3

Cultural Safety

In this chapter, Cultural Safety, we describe the concept and the rationale for its preferred use as an underpinning philosophy and guiding principles for practice. The practice principles of cultural safety are discussed, including reflection on practice; the importance of communication and asking questions; consideration of power differentials; being mindful of how colonization impacts practice; racism and discrimination awareness and ensuring that professionals do not diminish, demean, or disempower others through their interactions.

This chapter will discuss cultural safety in more detail and explore the elements that make it a relevant approach for the U.S. health care and human services environments.

Chapter Objectives

After completing this chapter, you should be able to:

- define cultural safety
- describe the pathways to cultural safety

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- identify the principles of culturally safe practice
- apply cultural safety to scenarios.

What Is Cultural Safety and What It Is Not

Cultural safety is both a philosophy and a way of working in professional health and human service settings. It is about ensuring that the cultural background of the professional does not dominate or put at risk the safety and well-being of any individual or group of a different cultural background to the professional. It is about *how* we do things, not just what we do.

Cultural safety is not about feeling guilty or believing any culture or cultural group is better than another. It is not a checklist for how to approach different groups. It is about becoming aware of one's own culture and understanding how it may interface with other cultures, with culture being more than race or ethnicity.

Why Cultural Safety as a Preferred Approach?

Cultural safety has been identified as a way of addressing social and health inequities, with its broader definition of culture than most other approaches that focus mainly on ethnicity or racial differences. It has arisen from an Indigenous perspective, from a country with a similar colonizing past to the U.S., which has demonstrated better outcomes are possible when there is the will (e.g., see Kurtz et al., 2018). Cultural safety is also relevant and beneficial to all participants in the healthcare experience, both clients and professionals delivering services.

Pathways to Cultural Safety

Some writers have conceptualized cultural safety as the third level in a set of three levels of cultural understanding (see Fig. 3.1). We, on the other hand, view cultural safety less as a hierarchy, but more like a continual

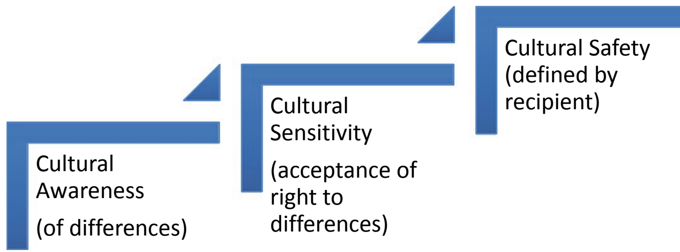

Fig. 3.1 Original stages of cultural safety as defined by Ramsden (Taylor & Thompson-Guerin, 2019)

process of reflection on and action applied to professional practice. First, let's review the levels of cultural safety as articulated in the New Zealand concept, before addressing more fully the application of cultural safety in practice.

The original stages of cultural safety, articulated by the late Irihapeti Ramsden, were transformative and had an impact that helped reshape nursing and midwifery education in New Zealand, Canada and Australia (Darroch et al., 2017). Sadly, this inspirational academic, whom one of the authors was fortunate to meet in the early days of cultural safety development, passed away before it could be seen where her work traveled. Ramsden (2002) was quick to acknowledge that the idea for cultural safety stemmed from a young Māori (the Indigenous people of New Zealand) midwifery student, who challenged the academy to think not only safety in terms of health and medical procedures, but in terms of culture. Others, such as Diane Wepa (2015), have taken on the further development and articulation of cultural safety. Curtis et al. (2019, p. 14) reviewed the literature around the concept of cultural safety and developed a new definition that makes the link to health equity more overt:

> Cultural safety requires healthcare professionals and their associated healthcare organisations to examine themselves and the potential impact of their own culture on clinical interactions and healthcare service delivery. This requires individual healthcare professionals and healthcare organisations to acknowledge and address their own biases, attitudes, assumptions, stereotypes, prejudices, structures and characteristics

> that may affect the quality of care provided. In doing so, cultural safety encompasses a critical consciousness where healthcare professionals and healthcare organisations engage in ongoing self-reflection and self-awareness and hold themselves accountable for providing culturally safe care, as defined by the patient and their communities, and as measured through progress towards achieving health equity. Cultural safety requires healthcare professionals and their associated healthcare organisations to influence healthcare to reduce bias and achieve equity within the workforce and working environment.

A critical moment for the authors of this book came when Ramsden challenged non-Indigenous health professionals and academics to accept their own role in developing and implementing cultural safety. She suggested that cultural safety is everyone's responsibility and that it should not always fall to the members of the minority groups to explain their needs or adapt to the dominant cultures. Ramsden's message to the non-Indigenous audience was that the onus was on those in positions of power to examine their own cultures and seek to decolonize their engagements with those who differ in whatever aspect of culture.

In seeking to apply cultural safety in practice, we found that the cultural awareness stage really required an examination and understanding of our own cultures prior, and in addition, to developing awareness about others. We have chosen to make what was implicit in the original diagram more explicit in our model of cultural safety, shown in Fig. 3.2.

1. *Self-awareness*

Cultural awareness, usually considered the first step in the cultural safety literature, is about being conscious that there are differences between people. However, self-awareness may in fact be necessary in order to recognize our own individual culture(s). It is often not until we encounter someone from a different cultural background to ourselves that the influence of our own culture becomes apparent. For example, if you have been raised to view punctuality as a virtue, an important part of your core values, and you encounter someone for whom time is flexible, tension may arise. Imagine you have an appointment to meet

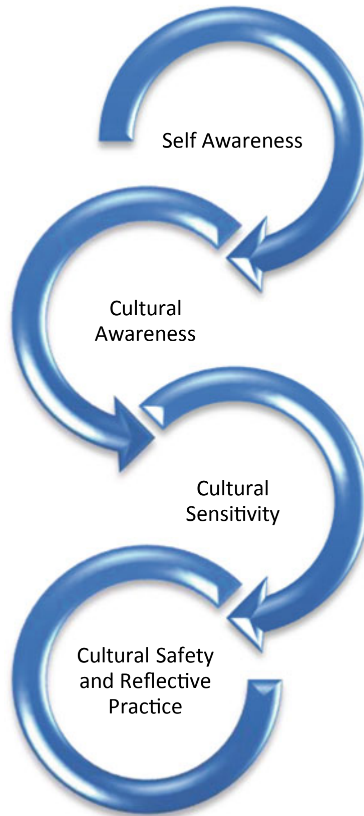

Fig. 3.2 An aspirational model of cultural safety—always incorporating new understandings and reflections to enhance culturally safe care, as defined by recipients (Taylor & Thompson-Guerin, 2019)

at 3:00 pm and your client arrives around 3.30, completely relaxed and unable to understand why you can't see them. How you respond will reveal much about the cultural interface. This doesn't mean there is no room to find common ground or that your needs have to be placed below those of the client's culture. It's how we arrive at that space that will determine the cultural safety of an engagement. Do you send them away because they 'missed' the appointment? Do you assume their lateness is a 'cultural thing'? How do you react when you are face-to-face with your

late client—are you irritated or welcoming? Are you aware of your own reaction to the situation when faced with it?

There is no definitive answer here. Just think about the possible implications. If your client is late and you assume it is because their cultural background is less concerned with punctuality than you are—what are you engaging in? If you are even a little irritated by their lateness, what could be the impact on the encounter? Might you hurry things along, mindful of those coming after and potentially miss something important? What if they had been caught in traffic or even in a car accident? Would you have a different response?

The question is are you aware of your responses and where they come from? What presses your buttons? What makes you more or less likely to be patient with someone? Why? What is it about your own culture, identity or experiences that influence your own reactions? Cultural safety is not about saying anything goes and you just deal with it, but it is about making sure your culture just doesn't take precedence, because you are the one in the position of power. Working in the health and human services sectors does not come with a pass to engage in 'my way or the highway' philosophy. How might these interactions influence health or well-being outcomes and contribute to health equity, or inequities?

Activity

Take some time to reflect on your own culture:

- How do you feel about health? What is your own definition or understanding of health? Is health a personal responsibility or a communal one? Or is your health in the hands of a higher being? Who should be involved in your healthcare decisions—you and you only, or your extended family? Who do you want to be involved when discussing your own health?
- How do you show respect for authority? Do you look a person in authority in the eye or do you look down to show respect? How might you feel about someone who doesn't look you in the eye when speaking? What assumptions do you make about eye contact in communication?

- How do you feel about government involvement in your health? What role should the government have, if any? Explain your reasoning.
- How important is punctuality to you? From your perspective, what does it say about someone to be punctual?
- What is more important in your life—having a job and being financially secure or having good relationships with family and friends? Among your friends and family, how are these values expressed or experienced? What, if any, reactions do you have when coming in contact with others who may have differing values?

In answering these questions, it is likely that the answer to most of these may be 'that depends'. Context is important and you may find yourself moving along a continuum depending upon the situation. From a cultural safety perspective, it's necessary to know what biases, expectations, beliefs, and behaviors you are bringing into the encounter with someone who may hold different cultural perspectives, so as not to impose these on your client.

2. *Cultural awareness*

Cultural awareness, as already stated, is awareness of culture. The obvious or exotic differences are often easier to identify than the more subtle differences. These might include the mode of dress, foods people eat, or music preferences. However, cultural awareness also seeks to uncover the less obvious, including interpersonal behaviors, such as showing respect for authority by looking down, which may contrast with another culture that shows respect by looking directly at the person in authority as mentioned above. This could be a practice of some cultural groups, but of course, that doesn't mean every member of that group will display the same behavior, so cultural awareness learning is always to be taken with caution about applying such knowledge.

Cultural awareness is a stage that many people find very interesting and enjoyable and may include learning new words and protocols for interacting or communicating. These differences can be observed and enjoyed or visited for a period without requiring any fundamental change

in practice or attitude. For some, it can be a little like going to a museum, but then you go home and continue to do things as you would before the visit. Indeed, many people experience cultural awareness when they go on a trip, maybe to another country. Unfortunately, many professional development workshops and educational settings tend to limit their cultural training to this stage of awareness. Cultural awareness also requires an understanding of one's own culture and the commonalities across all cultures that allow people to relate to and interpret any perceived differences.

Cultural awareness, simply put, is being aware that people are different. We discuss it again here because it is a widely used terminology, both within the domain of cultural safety as well as more generally. Cultural awareness is not entirely natural, it is not something that you are born with; awareness of differences between people is social and develops over time. If you watch small children, for example, two- to four-year-olds, they would generally not 'see' differences between people—kids are kids, grown-ups are grown-ups, and that's basically all they understand. Being aware that people are different is not problematic, but what is important is what you think of those differences and how you act on them.

For a long time, health professionals adopted the practice of treating everyone the same, intended to demonstrate a lack of prejudice on the part of health services and professionals. However, evidence has suggested that disparities in health and social outcomes of some populations can be attributed in part to cultural differences between clients and care providers. Increasingly, people began talking about the need to be 'culturally aware' and not assume everyone belongs to a homogenous base, that everyone is coming from the same position.

Cultural awareness approaches often focus on learning about the things that make cultural groups different from one another, while overlooking many of the features in common. While a useful first step, learning these sorts of details can also lead to stereotyping and inappropriate behavior or interactions. It is not possible to learn everything there is to know about all the cultures that you encounter in your professional practice or your life and experience. This is also why the cycling between cultural awareness and self-awareness is so critical. There is an old saying

that if you are pointing the finger at someone, there are three pointing back at you. When we only focus on 'the other' and their cultural 'ways', we tend to see them as exotic and different, but fail to see how they are also human variations. When we look at ourselves (three fingers pointing back at you) and engage in self-awareness and see how we ourselves are culture-bearers, we can understand the complexity, nuance, and fluidity of cultural identities. Cultural safety principles provide a useful addition to your knowledge base as they can be applied to any point of 'perceived' difference between you and those in your care, including age, socioeconomic status, genders, abilities, religions, or sexualities.

3. *Cultural sensitivity*

Cultural sensitivity is intended as the next step up from cultural awareness. It means being sensitive to the differences learned about through cultural awareness. Sensitivity assumes that professionals can apply their awareness of cultural differences to their own practice. Cultural sensitivity validates the right to difference. Article 22 of the Universal Declaration of Human Rights states that:

> Everyone, as a member of society, has the right to social security and is entitled to realization, through national effort and international co-operation and in accordance with the organization and resources of each State, of the economic, social and cultural rights indispensable for his dignity and the free development of his personality. (United Nations, 1948)

Cultural sensitivity is also thinking about your own attitudes and beliefs and how they might affect the person you are working with, as well as taking into account the cultural issues that might influence your clients.

In this step you might say, 'OK, there are cultural differences, and now I can be sensitive to those differences. As a professional, I can consider different modes of operating for my clients'. Difference is legitimated—difference is OK—and it is about being sensitive to the possibility that my difference might impact on others. In this stage, the professional

reaches an understanding that individuals are entitled to hold differing worldviews, values, knowledge, and beliefs. It should not be a matter of leaving these cultural foundations at the door in order to access care. The professional needs to be sensitive to differing needs and expectations, and work to accommodate these where possible. It is not and should not be the goal to 'convert' or 'colonize' someone to your preferred culture. This is challenging when certain experiences conflict with your personal beliefs and values.

Cultural safety does not ask you as the professional to change any of these aspects—you have just as much right to your culture as those you seek to provide service to—but what is important is that in choosing a service career, you are not trying to diminish, demean, disempower, or impose your views on another. You may have strongly held views about abortion, for example, but in providing professional care to another, these should not come into the engagement with a client. Indeed, for culturally safe practice, you need to be well aware of how your views may harm the outcomes for your client if you do not manage it. If this is untenable to you as an individual, you may have to think about your career choices, as the professional role is about providing judgment-free, culturally safe care. This is absolutely essential for health and outcomes to improve.

There is recurring debate in this country about the 'right to discriminate' on the basis of 'religious protection'. On a personal level, that is something for an individual's conscience. In health and human service provision, however, think about what this actually means. Look at the following scenario:

Scenario

Two women bring a baby to the local clinic. The staff member asks the mother to complete the paperwork. Both women put their name on the form, only to be told that the clinic would need to know who the 'actual mother' was.

- What message has the couple received from this interaction?
- Whose construct of family is being privileged?

- What are the potential risks to the baby and parents of this experience?
- How might a professional manage their personal belief system when encountering someone with different beliefs?

Sensitivity is also about being sensitive to elements of racism, discrimination or othering. Intent is not enough to guard against a client experiencing racism, discrimination or feeling 'othered'. If the women took offense at the question about who is the 'actual' mother and the professional stated, 'Oh, I don't have a problem with same-sex couples. I have friends who are gay', does this make a difference? The women may have experienced the comment as insensitive and discriminatory regardless of the intent of the staff member.

Mistakes are often unavoidable, but how they are managed reveals much about character and safety. Reflection in and on practice is a necessary tool to achieve cultural safety. So rather than being anxious about making a mistake, think about how this might have been done differently. Let's accept there was a 'clinical' reason for asking such a question—perhaps a hereditary concern, for example. A more culturally sensitive approach would be to preface any such question with an explanation: 'I just need some background information that could be relevant, would you mind specifying who is the birth mother?' Unless there is a rationale for the question, it has the potential to demean the family, whether intended or not. And, if a mistake or a potentially insensitive comment or question is made, then, acknowledge it, apologize, and demonstrate actions for reparations or changing behavior.

4. *Cultural safety*

Irihapeti Ramsden (2002), who spearheaded the original cultural safety movement in New Zealand, believed that it was not enough to focus on the 'exotic' aspects of an individual's or group's culture as was often done in cultural awareness, cultural sensitivity or trans-cultural nursing approaches. In contrast to trans-cultural nursing, which originally sought to describe and respond to the cultural differences, cultural safety involves recognition of power imbalances and historical, political, social, and economic structures. Cultural safety requires the

health professional (or others) to understand their own culture and to acknowledge the power imbalance brought about by dominant systems. It requires professionals to actively seek to ensure no 'cultural harm' is done through actions that may impact on clients.

Cultural safety has gained momentum in places like Canada and Australia, with a growing body of literature challenging existing approaches to health and social care for Indigenous and other peoples. It is important to acknowledge that the cultural safety framework itself came from Indigenous Peoples. However, rather than suggest simply applying a foreign concept to an American context, it is obvious that without some adaptation and regard of local contexts, histories, and worldviews, this act itself would be an unsafe one. While cultural safety is an Indigenous construct, it requires the dominant or colonizing culture to engage in processes of self-reflection and decolonizing practice that ultimately has relevance for any client.

Examining the New Zealand experience suggests that clinical competencies, technical expertise, and theoretical knowledge form only part of the care equation when the recipients of care differ in some way from the professional. For example, a health professional may have the technical skills to administer a vaccine, may know vaccination guidelines and timeframes, and may be very knowledgeable about the diseases that are prevented through vaccination programs. But what skills are required when trying to administer a vaccine to a four-year-old who is very distressed or when working with a family who may have good reasons to distrust or be skeptical about vaccinations?

Although cultural safety has arisen from the disciplines of midwifery and nursing, other health disciplines as well as social and human services have found or are finding relevance for their practice. Even where other philosophical frameworks have emerged, there can be no denying that the New Zealand experience has had a profound influence in focusing on culture and colonization in health. There are numerous readings and resources that might be examined for a deeper understanding of the development and conceptualization of cultural safety.

Readings
To learn more deeply about these topics, the following readings are a good place to start:

Irihapeti Merenia Ramsden's PhD thesis: '*Cultural Safety and Nursing Education in Āotearoa and Te Waipounamu*' (2002) is available online through Massey University, New Zealand.

Browne, A., Varcoe, C., et al. (2009). Cultural safety and the challenges of translating critically oriented knowledge in practice. *Nursing Philosophy, 10*(3), 167–179.

Curtis, E., Jones, R., Tipene-Leach, D., et al. (2019). Why cultural safety rather than cultural competency is required to achieve health equity: A literature review and recommended definition. *International Journal of Equity in Health, 18,* 174. https://doi.org/10.1186/s12939-019-1082-3

Smith, S. (2012). *Cultural safety in nursing education: Increasing care for LGBT individuals*. http://hdl.handle.net/2376/3442. Washington State University, Master of Nursing. https://research.libraries.wsu.edu/xmlui/handle/2376/3442

Cultural Safety Principles

The following is a brief summary of the principles of cultural safety, adapted from the Nursing Council of New Zealand (2011):

1. The need for health and human services professionals to *reflect on their practice* is a critical aspect of culturally safe practice. As most health and human service professionals are members of dominant cultural groups, think about how this might impact on clients who are members of minority groups. Remember too, that dominant and minority are relative terms. For example, women are not necessarily a minority but have specialized healthcare needs that can render them a 'vulnerable' group in certain contexts.
2. *Talk, ask, engage in dialogue with the client*. This might seem obvious. Yet there are countless examples of encounters where clients are

spoken about, around, and on behalf of, but often not talked to or with. (See the chapter *Intercultural communications*). A culturally safe approach will require true engagement with the client to understand their unique needs, beliefs, understandings, and preferred ways of doing things. Where there is a perceived or actual barrier to discourse (or conversation), clients can remain un-engaged and un-empowered in response to their own health care or other needs. Talking, asking, and engaging with the client is not always easy to achieve so this topic will be discussed further in later chapters.

3. *Seek to minimize the power differentials between yourself and your client*. Western healthcare and human services have traditionally been hierarchical in nature, although this is slowly changing. Professionals may be wittingly or unwittingly in positions of power over their clients. What might shift the power balance in your professional practice setting? Language is a very important indicator of power in healthcare. Think about the way in which clients are sometimes referred to as 'non-compliant', 'absconder', or 'frequent flyers'. These kinds of labels position the professional as the one in power, whereas the clients are reduced to simple labels.
4. *Undertake a process of decolonization.* This was a somewhat controversial aspect of the cultural safety model that was criticized in the press in New Zealand and Australia, countries with more recent colonizing histories than the U.S. It is this element, however, that separates cultural safety from all other approaches. The original concept of cultural safety involved acknowledging the key role of a colonizing history in contemporary health and social outcomes for Indigenous Peoples specifically. While the colonizing experience of New Zealand differs somewhat from that of the U.S. (see the chapter on global issues for details), we examine what a decolonizing process may mean in a U.S. setting.
5. *Ensure that you do not diminish, demean, or disempower others through your actions*. Sometimes it is easier to identify culturally unsafe practice than it is to identify culturally safe approaches. Both, however, require a level of self-awareness and a willingness to critique practice and systems. Actions can include subtleties of body language, how

you say things and what you say, as well as more overt behaviors. We provide numerous examples throughout this book.

6. *Undertake to examine your own and others' potential for racism, discrimination, stereotyping, or othering*. Understanding racism and discrimination involves realizing how these are experienced by those on the receiving end—not about an individual's intent. It is not enough to declare that we are not 'racist' or 'sexist' or 'homophobic' or any other discriminating label if the person we engage with is experiencing our interactions as such. Interrogating our assumptions and being mindful of the tendency to view people as 'the other' are all principles that can be applied to professional practice.

Critical Thinking

What are some fundamental differences between New Zealand and the U.S. that might make the transferability of cultural safety more challenging?

The New Zealand state nursing exam has included questions focusing on cultural safety. What do you think of this idea for the U.S.? How would it be received locally for psychology and other health or human service professionals? What are the arguments for and against?

In 2015, the MCAT, the exam for entrance to medical school, added a new section, the Psychological, Social and Biological Foundations of Behavior, which requires an understanding of cultural and social differences, social stratification, and access to resources, and factors that influence communication and behavior. Indeed, concept 9 of this section relates specifically to cultural and social differences and how they relate to well-being (see the Association of American Medical Colleges, n.d., for more information).

There remains no single, standardized, or universally accepted model of cultural education for settings outside of New Zealand. In the absence of a fully articulated, locally relevant and universally accepted philosophy, cultural safety has been examined for its relevance to the U.S. and other healthcare and human services settings. It is a concept that is yet to be fully considered for its appropriateness in the U.S. context. Review the following scenarios:

Scenario

An elderly veteran was called to a clinic to collect their new hearing aid. They have lost or broken several in the past. On arrival the receptionist said in front of a waiting room of other people: 'Now (name), how many is this? You can't keep getting them replaced you know. You better look after this one!'.

The veteran was furious at the treatment. They turned and walked out without the hearing aid.

- What elements of culturally unsafe practice can you identify?
- What cultural differences might have influenced their response?
- What role, if any, should the receptionist have in commenting on a client's reason for attending?
- What may have caused them to leave the clinic without being seen?
- How would you try to make this a culturally safe encounter for the elderly veteran?
- As you read the scenario, did you imagine a particular gender for the receptionist and the veteran? What might this say about unconscious bias?

Scenario

A young couple, still in their teens, has been asked to sign consent for a major operation for their child. Both seem unwilling to sign anything. Some staff are suggesting involving Child and Youth Services if they won't sign. They are, after all, putting their child at risk by delaying surgery. The doctors have already spoken to the parents and have now requested nursing staff to do what they can to obtain consent. The mother signs the form but then both parents leave their child in the hospital and return home.

Using the principles, answer the following:

1. Reflection on practice. How would you feel about your practice if you were involved in the above scenario?
2. Who has the power in this scenario? What pressures are brought to bear to obtain consent? Even though consent has been obtained, has it been done in a culturally safe manner? If not, why not?

3. What dialogue could have been engaged in with the parents? Would you have involved anyone else—if so, who and why?
4. What aspects of this encounter might be considered as colonizing in nature? How might you decolonize this scenario?
5. What may have been behind the responses? Are there possible cultural issues resulting in the parents' reluctance? You might need to investigate local cultural norms for child rearing, roles, and responsibilities.
6. How might this have been managed differently? What evidence is there that this family may have been demeaned, disempowered, or diminished?
7. Does the context make a difference in this scenario? If so, in what ways does it make a difference? What needs to be taken into account?

Looking at the above, it is important not to apply the same expectations to everyone in order to be equal and reasonable. For the young parents (any parents), depending on individual circumstances, they may have been reluctant to sign a consent form because of cultural considerations, or simply because of past experiences or any number of other possible explanations. European or White Americans for example, may expect biological parents to be the ones responsible for providing consent for their children. Biological parents are therefore naturally the first ones spoken to about their children and the first ones from whom information is sought. However, not all cultures, and therefore, not all White or European people, construct parental responsibility in the same way.

Some cultures hold biological parents responsible for nurturing and care, but also share the responsibility with others in their kinship systems for major decision-making. Therefore, without consideration of the potential for a different set of needs, treating this young family the same as everyone else might not in fact be equal. It could have put them in an untenable situation from which they felt compelled to leave. They may simply have wanted other family there to help make the decision. Perhaps both had jobs they needed to go to and could not afford to lose. That is not to say that these are the case in every situation. However, these are things to be examined in context. Rather than compel someone to consent, asking questions such as, 'Is there anyone else we can contact to help you right now?' or instead of judging the actions, or make assumptions, greater effort could have gone into talking about the parents' reluctance.

Health and human services professionals may not know, and not need to know, what is behind the preferences and decisions of clients and communities in order to be culturally safe. They simply need to be aware of the right to be different, and to respect the right to one's own worldview and cultural values.

Making It Local

Think about also the transferability of cultural safety principles to clients who differ from health and human service professionals in other ways—either by religion, gender, socioeconomic status, abilities, sexuality, or age.

Do you have any particular groups within your local area that may also require care that is regardful of certain differences? Who are these groups? How might their 'cultural differences' need to be incorporated into their care? For example, is there a large aging population or LGBTQ community in your region? Do some staff have unexamined, negative attitudes toward older or LGBTQ people that might affect the care provided? What about rural populations? There is research to suggest that some rural-backgrounded people may delay seeking health care because of a cultural mindset that prioritizes their work over their own health, for example. Of course, this could equally apply to others on the basis of economics, gender, or other influences, but what is important is to recognize any reaction you might have to specific cultural groups and ensure that any negative biases or assumptions do not impact on care provided.

What is the demographic makeup of your community and what might this mean for shaping practice or preparing for practice?

Conclusion

In this chapter, we have identified cultural safety as a useful framework for examining and critically reflecting upon practice. This text does not

seek to provide a prescriptive approach to the care of clients of a differing background to the health professional. Instead, it is hoped that students and health professionals will develop a set of culturally safe principles for practice; examine previously held knowledge, beliefs, attitudes, and understandings; and develop readily transferable skills for practice in any setting.

References

Association of American Medical Colleges. (n.d.). *Psychology, social, and biological foundation of behavior section: Overview*. https://students-residents.aamc.org/applying-medical-school/article/mcat-2015-psbb-overview/.

Curtis, E., Jones, R., Tipene-Leach, D., et al. (2019). Why cultural safety rather than cultural competency is required to achieve health equity: A literature review and recommended definition. *International Journal of Equity and Health, 18*, 174. https://doi.org/10.1186/s12939-019-1082-3.

Darroch, F., Giles, A., Sanderson, P., Brooks-Cleator, L., Schwartz, A., Joseph, D., & Nosker, R. (2017). The United States does CAIR about cultural safety: Examining cultural safety within indigenous health contexts in Canada and the united states. *Journal of Transcultural Nursing: Official Journal of the Transcultural Nursing Society, 28*(3), 269–277. https://doi.org/10.1177/1043659616634170.

Kurtz, D. L. M., Janke, R., Vinek, J., Wells, T., Hutchinson, P., & Froste, A. (2018). Health sciences cultural safety education in Australia, Canada, New Zealand, and the United States: A literature review. *International Journal of Medical Education, 9,* 271–285. http://dx.doi.org.ezaccess.libraries.psu.edu/10.5116/ijme.5bc7.21e2.

Nursing Council of New Zealand. (2011). *Cultural safety, the Treaty of Waitangi and Maori health: Guidelines for cultural safety*. Nursing Council of New Zealand.

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

Taylor, K., & Thompson-Guerin, P. (2019). *Health Care and Indigenous Australians: Cultural safety in practice* (3rd ed.). Red Globe Press. ISBN-13: 9781352005424.

United Nations. (1948). *Universal Declaration of Human Rights* (United Nations General Assembly in Paris, General Assembly Resolution 217 A). https://www.un.org/en/universal-declaration-human-rights/.

Wepa, D. (Ed.). (2015). *Cultural safety in Aotearoa New Zealand* (2nd ed.). Cambridge University Press. https://doi.org/10.1017/CBO9781316151136.