Cultural Safety
Dr. Carrie Bourassa with Dr. Janet McElhaney & Eric Oleson

Introduction

Cultural Safety is a broad concept. The term was developed in the 1980s in New Zealand in response to the Indigenous Māori people's discontent with nursing care. Māori nursing students and Māori national organizations supported the theory of "cultural safety," which upheld political ideas of self-determination and de-colonization. Cultural safety was developed by non-dominant Maori people reacting to negative experiences in the health and nursing system (NAHO, 2006). Cultural safety analyzes power imbalances (throughout society and throughout healthcare practice); addresses institutional discrimination, colonization, and relationships with colonizers, as they apply to health care; requires an examination of how personal biases, authority, privilege and territorial history can influence the relationships between health care providers and Indigenous people; and relies on both self-reflection and critical reflection. A key element of culturally safe practice is establishing trust with the patient, and culturally safe care empowers people because it reinforces the idea that each person's knowledge and reality is valid and valuable. (NAHO, 2006)

It is well documented that disparities in health exist on the basis of race in Canada (Lasser et al, 2006). Racism, oppression, historical legacies and government polices continue to perpetuate the ongoing state of Indigenous Peoples' health inequities in many Indigenous communities (Virginia Department of Health, 2013). Indigenous Peoples carry an inordinate burden of health issues and suffer the worst health of any group in Canada. Beyond that, Indigenous people experience the poorest living conditions, inequitable access to education, food, employment and healthcare/health services in a country that reliably ranks in the top ten on the United Nations human development index (Diffey and Lavallee, 2016; Allan & Smylie, 2015; Reading & Wien, 2009). Not surprisingly, inequitable access leads to the worst health outcomes (Aboriginal Health Advisory Committee, 2012; Reading & Wien, 2009), but most importantly racism has been identified as the major factor in creating and reinforcing these disparities (Diffey and Lavallee, 2016; Allan & Smylie, 2015; Hart & Lavallee, 2015; Loppie, Reading, & de Leeuw, 2014). This racism is rooted in our colonial history and the processes that have – and continue to – disconnect Indigenous communities from their lands, languages, and cultures (Diffey and Lavallee, 2016; King, Smith, & Gracey, 2009; Commission on Social Determinants of Health, 2007).

Current research has demonstrated that racism has effects on the health and well-being of Indigenous people. According to Allan and Smylie (2015) studies conducted among university students in Alberta in 2007 and the US and Australia in recent years have revealed that experiences of racism "were indicative of racial battle fatigue" (Allan and Smylie, 2015: 9). A study cited by Allan and Smylie (2015) using data from the 2003 Canadian Community Health Survey (CCHS) revealed that there are health disparities experienced by racialized groups in Canada that cannot be explained by socioeconomic status, indicating that these disparities are evidence of the deterioration that occurs in experiencing daily racism and discrimination over time within social institutions and

daily life. Racism is seen as a chronic stressor linked to the ill-health of both African Americans and Indigenous Australians (Allan and Smylie, 2015). The Health Council of Canada (2012) released a report after hosting a series of seven regional discussions across Canada with Indigenous stakeholders. Participants indicated that Indigenous participants did not favour using mainstream health services because they experiences stereotyping, discrimination, racism and often felt minimized, judged or ignored. They also noted that most health care practitioners were often unaware that they were being racist or judgemental and felt that most of the issues were systemic in nature. The report also documented that healthcare systems also valued and prioritized "western" health systems and values over traditional medicine and noted communication issues between the patient (complicated terminology, not valuing traditional holistic values or medicines, for example).

Racism can, in fact, be lethal. There have been documented cases across Canada regarding the harmful and deadly impacts of racism particularly within the healthcare system. One particularly fatal incident was the death of Brian Sinclair, a 45 year old disabled, First Nation man who sought treatment in the Winnipeg ER for a bladder infection. It is important to note that he was referred there by a community physician and while he waited for treatment, he vomited on himself several times prompting other ER patients to ask the health care staff to help Mr. Sinclair seeing that he was in obvious distress. After waiting 34 hours for treatment Mr. Sinclair died of a bladder infection having never seen one physician. Although a provincial inquest was launched to investigate whether Mr. Sinclair's race or disability (or both) had anything to do with the lack of care and treatment, it was withdrawn by the family "due to frustration with its failure to examine and address the role of systemic racism in his death, and in the treatment of Indigenous peoples in health care settings more broadly" (Allan and Smylie, 2015). There were many assumptions made about Mr. Sinclair, including that he was intoxicated and homeless. These assumptions ultimately played a role in his death.

Understanding Cultural Safety

Cultural safety is based on the understanding of power differentials in the health care system; it exposes the social, political and historical contexts of health care and enables practitioners to consider difficult concepts such as racism, discrimination and prejudice. Colonization has contributed and continues to contribute to the health disparities faced by Indigenous people today (Aboriginal Nurses' Association of Canada, 2009).

Culturally safe practices seek to minimize the power differentials between health professionals and clients (or community), in recognition of a partnership that reflects a determining voice for the person or persons seeking care.

Cultural safety is an outcome, defined and experienced by those who receive the service. Patients feel safe based on respectful engagement that can help them find paths to well-being and this requires acknowledgement that we are all bearers of culture—there is self-reflection about one's own attitudes, beliefs, assumptions, and values (Health Council of

Canada, 2012). *Culturally safe care*, then, requires building trust with Indigenous patients and recognizing the role of socioeconomic conditions, history, and politics in health; requires communicating respect for a patient's beliefs, behaviours, and values; and ensures the client or patient is a partner in decision-making.

Cultural safety reveals the truth about health inequities and points, without shame, to oppression as a main cause of health inequities by harnessing critical thinking and self-reflection— a teachable skill. Self-reflection is a value that nourishes cultural safety; the provider is better able to understand the upstream barriers (e.g., structural racism, discriminatory laws, historical legacies, uneven distribution of economic opportunities, etc.) and their connection to the downstream effects (e.g., person-to-person mediated racism, classism, cycle of poverty, etc.) influencing the health and healing of those defined as under threat (Royal College of Physicians and Surgeons of Canada, 2013).

Though health researchers and practitioners frequently use similar sounding terms (e.g., cultural awareness, cultural sensitivity, and cultural competence), these terms lack cultural safety's *political commitment* to equity in health care research and delivery, which is necessary to address health inequities between Indigenous and non-Indigenous peoples (Darroch et al, 2016). For example, cultural safety subsumes the concepts of cultural awareness, cultural sensitivity and cultural competency (Brascoupé & Waters, 2009).

Diffey and Lavallee (2016) point out that despite the name "cultural safety" it is not *culture* but power inequities that are considered. Furthermore, the decision about whether a clinical encounter between a patient and clinician is *safe* lies with the Indigenous patient. They argue that issues of race and social difference are explicitly identified as originating in colonial power struggles, not as matters of *culture* or *ethnicity*. Thus, by addressing colonial-based racism at these higher levels, safety in clinical encounters is ensured (Ibid, 2016).

Cultural safety, in fact, takes us beyond cultural awareness and the acknowledgement of difference between cultures. It surpasses cultural sensitivity, which recognizes the importance of respecting difference. Cultural safety helps us to understand the limitations of cultural competence, which focuses on the skills, knowledge, and attitudes of practitioners. One major limitation of cultural competence is the reduction of culture into a set of skills for which practitioners can gain knowledge. Furthermore, the focus in cultural competency is on learning rather than action (Brascoupé and Waters, 2009). Cultural safety is predicated on understanding power differentials inherent in health service delivery and redressing these inequities through educational processes (Aboriginal Nurses Association of Canada, 2009) It is a patient-centered approach and encourages self-reflection among health care practitioners which is seen as an essential skill fundamental to the relationship between patient and physician (Indigenous Physician's Association of Canada, 2009). Cultural safety focuses on systemic issues including colonial-based racism as noted by Diffey and Lavallee (2016). Moreover, the patient is not a "passive receiver" but rather a "… powerful player in the relationship. Its

success therefore cannot be evaluated as a function of knowledge of the practitioner, but is an outcome in and of itself that the practitioner can only help facilitate" (Yeung, 2016).

In practice cultural safety focuses on the shared concepts of respect, dignity, attention, learning together, shared knowledge and shared meaning. Practitioners are asked to examine the underlying social determinants of health and how colonization has impacted Indigenous people and continues to impact Indigenous people through legislation and policy (Yeung, 2016). The patient-practitioner relationship is redefined using a cultural safety model that endorses a shared power paradigm and ensures the patient is perceived as a patient of value (Ibid, 2016).

Despite evident resilience, health disparities between Indigenous and non-Indigenous people remain high. Much more work is needed in health-related fields to narrow and ultimately close the gap between Indigenous and non-Indigenous peoples' health. One way to achieve this is to identify practices in both health *research and practice* that bridge the knowledge systems between these communities to promote community-based participatory research, Indigenous sovereignty, and practices that are considerate and respectful of Indigenous peoples—that is, those that demonstrate cultural safety, which embodies cultural awareness, cultural sensitivity, and cultural competence. According to Yeung (2016: 4): "Cultural safety therefore extends beyond clinical practice to become a moral discourse for informing policy analysis. It is necessarily coupled with application at systemic levels, including consideration of whether mainstream health policies put Indigenous peoples' health at risk, or whether they fail to address gaps in health in Indigenous populations, thereby also producing a lack of safety."

It should not be lost on individuals that cultural safety is, at the core, also very political and, as noted earlier, arose in fact as a political response by the Māori people's discontent with nursing care. According to Brascoupé and Waters (2009: 12-13): "the concept of cultural safety becomes a challenge to the power establishment in wider society, defined not just as a measure of the effectiveness of policy and delivery, but as a very real part of a political power struggle for control over one's own life. Cultural safety becomes a means of changing broad attitudes and deep-seated conceptions, on an individual and community-wide basis." This is particularly powerful and a central tenet of cultural safety in Canada given the history of assimilation policies in Canada. Not only are there historic policies that have inter-generational impacts on Indigenous peoples' health and well-being but neo-colonial policies continue to impact Indigenous people through current legislation including the *Indian Act.* The Truth and Reconciliation Commission (TRC, 2015) notes:

> *"For over a century, the central goals of Canada's Aboriginal policy were to eliminate Aboriginal governments; ignore Aboriginal rights; terminate the Treaties; and, through a process of assimilation, cause Aboriginal peoples to cease to exist as distinct legal, social, cultural, religious, and racial entities in Canada"*

Remembering the Royal Commission on Aboriginal Peoples

It is striking that the *Royal Commission on Aboriginal Peoples Volume 3, Gathering Strength, Chapter 3 Health and Healing,* begins by outlining the poor health and socio-economic status of Indigenous people in Canada – something that as Indigenous scholars we continue to lament today. They also note that this ill-health and poor socio-economic status can be linked to the colonial policies and experiences since the time of contact. Moreover, RCAP speaks to the need for access to services "sensitive to their unique history and needs" (RCAP, Vol. 3: 184).

Five themes emerged from their discussions with Indigenous people across Canada:

1) The demand for equal outcomes (equality for all in health care);
2) The belief in interconnectedness (holistic concepts of health);
3) The transition from dependency to autonomy;
4) The need for culture-based programming; and,
5) A new role for traditional healing

Based on these themes they make several recommendations in the chapter. Most of which are never implemented in mainstream policy, legislation or programming. The first set of recommendations are from *Section 2.4 Characteristics of a New Strategy:*

1) Pursuit of equity in access to health and healing services and in health status outcomes;
2) Holism in approaches to problems and their treatment and prevention;
3) Aboriginal authority over health systems and, where feasible, community control over services; and,
4) Diversity in the design of systems and services to accommodate differences in culture and community realities.

They recommend a health strategy based on the following:

- equitable access to health services and equitable outcomes in health status;
- holistic approaches to treatment and preventive services;
- Aboriginal control of services; and.
- diversity of approaches that respond to cultural priorities and community needs.

These recommendations are strongly aligned with the concepts associated with cultural safety. While the model of cultural safety was in its infancy when the RCAP report was drafted, the recommendations remain relevant today. Unfortunately, little progress has been made since 1996 when the report was released and, in fact, the gap in terms of ill-health and poor socio-economic status between Indigenous and non-Indigenous Canadians has grown (Yeung, 2016; Hole et al, 2015). Cultural safety in practice promotes the integration of holistic approaches to health; Indigenous control of services; equitable access to health services (with the hope of equitable outcomes in health status) and creating culturally safe care using diverse approaches.

In addition to advocating for self-government and self-sufficiency, in Section 3.1 RCAP further recommended the following elements to a strategy:

1) the reorganization of health and social service delivery through a system of healing centres and lodges under Aboriginal control;
2) an Aboriginal human resources development strategy;
3) adaptation of mainstream service, training and professional systems to affirm the participation of Aboriginal people as individuals and collectives in Canadian life and to collaborate with Aboriginal institutions; and,
4) initiation of an Aboriginal infrastructure program to address the most pressing problems related to clean water, safe waste management, and adequate housing.

One of the recommendations of RCAP (3.3.12) was the "equitable access to appropriate services by all Aboriginal people" yet twenty years later many Indigenous people do not have access to a primary care physician (Royal College of Physicians and Surgeons of Canada, 2013).

Moreover, RCAP speaks to the need for more Indigenous health care practitioners, particularly physicians yet twenty years later we continue to grapple with a shortage of Indigenous healthcare practitioners from physicians to nurses to clinicians. The Health Council of Canada report released in 2013 entitled *Empathy, Dignity and Respect: Creating Cultural Safety for Aboriginal People in Urban Health Care* emphasized the systemic racism faced by Indigenous people in hospital settings and that participants indicated they felt more comfortable and safe when they saw Indigenous staff and clinicians. The report also recommended an Aboriginal human resource strategy in addition to *cultural safety training* (Health Council of Canada 2013).

Not only do we need more Indigenous physicians and health care providers, but we need to ensure that the allied or non-Indigenous physicians and health care providers are indeed providing culturally safe services. Firstly, we urgently need more Indigenous physicians. It is difficult to obtain the actual numbers of Indigenous physicians in Canada. In 2005 there were 61, 622 physicians in Canada and there was an *estimated* 100 to 150 Indigenous physicians (Anderson & Lavallee, 2007). Although the Aboriginal Health Human Resource Initiative announced in 2004 was to spend $100 million over 5 years to increase the number of Aboriginal people working in health careers this did not seem to translate into high rates of physicians and clinicians. Accurate statistics are difficult to obtain. While it is estimated that 3,000 Indigenous physicians are needed across Canada, a "best guess" is that there are only 300 right now (Many Guns, 2016). However, according to Dr. Alika Lafontaine, Past President of the Indigenous Physicians' Association of Canada (IPAC), he estimates that based on graduation rates out of the medical schools, Canada has graduated approximately 1,000 Indigenous physicians since the late 1990s (personal correspondence, October 31, 2016). However, with over 80,000 physicians in Canada, Indigenous people remain well under-represented.

Secondly, there is a need to provide more training to ensure existing physicians and health care providers are providing culturally safe care. The HCC report (2013:37) was very clear on this:

> *"A frequently repeated theme in the regional discussions was*
> *the importance of training activities that fill in the considerable*
> *gaps in knowledge, understanding, and experience that most*
> *Canadians have in relation to First Nations, Inuit, and Métis*
> *people, cultures, and communities".*

The report also noted that cultural safety training must develop knowledge about both historic and present day Indigenous people and experiences. The training must also incorporate activities that assist participants in understanding the impacts that their own perceptions of Indigenous people might have on
their practice and, ultimately, on health outcomes for Indigenous patients. Finally, it must develop an understanding and skill set that will help them engage with Indigenous people in ways that provide cultural safety (HCC, 2013). The National Collaborating Centre for Aboriginal Health (NCCAH) compiled an *Environmental Scan of Cultural Competency and Safety in Education, Training and Health Services* in 2013. They list seven professional cultural training programs across the country. Most of them have the same themes in terms of curricula content: communication, leadership, health and/or wellness, understanding the differences between cultural awareness/competency/sensitivity/safety, history of colonization, Indigenous/Traditional Knowledge, concepts of oppression/racism/discrimination (Baba, 2013).

More recently, the Truth and Reconciliation Commission (TRC) made several recommendations specific to health recruitment and training:

> 23. We call upon all levels of government to:
> i. Increase the number of Aboriginal professionals working in the health care
>   field.
> ii. Ensure the retention of Aboriginal health care providers in Aboriginal
>   communities.
> iii. Provide cultural competency training for all health care professionals.
>
> 24. We call upon medical and nursing schools in Canada to require all students to
> take a course dealing with Aboriginal health issues, including 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. This will require skills-based training in intercultural competency,
> conflict resolution, human rights and anti-racism.
> (TRC, 2015: see:
> http://aptn.ca/news/2015/06/02/read-94-recommendations/)

Over twenty years of repeated calls for mandatory cultural competency or safety training, millions of dollars poured into Aboriginal Health Human Resource plans, a multi-million dollar Royal Commission that feels eerily similar to the recommendations made by the recent Royal Commission. Yet the reality in our Indigenous communities Northern, on-reserve, off-reserve, urban or rural from coast to coast is that our health remains poor, economic, employment and education opportunities bleak, and by all counts not very much has changed. Not much has changed despite a Royal Commission that held such promise and hope and so many incredible opportunities for change. In re-reading just Volume 3 Chapter 3 I can see so many recommendations that could still be implemented twenty years later. Not much has changed after a Formal National Apology by our Prime Minister and ninety-four recommendations made by the Truth and Reconciliation Commission. Why are we holding out hope that this idea or theory of cultural safety might transform this system? If not much has changed and, indeed, the gaps in almost every measure of the determinants of health are widening, why are we focusing on this?

We focus on this because reconciliation is only beginning. Because we needed twenty years to wake up and understand what RCAP was really all about. RCAP still has something to teach us. As I re-read Volume 3, Chapter 3 for about the thirtieth time in my career I was struck by what I missed so many times before. I missed the theme of self-determination. We must shake up the system and re-balance it. We live in a system of power and control – one where for centuries Indigenous people have had no power and no control. Cultural safety is based on the understanding of power differentials in the health care system; it exposes the social, political and historical contexts of health care and enables practitioners to consider difficult concepts such as racism, discrimination and prejudice. Colonization has contributed and continues to contribute to the health disparities faced by Indigenous people today (Aboriginal Nurses' Association of Canada, 2009). As we are able to balance out the power differentials and become self-determining through cultural safety we can begin to address the inequities that have plagued us for centuries.

"Taking a cultural safety approach to dealing with inequities enables physicians and other care providers to improve health care access for patients, aggregates, and populations; acknowledge that we are all bearers of culture; expose the social, political, and historical context of health care; and interrupt unequal power relations." (IPAC, 2009)

The Indigenous Physicians' Association of Canada, Aboriginal Nurses' Association of Canada, Canadian Nurses' Association, College of Family Physicians of Canada and Royal College of Physicians and Surgeons of Canada have all called for cultural safety training ranging for their members. It has ranged from recommending short workshops at conferences to integrating more content in medical school curricula to advocating for mandatory accreditation for physicians and surgeons. Indigenous organizations and communities need to be involved in how the training is structured to ensure that the difficult issues regarding systemic racism, white privilege, stigma, discrimination, ongoing impacts of colonization, for example, are included in any cultural safety training.

It is important to include positive topics as well such as leadership, accountability and Indigenous Knowledge but not at the expense of glossing over the uncomfortable issues that must be addressed in order for us to move forward together.

As Lavallee et al (2009) describe, cultural safety is the embodiment of two concepts: challenging privilege and addressing power imbalances. Culturally safe practice is predicated on critical self-reflection that seeks to interrupt racism and oppression. Reflecting on one's privilege and how this translates into the power differential within the patient–provider relationship is a first step. The health care provider then moves from reflection into active practices that challenge stereotypes, address inequities, and facilitate self-determination with Indigenous patients. While responsibility for ensuring cultural safety rests with the provider, evaluation of whether cultural safety is achieved lies with the Indigenous patient. Thus it is imperative for any cultural safety training to include these topics and to have a facilitator who has the skills to walk participants through this process.

Recommendations – Where are We?

In 2015 the Truth and Reconciliation Commission (TRC) made several recommendations specific to health and healing. Four are directly related to patient care, training and transforming the health care system. Cultural safety can promote reconciliation by focusing on research that addresses patient care, structural racism, systemic inequalities, socio-economic inequalities, inter-generational trauma, spiritual healing, capacity building and training of both Indigenous and non-Indigenous health professionals.

The TRC (2015) recommended the following:

> 18. We call upon the federal, provincial, territorial and Aboriginal governments to acknowledge that the current state of Aboriginal health in Canada is a direct result of previous Canadian government policies, including residential schools, and to recognize and implement the heath care rights of Aboriginal people as identified in international law, constitutional law and under the Treaties.

> 19. We call upon the federal government in consultation with Aboriginal peoples, to establish measurable goals to identify and close the gaps in health outcomes between Aboriginal and non-Aboriginal communities, and to publish annual progress reports and assess long-term trends. Such efforts would focus on indicators such as: infant mortality, maternal health, suicide, mental health, addictions, life expectancy, birth rates, infant and child health issues, chronic diseases, illness and injury incidence, and the availability of appropriate health services.

> 22. We call upon those who can effect change within the Canadian health-care system to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients.

In essence, the TRC recommended that research be undertaken to track appropriate health indicators in partnership with Indigenous people to identify and close the gaps in health outcomes. Acknowledging both the link between colonization and ill-health of Indigenous people and the benefits of traditional healing practices and Indigenous healing practitioners would be extremely beneficial both in research and in practice.

Research must inform practice and it is essential for research with Indigenous communities to follow community-based participatory research principles and employ Indigenous Research Methodologies (IRM). Browne et al (2016) outline ten strategies that serve as health equity guidelines for organizations and providers based on an ethnographic research study. These strategies are aligned with recommendations from the HCC report released in 2012. The strategies include:

1. Explicitly commit to fostering health equity in partnership with Indigenous peoples in mission, vision, or other foundational policy statements
2. Develop organizational structures, policies, and processes to support the commitment to health equity
3. Optimize use of place and space to create a welcoming milieu
4. Re-vision the use of time
5. Continuously attend to power differentials
6. Tailor care, programs, and services to local contexts, Indigenous cultures, and knowledge systems
7. Actively counter systemic and individual experiences of racism and intersecting forms of discrimination
8. Tailor care, programs, and services to address interrelated forms of violence
9. Ensure opportunities for meaningful engagement of patients and community leaders in strategic planning decisions
10. Tailor care to address the social determinants of health for Indigenous peoples

Similarly, the Health Council of Canada in 2012 recommended:

1. Provide patient-centred care that meets patient-identified needs.
2. Look for and create opportunities for partnership and collaboration that will enhance cultural safety for First Nations, Inuit, and Métis people.
3. Look for and create opportunities for partnership and collaboration that will increase your organization's capacity to provide culturally competent services and enhance cultural safety for First Nations, Inuit, and Métis people who engage with your organization.
4. Take leadership from First Nations, Inuit, and Métis people and acknowledge their expertise with respect to the identification of their individual and collective needs, capabilities, strengths, and opportunities.
5. Value and acknowledge the knowledge, expertise, and skills of traditional healers, counsellors, teachers, and other traditional knowledge keepers and practitioner.
6. Develop policies and initiatives that will support the recruitment and retention of Aboriginal employees at all levels of your organization.

7. Develop methodologies that can be used to assess qualitative outcomes of activities that enhance cultural competency and cultural safety
8. Use collaboration and partnership opportunities to enhance the cultural competency of urban health systems and cultural safety for First Nations, Inuit and Métis community members using those systems.
9. The HCC also noted that research enhances accountability and understanding and builds capacity within communities (2012).

There are several community-based Indigenous health research projects across Canada that are lead by Indigenous health researchers and communities that are directly related to cultural safety and may are funded through the Canadian Institutes of Health Research. These are positive, if not slow, steps toward enhancing capacity, accountability, leadership and building models of care. Research, that is, more of it with, by and for Indigenous people, is but one recommendation, although it is an important one.

The NCCAH (2013) identified five organizations the provided Indigenous core competencies but none really had a framework. An interesting framework for consideration that could be widely applied was developed by the Royal College of Physicians and Surgeons in consultation with their Indigenous Health Advisory Committee. It is called the The CanMEDS Physician Competency Framework. It describes the knowledge, skills and abilities that specialist physicians require to deliver effective health care. In reality, many of the framework's tenets can easily apply to *other* health care professionals within a health care setting.
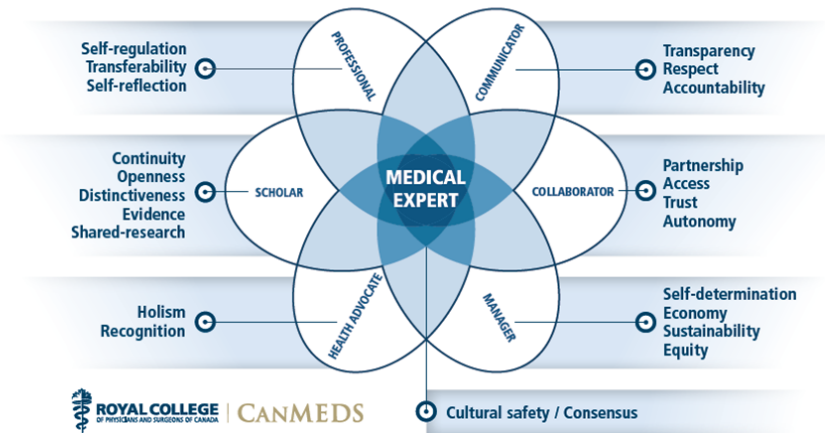
The framework is based on seven *Roles* that all physicians need to be competent in. By mapping Indigenous health values against each Role (Figure 1), providers begin to reflect on their personal biases as well as the effects of their clinical skills on patient relationships. Providers who embrace these values do not interrogate or challenge Indigenous knowledge and ways of being, nor force patients into submitting to the health system, deliberately or through carelessness (Lavallée et al, 2009).

As shown in Figure 1, interpreting Indigenous health values through the CanMEDS Framework results in seven principles to guide culturally safe interventions; patients can realize their full potential as Indigenous people without feeling threatened.

Figure 1[1]
Indigenous health values and principles for culturally safe interventions

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'Mapping' Indigenous Health Values as Interpreted Through the CanMEDS Framework

Self-regulation / Transferability / Self-reflection — PROFESSIONAL
COMMUNICATOR — Transparency / Respect / Accountability
Continuity / Openness / Distinctiveness / Evidence / Shared-research — SCHOLAR — MEDICAL EXPERT — COLLABORATOR — Partnership / Access / Trust / Autonomy
Holism / Recognition — HEALTH ADVOCATE
MANAGER — Self-determination / Economy / Sustainability / Equity

ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF CANADA | CanMEDS

Cultural safety / Consensus

PRINCIPLES FOR CULTURALLY SAFE INTERVENTIONS

Medical Expert	Communicator	Collaborator	Manager	Health Advocate	Scholar	Professional
The culturally competent physician embraces Indigenous knowledge.	Honest and respectful dialogue about health is a mutual responsibility between the patient/family/community and the physician.	The Indigenous patient-physician relationship is sacrosanct and without hierarchy or dominance.	Physicians are equipped with the tools, knowledge, training & experience to improve Indigenous health.	Indigenous identity promotes holistic health & encourages active participation of Indigenous people as agents of change for health.	Indigenous health is an integral component of medical research, education, training and practice.	Physicians are committed to the wellbeing of indigenous patients, their families, communities & cultures.

Guiding principles, emanating from Indigenous values, serve to deconstruct the power differentials at the system and personal levels and provide ways in which new partnerships based on respect and understanding between providers and the Indigenous communities they serve. The use of culturally safe methods fosters personal and professional development and makes changes possible. As well, viewing culturally safe practice through the framework of the CanMEDS physician Roles brings stronger attention to Indigenous health, facilitates transference into education and practice, and provides direction for leadership.

What is most important is that the patient remains in control (patient-centred care). One of the overarching principle as stated in the College's Indigenous health values and principles statement is:

> The (health) care of an Indigenous person reflects the dimensions of quality for patient-centred care that resonate with his/her culture in all stages of that person's life. The physician demonstrates empathy, open-mindedness, consensus and understanding of the issues facing Indigenous people and the social determinants of health that contribute to their health status. The decision-making process recognizes the value of indigenous peoples' self-determination through the principles of ownership, control, access and possession and the benefits of making unencumbered and informed choices to promote health-sustainability and equity.

Conclusion – We Do we Need To Go?

An Elder I know often reminds me that "we don't know what we don't know". As I am thinking about the magnitude of the work that has been done by some of the most amazing people I know I am overwhelmed with joy and gratitude. On the other hand, I know there is so much more to do and I as I ponder on what I must "recommend" I am similarly overwhelmed but in a different way. There is so much that I don't know and so much to do. Yet we are strong people. Survivors. There has been much done yet it seems like little accomplished. Or maybe I am being too harsh. Maybe my expectations in changing a colonial system in twenty years or less is too high. Well, if you don't have expectations no one will ever meet them. Someone very wise told me that.

We have learned much from those who have gone before us. Those who paved the way and did the hard work. We have a path to follow now – a path that was not there before. We have similar, if not the same recommendations being made over and over again. Why is this important? Because we know what we need in our communities. We always have. We must continue to demand what we know we need and want. Our relatives said it in RCAP, they said it through the TRC and they are saying it through our all of important community-based research projects. So to summarize we need:

1) Self-determination
2) More Indigenous physicians, health care providers, clinicians and researchers
3) Culturally safe allied physicians, health care providers, clinicians and researchers (ie. Who are appropriately trained in culturally safe training that includes the tough topics of white privilege, systemic racism, discrimination)
4) More research is needed to document poor health outcomes related to racism and stereotyping faced by Indigenous communities and then to evaluate culturally safe interventions
5) To develop culturally safe models of care for health services offered to Indigenous people regardless of location
6) Self-determination (wait, did I say that already? Well, it's worth stating again)
7) To value and acknowledge the knowledge, expertise, and skills of traditional healers, counsellors and Indigenous knowledge
8) To find better ways to develop partnerships and collaborations with Indigenous communities and organizations where they determine the nature of such partnerships/collaborations
9) To prioritize and provide patient-centered care
10) To challenge privilege and practice self-reflection daily
11) Allies and champions to practice being culturally safe
12) Research and theory to translate into policy at all levels

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