

Intersections between interprofessional practice, cultural competency and primary healthcare

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Abstract

The concepts of interprofessional collaborative practice (IPCP), cultural competency and primary healthcare (PHC) appear to be linked in theory and practice. This discussion article provides arguments explicating the potential linkages between IPCP and cultural competency. We argue that cultural competency is an important component of IPCP both for relationships with patients and/or communities in which providers work and between team members. Organizational structures also play an important role in facilitating IPCP and cultural competency. The integration of both IPCP and cultural competency has the potential to enhance positive health outcomes. Furthermore, we argue IPCP and cultural competency have important implications for PHC service design, given interprofessional teams are a key component of PHC systems. Linking these concepts in providing PHC services can be essential for impacting outcomes at all levels of primary healthcare, including patient, provider and systems.

Keywords

Cultural competency, cultural safety, interprofessional practice, interprofessional teams, primary healthcare

History

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Introduction

Interprofessional collaborative practice (IPCP), cultural competency and primary healthcare (PHC) are concepts linked both in theory and practice. In this article, we explore intersections between IPCP and cultural competency and implications for designing PHC services, beginning with a brief analysis of IPCP frameworks and cultural competency models. In addition, the relationships to patients and communities, between healthcare providers and the role of organizations are discussed.

IPCP frameworks

IPCP is an important component of healthcare and has received significant attention in healthcare renewal in Canada (e.g. Health Council of Canada, 2005). IPCP is defined as the organized and interconnected practice among professionals from different disciplines (D'Amour & Oandasan, 2005). Collaborative practice "enhances patient and family-centred goals and values, provides mechanisms for continuous communication among caregivers, optimizes staff participation in clinical decision-making within and across disciplines and fosters respect for disciplinary contributions made by all professionals" (Health Canada, 2003 as quoted in CIHC, 2009, para. 3). Although inclusivity is ideal, implementation in practice is much more difficult and influenced by professional cultures and who really counts in decision making (Orchard, Curran, & Kabene, 2005)

A framework for interprofessional education for collaborative patient-centered practice was developed by D'Amour & Oandasan (2005) in which the patient is central to the team. Interdependence of the relationship between patients and professionals is noted and the patient's needs determine what type of care will be provided by which provider. IPCP can occur in different ways with healthcare providers organized in teams or in other ways such as collaboration, coordination and networking (Reeves, 2012). IPCP is impacted by interactional factors between providers including negotiation and connections. Connections are described as the development of trust, commitment to each other and to teamwork, knowing one another's knowledge, skills and roles, social interaction and communication among healthcare providers. IPCP is also influenced by organizational factors, such as, governance models and leadership styles. Organized clinical care (e.g. algorithms, prescribed communication strategies, clearly defined expectations) impact the practice of healthcare providers. Finally, IPCP is influenced by external or systemic factors such as the structure of the healthcare system, government policies and regulatory bodies. Outcomes for IPCP are expected at all levels: patient; provider; organization; and system (D'Amour & Oandasan, 2005). The ultimate goal of IPCP is the improvement of patient outcomes (e.g. Banfield & Lackie, 2009; CIHC, 2010). Job satisfaction, improved recruitment and retention and system effectiveness including cost efficiencies have also been shown (Suter & Deutschlander, 2010). However, there are few sources explicating the relationships between cultural competency and IPCP (Banfield & Lackie, 2009; Purden, 2005).

IPCP has recently advanced through the development of the interprofessional Competency Framework (CIHC, 2010). Competencies outline the knowledge, skills and behaviors

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required by healthcare providers to facilitate IPCP. Six competency domains are outlined: “interprofessional communication; patient/client/family/community-centered care; role clarification; team functioning; collaborative leadership; and interprofessional conflict resolution” (p. 9). All domains are situated within the complex healthcare environment, and continuous quality improvement initiatives. Interprofessional competencies have also been criticized. Competencies focus on teams but have largely excluded other types of interprofessional working together such as collaboration and networking. Also, there is a lack of measurement regarding competencies; in particular the actual implementation of the competencies and their effectiveness has yet to be determined (Reeves, 2012). Further, frameworks of interprofessional competencies do not make explicit the cultural competencies needed for effective IPCP.

Cultural competency¹ models

Various models for the facilitation of culturally congruent care have been developed including cultural awareness, sensitivity, competence, safety and advocacy. These cultural competency models are outlined in the following sections of this article, but first we invite readers to reflect on their understanding of culture, its complexity, the influence of history and politics impacting individuals, groups, healthcare providers and the healthcare setting.

Definitions of culture range from race and ethnicity to a broader, more complex concept recognizing the fluidity of intersecting dimensions of cultural identities (Arthur & Collins, 2010). Culture is often “defined narrowly as shared values, beliefs and practices, and often conflated with ethnicity. . . culture thus defined operates as the primary explanation for why certain people or groups experience various health, social or economic problems” (Browne et al., 2009, p. 168). A common consideration to enhance cultural competency is to move beyond a position of ethnocentrism to recognize the strengths of multiple perspectives for IPCP.

Cultural awareness

Cultural awareness focuses on the similarities and conversely the differences between cultures as a basis for working with members from another culture. Cultural awareness provides an initial step in understanding difference focusing on traditions often perceived as *exotic* rather than incorporating context (e.g. social, political; Ramsden, 2002). Awareness programs, often offered in a single workshop, ongoing training sessions, or field trips, may further instill stereotypes; cultural awareness does not always translate to more inclusive action (Myers Schim, Doorenbos, & Borse, 2005).

Cultural sensitivity

In contrast to cultural awareness, cultural sensitivity requires one to analyze attributes of one’s own cultures and the potential effect of others (Myers Schim et al., 2005). Cultural sensitivity recognizes the validity of difference and encourages the initiation of self-exploration (Ramsden, 2002) but the focus remains on the individual healthcare provider where power and objectification persist with the outsider looking in on the *other* (Carberry, 1998). Culturally sensitive approaches are often superficial and rest in

the foundations of multiculturalism. Multiculturalism, highly valued in Canadian society, is the basis for cultural sensitivity promoting tolerance of *others* different from our *dominant* society, while the source of dominance continues to be unquestioned (Browne et al., 2009).

Cultural competence

Cultural competence models in healthcare organizations originate in western nations with a goal of addressing inequities, particularly those from various ethnocultural groups (Thomson, 2005). Betancourt, Green, & Carrillo (2002) define cultural competence as:

A set of behaviours and attitudes and a culture within business or operation of a system that respects and takes into account the person’s cultural background, cultural beliefs, and their values and incorporates them in the way healthcare is delivered to that individual (p. 3).

Cultural competence focuses on learned behaviors and action (Myers Schim et al., 2005) and can be applied both at individual or organizational levels (Betancourt et al., 2002). Five key components of cultural competence include: cultural awareness (personal and others’ cultures and values); cultural skill (cultural assessment with clients); cultural knowledge (understanding and recognizing patterns of behaviors, beliefs and practices); cultural encounters (interfacing with other cultural members); and cultural desire (striving for ideal interactions with clients of various cultures; Campinha-Bacote, 2002; Clingerman, 2011). Even though cultural competence moves well beyond cultural awareness and sensitivity, care provided is still determined by the provider and the system. Power differentials continue between the patient, provider and system; contextual influences (e.g. historical, social and political) are not included, and patient voice in the appropriateness of care is not explicit (Carberry, 1998).

Cultural safety

Both the colonial context of New Zealand and the poor health status of its indigenous population give rise to the concept of cultural safety (Ramsden, 2002). Cultural safety is defined as:

The effective practice for 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. . . 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, p. 4)

Cultural safety includes five key components: analysis of personal, professional and health system cultures and their impact on the patient or community; diversity, recognition and legitimacy of difference; consideration of historical, social, economic and political influences on health and healthcare experiences of individuals and communities; recognition of power differentials between the patient and the healthcare provider; and the involvement of the patient in their care. Cultural safety incorporates the principles of partnership; participation; and protection. Culturally safe care and services should be defined and determined by individuals and communities themselves (Nursing Council of New Zealand, 2005; Ramsden, 2002).

¹In this article, cultural competency refers to the group of competencies required by professionals for competent cultural care. It encompasses various models; this terminology is frequently used and generally well understood in healthcare (Carberry, 1998). Cultural competence as a model will be discussed later; this general term used here does not refer to that specific model.

Based on partnership and participation, cultural safety is aligned with the inclusion of patients, family and communities as equal members of the healthcare team.

Cultural safety focuses on relationship and social justice with a critical analysis of historical, political and social knowledge of individuals and institutions. Critical reflection is essential to facilitate practitioners' discovery of new meaning or reconstructing existing meaning (Browne et al., 2009) enabling culturally safe care for individuals and communities.

Cultural advocacy – beyond cultural safety to social justice action

Cultural safety promotes understanding of context (e.g. history, economic, political and social) for vulnerable populations in healthcare environments. Reframing cultural safety is proposed to develop a space where “cultural meanings are being negotiated and transformed through the medium of language” (p. 230) where the healthcare context can contribute to cultural meanings between healthcare providers and patients (Reimer Kirkham et al., 2002). Moving beyond cultural safety requires an emphasis on action. Advocacy and action for social justice are essential components of professional behavior. Action will facilitate fully the co-creation of relational practice between providers and patients. From this perspective, cultural competency is viewed beyond a *cookbook* approach and focusing on *others*, who are identified as diverse. Cultural advocacy implies a lifelong learning process and commitment to social inclusion, equity and professional action. Wherever possible, it is prudent to include members of non-dominant groups to be part of the delivery and design of cultural competency initiatives. Giving voice to their experiences is a direction for cultural advocacy and fostering stronger partnerships between healthcare and individuals and communities.

The various cultural competency models discussed in the previous sections of this article build on one another. Cultural awareness is a very basic component of cultural competency with short comings which other cultural competency models then begin to address. There is overlap between all models and ultimately, the highest level of cultural competency is what we have called cultural advocacy. Figure 1 shows the overlap and movement from one model to the other.

Interrelationships between IPCP and cultural competency

Some possible ways that cultural competency impacts IPCP are discussed in the following sections: the patient and community; healthcare providers; and organizations.

Relationship to the patient and community

Ideally, healthcare providers' practice should be influenced by the individual patient and/or the community. In reality, care is influenced by other components such as the professional sector and the healthcare system (Kleinman, 1980) as well. Patients may also have various needs (e.g. language) that impact healthcare practices. In the cultural safety model, needs are determined by the patient or significant others; they determine the effectiveness of the care provided by the collaborative practice of healthcare providers. Interactions between two individuals (patient and healthcare provider) are always bicultural (Ramsden, 2002), where a minimum of two different cultures interact. It is acknowledged that healthcare providers have their professional culture and language which is the dominant culture (the culture that holds the power) in a healthcare interaction. In addition, providers bring their own personal cultures from a dominant culture or a less privileged one. Attention to historical and socio-political issues and power differentials and their impact on the care is required to ensure culturally safe care for all individuals and communities. Curriculum for residents and physicians in Canada underscores the need for self-reflection when providing care to Aboriginal peoples to ensure culturally safe care (The Indigenous Physicians Association of Canada and the Royal College of Physicians and Surgeons of Canada, 2009). Moving beyond cultural safety, to cultural advocacy, interprofessional team members are responsible to identify recurring issues and work to mobilize resources for health and well-being addressing ongoing systemic barriers. As healthcare providers we need to ask patients and community representatives about their needs and whether their needs are being met by the care provided. The importance of building relationships (e.g. trust) cannot be underestimated in moving toward cultural competency. Continual self-reflection on our practice is critical for ongoing evaluation of cultural competency of our care. As healthcare providers, advocacy is essential to address recurrent inequities to promote

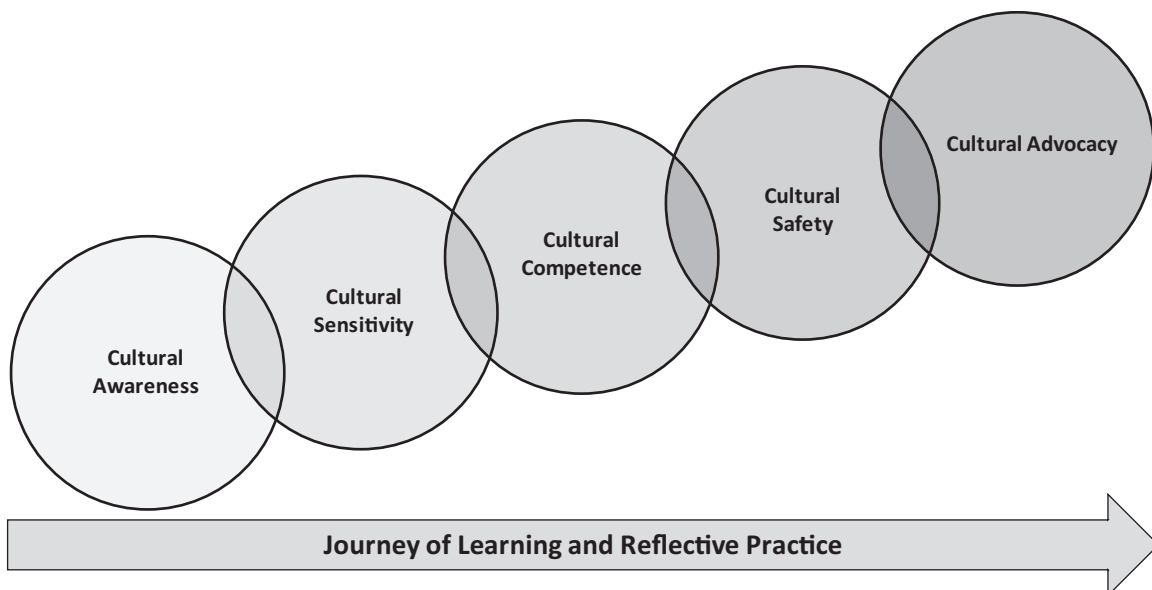


Figure 1. Moving towards cultural competency in practice.

social justice. Given the systemic influences on healthcare provider roles, we need to be mindful of the need for advocacy to address the social inequities in our society (Mikkonen & Raphael, 2010).

Relationships among healthcare providers

Interactions between team members are influenced by cultural competency practices of individual team members. Cultural competency not only focuses on the patient, family, or community but should address interactions between healthcare providers and between providers and the healthcare system (Ramsden, 2002). Safety should exist among team members through recognition and reflection of their own professional cultures, acknowledgment of difference, recognition of outside influences (e.g. historical, political, social) on providers and attention to potential power differentials between professionals (i.e. nurse/physician, nurse/physiotherapist). For example, teams are diverse in many ways, made up of people of different ethnocultural and professional backgrounds. Hence, cultural competency is needed for teams to function effectively; when team members practice cultural competency they help to create safety within the team.

Territoriality and turf protection are common barriers to effective IPCP (Solheim, McElmurry, & Kim, 2007). Cultural competency provides an opportunity to address these issues through critical reflection of historical and socio-political impacts of different healthcare providers and their relationships to each other. Through mutual respect and frank discussion of such issues, movement towards a reconciliation of such barriers can be realized through shared power to enhance service delivery. For example, team effectiveness training should include self-reflective exercises, discussions about underlying power differentials, and how to address these issues. Power differentials are often the underlying issue when different providers work together, but are generally not addressed head on, but implicitly acted on with no real resolution of the issues. In moving beyond cultural safety, team members should actively evaluate ongoing inequities in the team and advocate for resolution through additional team effectiveness training and ongoing team discussions to address power differentials, territorialism and turf protection (Kleinman, 1980).

The use of “paraprofessionals” on healthcare teams for communities of different cultures is common practice as healthcare professionals from various backgrounds can be potentially difficult to recruit (Purden, 2005). Paraprofessionals have been defined as frontline providers created through technological and medical sub-specialization (Kleinman, 1980). Unlike the traditional professions (e.g. medicine, nursing), many are unlicensed, but those who are licensed are done so through “subsidiary paraprofessional organizations... [with a] restricted scope of practice” (Kleinman, p. 54). The language of professional and paraprofessional is foundationally hierarchical which raises questions about the definition of the term “professional” which continues to be debated. Paraprofessionals may provide a bridge for providers from the dominant culture serving patients from other cultural backgrounds. Roles for paraprofessionals are not clearly understood (Jackson, Brady, & Stein, 1999; Purden, 2005) by healthcare team members. Paraprofessionals are often used for translation, rather than providing the care they were trained to deliver. Purden (2005) offers the example of paraprofessionals in Aboriginal communities where they work closely with patients and are highly involved in the cultural and socio-political context. Here, paraprofessionals are frequently not included as part of the team implying they have little to contribute or there is a lack of confidence and respect for their abilities (Jackson et al., 1999). Power differentials are common where one

is in charge of the other and significant gaps may exist in salaries and benefits (Jackson et al., 1999). Incorporating cultural competency could ensure the value of and respect for paraprofessional team members and work towards more effective IPCP where the care of patients and communities is the goal. The use of a cultural competence model could facilitate the giving of voice to healthcare providers, the ability of addressing their concerns, and allowing them to use their expertise. This means going beyond professional titles to consider who is in the best position to contribute care to the patient. The inclusion of less powerful members and explicitly valuing their knowledge are keys for demonstrating cultural competency between healthcare providers. Of course, there are also many system influences (e.g. lack of time, hierarchical structures) impacting IPCP which often do not support the ideals of collaborative practice.

Relationship to organizations

Cultural competency can also be applied at the organizational level, both in healthcare organizations and educational institutions where healthcare providers are trained. A culturally competent organization is one with policies in place to address diversity, creating a culture of respect and support for patients, providers and administrative staff (Betancourt et al., 2002). For example, organizations can undertake a comprehensive policy review paying attention to interchanges between individuals and organizational policies and processes. Such reviews have the potential to explicate marginalization of individuals and communities (Pence & McMahan, 2003). Once completed, policies that undermine cultural competency need to be revised and new policies instituted to ensure unwritten policies that allow racism and culturally unsafe care are not allowed to continue (Bacchi, 1999). Leadership support of cultural competency is essential through cultural competency training and continual self-reflection of all levels of leadership including senior executives, review of organizational policies and support for training healthcare providers (Edwards & Sherwood, 2006). Although this may seem obvious, the focus on cultural competency has been directed at the level of service providers and there continues to be a lack of focus on cultural competency for managers and other system administrators. Organizations may have competing agendas where there is an overall lack of interest and training in cultural competency, and organizations may not be open to new ideas surrounding cultural competency models.

Ultimately, the impact of cultural competency should be a positive influence on IPCP outcomes at the patient, provider, organizational and system levels. In alignment with authors’ research and practice, culturally competent care will ideally have a direct influence on the quality of care and patients’ perceptions of care where needs are better met and a positive impact on health outcomes can be realized. Outcomes at the provider level will also be influenced through improved interprofessional functioning, job satisfaction and recruitment and retention of healthcare providers (Suter & Deutschlander, 2010). Finally, it is hoped that at the organizational and system levels a more effective functioning healthcare system can be a reality.

Implications for primary healthcare service design

PHC renewal is common to most healthcare agendas across jurisdictions in Canada and internationally. One of its foundational principles is that of interprofessional team development (Health Council of Canada, 2005). New Canadian initiatives in PHC redesign include the integration of interprofessional teams (e.g. Primary Care Networks in Alberta; Family Health Teams in Ontario, Integrated Health Networks in British Columbia). The increased complexity of PHC, the increasing complexity of

patient needs (e.g. multiple chronic conditions) and the need for coordination among services and providers, makes IPCP a necessity in PHC systems in Canada and other countries such as the United States (e.g. Solheim et al., 2007).

As noted earlier, authors suggest that cultural competency training can be used to enhance effective collaborative practice. Indeed, IPCP is based on recognizing each other's different roles and the development of respect and trust among providers (e.g. Suter, Taylor, Arthur, & Clinton, 2008). Unfortunately, cultural competency training has not been seen as one of the ways in which interprofessional functioning can be enhanced, instead education is focused on cultural awareness, that is, learning what others do, clarifying roles and respect for one another's expertise. Power differentials have for the most part been avoided, though they underlie many of the issues arising in healthcare teams (e.g. territorialism, turf protection).

Another key pillar of PHC is intersectoral collaboration (Thomas, 2006). IPCP must go beyond the healthcare sector and develop partnerships with social services, justice, employment, housing and others to better address the determinants of health. Cross-sectoral work increases the providers one works with at various levels. Power differentials, turf protection and self-supporting organizational agendas are common among cross-sectoral teams. Cultural competency has the potential to ensure valuing of participants' contributions and thereby facilitating interprofessional functioning across sectors.

We live in a world where there is huge diversity in our population that continues to grow (Myers Schim et al., 2005). Culturally competent care increases access for individuals and communities of different cultures and enhances the possibility for more culturally acceptable healthcare services (Kulwicki & Miller, 2000). Care based on cultural competencies has the potential to address health disparities (Clingerman, 2011), incorporating equity, another key principle of PHC (Thomas, 2006). Cultural competency training fosters patient-centered care, another important aspect of PHC, allowing the patient or significant others to determine needs and be involved in their care. Culturally competent providers working with communities can advocate for a participatory approach where communities are equal partners in needs assessment, healthcare planning and implementation of services. Considering our diverse populations, it is also important to take advantage of diversity of healthcare professionals within teams. In fact, PHC systems should plan for diversity in their workforce to better mirror the characteristics of the populations they serve (e.g. Aboriginal, ethnicity, sexual orientation). Cultural competency training is essential for such diverse teams to enhance interprofessional functioning.

Despite the importance of cultural competency training, an overall lack of such training for healthcare professionals has been noted (Oelke, 2010). Planning PHC services for our diverse population requires specific attention to cultural competency for IPCP both in training current and future providers. All current providers working in PHC settings should be provided with updated training in cultural competency including cultural safety and cultural advocacy. Relationships between effective interprofessional functioning and cultural competency should be made clear to participants throughout the curriculum to ensure effective interprofessional teamwork in all PHC settings. Occasion should be provided for service providers to regularly revisit cultural competency education with accompanying opportunity for practice of their knowledge, skills, attitudes and behaviors. Continual self-awareness and reflection will ensure a workforce able to meet the needs of our patients and communities.

PHC organizational policies also need to be reviewed and appropriately updated to address cultural competency. Policies should be evaluated for institutional racism (Jones, 2001)

including historical insults, societal norms and privileges perpetuated by current structures with intentional and unintentional actions, or inaction, to ensure a culturally competent organization will meet the needs of diverse patients and providers working within PHC organizations. Healthcare providers work in organizations and systems where structures need to support staff. Policy development and revisions is an ongoing process and not necessarily the focus or priority of organizations.

Evaluation and research on PHC services should include a focus on cultural competency. Cultural competency, particularly cultural safety and cultural advocacy have not been well studied in healthcare. There is a need to look at the outcomes of cultural competency in practice as well as its application to organizational policy (Ramsden, 2002). Evaluation of PHC services should explore such questions as: how does cultural competency impact patient, provider, organization and system level outcomes; do patients perceive care to be culturally safe, are they *comfortable* with the care they receive; do they feel respected and included as part of the interprofessional team and in the planning and delivery of their care; how does cultural competency training impact interprofessional functioning; and how have organizational policies reflected cultural competency frameworks? Evaluation and research results will assist in continual improvements in the area of cultural competency for education and practice of interprofessional teams in PHC.

Concluding comments

Cultural competency has been recognized as valuable for individual healthcare providers, although not specifically applied to IPCP. The change in the demographics of our population supports the need for cultural competency as a foundational component of healthcare systems. But patients, providers and organizations are situated in a large complex system with socio-political influences and cultural values of external systems and societies (e.g. healthcare system, government policies at all levels) impacting patients' perceptions of care, healthcare providers' practice and organizations' abilities to enact cultural competent approaches. This article focused on the intersections between IPCP, cultural competency and primary healthcare. However, we also want to emphasize the importance of providing adequate training for both pre- and post-licensure students and staff. Although cultural competency may be developed through trial and error, this may not be the most ethical or effective way to address patient needs or to achieve high-functioning interprofessional teams. In this article, we have argued that cultural competency is an essential aspect of health provision at all levels. In turn, it is important for future researchers to demonstrate how cultural competency can be embedded in the preparation of our future healthcare service providers, administrators and leaders.

Declaration of interest

The authors report no declarations of interest. The authors alone are responsible for the content and writing of the article.

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