Fulfilling cultural safety expectations in specialist medical education and training: considerations for colleges to advance recognition and quality

Positionality statement

As a proud Biripi man, academic, doctoral student, and former medical practitioner working daily at the cultural interface, I perceive myself as a conscious mediator of conflicting Indigenous and Western health paradigms. The term "Indigenous" in this article respectfully and collectively refers to the First Peoples of lands which have been colonised, including Aboriginal and Torres Strait Islander, Māori and other First Nations peoples. My experiences within these spaces have formed a unique perspective that is continuously confirmed and challenged. As I educate in the Indigenous Health space, I am constantly reminded of the fact that I do not hold all knowledge, I am but a learner akin to the students I profess to teach. My experiences have moulded my understanding of what appropriate and effective health care for Indigenous peoples looks like to "me", but am critically aware that perspectives are myriad, dynamic and equally valid.

Introduction

With growing attention and priority regarding cultural safety in the Australian, Aotearoa, and indeed global health care environments, an equally significant concern is mounting vis-à-vis the capacity of medical professionals to provide care that is deemed culturally safe by Indigenous peoples.[1-3] Furthermore, it is increasingly evident that health inequities within Indigenous populations "are primarily due to unequal power relationships, unfair distribution of the social determinants of health, marginalisation, biases, unexamined privilege, and institutional racism,"[4] prompting the need for attention at a variety of levels within health care, including at the systemic, organisational and individual levels.

Along with medical schools and pre-vocational medical training institutions, specialist medical colleges have a considerable responsibility to ensure their organisation and training programs commit to developing medical professionals who can demonstrate cultural competence within clinical contexts.[5] Despite this, some have questioned such focus on cultural competence, with an equity-based model that promotes practitioner transformation through centring notions of critical consciousness, self-reflexivity, and power inequality within health care environments more aligned to concepts of cultural safety and responsiveness.[4,6] Central to a critical reflexive approach are immersive experiences that promote perspective transformation through challenging learner's beliefs, assumptions and biases.[4,7]

Unlike traditional components of medical training that adopt well defined competencies to determine progression, cultural safety training is nebulous.[8] This is due to ambiguities surrounding the concept of *culture* and cultural safety, which focus heavily on introspection and critical consciousness of power differentials within societal structures and systems, including health care.[8,9] It is purported that such disparities in power are directly linked to the colonisation of Indigenous lands and have constructed and maintained health inequities that disadvantage Indigenous peoples.[10,11] European-based systems (eg, health care) were forcibly introduced during colonisation, often conflicting with Indigenous ways of knowing, being and doing.[12] The manifestation of such epistemological, ontological and methodological conflict is inequity regarding access to, and participation in, such public systems, resulting in disproportionate outcomes.[13]

As an Aboriginal man who works in this space, I am both concerned and optimistic. On the one hand, my experience is that specialist medical colleges, compared with primary medical schools, have a long way to go to realise an organisational structure and operational approach that facilitates culturally responsive and safe care through employees, trainees and Fellows. Conversely, specialist medical colleges are well placed to learn much from primary medical education and the significant progress made in this context over the past two to three decades. In many ways, specialist medical colleges are fortunate that medical schools have blazed an important trail in this area, with many difficult lessons overcome, albeit with further challenges ahead, to realise an appropriate direction for the development and delivery of Indigenous health and cultural safety curricula.

Along with a commitment by medical schools in recognising and supporting such advancement, many Indigenous peoples have worked tirelessly within university and health services to grow this field and hold the space within the broader medical curriculum and Academy. Furthermore, Indigenous medical education and training stakeholder bodies such as the National Aboriginal Community Controlled Health Organisation (NACCHO), Leaders in Indigenous Medical Education (LIME), Australian Indigenous Doctors' Association (AIDA), Te ORA (Te Ohu Rata O Aotearoa – Māori Medical Practitioners Association), First Nations Health Authority (FNHA), National Consortium for Indigenous Medical Education (NCIME), Indigenous Physicians Association of

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Canada (IPAC), and the Association of American Indian Physicians (AAIP) have provided significant contribution and direction to Indigenous health and cultural safety within the medical and broader health care context in Australia, Aotearoa and Turtle Island.

There are myriad challenges for specialist medical colleges in fulfilling the social, political and moral expectations and obligations of cultural safety. These require a long term commitment considering the context of the college, training programs and the staff, members and community. It is acknowledged, based on size, scope, and volume of members, that specialist medical colleges have varying capacity to meet such expectations, particularly smaller colleges; however, it is essential for those colleges to understand the importance of this area and, through regular self-reflection and critical consciousness, strive to utilise their capacity to effect positive change in this area.

The CONSIDER reporting criteria checklist for health research involving Indigenous peoples[14] was completed for this article and can be found in the Supporting Information.

Common pitfalls

Reactive rather than proactive

Much of the progress made by specialist colleges in the areas of Indigenous Health and cultural safety has been a result of the nudging stick of accreditation standards. Although the author acknowledges that colleges have not traditionally had the capacity to advance in this space, a need to prioritise this area has been evident for several decades now,[15] with an increasing number of available resources to support planning and operationalising an organisational strategy.[16] Colleges may be challenged by a perceived anxiety or uncertainty of progress in this area. An alternative is to positively change this perception to proactive contribution to social justice and closing the health gap between Indigenous and non-Indigenous peoples.

Cultural load

A common issue supported via both anecdotal and scholarly evidence is the concept of cultural load, whereby Indigenous staff are overburdened with all Indigenous-related responsibilities.[17] These responsibilities include education of non-Indigenous colleagues regarding Indigenous cultures, practices and racism; fulfilling cultural responsibilities external to the workplace; being involved in various committees and Boards as an Indigenous representative; living and working off Country; dealing with the impacts of intergenerational trauma and racism; and attempting to accurately represent all Indigenous peoples when asked pan-Indigenous questions, despite the significant diversity within and between Indigenous cultures. Cultural load can have an impact on any Indigenous person, including college staff and committee members, as well as trainees and Fellows. Colleges should be cognisant of cultural load and not place any additional burden on Indigenous staff, members or stakeholders.

Uninformed assumptions

Something witnessed frequently during my time in the specialist medical education and training space is an assumption by colleges and accreditation bodies that Indigenous organisations and networks are freely available to offer their guidance and support. Although most, if not all, Indigenous medical and other health bodies are supportive of college transformation in this context, it is important for colleges to be aware that such Indigenous groups are almost always operating at full capacity, often with limited staff to action the flood of daily requests they receive, with patience needed to establish a genuine, trusting and fruitful relationship.

Further to this issue is a common misunderstanding that only Indigenous peoples should be involved in the advancement of the Indigenous agenda, which, as has been previously identified, is the attainment of self-determination and social justice, including in the health care context.[18] Non-Indigenous peoples are crucial to achieving this goal and can contribute through practising critical allyship. This includes a commitment to ongoing critical self-reflection, particularly regarding positions of privilege and/or oppression in various systems of inequality, such as health care.[19]

It is worthy to note that a commitment to cultural safety does not merely involve a high level strategy and an annual workshop or online module. It is naïve to think that such critical consciousness of power structures and their construction and maintenance of inequity can be attained via such rudimentary and symbolic approaches. A genuine commitment entails ongoing intensive work that delves into the complex realities in which Indigenous peoples are positioned. It invites colleges, their staff and its members to go on a journey, one in which courage, empathy and open-mindedness are prerequisites to achieve such critical consciousness of the underlying circumstances which have constructed and sustained the "gap" observed in health outcomes between Indigenous and non-Indigenous populations.

Lack of sustained direction having and impact on progress

Another common observation is a slowing of college focus in this context. Although, to the credit of many, if not all colleges, an enduring commitment is evident to some degree, colleges can tend to lose sight of their focus in this context, often due to a lack of direction and support. What has been apparent during my experience is that the planning and strategising of Indigenous health and cultural safety initiatives within colleges (eg, establishing committees and trainee scholarships, developing a Reconciliation Action Plan or Indigenous strategy, reaching out to an Indigenous organisation to support college activities) often eventuates without many significant issues or delays (in most cases). However, where progress tends to become impeded is in the successful execution of college strategies or plans, as well as in the maintenance of relationships with Indigenous organisations. In many cases, such

inertia lies outside the control of colleges; however, a general lack of awareness regarding the labour burden within Indigenous organisations and the lack of power granted to Indigenous college committees to effect change are but two examples of many potential barriers to college progression in this context. A potentially tangible solution, or at least a key consideration to address such obstacles, is the development of the college's internal Indigenous capacity.

Where should specialist medical colleges direct their efforts?

Building the internal capacity

For colleges to develop cultural safety within their organisation in an effective and efficient manner, they must first consider building their internal Indigenous capacity to support an equity-based approach.[20,21] This includes employing full-time (or part-time for smaller colleges) ongoing Indigenous college staff at different levels within the organisation, as has been identified and evidenced in clinical and tertiary education contexts.[22,23] Such staff should lead or have considerable input into curriculum development and cultural safety activities and guide the college in its pursuit of social justice. Colleges should also consider establishing an Indigenous strategy or framework, such as a Reconciliation Action Plan, that incorporates Indigenous ways of knowing, being and doing to guide the organisation in its activities. Furthermore, mandating cultural safety education and training for all college employees, regardless of their position, demonstrates an organisational commitment to cultural safety and social justice.[4]

The formation of an Indigenous committee that comprises a majority Indigenous membership, reports directly to the college Board, and holds considerable power to effect change within the organisation can substantially contribute to the cultural safety of the college.[6] Moreover, appropriately prioritising Indigenous health and cultural safety through regularly reviewing the college's structure and operational approach is also beneficial and will further enhance Indigenous governance within the college.

Building the desirability

Prospective and current Indigenous trainees and staff must perceive the college and training program as safe and attractive to fulfilling their needs and aspirations.[24] This includes providing opportunities for:

- economic support, such as scholarships, reduced exam fees, and conference attendance;
- cultural support, such as Indigenous college, trainee and Fellow mentors; special consideration policies for significant cultural occasions (eg, Sorry Business); and facilitating an Indigenous trainee network; and
- political support, such as establishing an Indigenous trainee committee that can report suggestions and concerns directly to the Board.

Prospective and current Indigenous trainees, Fellows and staff must feel a sense of belonging within the college, where their perspectives are valued and an understanding of unequivocal support is established.[25]

Building the training program

Within specialist medical training programs, there is an evident dearth of Indigenous health and cultural safety focus relative to core curriculum components, with many colleges opting to outsource such content from external organisations, such as online modules.[16] Although such educational methods can provide benefit, particularly during the early stages of intercultural development, a severe lack of critical transformative immersive opportunities with Indigenous peoples and communities can limit such development.[7] This is of particular concern to the construction of an understanding, albeit never fully appreciated, regarding the lived realities and diverse perspectives of Indigenous peoples, a significant component to the development of both cultural humility and cultural responsiveness.[7]

Ensuring both quality and quantity of these topics in the curriculum is vitally important to trainee and Fellow development, as well as Indigenous patient health care experiences and outcomes.[4] This involves allowing adequate space in the curriculum for content and pedagogical approaches that facilitate the development of cultural humility and critical consciousness. Furthermore, such education and training should be compulsory for all trainees, with any failed assessment components ideally denoting a failed grade or examination to reflect importance.

Building the continuing professional development program

Like college training programs, continuing professional development opportunities focused on Indigenous health and cultural safety are frequently offered in the form of online modules or one-off workshops that are detached from the required transformative immersive experience. Moreover, mandating such ongoing development, which is generally moving in a positive direction, must be expedited if culturally safe medical care for Indigenous peoples is to be realised. It must not be overstated that declaring such ongoing training compulsory for Fellows, regardless of their position within the specialty or broader medical sphere, is crucial for such realisation.[26]

Building and maintaining partnerships

Arguably the most important consideration to support college development in this space is the building and maintenance of reciprocal, trusting relationships and partnerships with a range of organisations, stakeholders and Indigenous community groups. These relationships and partnerships allow for the sharing of knowledge, experiences, lessons and resources, as well as enhancing capacity to develop quality resources through collaborative opportunities that are underpinned by shared values of trust and collegiality.[27] Relationships and partnerships are

inherently contextual and can take many forms, but must be reciprocal, particularly when Indigenous peoples and communities are involved. Within this context, such connections can and should be formed with other specialist medical colleges, universities and medical schools, and Indigenous-run and/or focused organisations such as NACCHO, LIME, AIDA, Te ORA, FNHA, NCIME, IPAC and AAIP.

Conclusion

Specialist medical colleges are prominently placed to promote, facilitate, and enact the principles of cultural safety within their institutions. If we are to close the gap in health outcomes between Indigenous and non-Indigenous communities, colleges must fully appreciate their role and the ongoing commitment required to realise such outcomes for its staff, members and the Indigenous community. Colleges must direct efforts to centre the development of critical allyship to support Indigenous peoples in managing cultural load, ensure Indigenous employees are respectfully engaged in the prioritisation of tasks and roles, and facilitate critical immersive activities for trainees and Fellows. They must always be conscious of the expectations of the Indigenous communities they profess to serve. It is not simply enough to undertake this journey as a reaction to the nudging stick of accreditation, rather it must be a genuine, proactive commitment that recognises the injustice of doing the bare minimum, progressing at a slow pace, or, worse, not progressing at all.

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1 Mithen V, Kerrigan V, Dhurrkay G, et al. Aboriginal patient and interpreter perspectives on the delivery of culturally safe hospital-based care. *Health Promot J Austr* 2021; 32: 155-165.

2 Australian Institute of Health and Welfare. Cultural safety in health care for Indigenous Australians: monitoring framework [Cat. No. IHW 222]. Canberra: AIHW, 2023. https://www.aihw.gov.au/reports/indigenous-australians/cultural-safety-health-care-framework (viewed Oct 2023).

3 Simmonds S, Carter M, Preval N, Wilson R. Baseline data capture: Cultural Safety, Partnership and Health Equity Initiatives: final report. Wellington: Medical Council of New Zealand, Te Ohu Rata o Aotearoa; 2020. https://www.mcnz.org.nz/assets/Publications/Reports/f5c692d6b0/Cultural-Safety-Baseline-Data-Report-FINAL-September-2020.pdf (viewed Feb 2024).

4 Curtis E, Jones R, Tipene-Leach D, et al. Why cultural safety rather than cultural competency is required to achieve health equity: a literature review and recommended definition. *Int J Equity Health* 2019; 18: 174.

5 Australian Medical Council. Standards for assessment and accreditation of specialist medical programs by the Australian Medical Council 2023. Canberra: AMC, 2023. https://www.amc.org.au/wp-content/uploads/2023/08/Standards-for-Assessment-and-Accreditation-of-Specialist-Medical-Programs-by-the-Australian-Medical-Council-2023-secured.pdf (viewed Oct 2023).

6 Browne AJ, Varcoe C, Lavoie J, et al. Enhancing health care equity with Indigenous populations: evidence-based strategies from an ethnographic study. *BMC Health Serv Res* 2016; 16: 544.

7 de Leeuw S, Larstone R, Fell B, et al. Educating medical students' "hearts and minds": a humanities-informed cultural immersion program in Indigenous experiential community learning. *Int J Indig Health* 2021; 16: 87-107.

8 Browne AJ, Varcoe C, Smye V, et al. Cultural safety and the challenges of translating critically oriented knowledge in practice. *Nurs Philos* 2009; 10: 167-179.

9 Sjoberg D, McDermott D. The deconstruction exercise: an assessment tool for enhancing critical thinking in cultural safety education. *Int J Crit Indig Stud* 2016; 9: 28-48.

10 Griffiths K, Coleman C, Lee V, Madden R. How colonisation determines social justice and Indigenous health — a review of the literature. *J Popul Res* 2016; 33: 9-30.

11 Reid P, Cormack D, Paine SJ. Colonial histories, racism and health — the experience of Māori and Indigenous peoples. *Public Health* 2019; 172: 119-124.

12 Hewlett N, Hayes L, Williams R, et al. Development of an Australian FASD Indigenous framework: Aboriginal healing-informed and strengths-based ways of knowing, being and doing. *Int J Environ Res Public Health* 2023; 20: 5215.

13 Zambas SI, Wright J. Impact of colonialism on Māori and Aboriginal healthcare access: a discussion paper. *Contemp Nurse* 2016; 52: 398-409.

14 Huria T, Palmer SC, Pitama S, et al. Consolidated criteria for strengthening reporting of health research involving indigenous peoples: the CONSIDER statement. *BMC Med Res Methodol* 2019; 19: 173.

15 Moodie PM. Aboriginal health. Canberra: Australian National University Press, 1973. https://openresearch-repository.anu.edu.au/handle/1885/114988 (viewed May 2024).

16 Australian Indigenous Doctors' Association. AIDA's cultural safety training. Canberra: AIDA. https://aida.org.au/cultural-safety-program/what-is-cultural-safety/ (viewed Oct 2023).

17 Australian Public Service Commission. Cultural load, it's a real thing! Canberra: Commonwealth of Australia, 2023. https://www.apsc.gov.au/working-aps/diversity-and-inclusion/diversity-inclusion-news/cultural-load-its-real-thing (viewed Oct 2023).

18 United Nations General Assembly. United Nations declaration on the rights of Indigenous peoples. Geneva, Switzerland: UN, 2007. https://social.desa.un.org/sites/default/files/migrated/19/2018/11/UNDRIP_E_web.pdf (viewed Oct 2023).

19 Nixon SA. The coin model of privilege and critical allyship: implications for health. *BMC Public Health* 2019; 19: 1637.

20 Phillips G, Brayshaw J, Fletcher M, Callister G. National Scheme's Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020–2025. Melbourne: Australian Health Practitioner Regulation Agency, 2020. https://www.ahpra.gov.au/About-Ahpra/Aboriginal-and-Torres-Strait-Islander-Health-Strategy/health-and-cultural-safety-strategy.aspx (viewed Oct 2023).

21 National Aboriginal and Torres Strait Islander Health Workers Association. Cultural Safety Framework. Canberra: NATSIHWA, 2016. https://www.naatsihwp.org.au/sites/default/files/natsihwa-cultural_safety-framework_summary.pdf (viewed Oct 2023).

22 Taylor EV, Lyford M, Parsons L, et al. "We're very much part of the team here": a culture of respect for Indigenous health workforce transforms Indigenous health care. *PLoS One* 2020; 15: e0239207.

23 Universities Australia. Universities Australia Indigenous Strategy 2022–25. Canberra: UA, 2022. https://www.universitiesaustralia.edu.au/wp-content/uploads/2022/03/UA-Indigenous-Strategy-2022-25.pdf (viewed Oct 2023).

24 Oliver R, Rochecouste J, Bennell D, et al. Understanding Australian Aboriginal tertiary student needs. *Int J High Educ* 2013; 2: 52-64.

25 Joy-Correll K, Nevill E, Bird-Matheson H, et al. Barriers and facilitators for Indigenous students and staff in health and human services educational programs. *Adv Health Sci Educ Theory Pract* 2022; 27: 501-520.

26 Wylie L, McConkey S, Corrado AM. It's a journey not a check box: Indigenous cultural safety from training to transformation. *Int J Indig Health* 2021; 16: 314-332.

27 Bailey S, Hunt J. Successful partnerships are the key to improving Aboriginal health. *NSW Public Health Bull* 2012; 23: 48-51. ■

Supporting Information

Additional Supporting Information is included with the online version of this article.