CULTURAL SAFETY CURRICULUM IN MEDICAL EDUCATION: *Does it work?*

Prepared by Denise Webb

Racism and discrimination within healthcare systems is a determinant of health that can create unsafe environments and influence clients' access to health care services and health-seeking behaviour, leading to vast health disparities and inequities (Allan & Smylie, 2015). In recent years, media attention on anti-Indigenous[1] racism specifically has increased, sounding an alarm on anti-Indigenous racism permeating within healthcare systems across Canada and the need to take action (Webb et al., 2023). Practices in culturally safe and anti-racist care are increasingly being considered as important measures that can combat anti-Indigenous racism and improve First Nations, Inuit, and Métis clients' access to health care and health care experiences (Health Standards Organization, 2022). Consequently, Indigenous cultural safety is gradually being integrated within medical education curricula at post-secondary institutions and adopted in the training frameworks of health care services, such as in hospitals and primary care facilities. These interventions also respond to the need to uproot the legacy

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(Allan & Smylie, 2015)

[1] The term 'Indigenous' is used in this document to refer collectively to the original inhabitants of what is now known as Canada including First Nations people, Inuit, and Métis people. Wherever possible, clear distinctions are made between these three distinct groups.

National Collaborating Centre for Indigenous Health
Centre de collaboration nationale de la santé autochtone

sharing knowledge · making a difference
partager les connaissances · faire une différence
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The need for cultural safety in medical curricula also runs at a deeper, underlying level. In many cases, paternalistic colonial ideologies ingrain medical education to the privilege of Western worldviews, while alienating and marginalizing First Nations, Inuit, and Métis ways of knowing and doing in the fields of science, health, and wellness.

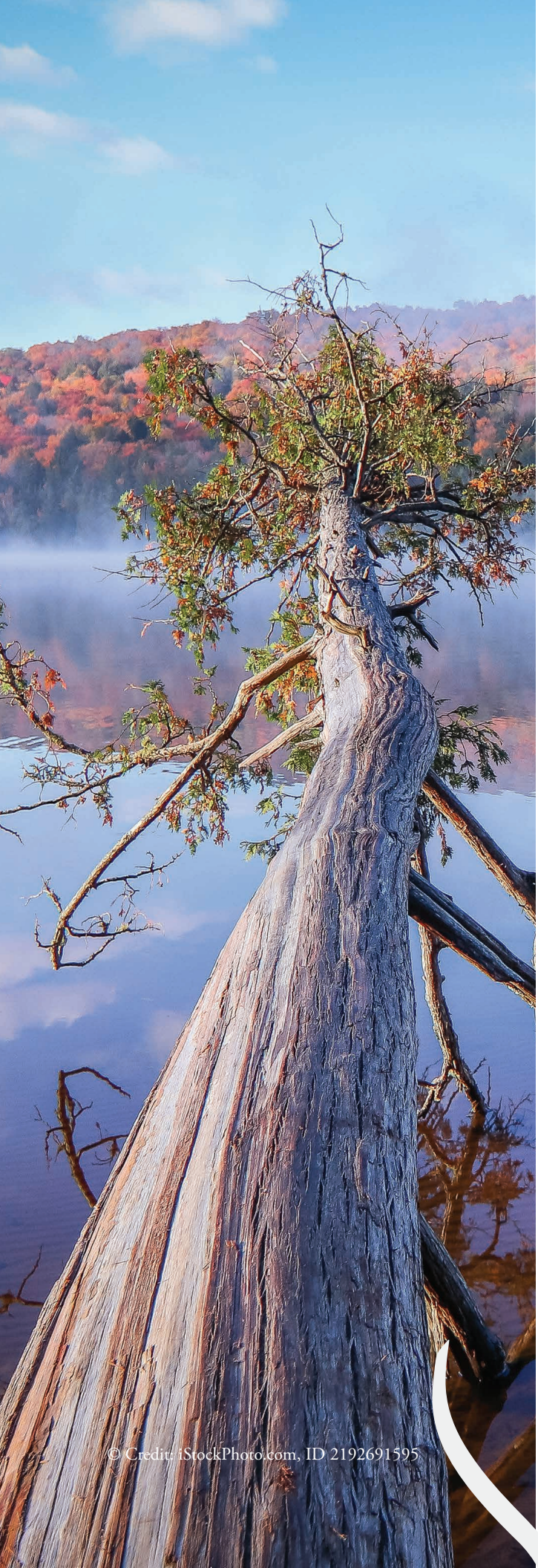
of colonialism that continues to affect health care education and practice and enhance this understanding among learners ranging from medical students, residents, to working professionals. This increased integration of Indigenous cultural safety also responds to the Truth and Reconciliation Commission of Canada (TRC) and its Calls to Action numbers 23, "to provide cultural competency training for all healthcare professionals" and 24, for medical and nursing schools to include a mandatory course about Indigenous health issues and "the history and legacy of residential schools, the United Nations Declaration on the Rights of Indigenous Peoples, Treaties and Aboriginal rights, and Indigenous teachings and practices [and] skills-based training in intercultural competency, conflict resolution, human rights, and anti-racism" (TRC, 2015, p. 3).

The need for cultural safety in medical curricula also runs at a deeper, underlying level. In many cases, paternalistic colonial ideologies ingrain medical education to the privilege of Western worldviews, while alienating and marginalizing First Nations, Inuit, and Métis ways of knowing and doing in the fields of science, health, and wellness. Razack et al. (2024) describe this alienation as epistemic violence; that is, "forms of knowledge that actively construct marginalised persons as 'Other'" (p. 3). This violence and "othering" can be operationalized through teachings that deny, neglect to include, or are ignorant to experiences and expertise from 'other' sources that are separate from the privileged knowledge system. For example, epistemic violence can exist in medical conclusions that are biased, untested, or lack critical appraisal. This is the case for conclusions that trace diabetes rates among Indigenous populations to genetic causes, as determined by non-Indigenous researchers and worldviews that are negligent of Indigenous ways of knowing, which tend to acknowledge the interconnections between and substantive impacts of socio-political, environmental, and economic factors, or collectively the social determinants of health, on diabetes rates (Razack et al., 2024). This sort of omission reinforces a power imbalance scaled toward non-Indigenous learners and Western ways of knowing (e.g., colonial individualistic ideologies that often link medical conditions to individual health behaviours or health status and do not account for societal or environmental impacts) and drives outputs in medical practice that sustain a system of oppression toward Indigenous populations.

Cultural safety in medical education is therefore necessary so as to not champion non-Indigenous learners as 'saviours' or other paternalistic figures delivering care, but rather to disrupt the power imbalance in medical education and instruct non-Indigenous learners to challenge and scrutinize their epistemologies, to the point of unlearning and relearning what they know about Indigenous health and wellness and the sustained effects of colonialization in medical thinking and understanding. This instruction must, of course, come from the leadership and creation of Indigenous expertise to shift the dynamic and privilege Indigenous knowledge systems in topics of Indigenous cultural safety.

Nevertheless, while there is an imperative to integrate Indigenous cultural safety into medical curricula, there is also interest in understanding if and how cultural safety curriculum works to influence learner's knowledge, practices, and engagement with Indigenous patients and in what ways (Hardy et al., 2023; Smylie et al., 2024). These questions apply to any non-Indigenous learners who are working within the health care system, including medical students, residents, and working professionals. However, preliminary searches on this topic reveal that the learning experience of medical residents with Indigenous cultural safety curriculum or training is particularly limited in the literature, leaving little to conclude about the impact of such interventions on their transition from classroom to clinical training and practice. Thus, the purpose of this fact sheet is to explore these critical questions with particular attention to medical residents. This investigation stems from a project partnership between the National Collaborating Centre for Indigenous Health (NCCIH) and the Canadian Paediatric Society (CPS). Together, the NCCIH and CPS co-developed an Indigenous child and youth health and cultural safety curriculum for paediatric residents – the curriculum is also applicable for other health professionals – and this review was completed to assist with the curriculum's evaluation (CPS, 2024).

The following sections review the fact sheet's methods and approach to a literature review, then explore the *if* and *how* cultural safety curricula and training works, beginning with a foundation of how curricula or training is often evaluated in the literature. Emergent gaps from the literature and considerations for future research are also discussed, followed by final conclusions.



Methods

This fact sheet employed a review of academic literature, searched for in Google Scholar and the Education Resources Information Center, using the terms “Indigenous” AND “cultural safety” AND “curriculum” AND “evaluation”, and related variations thereof. Sources were included if they provided an evaluation of Indigenous-specific cultural safety training or curricula, including outcomes for participants and/or recipients of care, and were intended for persons working or training in medicine. Any information pertinent to medical residents was intentionally isolated in the analysis of the findings. No time period or geographic restrictions were placed on the literature search.

Findings

A total of 22 evaluations of Indigenous cultural safety curriculum and training were identified, of which 13 were from Canada, six from Australia, one from New Zealand, one from the United States, and one international study. Eight of these studies evaluated curriculum for medical students, three of which focused on medical residents. One study evaluated cultural safety training for both residents and working medical professionals. The remaining 13 evaluations focused on cultural safety training programs for working health professionals outside of medical education (i.e., were not medical students or residents). All 22 evaluations inform this review. The following sections explore the *if* and *how* cultural safety curriculum and training works, beginning with a foundation of how curricula or training was evaluated in the literature.

How is Indigenous cultural safety curriculum evaluated in the literature?

The literature review found that evaluations of cultural safety curriculum or training are often completed by analyzing participants' pre- and post-participation surveys and/or interviews. Nine of the 22 literature sources employed this approach (Barnabe et al., 2021; Chapman et al., 2014; Crowshoe et al., 2028; Hulko et al., 2021; Liaw et al., 2015; Lin et al., 2023; Sauvé et al., 2022; Shah & Reeves, 2015; Wheeler et al., 2022). Five sources relied on only post-completion surveys from participants (Brewer et al., 2020; Doucette et al., 2014; Kerrigan et al., 2020; Maar et al., 2020; Neff et al., 2020), while three sources assessed the impacts of their training or curriculum through participant's pre-, during-, and post-learning evaluations (de Leeuw et al., 2021; Kerrigan et al., 2021; Waldner et al., 2022). In the latter, participants' reflective reactions during their training or curriculum helped researchers to follow the progression of their learning journeys.

One study also utilized post-completion questionnaires, however, did so from the perspective of unannounced Indigenous standardized patients – otherwise known as trained actors – as opposed to training participants (Smylie et al., 2024). Smylie et al.'s (2024) study was the only evaluation found in this review to be exclusively informed by simulated patient feedback.

The remaining four sources did not rely on pre-, during-, or post-intervention evaluations, but rather reviewed expectant and realized outcomes of cultural safety curricula or trainings through critical discussions with experts (Akearok et al., 2020; Hardy et al., 2023; Wylie et al., 2021), and examinations and reflections of how the curriculum or training interventions were developed (Jacklin et al., 2014).

Common indicators

From studies seeking feedback from participants, common indicators to measure the effects of cultural safety curriculum or training found in the literature included asking participants to reflect on:

- changes in their perception or attitudes towards Indigenous Peoples and communities, including self-awareness relative to biases, stereotypes, and prejudices;
- changes in their comfort level, confidence, or motivation in, or perceived barriers to, working with Indigenous patients;
- changes in their knowledge of Indigenous histories, sociopolitical issues, and determinants of health and well-being for Indigenous populations; and
- any practices or learnings they plan to carry with them into their career and future work.

Evaluations assessed these changes from immediately after participants completed the curriculum or training (Chapman et al., 2014; Shah & Reeves, 2015), to three (Barnabe et al., 2021; Crowshoe et al., 2018) or six months after completion (Liaw et al., 2015). Some studies also asked participants to assess changes in their ability and skill development resulting from the curriculum or training, such as the ability to build relationships and address health and social inequities (Barnabe et al., 2021), and communication skills, ability, confidence, and knowledge (Lin et al., 2023). In a unique approach to other evaluations, Sauvé et al. (2022) evaluated changes in participants' intercultural empathy, gauged by questions to assess personal abilities in empathetic perspective-taking, acceptance of cultural difference, empathetic awareness, and empathetic feeling and expression.

The use of unannounced Indigenous standardized patients blazes a trail to learning how evaluations can gain insight into the patient's experience.

In Smylie et al.'s (2024) evaluation informed by simulated patient feedback, the unannounced Indigenous standardized patients visited clinicians 8-10 weeks following their Indigenous cultural safety training. The patients were trained to evaluate the clinician's care and used standardized questionnaires to assess their experience and satisfaction, scoring the clinician's patient engagement, communication, and explicit biases. The patients were also asked whether they would recommend the clinician (Smylie et al., 2024). These indicators were used to understand the impact of Indigenous cultural safety training on clinical practice, specifically on quality of care (patient experience), odds of recommendation, and adherence to clinical practice guidelines.

In addition to practice indicators, many evaluations sought feedback on the curriculum or training structure, posing questions on what did or did not work for participants, its usefulness, and whether participants would recommend the intervention (Maar et al., 2020; Neff et al., 2020; Shah & Reeves, 2015). Standard and tested questionnaires to evaluate cultural safety were also employed by some literature sources (see Crowshoe et al. [2018], Smylie et al. [2024], and Wheeler et al. [2022] for examples). A full analysis on the development, types, and validity of indicators for cultural safety curriculum and training is beyond the scope of this review. The sources cited here, however, provide a strong starting point for interested readers.

Does cultural safety curriculum in medical education work ?

Cultural safety principles within medical practice are broadly understood. This review draws on the Public Health Agency of Canada's (PHAC) *Common Definitions on Cultural Safety* to discern the concept of cultural safety relative to cultural awareness, sensitivity, competency, and humility (PHAC, 2023). PHAC (2023) defines cultural safety as "about the experience of the patient" and "an outcome based on respectful engagement that recognizes and strives to address power imbalances inherent in the healthcare system. It results in an environment free of racism and discrimination, where people feel safe when receiving health care" (p. 9).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This shift in focus offers a novel approach to steer from participants' self-reporting bias, and instead learn from Indigenous patients, albeit trained or not.

Based on this understanding, and from this literature review, the short answer to the question of whether cultural safety curriculum in medical education works is yes. Yet, this brief analysis is largely based on participants' self-reported shifts in knowledge and attitudes after completing Indigenous cultural safety curriculum or training and is therefore limited by important considerations. Maar et al. (2020) expands on the definition of cultural safety to include principles of "empathy, respect, and relationship building skills toward Indigenous patients" (Maar et al., 2020, p. 1-2). These attributes can only be attested to by First Nations people, Inuit, and Métis people. Only they can truly confirm whether their care is culturally safe and free of racism and discrimination. In relying on learners' feedback, many of the evaluations collected in this review are inherently subject to participants' "self-reporting bias such as social desirability bias" (Hardy et al., 2023, p. 10). This feedback neither accounts for, nor can confirm, behaviour change in health care environments.

Smylie et al.'s (2024) evaluation offers a possible solution. The use of unannounced Indigenous standardized patients blazes a trail to learning how evaluations can gain insight into the patient's experience. Although the standardized patients were trained and posed as having a health need, potentially threatening the sincerity of the experience, Indigenous perspectives indeed informed researchers' understanding of the impacts of Indigenous cultural safety training on clinical care. Smylie et al. (2024) describe how this

Definitions of terms related to cultural safety (PHAC, 2023):

Cultural awareness
Understanding and acknowledging cultural differences

Cultural competency
Reflecting on one's own culture and continuing to understand and respect another

Cultural sensitivity
Respecting cultural differences

Cultural humility
Reflecting on personal biases and positionality

evaluation approach "contributes to the advancement of outcome measures from clinician focused assessment of knowledge, attitudes, and self-reported behavioral changes towards the appraisal of observed patient care" (p. 7). This shift in focus offers a novel approach to steer from participants' self-reporting bias, and instead learn from Indigenous patients, albeit trained or not.

Only one other study in this review included Indigenous people's perceptions on how quality of care changed, in this case, due to a "cultural respect workshop" for general practitioners working with Indigenous patients in Australia (Liaw et al., 2015). Following the workshop, Indigenous patients were nominated by the practitioner's office for phone interviews "to seek information about the cultural appropriateness of care they received at the practice, from reception to the consulting room" (p. 388). Of those contacted, some patients reported the training influenced the care environment, describing the practice as "friendlier" and more inclusive of information pertaining to the Indigenous population's health priorities and concerns (Liaw et al., 2015). Alternatively, Kerrigan's et al. (2021) evaluation of a cultural education podcast for hospital-based doctors in Australia stated plans to later evaluate the patient's experience because of the podcast; while Waldner et al.'s (2022) evaluation of pediatric residents participating in an immersive training program in Alberta, Canada had residents predict the program's impact on patients. Residents' predictions – that the program enhanced continuity of care, safety of the care environment, and patient's comfort level in interacting with residents – are of course unsubstantiated; however, they could be used to assess the validity of the training by seeking and comparing the truth of Indigenous patients' experiences to the resident's predictions.

How does cultural safety curriculum in medical education work?

Findings from this literature review suggest that how cultural safety curriculum works, in terms of its effects on learners' self-perceived changes in attitudes, knowledge, and behaviours, depends on a host of factors from modes of delivery to the detailed curriculum components. This review found cultural safety was often embedded in medical education curriculum through community immersion programs, such as medical placements in an Indigenous community (de Leeuw et al., 2021; Jacklin et al., 2014; Waldner et al., 2022), patient simulation exercises (Jacklin et al., 2014; Maar et al., 2020; Sauvé et al., 2022), and PowerPoint or other lecture-based modules (Doucette et al., 2014; Neff et al., 2020; Shah & Reeves, 2015). Within this range, interactive experiential delivery models, such as community immersion and patient simulation exercises, were valued as having the strongest influence on medical students' knowledge, skills, and attitudes in the realms of cultural safety.

Modes of delivery in medical education

In an assessment of first year medical student experiences in a community immersion program, de Leeuw et al. (2021) found that students perceived the program to transform their perspectives, overturn stereotypes, and improve their cultural sensitivity and cultural humility toward Indigenous people. Students stayed with First Nations families in rural and remote British Columbia and documented their reflections on this experience through creative works, such as journaling, poetry, and other arts-based outlets. The researchers analyzed these creative works and surmised that the program increased students' knowledge about Indigenous health, social determinants of health (SDOH), and traditional and holistic medicinal approaches (de Leeuw et al., 2021).


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While not an indicator of culturally safe behaviour or practice, participating in a community immersion program, in both studies, left medical students with an appreciation for Indigenous cultural and community pride.

(de Leeuw et al., 2021; Waldner et al., 2022)

Parallel experiences were reported by pediatric residents who completed a community immersion program at an outpatient pediatric clinic in a First Nations community in Alberta (Waldner et al., 2022). Here, residents self-reported improved knowledge and skills in challenging assumptions and building trust and relationships with Indigenous pediatric patients and their parents, as well as enhanced culturally safe communication (e.g., naturally and authentically communicating with respect and awareness). Residents indicated that they learned to view the child's care holistically, with consideration for the SDOH (e.g., transportation to care and Non-Insured Health Benefits coverage) and look beyond health challenges to recognize strengths within the family. Residents gained an interest in advocacy for improved Indigenous health, with one resident going on to work in the community after their placement (Waldner et al., 2022). While not an indicator of culturally safe behaviour or practice, participating in a community immersion program, in both studies, left medical students with an appreciation for Indigenous cultural and community pride (de Leeuw et al., 2021; Waldner et al., 2022). The interactive exposure to local First Nations culture seemed to shift students' knowledge, skills, and perspectives toward Indigenous health and the role they can play as allied practitioners to support Indigenous communities in improving health equity.

In this literature review, patient simulation exercises were found to generate similar learning outcomes to community immersion programs. A simulation exercise in Ontario encouraged family medicine residents to build "intercultural empathy [and] knowledge of Indigenous SDOH", by navigating through a series of scenarios in an app that call for residents to make decisions that balance Indigenous health and the impacts of the social determinant of health (Sauvé et al., 2022, p. 519). Residents reported increases in their empathic feeling, expression, and perspective-taking, as well as foundational knowledge about Indigenous people's experiences with SDOH and systemic racism in health care. Many reported

the simulation enhanced their motivation to practice cultural safety with Indigenous patients. While Sauvé et al. (2022) recognized the effectiveness of community immersion programs, they suggested simulation exercises can be equally effective and aligned with residents' resource and time constraints.

Maar et al. (2020) also evaluated Ontario medical students' experiences in completing simulated patient interviews with First Nations actors – an educational component also intended to prepare students for their month-long placement in an Indigenous community in Northern Ontario. Students reported improved sensitivity, confidence, and "cultural informed communication skills" (p. 5). To achieve these outcomes, Maar et al. (2020) shared a cautionary tale on the importance of co-developing medical scenarios with Indigenous actors to ensure scenarios are culturally safe for actors and authentic, realistic, and responsive for students. Previous iterations of the simulated patient interviews did not include this step, leading to much less success of the program. Maar et al. (2020) explain that before working with Indigenous partners to co-develop the training and recruit and train Indigenous 'standardized patients' for the medical scenarios, the process for running the scenarios was intrinsically not culturally safe. Indigenous staff playing the role of 'standardized patients' found cultural incongruity within the scenarios and struggled to stay 'on script' due to the inauthenticity of the cases based on their own lived experiences. The standardized patients would often break character, disrupting the evaluation of the training and learning experiences for students. Similar cautions are echoed for clinical case studies in cultural safety curriculum, as Jacklin et al. (2014) warn educators to ensure cultural safety principles are embedded in the development process and misconceptions and stereotypes toward Indigenous people are not reinforced.

Finally, lecture-based cultural safety curriculum in medical education yielded mixed results. In Smylie et al.'s (2024) evaluation, unannounced Indigenous standardized patients visited family practice and emergency care settings to assess the quality of care provided by non-Indigenous residents, academic physicians, and nurse practitioners following their completion of either intensive (10-hour) or brief (45-minute) online lecture-based Indigenous cultural safety training. The intensive program was an adaptation of the San'yas Indigenous Cultural Safety training program, while the brief program offered a "prejudice habit-breaking intervention" (p. 2).[2] The results of the assessment provided by the unannounced Indigenous standardized patients were compared to a control group who did not complete any cultural safety training. The evaluation found that compared to the control group, both the intensive and brief online training programs improved the quality of care provided by residents, academic physicians, and nurse practitioners, as measured by higher scores of patient experience. These clinicians also had greater odds of being recommended to family and friends by the standardized patients. While receiving higher scores and odds, the evaluation results noted only observable differences and did not yield any statistically significant differences between clinicians who did or did not receive Indigenous cultural safety training.

[2] See page three of Smylie et al. (2024) for a description of the different trainings.

Moreover, in a structural competency curriculum, family medicine residents in the United States learned about SDOH and cultural competency and humility through lectures and case studies (Neff et al., 2020). After completing the curriculum, the family medicine residents self-reported they valued the lived experiences embedded in the case studies; were inspired to become an advocate for improved health of their future patients; and their perspectives shifted as a result of the training, from casting blame or acting on misconceptions rooted in colonial thinking, to reframing their clinical discussions with patients to address the SDOH. Residents reported the training re-connected them with their original motivations to enter the medical field (Neff et al., 2020). While not tangible outcomes, one may surmise that putting these attributes into practice might align with cultural safety, as parallels can be drawn between aspirations for advocacy and addressing the SDOH to practicing with respect and empathy, which are just some of the core principles of culturally safe medical practice (Maar et al., 2020).

Doucette's et al. (2014) findings differed slightly from the examples provided above, based on an evaluation of a lecture based First Nations and Inuit cultural competence education as part of a tobacco dependence curriculum for dental hygiene students. Drawing from data derived from a standardized questionnaire, researchers found that the lectures significantly improved dental hygiene students' knowledge "of the sociocultural characteristics, health risks, and cultural healing traditions of First Nations and Inuit" (p. 682). However, the lecture-based education seemed to have little effect on the students' skills or comfort in working with or attitudes toward First Nations and Inuit patients, and no affect on their "perceived ability to communicate in a culturally sensitive manner with these populations" (p. 682). These findings are echoed in medical students' self-reported preparedness for a community immersion program in British Columbia. Here, students felt unprepared and lacked knowledge to frame their expectations for the program, despite their prior completion of self-directed Indigenous cultural safety training (de Leeuw et al., 2021).

Chapman et al. (2014) found similar results to Doucette's et al. (2014) findings in their quantitative analyses on a cultural awareness training program with emergency department nurses working with Indigenous patients in Australia. The program's lectures, mixed in with case studies and interactive activities, led to increases in the participants' cultural awareness and knowledge, however, had little to no effect on attitudes and relationships toward Indigenous people (e.g., demonstrated by questions around comfort level in working with Indigenous patients, feelings toward Indigenous health inequities, etc.).

Doucette et al.'s (2014) and Chapman et al.'s (2014) findings carry implications. On the one hand, the observed limited effects of their lecture-based training may be attributed to the lack of experiential learning, but on the other, the results may stem from the use of quantitative and standardized methods to evaluate outcomes, supplementing the use of self-reported results. Evaluations on experiential learning, like those described above, may therefore benefit from the use of mixed methods approaches, including both qualitative and quantitative methods, to gain a deeper assessment of the attitudinal changes of participants.

Curriculum components

In looking at both cultural safety curriculum for students and training for health professionals, some components are specifically highlighted by participants as strongly influencing their knowledge and awareness, shifting their perspectives, and/or enhancing their communication and cultural safety clinical skills – remembering however, that these outcomes are self-reported and only perceived by participants. The components highlighted by participants are most often patient-provider role playing (Barnabe et al., 2021; Lin et al., 2023; Maar et al., 2020), clinical case-based scenarios (Barnabe et al., 2021; Crowshoe et al., 2018), time for reflection and debriefing (Barnabe et al., 2021; Kerrigan et al., 2021), group discussions and peer interactions (Crowshoe et al., 2018; Lin et al., 2023), additional support from facilitators (Liaw et al., 2015; Wheeler et al., 2022), and storytelling and learning from lived experiences of Indigenous facilitators/educators (Crowshoe et al., 2018; Hulko et al., 2021; Kerrigan et al., 2021; Maar et al., 2020; Neff et al., 2020; Shah & Reeves, 2015). For example, in an equity training program for rheumatologists in Canada, the specialists reported on the significance of the training's role-playing exercise and the communication skills they acquired, helping them to be "humble and curious and strive to enter more of a dialogue with [their] Indigenous patients" (Barnabe et al., 2021, p. 6).

Meanwhile, general practitioners in Australia attributed their learning in a cultural respect workshop to the supportive environment created by, and their partnership with, Indigenous cultural mentors who were involved with the delivery of the training (Liaw et al., 2015). Indigenous cultural mentors worked alongside the workshop's educators to support and guide the general practitioners in implementing their learnings into practice. Further, nurses in British Columbia participating in a culturally safe dementia care program described how Elders' storytelling increased their knowledge of Indigenous realities because of "the teachings contained within the stories" (Hulko et al., 2021, p. 10).

This literature review also identified "needs" and "wants" for cultural safety curriculum or training, as reported by participants. These included more time for curriculum or training (Barnabe et al., 2021; Kerrigan et al., 2020; Sauvé et al., 2022; Shah & Reeves, 2015; Wheeler et al., 2022), follow-up training and online refreshers (Kerrigan et al., 2020; Lin et al., 2023; Wheeler et al., 2022), and specialty-specific case-based training and related practical advice (Barnabe et al., 2021; Chapman et al., 2014; Kerrigan et al., 2020; Lin et al., 2023; Wheeler et al., 2022). Hospital-based practitioners who completed cultural safety training in Australia articulated the need for more time in their one-day training to "avoid feeling overwhelmed, and to create opportunities for discussion and self-reflection" (Kerrigan et al., 2020, p. 5). This need was later addressed by the development of a cultural education podcast, which tackled time constraints and improved practitioners' ability to engage with and reflect on the content (Kerrigan et al., 2021). The podcast was led by Indigenous experts who responded to common questions by practitioners through storytelling. The experts provided listeners with calls to action and examples of behavioural change. Indeed, listeners self-reported positive changes in their knowledge and awareness of and communication with Indigenous patients (Kerrigan et al., 2021).

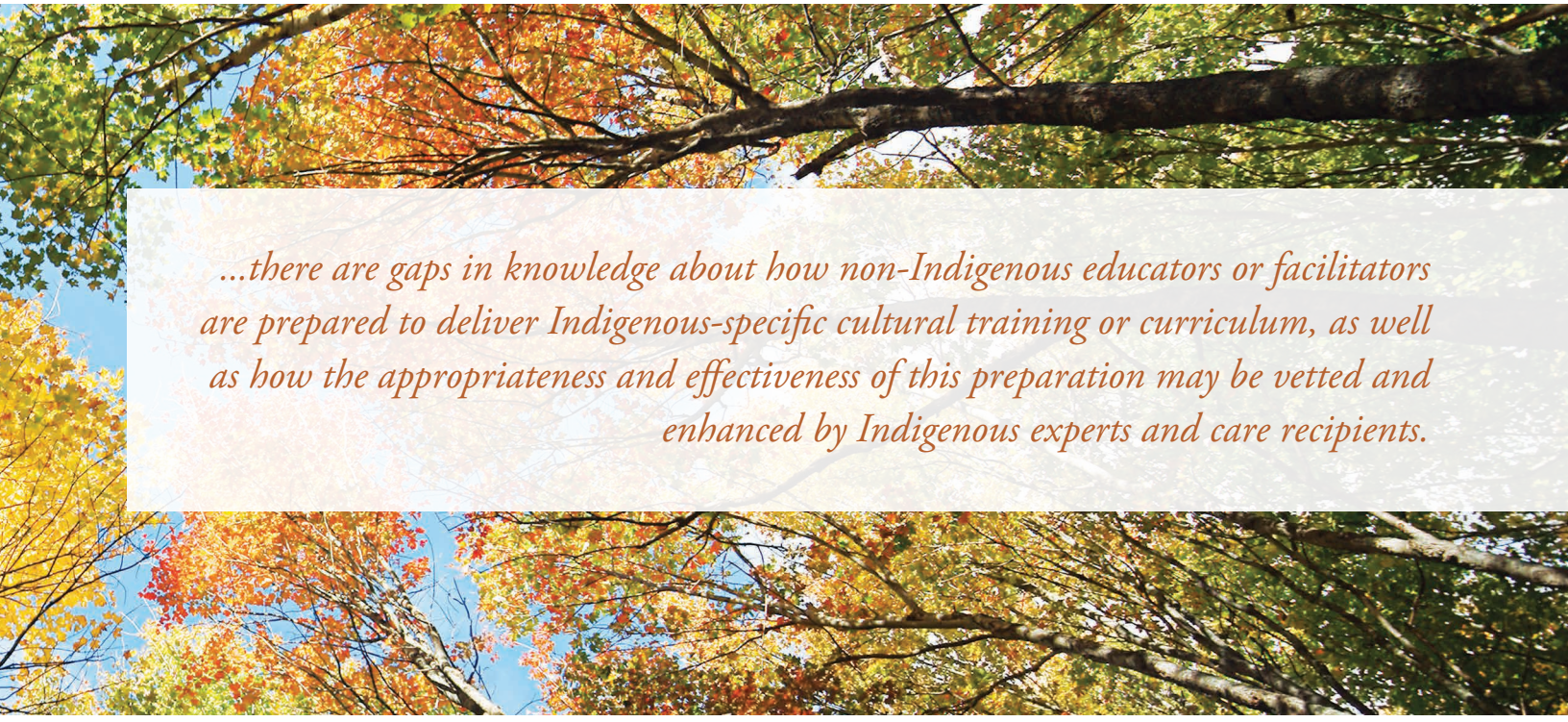
Gaps and further considerations

A key gap identified in this review is a paucity of evaluations pertaining to speciality-specific Indigenous cultural safety curriculum or training. This area is in dire need of further exploration to uncover the "if" and "how" cultural safety curricula or training works for different specialities and varying medical competencies, and what can be learned across disciplines (Wylie et al., 2021). Some evaluations related to specific medical specialities, such as curriculum for pediatric residents (Waldner et al., 2022) and training for rheumatologists (Barnabe et al., 2021); however, the outcomes of these evaluations did not review speciality-specific indicators.

There is also little information pertaining to how non-Indigenous educators or facilitators of Indigenous cultural safety training or curriculum are prepared to carry out this role. In a lecture-based Indigenous health curriculum for medical students in Ontario, Jacklin et al. (2014) stressed the importance of "faculty readiness" to deliver the curriculum, measured by their personal completion of similar training or education in Indigenous health, to provide "appropriate mentorship on [the] topic" (p. 149). Examples of such "faculty readiness" may be drawn from Neff et al. (2020), who describe group discussions, practice training sessions, and preliminary readings as preparatory interventions for facilitators of structural competency curriculum for family medicine residents. Nonetheless, there are gaps in knowledge about how non-Indigenous educators or facilitators are prepared to deliver Indigenous-specific cultural training or curriculum, as well as how the appropriateness and effectiveness of this preparation may be vetted and enhanced by Indigenous experts and care recipients.

Furthermore, there are important implications to consider in this research, such as issues surrounding accountability and institution of mandatory curriculum or training. This

review did not identify any means of ensuring learners are held accountable for translating their learning into culturally safe practice. Evaluations rely heavily on learners' self-reporting, with little to no evidence that the curriculum or training has influenced their practice or behaviours. This limitation correlates with related research investigating the impact of cultural safety training (Hardy et al., 2023; Webb et al., 2023). Moreover, there are diverse opinions on whether cultural safety curriculum or training should be mandatory for medical students and/or medical health professionals. In Nunavut, evaluators of a cultural orientation and safety app for health care professionals articulated tensions between mandatory training and cultural principles. Here, the evaluators experienced challenges in receiving participant feedback in using the app, prompting them to consider using incentives to elicit feedback, which would consequently promote use of the app. However, the evaluators noted that the consequential requirement to use the app to receive an incentive "would challenge the Inuit value of Pijitsirniq (to give without the expectation of return) and thus undermine the very Inuit values" the app tries to convey (Akearok et al., 2020, p. 698). Other common sentiments toward mandatory training include the potential for the training to be "off-putting" (Lin et al., 2023, p. 9), generate push back from practitioners (Kerrigan et al., 2021), or become a practice of "checking a box", effectively losing its meaning (Wylie et al., 2021, p. 323). Further work is needed in this area to determine an appropriate, effective, and meaningful path forward. The NCCIH's (2023) Cultural Safety chapters may serve as a launching pad to further investigate this critical topic, as the chapters provide insight into differing paths forward by collating the vast variety of best and promising practices to Indigenous cultural safety training and other initiatives taking place across the country. See NCCIH (2023) for more information.



...there are gaps in knowledge about how non-Indigenous educators or facilitators are prepared to deliver Indigenous-specific cultural training or curriculum, as well as how the appropriateness and effectiveness of this preparation may be vetted and enhanced by Indigenous experts and care recipients.

Indigenous people and their families and communities are the only people who may assess whether their care is culturally safe. Their perspectives must be included in the evaluation of cultural safety curriculum and training.

Conclusion

The evidence presented in this review suggests that cultural safety curriculum in medical education does work to influence the knowledge, awareness, and, in some cases, skills of medical students and residents within the realms of cultural safety. In expanding the scope of this review, the same may also be true for medical health care professionals as the result of cultural safety training. However, emerging gaps from the literature suggest there is more to be learned about the experience and outcomes tied to speciality-specific Indigenous cultural safety curricula, the orientation process for non-Indigenous educators or facilitators, measures to hold learners accountable to their cultural safety education, and theories of thought around the institution of mandatory curriculum or training.

Nevertheless, from the evaluations explored in this review, experiential learning and learning from Indigenous people's lived experiences were found to be highly valued by recipients of cultural safety curriculum. Common outcomes of curriculum or training for medical students, residents, and health professionals include improved knowledge and awareness of Indigenous health, traditional and holistic healing practices, and social determinants of health; increased interest in advocacy to improve Indigenous health and address inequities; and enhanced engagement and relationship building with Indigenous patients and their families through strengthened communication skills. Cultural safety curricula and training also often incited learners' expression of empathy and challenged learners to confront stereotypes toward Indigenous people, overturning previously held misconceptions for many learners.

These outcomes, however, are largely dependent on the self-reporting of medical students, residents, and health professionals, and therefore do not reflect behavioural change or the integral perspectives of Indigenous patients. Indigenous people and their families and communities are the only people who may assess whether their care is culturally safe. Their perspectives must be included in the evaluation of cultural safety curriculum and training. More patient-driven evaluations and knowledge is needed to fill this pivotal gap to truly understanding the effect that culturally safe interventions may have on the care Indigenous patients receive, as well as in disrupting the coloniality of and power imbalances engrained in medical education. Likewise, learning from Indigenous patients' perspectives will help to understand if the increased adoption and implementation of the TRC Calls to Action numbers 23 and 24 align with initial intentions of affecting change within medical education and health care delivery systems, and improving the quality of care for all Indigenous people.

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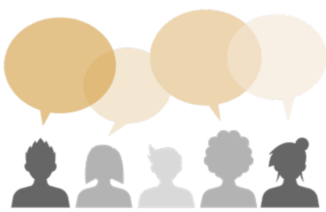
REFLECT

Talk to others in your community, reflect on the content of this fact sheet, and contemplate how you could make a difference in the health and well-being for yourself, your family or your community.



ENGAGE

Find local friendship centers, community organizations or groups where you can volunteer or participate in healthy positive actions. You too can share knowledge and make a difference in the health and well-being of First Nations, Inuit, and Métis Peoples' of Canada.

sharing knowledge · making a difference
partager les connaissances · faire une différence
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