who is a member of the RACP Ethics Committee, and Professor Noel Hayman, an RACP Fellow who is a member (and former chair) of the RACP Aboriginal and Torres Strait Islander Health Committee.

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

We support having a nationally consistent definition, and we support this proposed definition.

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

We are a part of the National Medical Training Advisory Network (NMTAN) and have been participating in the Steering Committee for the NMTAN Specialist Trainees in the Medical Workforce project, which is in the process of specifying agreed minimum and best practice standards regarding attracting, recruiting and retaining Aboriginal and Torres Strait Islander doctors into medical specialties.

We understand that project is being undertaken in coordination with this consultation in that one of the agreed standards is that specialist medical colleges agree to use common definition of cultural safety throughout all college material (and, where feasible, throughout Australia's health system).

We understand the proposed definition will flow through to the AMC's Standards and Guidelines; we also note the AMC is a signatory to the National Scheme Aboriginal and Torres Strait Islander Health Strategy Statement of Intent, with which this definition is associated under the rubric of the Strategy Group's work.

For further information, please contact Samuel Dettmann, Senior Policy Officer, on 02 9256 5429 or via Samuel.Dettmann@racp.edu.au.

[1] Standards for Assessment and Accreditation of Specialist Medical Programs and Professional Development Programs by the Australian Medical Council 2015, p. v.

14 May 2019

Australian Health Practitioner Regulation Agency
AHPRA
GPO Box 9958
Melbourne
VIC 3001
E: rap@ahpra.gov.au

Dear Sir/Madam,

Consultation on the definition of 'cultural safety'

I am writing to you in my capacity as Chairperson, Indigenous Health Committee ('IHC') of the Royal Australasian College of Surgeons ('RACS'). RACS is the leading advocate for surgical standards, professionalism and surgical education in Australia and New Zealand.

My letter is in response to a document received from the Accreditation Scheme's Aboriginal and Torres Strait Islander Health Strategy Group (Strategy Group) and its partner the National Health Leadership Forum (NHLF), inviting feedback on the definition of 'cultural safety'.

The purpose of my letter is three-fold. Firstly, to raise awareness of the existence of RACS IHC; secondly to express support for consultation around the definition of 'cultural safety' and thirdly; in lieu of the time frame that we became aware of the consultation process to ask for an extension to provide a considered response.

RACS IHC understands responding to the needs and circumstances of Aboriginal and Torres Strait Islander people is essential to provide a safe inviting environment for the delivery of professional equitable health care. We consequently support and encourage AHPRA initiative to seek consensus around the use of the term 'culturally safe'.

Additionally, we accept the issues affecting Aboriginal community and people's health and wellbeing are complex and broad in scope and thinking around this issue is crucial in stimulating informed discussion and debate around Closing the Gap in Aboriginal and Torres Strait Islander health inequities.

It is also noted several specific questions were asked to be considered by respondents when considering the term 'culturally safe'. We acknowledge the questions asked for consideration are very significant in implication and ramification and therefore warrant a considered response.

As a body representing medical practitioners and with an IHC formally constituted to progress and facilitate institutional change and improved equitable access to professional medical care for Aboriginal and Torres Strait Islander people, are we able to obtain a time extension to provide a considered response to this important project? We would also like to inform your committee that at the time of our meeting to consider this project, we had no Aboriginal and Torres Strait Islander surgical fellows present and therefore feel that any appropriate response must be informed by their thoughts and opinions.

College of Surgeons of Australia and New Zealand ABN 29 004 167 766

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Also, as the peak surgical college in Australia with an existing Indigenous Health Committee comprised of Indigenous surgeons and professionals we wonder if you would consider allowing us to be part of the Aboriginal and Torres Strait Islander Health Strategy Group?

We look forward to your reply and again applaud APHRA and its partners on devising the initiative and posing significant questions for consideration.

For future correspondence in relation to our request could you please send through communications to RACS Indigenous Health Senior Project Officer, their contact details are below.

Damien Loizou
Senior Project Officer
Indigenous Health
Royal Australasian College of Surgeons
E: damien.loizou@surgeons.org
T: 03 92491115

Yours sincerely,

Maxine Ronald
Chairperson
Indigenous Health Committee
FRACS

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Dear Strategy Group,

I received an email on the 4th of May asking for feedback on the Proposed National Definition of Cultural Safety.

My understanding is that the proposed definition to be commented upon is:

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

My feedback on the proposed draft is as follows:

Comment:

I know I was not asked to comment on the definition, but I am unclear why the terms 'cultural safety' has been deviated into an definition that singles out one specific culture. The term 'Cultural safety' originated in New Zealand and was developed to include any/all cultural groups. It stated: that Cultural Safety was *'effective nursing practice of a person or family from another cultural and is determined by that person or family'* (Nursing Council of New Zealand, 2005, p.5). It goes on to outline the scope of culture and does not single out any specific culture. Cultural safety is in jeopardy if one cultural group assume control of the definition or word 'culture'. As if all other cultures are not worthy or are valuable.

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

   Yes, one definition of Cultural Safety will be helpful. It will reduce ambiguity and help with clarification. I fear the proposed definition is not it.

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

   No, not at all. It negates all other cultures (other than Aboriginal or Torres Strait Island culture, of which by the way, there are many cultural subgroups and practices) and reduces the word and meaning of culture to the sphere of the Australian Indigenous culture. The word culture has a far wider scope and includes all cultures not just the Indigenous culture referred to in the definition.

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

   No, for the reasons cited above. The Australian Aboriginal and Torres Strait Islander cultures are important and vital for nurses to understand, but other cultural groups also require sensitive and appropriate cultural care. Cultural safety should be practiced with all cultural groups and a definition that fails to recognise the wider and more person-centred nature of the care nurses provide across a wide range of ethnic and cultural groups is weak and in fact promotes a sort of cultural bias and this is not a safe or effective way to offer individual, and institutional knowledge, skills, attitudes and competencies needed to deliver optimum health care for any cultural group.

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

   I'd go with the following definition: Cultural Safety is: 'The individual and institutional knowledge, skills, attitudes and competencies that impact upon a person or family from another culture and is determined by that person or family. Cultural includes, but is not restricted to, age or generation; gender; sexual orientation; occupation and socioeconomic status; ethnic origin or migrant experience; religious or spiritual belief; and disability. The nurse delivering the nursing service will have undertaken a process of reflection on their own cultural identity and will recognise the impact that their personal culture has on professional practice. Unsafe cultural practice comprises any action which diminishes, demeans or disempowers the cultural identity and well-being of an individual' (This is pretty much taken from the NZ original definition and in my view offers a far more culturally inclusive take on what Cultural Safety is and how it could be appropriately applied).

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

While I recognise and value the culture and values of traditional Australian Indigenous people, theirs is not the only culture I have encountered in my nursing career. Even in Australia there are a host of new and significant cultures that nurses need to recognise and deal with in ways that involve inclusiveness and sensitivity. We are also preparing nurses to function in a global nursing and health arena and as such any limitation of what culture means will hinder the application of cultural safety for the wider practice. I believe that the wider and more inclusive the definition the greater will be the likelihood of its acceptance and application. As it will translate in to a greater understanding of what cultural safety means and how it can be applied. The original NZ definition includes the line, "Unsafe cultural practice comprises any action which diminishes, demeans or disempowers the cultural identity and well-being of an individual" and I feel that the definition of Cultural Safety proposed to support the NHLF and National Scheme does exactly this as the proposed definition (while it may not be its aim) means that all cultures other than the Indigenous Australian cultures are excluded and as such the definition fails to recognise the wider application of the word "culture" and indeed, may inadvertently lead nurses to misunderstand the application and appropriateness of Cultural Safety for other cultural groups. Cultural Safety will only be achieved if all cultures are recognised as having equal worth and being equality valid. This definition fails to capture the wider scope that the original meaning of Cultural Safety.

Cultural safety must encompass all cultures or it simply will not be safe. Here is your definition again but from other cultural groups perspective:

> *Cultural safety is the individual and institutional knowledge, skills, attitudes and competencies needed to deliver optimal health care for White Arian Peoples in Third Reich as determined by the White Arian People of the Third Reich, the individuals, families and communities. (Where will this definition leave the Jews, Travellers, and other marginal cultural groups?)*
>
> *Cultural safety is the individual and institutional knowledge, skills, attitudes and competencies needed to deliver optimal health care for Afrikaners Peoples as determined by Afrikaners individuals, families and communities. (Where will this definition of Cultural Safety leave the multitude of other cultural groups across Sothern Africa?)*
>
> *As those above are, I am sure the definition below would be abhorrent to any one considering the meaning of Cultural Safety…*
>
> *Cultural safety is the individual and institutional knowledge, skills, attitudes and competencies needed to deliver optimal health care for White Australians as determined by White Australian individuals, families and communities. (Don't nurses in Australia need to understand how to provide safe cultural care to all the cultural groups in Australia?)*

The definition needs to capture all cultures or it is simply not safe for any.

This is why the following definition based on the original NZ (developed by a Maori scholar, Iripapeta Ramsden) and modified a little here may be more appropriate.

Cultural Safety is: 'The individual and institutional knowledge, skills, attitudes and competencies that impact upon a person or family from another culture and is determined by that person or family. Culture includes, but is not restricted to, age or generation; gender; sexual orientation; occupation and socioeconomic status; ethnic origin or migrant experience; religious or spiritual belief; and disability. The nurse delivering the nursing service will have undertaken a process of reflection on their own cultural identity and will recognise the impact that their personal culture has on

professional practice. Unsafe cultural practice comprises any action which diminishes, demeans or disempowers the cultural identity and well-being of an individual.'

With the greatest respect, David

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I ACKNOWLEDGE AND PAY MY RESPECT TO THE TURRBAL, JAGERA/YUGGERA, AND YUGAMBEH PEOPLES AND NUGUNNAWAL PEOPLE OF THE ACT ON WHOSE LAND I LIVE AND WORK.

Shae Bradshaw
Board Services Officer
Medical Board of Australia
Medical Radiation Practice Board of Australia
Australian Health Practitioner Regulation Agency
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THELIMENETWORK

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15 May 2019

Re: AHPRA Consultation on Cultural Safety Definitions

The Leaders in Indigenous Medical Education (LIME) Network Reference Group welcomes this opportunity to provide a submission regarding the consultation paper, *Have your say: Consultation on the definition of 'cultural safety'*. Please find below responses to the consultation questions:

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

There is considerable diversity in the understanding and meaning of cultural safety. This is a body of work that has been continuing for many years both locally and internationally. Whilst we appreciate the utility that the adoption of a single definition by AHPRA could present, we note that it will not, and should not, stop that continued conversation. Indeed, there is a risk that the creation of a single definition could undermine the importance of, and emphasis on, the deeper nuances, complexities and realities related to this area.

Adopting a single definition could be problematic as it reinforces the notion of a single achievable skill that is an end point of learning and precludes the understanding of an evolving capability that relies on continued self-reflection and responsiveness. This is not the same as, for example, various other competencies, or skills, expected of health care providers. The adoption of a single definition reinforces a narrower gaze and would appear to ignore the understanding that there is a continuum of learning, ability, skill, knowledge, ways of working that reflect a person or systems journey towards providing culturally secure care.

The distinction between capability and competency is important here. Getting services and health care providers to be capable—moving from the point of *knowing* to the point of *being* is an important task for health educators and system managers. Adopting a single definition, however, reflects a competency approach—you either 'are' or you 'are not' (competent). This does not reflect the continuum of capability-building that most practitioners are on in this area and ignores the reality that there is no end point in this journey – as should be the case for lifelong learners. Further, it embeds the assumption that there is a point when one is acceptable enough to be considered safe but fails to consider who decides if enough is enough and ignores that Aboriginal and Torres Strait Islander peoples will have varying expectations depending on a range of factors [1].

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

It is our view that a single definition cannot capture the elements of what cultural safety is. One of the difficulties is that there continues to be considerable debate around the use of the term "cultural safety". Similarly, different terms have a fraught connotation including cultural capability, competence, awareness,

security and humility [2]. The literature abounds with the rationales for one particular term over another. Whilst it is acknowledged that AHPRA has gathered together many people to talk about the question, the brief consultation paper and the limited scope and time frame of the consultation period doesn't reflect the need for a deep engagement with those who have theorised the issues at length [3-5].

Professor Juli Coffin has done quite a bit of this work and she aims for cultural security [6-7], but it is all dependant on the lens, from whose perspective, at what stage and in what context it is being considered. Is it from the perspective of the service provider, the health service organisation/system, or the client?

Aboriginal and Torres Strait Islander people should experience cultural security in the health care environment and for this to occur, the health care service needs to ensure a culturally safe environment that is filled with culturally responsive and capable practitioners. A recognised strength of the draft definition is that it highlights that it is Aboriginal and Torres Strait Islander people, families and communities that decide whether health care providers are delivering culturally secure care.

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

We do not support the proposed draft definition as it fails to acknowledge the role of white privilege, and how that should be addressed by health care practitioners and health care services.

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

There is a considerable body of work being undertaken in Aotearoa that AHPRA should consider, including the evidence base considered by the Medical Council of New Zealand. They have been considering these matters for more than 10 years and continue this work in partnership with Te Ohu Rata o Aotearoa [8-11].

Whilst there are clear differences between Aotearoa and Australia, it would seem reasonable to expect that AHPRA should have a longer consultation process given the complexity of the work and should take the time to examine the processes of the work done in Aotearoa, and reconsider its current approach.

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

We have a number of concerns and questions:

- Why does this work fall within the remit of AHPRA, a regulatory body? Whilst it may have a credentialing role, it does not have a training or education role. Therefore, there is no notion of education and training to underpin any requirement to adhere to the single definition.
- Why is this work being undertaken with such a short public consultation process, and not being built on an examination of the existing evidence base, including the work in Aotearoa and other similarly post-colonial nations?
- The consultation document does not address the reasons why we need a national definition, nor what its purpose might be.

- The context across Australia is diverse. How will that be reflected in AHPRA's work? How will the single definition be considered by diverse local communities?
- How will the single definition affect the work by the Australian Medical Council with regard to its standards?

Thank you for the opportunity to comment.

On behalf of the Leaders in Indigenous Medical Education (LIME) Network Reference Group,

Professor Shaun Ewen
Project Lead, LIME Network
Pro Vice-Chancellor (Indigenous)
Director, Melbourne Poche Centre for Indigenous Health
Faculty of Medicine, Dentistry & Health Sciences
The University of Melbourne
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The Pharmacy Guild of Australia

SUBMISSION

Consultation on the definition of 'Cultural Safety'

National Registration and Accreditation Scheme's Aboriginal and Torres Strait Islander Health Strategy in partnership with the National Health Leadership Forum

Date submitted: 15 May 2019

Contact: Claire Bekema
Pharmacy Workforce Advisor
Policy and Regulation
Claire.Bekema@guild.org.au
02 6270 1888

BACKGROUND

The Pharmacy Guild of Australia (the Guild), is the peak pharmacy organisation representing Community Pharmacy. The Guild aims to promote, maintain and support community pharmacies as the most appropriate primary providers of services related to optimum therapeutic use of medicines and medication management to improve the health care outcomes of the community.

There are approximately 5,700 community pharmacies across Australia, delivering highly accessible professional health services, medicines and health advice. Community pharmacy is consistently seen by the Australian public as a trusted and valued part of our nation's health care system.

The Guild welcomes the opportunity to provide this submission to the National Registration and Accreditation Scheme's Aboriginal and Torres Strait Islander Strategy Group (Strategy Group) in partnership with the National Health Leadership Forum (NHLF) consultation on the Definition of 'Cultural Safety'.

Feedback Questions

Q1. Will having a single definition for the National Scheme and NHLF be helpful? Why or Why not? Are there unintended consequences of a single definition?

The Guild supports a single definition of Cultural Safety for use by the National Registration and Accreditation Scheme (National Scheme) and the NHLF Member organisations. We believe an agreed definition will provide clarity and support consistent use of the term 'Cultural Safety' as an understood definition across multiple health professions.

An agreed definition may alleviate confusion and the inclusion of other groups under the one term 'Cultural Safety'. For example, the inclusion of Culturally and Linguistically Diverse (CALD) may be better placed under its' own definition, or a broader Diversity definition. The agreed national definition may reduce the use of multiple terms by individuals and organisations who without intention may use these multiple terms interchangeably without fully understanding the meanings. A nationally recognised definition will support consistency across health disciplines.

The Guild does not consider there are unintended consequences if the definition is co-designed, and agreed to by Aboriginal and Torres Strait Islander people, organisations and health professionals. The Guild further supports the final agreed definition being used in future relevant professional standards and guidelines.

Q2. Does this definition capture the elements of what cultural safety is? If not, what would you change?

The Guild believes this definition captures the elements of cultural safety.

Q3. Do you support the proposed draft definition? Why or why not?

The Guild supports the proposed draft definition and the intention that the definition is a foundation for embedding cultural safety across the National Scheme. This definition captures 'individual, institutional knowledge, skills, attitudes and competencies' as determined by Aboriginal and Torres Strait Islander

individuals, families and communities. These elements are important to ensuring cultural safety of Aboriginal and Torres Strait Islander patients and patient centred care.

The Guild has supported the amendment of the National Law to include an additional guiding principle, "to foster cultural safety for Aboriginal and Torres Strait Islander Peoples" and supported retention and strengthening of this criteria in the Accreditation Standards.

The Guild believes that cultural safety is key to providing access to community pharmacy and community pharmacy services for Aboriginal and Torres Strait Islander people. The elements in the definition recognise both individual health professionals' knowledge, skills, attitudes and competencies, as well as the accountability of pharmacy owners to ensure their businesses and staff are providing clinically and culturally safe care.

Q4. What other definitions, frameworks or policies should NRAS and NHLF's definition of cultural safety support?

In the absence of an agreed national definition, the Guild has in the past drawn on a broad range of definitions and factsheets encompassing 'cultural safety, cultural awareness, cultural respect, cultural sensitivity and cultural awareness'. This has included definitions provided by Members of the NHLF, such as Indigenous Allied Health Australia (IAHA), the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM), the National Aboriginal Community Controlled Health Organisation (NACCHO) and the Australian Indigenous Doctors' Association's Cultural Factsheet.

An agreed national definition may also support organisations more broadly to develop definitions such as 'Culture' and 'Diversity' and other groups separate to Aboriginal and Torres Strait Islander people.

The Guild believes that an agreed definition will support profession specific professional practice and competency standards, codes of conduct and guidelines and assist the quality management and improvement systems (e.g. health service accreditation – QCPP).

Q5. Is there anything else you'd like to tell us about the draft definition?

The Guild suggests the development of factsheets or policy positions that include definitions of other terms that have been used previously, or may continue to be used, may assist bringing people 'along the journey' of understanding why there is a difference in the terminology and why they shouldn't be interchanged. An example of other terms includes cultural awareness, cultural responsiveness and cultural competency.

The Guild commends the range of definitions provided in the Australian Pharmacy Council's draft Accreditation Standards for degree programs that are currently under review. The Glossary includes definitions of culture, cultural diversity, cultural safety, equity/health equity, health disparity, inclusion and social determinants of health. As a group of terms, these clearly outline the differences and instances when each should be used, distinguishing between our multicultural nation and our first peoples.

Kia Ora
Thank you for providing us a link to the consultation on cultural safety.

The Physiotherapy Board (NZ) has a cultural competence Standard for Maaori and tauiwi. See link below.

We are of the view that cultures and attitudes to others are unique; as they are to us here in Aotearoa. They are not transferable in entirety nor do we think it appropriate that we provide 'our views' of what the Australian cultural definition should be or that we comment on your proposed definition.

The definitions are very important and we absolutely acknowledge and praise the work you are doing in this area. They have been developed by those who know and live them.

Again our overriding comment is that the concept and the development is positive and we definitely support you in the development.

https://www.physioboard.org.nz/wp-content/uploads/2018/03/Physiotherapy-Board-Code-Standards-Thresholds.pdf

Whilst the two Boards share the Physiotherapy Practice Thresholds in Australia and Aotearoa New Zealand; it is absolutely acknowledged that when it comes to aspects of our cultures – these are unique in each of our countries and cannot be the same. They are and should rightly so be different and developed from within the cultures of the country.

Thank you again for the opportunity to comment – it is very much appreciated.

Nga mihi

Jeanette Woltman-Black
Chief Executive
The Physiotherapy Board of New Zealand

Physiotherapy Board
of New Zealand Te Poari Tiaki Tinana o Aotearoa

RANZCO | Celebrating our 50th year
THE LEADERS IN COLLABORATIVE EYE CARE

15 May 2019

Australian Health Practitioner Regulation Agency
51/680 George St
Sydney NSW 2000
Via E-mail: rap@ahpra.gov.au

RANZCO response: Public consultation on the definition of 'cultural safety':

The Royal Australian and New Zealand College of Ophthalmologists (RANZCO) welcomes the opportunity to provide feedback on the definition of 'cultural safety' consultation by the Australian Health Practitioner Regulation Agency (AHPRA). RANZCO's mission is to drive improvements in eye health care in Australia, New Zealand and the Asia Pacific Region through continuing exceptional training, education, research and advocacy.

We (RANZCO) affirm our acknowledgement of the importance and value of 'cultural safety'. Having a workable definition of cultural safety further builds on existing cultural competency tools to ensure health professionals can most effectively communicate and establish relationships of care with their patients.

We are of the opinion the definition has been credibly developed by AHPRA and a reasonable solution to a complex set of words. We therefore endorse the implementation of the proposed definition and appreciate the considerable consultations undertaken by AHPRA with Aboriginal and Torres Strait Islander stakeholders.

RANZCO appreciates the opportunity to provide feedback and looks forward to seeing the outcomes of this consultation. Should you require any further clarification, please contact RANZCO Senior Manager Policy and Projects, Alex Staric at astaric@ranzco.edu

Sincerely,

Dr Ashish Agar
Aboriginal and Torres Strait Islander Eye Health Committee Co-Chair, RANZCO

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I can confirm that The Royal Australian and New Zealand College of Radiologists is supportive of AIDA's recommendations and views on the consultation and the proposed definition and defer to them in this instance.

Thank you

Have I been of assistance to you today? Click here to respond.

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From: Shae Bradshaw <Shae.Bradshaw@ahpra.gov.au>
Sent: Thursday, April 4, 2019 4:38 PM
Subject: Consultation on cultural safety definitions

Good afternoon

AHPRA, National Boards and Accreditation Authorities in the National Registration and Accreditation Scheme have partnered with Aboriginal and Torres Strait Islander health leaders and the National Health Leadership Forum (NHLF) to release a six-week public consultation. Together, these entities are seeking feedback on a proposed definition of 'cultural safety' to develop an agreed, national baseline definition that can be used as a foundation for embedding cultural safety across all functions in the National Scheme and for use by the NHLF.

There are 44 organisations represented in this consultation, which is being coordinated by the Aboriginal and Torres Strait Islander Health Strategy Group (Strategy Group), which is convened by AHPRA, and the NHLF. The consultation is a continuation of the work by the National Scheme's Strategy Group that has achieving health equity for Aboriginal and Torres Strait Islander Peoples as its overall goal.

The consultation paper is published on the AHPRA website and is open for six weeks **closing at 5pm on Wednesday 15 May, 2019.** Please circulate this email to your networks and interested stakeholders.

If you have any questions, please refer to the media release or contact Ms Jayde Fuller, Program Manager, at jayde.fuller@ahpra.gov.au or (07) 3149 6948.

Kind Regards

Shae Bradshaw
Board Services Officer
Medical Board of Australia
Medical Radiation Practice Board of Australia

Web | www.ahpra.gov.au

Australian Health Practitioner Regulation Agency
G.P.O. Box 9958 | Melbourne VIC 3001 | www.ahpra.gov.au

15th May 2019

Dear AHPRA

Re: Sydney Dental School's Response to AHPRA Cultural Safety Definition

Aboriginal and Torres Strait Islander peoples experience poorer dental and oral health in comparison to non-Aboriginal and Torres Strait Islander people in Australia. Higher Education Reviews have identified the need for tertiary institutions to incorporate Aboriginal and Torres Strait Islander culture and knowledge more widely into curricula to improve educational outcomes for Aboriginal and Torres Strait Islander peoples and to increase cultural competence for all students.[1]

All Dental Schools are seeking to provide a culturally safe dental and oral health workforce, with numerous goals and objectives being implemented into strategic documents within all dental schools to develop a greater awareness of cultural competence and social responsibility within their students.

Sydney Dental School conducted a comprehensive curricula review, to identify current Aboriginal and Torres Strait Islander cultural content and strategies, and ascertain changes required to ensure graduates achieve a minimum standard of Aboriginal and Torres Strait Islander cultural knowledge and skills. Research findings suggest students need to acquire an accurate Aboriginal and Torres Strait Islander history, consider their own world view, engage with Aboriginal and Torres Strait Islander peoples and reflect on these new experiences, through a comprehensive Aboriginal and Torres Strait Islander curricula framework woven throughout each year of dental and oral health curricula. Additionally, employment of Aboriginal and Torres Strait Islander academics and a contemporary

Aboriginal and Torres Strait Islander student recruitment and retention plan are required.[2,3,4] Together these strategies should enable Aboriginal and Torres Strait Islander students to navigate the higher education journey, facilitating cultural exchange as academics and students share with each other, increasing cultural safety, improving oral health and increasing the Aboriginal and Torres Strait Islander dental and oral health workforce.

With regards to the proposed cultural safety definition, it is extremely difficult to define cultural safety in one sentence. Aspects of the proposed definition are broad enough to maintain relevance to all health practitioners, identifies the need for strong institutional governance and active individual participation, and acknowledges that engagement with Aboriginal and Torres Strait Islander families and community is paramount in increasing cultural safety. However, there is no acknowledgement of the Aboriginal and Torres Strait Islander people's strong connection to land, historical experiences or holistic view of health and well-being. CATSINaM's Cultural Safety Position and the National Aboriginal and Torres Strait Islander Health Workers Association Cultural Safety Framework incorporate these aspects.[5]

The following alternative definition attempts to encompass the additional elements required. As a result of our experience in dental education, research and service provision, we propose an amended definition as follows:

Alternative Cultural Safety Definition

'Cultural safety is a philosophy of practice taking into account Aboriginal and Torres Strait Islanders peoples strong connections with the land, historical experiences, and views of health and well-being as described through the social determinants of health. Cultural safety requires health care professionals to undertake an ongoing process of self-reflection and cultural self-awareness, to ensure individual and institutional knowledge, skills, attitudes and competencies needed to deliver optimal health care for Aboriginal and Torres Strait Islander peoples are achieved, as determined by Aboriginal and Torres Strait Islander individuals, families and communities.'

Sydney Dental School supports aspects of the proposed cultural safety definition, however would recommend incorporating additional items as per the alternative definition provided. All dental educators and professionals are encouraged to work together to improve dental outcomes for Aboriginal and Torres Strait Islander peoples and produce a culturally competent and safe dental and oral health workforce.

Prepared by Cathryn Forsyth

Lecturer - Aboriginal & Torres Strait Islander Lead

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Feedback for AHPRA in relation to
Have your say: Consultation on the definition of 'cultural safety'

Thank you for an opportunity to provide feedback to AHPRA, in relation to *Have your say: Consultation on the definition of 'cultural safety.'* The University of Sydney's Faculty of Medicine and Health (FMH) First Peoples Network comprises Aboriginal and Torres Strait Islander academics and professionals from the FMH. Please see our feedback below.

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

   A single definition of cultural safety is helpful. However, a single definition, without a broader framework, will not increase cultural safety or support the evaluation of cultural safety. Furthermore, the definition and any associated framework needs to be flexible, to allow for the concept of cultural safety to evolve over time.

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

   This definition does not capture the essential elements of cultural safety. The definition and/or framework for cultural safety should capture:

   The relationships between the person and the health professional.
   This relationship reflects cultural communication protocols, to build relationships and nurture relationships. The relationship should make the person feels safe and comfortable, so they can share information and feel they are heard. The health profession must understand the broader power imbalances of social relations, not just the power imbalances between the person and health professional.

   The assessment process, which value the person and their culture.
   Many assessments are grounded in western constructs of health and wellbeing. Health professionals need to critique assessment frameworks and understand how they can be applied across cultural settings. Culture is not just about how we think about health and wellbeing, but it is our everyday ways of knowing, doing and being.

   Decolonising practices
   Decolonising practices are actions and approaches which incorporate an understanding of the Australian contexts, like history and politics. These understandings are used to critically reflect on individual, professional and organisational world views. Critical reflections should lead to affirmative actions that privilege the voices of Aboriginal and Torres Strait Islander people and minimise the cumulative effects of ongoing social inequities and imbalances.

   Health professionals, disciplines and organisations, who critically reflect on systems, processes and structures.
   Systems, processes and structures can oppress people, and/or they can facilitate human-rights and strength-based approaches in health care. Racism, elitism, sexism, ableism and all the 'isms' need to be considered in this context. Health professionals making

decisions in and about systems, processes and structures need to be accountable and transparent, not just to their organisations but also to the communities that they serve.

Health policy and other policies that enhance health (like housing and education) are embedded in a human-rights based and strength-based approach.
This means that policies should address the social inequities and social imbalances, using a human-rights based and strength-based approach. Policies need to be adequately funded to address these inequities and imbalances. They also need to support and compliment Aboriginal and Torres Strait Islander people's healing, self-empowerment and leadership.

The Aboriginal and Torres Strait Islander health organisations and workforce are valued.
Aboriginal and Torres Strait Islander people are involved in every level of care and all decision-making processes, in the health and health-related industries. ACCHOs hold many significant roles in implementing culturally safe services and partnering with other organisations.

Elders and other key Aboriginal and Torres Strait Islander community members are involved in the design and evaluation of services and policy.
Local communities and national leaders' involvement in design and evaluation of services and policies are paramount to any culturally safe service.

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

   We do not support the current draft definition. The definition does not capture essential elements of cultural safety and it will not be beneficial in supporting and/or evaluating cultural safety.

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

   At a minimum, NRAS and NHLF should consider the following definitions, frameworks and/or work:

   - NATSIWA's cultural safety framework
   - CATSINaM's policy on cultural safety
   - Gayaa Dhuwi (Proud Spirit) Declaration
   - Iripaheti Ramsden's work.

   NRAS and NHLF should consider how their national definition and/or work supports localised ways of knowing, doing and being. For example, NPYWC has a policy called Malparara Way, which informs cultural safety.

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

   We have no further comments.

If you have any queries relating to the content of this document, then please contact Dr Chontel Gibson (Lecturer), who compiled this document on behalf of the FMH First Peoples Network or Professor Juanita Sherwood (Associate Dean – Indigenous Strategies and Services), who leads the FMH First Peoples Network. Chontel and Juanita can be contacted via their emails: Chontel.Gibson@sydney.edu.au and Juanita.Sherwood@sydney.edu.au.

Good Morning APHRA,

Thank you for this opportunity to provide feedback on the definition of "Cultural Safety" as part of the AHPRA Reconciliation Action Plan as below.

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

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

I would like to propose the inclusion of the words "application of" into the definition as per below:

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

I believe that unless these knowledge, skills and attributes are applied, we may only be providing an understanding of cultural safety by way of terminology, rather than an application of cultural safety.

Regards

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I acknowledge the traditional owners of the land I work on, I also acknowledge the Elders past and present.

Townsville Aboriginal and Islander Health Service

National Registration and Accreditation Scheme's Aboriginal and Torres Strait Islander Health Strategy Group AND the National Health Leadership Forum (NHLF)

Research Consultation Report - May 2019

BACKGROUND

TAIHS is invited to contribute to a National Survey on the definition of Cultural Safety released by the National Registration and Accreditation Scheme's Aboriginal and Torres Strait Islander Health Strategy Group in partnership with the National Health Leadership Forum (NHLF). The NHLF is the national representative body for Aboriginal and Torres Strait Islander peak organisations who provide advice on health related matters. Since the establishment of the NHLF in 2011, the NHLF has brought together Senior Aboriginal and Torres Strait Islander health leaders to consider and consult on the health policies for Australia's First Peoples.

By participating in the National Survey, TAIHS will contribute to the final definition of Cultural Safety which will be applied in the context of the National Registration and Accreditation Scheme, and by NHLF member organizations through embedding cultural safety within AHPRA Codes of Practice, Codes of Conduct, Registration Standards and Guidelines relevant to all regulated professions.

CONSULTATION METHOD

TAIHS involved all staff in the consultation process, including professional health staff and community services staff. While health staff work at the coalface of health services, many community services staff refer clients to health services and many of those staff maintain their own views on cultural safety in health service delivery from organisational, personal and community perspectives.

The following mechanisms were implemented to elicit feedback from the TAIHS community in regards to the research questions by:

- Attending Focus Groups;
- One-on-one meetings;
- Feedback to questions via electronic response from individuals.

Unfortunately, due to time constraints TAIHS was unable to host broader community feedback events in regards to this survey; as such, in the context of this consultation, 'TAIHS Community' refers to TAIHS Staff only. TAIHS staff includes both Indigenous and non-Indigenous personnel.

While respondents did not want to be individually identified in regards to feedback provided, the following is a list of professional disciplines of the respondents:

- Health Practitioners

- Health Professionals
- Non-Clinical Staff (these people being part of the Corporate team at TAIHS)

NHLF QUESTIONS POSTULATED TO RESPONDENTS:

The questions postulated to respondents as per the NHLF survey were as follows:

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

    - Ultimately, our consultation revealed that a single definition of Cultural Safety would be beneficial in order to promote a unified method of culturally safe practice. However, the unintended consequences of a single definition are as follows: without being specific about what constitutes culturally safe care included in the definition, there is likely to be no change in the provision of cultural care to our people.

    - In order for change to occur, there would need to be Nationally recognised training programs for the care of Aboriginal people and the care of Torres Strait Islander people. These programs would also need to include the option of tailoring such programs to address the needs of different skin groups. This would also require a National registry of programs, and those who can deliver them in various community settings. The registry would need to be linked to Elder groups in communities and a minimal charge for community education could then be applied.

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

    This definition in no way adequately covers what needs to be stated and implemented to address cultural safety; however, it does highlight the key concepts of cultural safety cross-culturally. The definition needs to be expanded to include the core concepts of cultural safety which are inclusive of:
    - cultural awareness
    - cultural competence
    - cultural capability
    - cultural proficiency
    - cultural respect
    - cultural security
    - cultural appropriateness
    - cultural understanding
    - cultural responsiveness;
    - cultural safety.

    In order to achieve this, TAIHS recommends some clear definitions regarding what constitutes the above factors in order to deliver culturally safe and secure care.

Perhaps some values statements relevant to each aspect of care would support broader professional staff knowledge and skills development.

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

In principle, we support the intention of the definition; however, we believe there needs to be further inclusions in order to portray to true context of cultural safety as referenced in our feedback.

In accordance with the statement below, please refer to the basic cosmetic changes to the statement as suggested by respondents. It was further recommended that the words 'Institutional' and 'Optimal' be removed.

Please feel welcome to contact TAIHS should you wish to consult further with our team.

Purpose of the Definition:

Cultural Safety is the individual and (institutional) collective Cultural knowledge, skills, attitudes, Beliefs, respect and competencies that are needed to deliver (Optimal) the best possible health care and continual education for Aboriginal and Torres Strait Islander Peoples as determined by Aboriginal and Torres Strait Islander individual, families and Community.

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

TAIHS supports NACCHO (NACCHO, 1992), with regard to the various frameworks, policies and principles that need to be referenced as part of this body of research.

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

Please refer to the verbatim feedback as outlined below.

In the spirit of capturing individual feedback, please refer to the following verbatim comments made by respondents:

- It's important that our mob feel empowered to learn about their healthcare, their health conditions and how to manage these important facets of their everyday life. This will support people to adopt their own culturally safe practices through an informed approach.

- We need to encourage our people feel confident about managing their own healthcare, this will build their own knowledge, skills and resilience.
- Storytelling must become part of the healthcare consultation process, through storytelling people can understand better, they can relate their situation to another.
- Group yarning facilitated by a member of our mob is important, it helps people to learn and reflect together, it also helps to build trust, bonds and relationships – that sense of belonging helps people to feel culturally and personally safe.
- Healthcare delivered to our mob by our mob is critical to the achievement of better outcomes.
- It's critical that non-Indigenous Doctors, Nurses and other health professionals understand the importance of listening to, and learning from our mob – our people should never be exposed to disempowering and demeaning words, actions and/or service delivery.
- Our mob needs to have access to bio-psychosocial models of care as a foundation to care giving, this will help to engage and involve them in decision making and directing their care – this includes the physical, emotional, social, mental and spiritual contexts of being and living.
- Knowledge and acceptance of cultural and spiritual beliefs of Aboriginal and Torres Strait Islander people is important to cultural awareness, people should always demonstrate respect for Indigenous belief and cultural systems.
- Integrated, holistic care is crucial to our mob and the outcomes they achieve in relation to self.
- We need to close the power imbalance between patient and health professional.
- Health Professionals both Indigenous and non-Indigenous need to always consider difference, and reflect on practice but always allow the patient to inform and direct their care - sure assist them and encourage them to be part of the process of directing care. Most importantly, younger ones especially, need to be reminded of the impact and long term effects of colonisation and forced removal; more importantly the impact on our mob's families, culture and lives.
- It's important to consider different cultural groups within 'culture in practice' (eg. different tribes/skin groups, language, sacred places, lore and family and kinship groups).
- Cultural awareness is important in our practice environments, the knowledge, attitudes and values of all staff (Indigenous and non-Indigenous) need to reflect the values of Aboriginal and Torres Strait Islander people in order to demonstrate Respect, Equality and Equity.
- In order to create a culturally competent workforce, all staff need to be open to hearing the truth about the history of Australia; in particular, the degradation of our First Nation's peoples.
- Professionals need to understand that history does have an influence on health and behaviour, body language is important and exercising patience is always required with our mob.
- Staff; in particular, non-Indigenous staff and sometimes Indigenous staff need to demonstrate positive attitudes in their interactions with our mob, even when dealing with angry and/or violent and/or aggressive clients. They need to get to the bottom of the problem, then they will be able to help that person. In failing to see through the anger, we fail to support some of the most vulnerable people accessing our services. By warming to those who need us the most, we provide a truly culturally safe environment.

- It's important that all professional staff are culturally capable; moreover, that they possess the knowledge and skills required in order to provide care that is holistic, patient centred and delivered with loving kindness. Patients need to feel that the health professional understands them, and that their behaviour in practice is congruent with such attitudes.
- Culturally proficient care is underpinned by our desire as professionals to provide the best treatment available to our mob which, is strongly influenced by our own values and beliefs; however, the organisation sets the tone for this and needs to take absolute accountability for the messages send to our community.
- All professionals need to continue to respect the cultural boundaries associated with Men's and Women's Business, never assume that a woman is comfortable with a male service provider and vice versa, always ask the preference of the patient.
- All professionals working in Indigenous services need to have fundamental understanding of family, connections and responsibilities.
- Demonstrating respect will encourage people to have a sense of belonging and it will support people to be themselves which, is part of forming and maintaining identity and feeling not only supported but self-determined.
- Respect is an individual concept, the way we demonstrate respect will be different for each individual person; however, the concept of respect remains the same.
- Dress code is important to the delivery of care and services. Staff should always take pride in their appearance, never dress down because it puts our culture down.
- Management needs to remember why Aboriginal Community Controlled Organisations are here; in particular, non-Indigenous leaders need to understand how their communication does, and will impact the way our people (ie. all staff) deliver care and services.
- Aboriginal and Torres Strait Islander staff need to be prioritised in organisations for training and development into positions that non-Indigenous people hold, particularly in Aboriginal Community Controlled Health Services. Continuous professional development should be prioritised for our mob before non-Indigenous people, unless agreed by cultural leaders/mentors in Indigenous organisations.
- Our mob needs to be supported by Managers and workforce leaders to take up senior roles in organisations, not just in health but in other service areas too (eg. corporate services, community services etc.).

References:

National Aboriginal Community Controlled Health Organisation. (1992). *Creating NACCHO Cultural Safety Training Standards and Assessment Process.* (2011). Retrieved from http://www.csheitc.org.au/wp-content/uploads/2015/11/CSTStandardsBackgroundPaper-NACCHO.pdf

SUBMISSION TO THE ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH STRATEGY GROUP: DEFINTION OF CULTURAL SAFETY

May 2019

INTRODUCTION

The Aboriginal and Torres Strait Islander Strategy Group (Strategy Group)[1], convened by the Australian Health Practitioner Regulation Agency (AHPRA) and the National Health Leadership Forum (NHLF) are consulting on a proposed definition of "cultural safety". The intent is to develop an agreed, national baseline definition that can be used as a foundation for embedding cultural safety across all functions in the National Registration and Accreditation Scheme (NRAS) and for use by the NHLF.

The proposed definition of cultural safety, on which feedback is sought, is:

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

Feedback is sought on the following five questions in relation to this definition. Universities Australia's (UA's) response to these questions has been developed in consultation with UA's Health Professions Education Standing Group (HPESG).

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

   Having a single term, "cultural safety" which refers to specific elements that make health organisations and systems more effective for Aboriginal and Torres Strait Islander people is considered useful. Multiple terms can cause confusion. An unintended consequence of a single term could arise if its definition was too narrow, however the proposed definition of cultural safety appears sufficiently broad. UA recognises that outside of the health system, other terms may continue to be used. This has the potential to cause confusion however it is clear that the proposed definition specifically refers to health services and systems.

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

   According to the Aboriginal and Torres Strait Islander Health Curriculum Framework[2]: *"The concept of cultural safety in health service delivery focuses on the subjective experience of the health service user, whereby they experience an environment that does not challenge, assault or deny their cultural identity. Cultural safety is enabled if the people who work there show respect and sensitivity for the different cultural needs of Aboriginal and Torres Strait Islander*

[1] The Strategy Group comprises 44 organisations including AHPRA, NHLF, Aboriginal and Torres Strait Islander health leaders National Boards and Accreditation Authorities in the National Registration and Accreditation Scheme (NRAS).

[2] Commonwealth Department of Health 2016 Aboriginal and Torres Strait Islander Health Curriculum Framework: http://www.health.gov.au/internet/main/publishing.nsf/Content/aboriginal-torres-strait-islander-health-curriculum-framework

peoples and are aware of how their own cultural values may have an impact[3]. A culturally safe setting allows for shared learning, shared meaning and genuine listening with full acceptance of Aboriginal and Torres Strait Islander diversity[4].”

The proposed definition seems to capture the subjective nature of cultural safety while highlighting the contributions and responsibilities of both individuals and services:

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

A suggested minor addition is for the definition to include reference to the need for these elements to be actively developed and applied.

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

The proposed definition is supported.

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

It would be useful to link the proposed term and definition to the Aboriginal and Torres Strait Islander Health Curriculum Framework. Use of the Framework is voluntary, however, it has been widely disseminated within the higher education sector and offers a model to implement Aboriginal and Torres Strait Islander health curricula in a more consistent way. Cultural safety is referenced in a number of places in the Framework, including a section on definitions. As the Framework is used as a reference by a number of higher education providers it would be useful for the definitions and terms to align with that proposed.

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

UA supports reference in the proposed definition to both individual and institutional knowledge, skills and competencies. It is important that both elements - individual and institutional - act together for cultural safety to be achieved. It would be useful to include a short explanatory note to this effect alongside the proposed definition.

The proposed definition will be used as a foundation for embedding cultural safety across all functions in the National Registration and Accreditation Scheme (NRAS), presumably including health professional course accreditation standards. While outside of this specific consultation, UA seeks advice on any planned implementation of the proposed definition across the higher education and health sectors. In particular, it would be helpful to know how attainment of cultural safety will be measured in situations where individual and institutional application do not match, as for example may occur in a clinical placement.

[3] Phillips, G 2004 , *CDAMS Indigenous Health Curriculum Framework, The Project Steering of Australian Medical Schools*, CDAMS, University of NSW, Sydney.

[4] Eckermann, A-K, Toni D, Chong, E et al. 2010, *Binan gooniji: bridging cultures in Aboriginal health*, (3rd edition), Elsevier, Chatswood.