LITERATURE AND ENVIRONMENTAL SCAN OF CULTURAL SAFETY IN MEDICAL TRAINING

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Te Kaunihera o Ngā Kāreti Rata o Aotearoa
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TE OHU RATA O AOTEAROA
TeORA
MĀORI MEDICAL PRACTITIONERS

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Executive Summary

Purpose

The purpose of this literature and environmental scan is to identify cultural safety education and training initiatives available in the health sector in Aotearoa and internationally and assess what can be learnt regarding 'what works' to support doctors to practice in a culturally safe way. It addresses three research questions:

- What cultural safety education and training initiatives in the health sector (and other comparable sectors) are being provided in Aotearoa and other jurisdictions?
- To what extent do the education and training initiatives currently available in Aotearoa focus on 'cultural safety' versus 'cultural competence' and what is the place of Hauora Māori teaching in medical colleges?
- What are the characteristics of education and training entities, initiatives and assessment methods that evidence shows best meet the cultural safety training needs of doctors?

Method

This literature scan incorporates information from 41 journal articles and reports, which were used to provide a summary of evidence in relation to the research questions. Although comprehensive, the search was not systematic. Therefore, the literature scan may be missing some relevant studies or documentation.

The environmental scan identified and reviewed 24 publicly available materials related to cultural safety and cultural competence training for doctors, including medical college curricula, continuing professional development (CPD) programmes, and course outlines from training providers.

The scan was supplemented by interviews with representatives (such as academic advisors or training officers) from a sample of six medical colleges. In order to gather feedback from a range of college contexts, the sample of six colleges included: Australasian and Aotearoa-specific colleges; colleges of different sizes, including one considered 'very small'; colleges with low Māori representation amongst trainees and fellows, and one with higher Māori representation; and colleges in specialisations that have close contact with patients, and those that do not.

Key findings

What is currently provided

1. The majority of 'cultural safety training' currently offered to doctors in Aotearoa is within the realm of cultural competence, rather than cultural safety

Cultural competence and Hauora Māori are emphasised as core aspects of medical education in Aotearoa. Curriculum content primarily fits within the cultural competence domain, with a focus on teaching knowledge, skills and behaviours to prepare doctors to effectively interact in cross-cultural settings. Aspects relating to cultural safety generally emphasise engagement in self-reflection and self-awareness, however, there is a gap in provision of learning regarding racism, privilege, prejudice, discrimination and bias. Further, the behaviour of the individual is emphasised in the doctor-patient interaction with little to prompt critique and action to dismantle structural factors. While some colleges interviewed had learning materials defining cultural safety, interviews generally showed a lack of clarity on definitions and distinctions. The 2019 Statement on *Cultural Safety* has impacted medical colleges and has led some to review and/or change their curriculum, while other colleges still use the term 'cultural competence'.

2. Education and training in Aotearoa draws from a mixture of didactic, interactive, and experiential modes of learning

All colleges in Aotearoa expect trainee doctors to participate in cultural competence and safety learning. Cultural safety training and education in Aotearoa draws from didactic, interactive, and experiential methods. Most colleges use online learning as a key didactic method. Interactive learning receives less emphasis. Though peer group discussions and practice audits are a key part of training programmes, cultural safety is generally an aspect rather than focus of these discussions. Some of the interviewed colleges offer combined didactic and interactive learning through the MIHI 501 course, which fits within cultural competence and Hauora Māori domains and is highly regarded. Colleges value experiential learning as a way of encouraging learning to reflect on privilege, prejudice and bias. For some colleges this takes the form of mandated noho marae participation or placements with Māori health providers.

3. Cultural competence and Hauora Māori are integrated and immersed within college curricula in Aotearoa

The literature emphasises the importance of using a combination of immersed specified content, integration of cultural safety in relation to other aspects of curriculum, and independent self reflection integrated with cultural safety theory and clinical experience. In Aotearoa, all curricula reviewed by this study included immersed learning modules focusing on Hauora Māori, Indigenous health, health equity, cultural competency and/or safety. Representatives from the colleges perceived these as key to developing culturally safe practice in their trainees, emphasising the importance of integrated learning. Representatives reported that Indigenous health issues are embedded across all areas. Immersed topics mostly fit within cultural competence and Hauora Māori, with less emphasis on cultural safety.

Colleges are mostly aware of this and expressed the desire for learning material

on training and education for cultural safety. College representatives also discussed and emphasised the importance of placements and provision for independent learning as a means of integrated cultural safety development.

4. There is no standardised approach to the assessment of cultural safety

The literature shows that assessment mechanisms focus on knowledge and skill acquisition, attitudinal change, and perceived ability to deliver culturally competent care. There is little discussion in the literature regarding assessment of behavioural change, though behavioural change can be encouraged and reinforced through frequent assessment and feedback, prompting continued effort and commitment to change. There is lack of standardised methods and tools to assess doctor provision of culturally safe or competent care. Assessment methods rely on self-report tools, many of which have not been validated and are subject to biases. Other assessment methods include observations, examinations, assignments, case scenarios, reflection journals, informal presentations, group discussions, essays, and critical analysis. Very few assessment methods assess culturally safe practice from a patient perspective.

5. The effectiveness of cultural safety and competency training as a means to eliminate disparity is not well understood.

This review did not identify any studies that directly investigate whether cultural safety training reduces health outcome inequity, indicating a lack of research focus in this area. Effectiveness of cultural safety training and education as a means to eliminate disparities is therefore not well understood. The scan revealed only a small amount of evidence that participation in cultural safety or competence training results in improved knowledge of cultural factors impacting practice, improved attitudes, improved communication and relationship building, and improved reflections on held stereotypes, values and privileges. Studies that reported these improvements often had weak methodological rigor and were largely based on clinician self-reported data, rather than patient experience data.

Furthermore, few cultural safety programmes have undergone long term evaluation therefore there is little to no available evidence of cultural safety training leading to substantiated change. There has also been little research on relationships between cultural safety training, patient experience/satisfaction, and equity of outcomes. Hence, the evidence base regarding the extent to which cultural safety education results in improved patient-related outcomes is weak.

6. Organisational position statements on cultural safety are vital to support culturally safe practice

The evidence shows that relying on education and training of doctors to enhance the cultural safety of doctors is inadequate as a stand-alone strategy to improve equity of health outcomes. Achieving more equitable health outcomes also requires structural changes at the organisational level, to reinforce and sustain behavioural change in doctors. Medical colleges, accredited training institutions and entities that employ doctors need to develop an organisational approach to culturally safe practice. Most medical colleges in Aotearoa have a position statement or policy that focuses on cultural competency, Indigenous health, or Māori health, which sets out a commitment to culturally competent practice at

an organisational, systemic and individual level. However, interviewees reported mixed experiences regarding the extent to which their college had embraced organisational level cultural safety actions and initiatives.

7. Longer term education and training programmes are key to allow absorption of meaningful information relating to cultural competency and cultural safety

The evidence suggests that long term education and training programmes are more effective than short or one off learning opportunities, which are critiqued as being inadequate at providing opportunity to meaningfully absorb information. The literature indicates that didactive and interactive aspects of most cultural competence and cultural safety initiatives are given within 36 hours (or less) of formal learning time. In the experiential domain, duration ranged from one to five days. Aotearoa findings from the present study reflect this evidence. 'Immersed' didactic and interactive components of vocational programmes were allocated between 3 and 28 hours. Interviewees in this study state that more time is spent by trainees in undertaking reflection and learning related to cultural safety and competence as opposed to the time that is spent in formal courses.

1. Introduction

1.1 Purpose

This literature and environmental scan is an input into the development of a cultural safety training plan for medical colleges in Aotearoa. The purpose is to identify what cultural safety education and training initiatives are available in the health sector in Aotearoa and internationally and assess what can be learnt regarding 'what works' to support doctors to practice in a culturally safe way.

This work builds on findings from previous work including the *Choosing Wisely means Choosing Equity*[1] report completed as part of the Choosing Wisely campaign, which identified that cultural safety is a pre-requisite for shared decision-making between clinicians and consumers. It also builds on *Cultural safety within vocational medical training*[2] , a report commissioned by CMC in conjunction with Te ORA.

1.2 The Research Questions

The literature scan and environmental scan have been framed around the following questions:

- What education and training initiatives in cultural safety in the health sector (and other comparable sectors) are being provided in Aotearoa and other jurisdictions?
- To what extent do the education and training initiatives currently available in Aotearoa focus on 'cultural safety' versus 'cultural competence'? What is the place of Hauora Māori teaching in medical colleges?3
- What are the characteristics of education and training entities, initiatives and assessment methods that evidence shows best meet the cultural safety training needs of doctors?

1.3 Definition of cultural safety

This research has used two key definitions of cultural safety. The Medical Council of New Zealand's definition of cultural safety, as provided in the Statement on cultural safety (2019) is:

> *The need for doctors to examine themselves and the potential impact of their own culture on clinical interactions and healthcare service delivery. The commitment by individual doctors to acknowledge and address any of their own biases, attitudes, assumptions, stereotypes, prejudices, structures and characteristics that may affect the quality of care provided. The awareness that cultural safety encompasses a critical consciousness* where healthcare professionals *and healthcare organisations engage in ongoing self-reflection and self-awareness and hold themselves accountable for providing culturally safe care, as defined by the patient and their communities.*

The Statement had been informed by Curtis and colleagues (2019) who in Why cultural safety rather than cultural competency is required to achieve health equity define cultural safety as:

> *Cultural safety requires healthcare professionals and their associated healthcare organisations to examine themselves and the potential impact of their own culture on clinical interactions and healthcare service delivery. This requires individual healthcare professionals and healthcare organisations to acknowledge and address their own biases, attitudes, assumptions, stereotypes, prejudices, structures and characteristics that may affect the quality of care provided.*
>
> *In doing so, cultural safety encompasses a critical consciousness where healthcare professionals and healthcare organisations engage in ongoing self-reflection and self-awareness and hold themselves accountable for providing culturally safe care, as defined by the patient and their communities, and as measured through progress towards achieving health equity. Cultural safety requires healthcare professionals and their associated healthcare organisations to influence healthcare to reduce bias and achieve equity within the workforce and working environment.*

These current definitions of cultural safety owe much to Irihapeti Ramsden and Māori nurses' seminal work in the 1990s (Papps & Ramsden 1996, cited in Curtis et al., 2019), which defined cultural safety as:

> *A focus for the delivery of quality care through changes in thinking about power relationships and patients' rights.*

Rooted in Critical Theory, Ramsden's work urged nurses to strive for social justice and was committed to 'unmasking oppressive ideologies' and employing 'self-reflection and critical consciousness' to be rid of biases, assumptions, stereotypes and prejudices. Ramsden describes the importance of examining one's own psychological interior as a start-point for transformative action. It was she who suggested that the 'culturally safe environment' was determined by the patient and that the 'culturally safe practice' could be measured by systematic clinical audits of health outcomes.

These definitions have framed our understanding of cultural safety, and have formed the basis of a rubric that differentiates cultural safety, cultural competence, and Hauora Māori. The rubric is provided in table 2, section 3.2.

It should be noted that the term 'cultural safety' is predominantly used in Aotearoa, likely reflecting its origins in Ramsden's work arising from nursing practice in Aotearoa. Other jurisdictions typically focus on cultural competence and related concepts including cultural sensitivity, cultural appropriateness and cultural awareness. Where evidence from the literature describes aspects of education and training that fit within the 'cultural safety' domain of the rubric, but are labelled as 'cultural competence' or a related term, this is noted within the report.

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1 https://journal.nzma.org.nz/journal-articles/choosing-wisely-means-choosing-equity
2 https://www.cmc.org.nz/media/w0be4zv5/final-te-ora-cmc-cultural-safety-report-20210512.pdf
3 This question is particularly important to explore, given that cultural competence training and the teaching of Hauora Māori courses in medical schools has been a priority for the past two decades

2. Method

2.1 Literature scan

The literature search was conducted using the following databases: Google Scholar, ERIC, ProQuest, PsycINFO, and Scopus. To conduct the search, we used combinations of subject/index terms and key words. All search terms used in the literature scan are provided in Table 1. Searches were conducted using all possible combinations from each of the columns.

Table 1: Search terms

SEARCH TERM 1	SEARCH TERM 2	SEARCH TERM 3
Cultural safety	Training	Doctor
Cultural competency*	Education	Medic*
Cultural appropriate*	Support	Health
Cultural sensitivity	Planning	Healthcare
Hauora Māori	Service delivery	Health pract*
Indigenous	Practice	Health professional
Equity	Initiative	Nurse
Te Tiriti	Professional development	Midwife
Treaty of Waitangi	Wānanga	Social work*
Tikanga Māori	Course	Kaiāwhina
Bias	Continuing professional development/CPD	Whānau ora navigator
Racism	Recertification	Clinician
Colonis*	Continuingmedical education/CME	
	Regular practice review/RPR	

Publication date parameters were set at January 2011 or more recent, with exceptions being:

- literature accessed via snowballing, where such literature provided unique or important evidence; and
- kaupapa Māori research.

The literature relating to the jurisdictions of Aotearoa, Australia, Canada; the United Kingdom and the United States was considered in scope. The initial search of the academic literature returned 2,092 articles. The search was conducted in Google Scholar. The four other search engines used (ERIC, ProQuest, PsycINFO, and Scopus) provided either a very modest number of additional articles or no additional articles.

The results were reviewed in-situ, at abstract level, with approximately 150 promising articles then accessed in full-text. Full-text articles were imported to NVivo (via Zotero), where they were scanned and thematically coded to ascertain their relevance for addressing one or more of the research questions. Roughly 20 further articles that

had been published in peer reviewed journals were accessed in full-text, snowballing from scanned articles.

Six systematic reviews are amongst the inclusions. Their reference lists were cross-checked against the scanned literature so that full-text articles could be excluded from the inclusions list, on the basis that relevant key findings are incorporated in one or more of the included systematic reviews. Further documents were excluded for various reasons, including the body of the article not being written in English, and articles only tangentially considering cultural competence and cultural safety in doctor education and training. This left a total of 41 articles included in the final literature scan.

2.2 Environmental scan and interviews with college representatives

An internet search was completed to access publicly available materials related to cultural safety and cultural competence training for doctors. This search identified 24 items including medical college curricula, CPD programmes, and course outlines from training providers.

The above search was supplemented by interviews with representatives (such as academic advisors or training officers) from a sample of six medical colleges in Aotearoa. In order to gather feedback from a range of college contexts, the sample of six colleges included: Australasian and Aotearoa-specific colleges; colleges of different sizes, including one considered 'very small'; colleges with low Māori representation amongst trainees and fellows, and one with higher Māori representation; and colleges in specialisations that have close contact with patients, and those that do not. The interviews were conducted online and sought information about curriculum requirements for cultural competence and cultural safety training, and CPD standards. Copies of the training materials were also sought for review.

2.3 Limitations

When considering the information provided in this literature scan, it is important to recognise that, although the search of the literature was relatively detailed and extensive, it is likely that some research or reports that address the key research areas were not identified in the search, and are therefore not included in this report.

Additionally, reviewed articles and reports were not formally assessed for quality, therefore no formal indication is able to be made regarding the strength of the evidence presented in the report. That said, many of the articles and documents included in this literature scan were systematic or narrative reviews of the existing literature, which are generally more reliable than individual case reports or empirical studies. Where information has been sourced from individual studies, we have attempted to address these limitations by clearly indicating the source of information presented. However, it is important that the information presented from non-systematic reviews or individual studies is interpreted with caution.

3. Key Findings

This section describes the key findings of the literature scan, and then outlines key themes that emerged from the interviews and environmental scan regarding the delivery of cultural safety education and training in Aotearoa.

3.1 Organisational position statements on cultural safety

Findings from the literature

There is a body of evidence stating that current cultural safety education and training for doctors is inadequate as a stand-alone strategy to enhance cultural safety in doctor practice and thereby improve equity of health outcomes (Clifford et al., 2015, 2017; Curtis et al., 2019; Laverty et al., 2017; Lenette, 2014; Truong et al., 2014).

Training and education focuses on individual doctor practice but the clinician-whānau interaction is only one aspect of supporting whānau to feel culturally safe. It is also vital for medical colleges, accredited training providers and entities that employ doctors to be culturally safe at the organisation level and there are a number of strategies for this (Berg et al., 2019; Clifford et al., 2015, 2017; Curtis et al., 2019; Downing et al., 2011; Laverty et al., 2017; Lenette, 2014; Matheson et al., 2018; Palmer et al., 2019; Shepherd, 2019; Truong et al., 2014).

The extent to which training and employment entities are themselves practicing cultural safety can either encourage or impede an individual doctor's ability to put into practice their learnings during interactions with whānau (Alizadeh & Chavan, 2016). Organisational ethno-centrism can deter doctors from using their understandings around culturally safe practice; whereas culturally safe practice is encouraged in organisations in which cultural safety is embedded in the policy documentation, procedures, and physical settings of the organisation (Truong et al., 2014). Achieving more equitable health outcomes requires structural changes at the organisational level, to reinforce and sustain behavioural change in doctors (Clifford et al., 2015, 2017).

There is a need for colleges, accredited training institutions and entities that employ doctors to develop an organisational approach to culturally safe practice (Clifford et al., 2015, 2017; Curtis et al., 2019; Dargaville, 2020; Matheson et al., 2018; Truong et al., 2014). Embedding cultural safety into policy documents, such as position statements and strategic plans, is more likely to result in sustained change within organisations (Truong et al., 2014). In Aotearoa, this requires developing and implementing documentation that meets Te Tiriti o Waitangi obligations through recognising and taking action to support equitable health outcomes for Māori (Waitoki, 2012).

Curtis and colleagues (2019) provide specific steps that organisations need to take to operationalise cultural safety. These include undertaking a self-review of the extent to which they meet expectations of cultural safety at an organisational level and identifying an action plan for development. This is supported by Jones et al

(2019), writing in the context of Indigenous health equity, who state that this must be formalised as part of institutions' policies, plans, and processes. Commitment to health equity and cultural safety should be explicit within the organisational vision, mission statements, strategic priorities, and strategies.

The current situation in Aotearoa

The environmental scan found that most medical colleges in Aotearoa have a position statement or policy that focuses on cultural competency, Indigenous health, or Māori health. These documents acknowledge college obligations under Te Tiriti o Waitangi (and other documents such as the Uluru Statement of the Heart, the Close the Gap Statement of Intent, and the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP)). The content of the position statements and policies typically set out a commitment to health equity and a commitment to culturally competent practice at an organisational, systemic and individual level.

A small number of colleges specifically have a position statement on cultural safety. Interviews with college representatives found that they were aware that cultural safety is an important enabler to health equity and stated an intent to align their documentation with the MCNZ statement on culturally safe care as part of the next review cycle.

Representatives from all six colleges interviewed stated that they had taken practical steps to work towards both cultural safety and health equity for Māori. These included developing Māori health strategies, convening Māori/Indigenous health committees, dedicated Indigenous seats on the Board or Council, and developing toolkits of cultural competence resources. Three of the six colleges had employed Indigenous people in roles intended to lead the implementation actions to support health equity.

These strategies had been examined in Cultural safety within vocational medical training in 2019 at which time governance positions for Māori and strategic planning including Treaty of Waitangi statements were poorly developed.

Interviewees reported mixed experiences regarding the extent to which their college had embraced cultural safety actions and initiatives. Four of the six college representatives reported that their college leadership strongly supported moves to increase the cultural safety of their organisation and its staff, fellows and trainees.

> *"I've seen authentic progress across and embedded in the entire organisation. The Board is committed and it [cultural safety] is espoused in the way that the college operates. It's not just 'tick box' (Interview, medical college representative).*
>
> *We have a good set of people and managers who have a commitment in this space, have worked tirelessly and see it as a responsibility to meet Treaty obligations. The leadership in Melbourne are fully on board." (Interview, medical college representative).*

The representatives of the two other colleges highlighted challenges in getting the college as a whole to embrace a focus on cultural safety.

> *"As a trans-Tasman college, we have to be tenacious. Over time, our*

Australian colleagues have become more receptive, and seen the value. New Zealand management is part of the leadership team and always brings it up." (Interview, medical college representative).

3.2 Curriculum content: Cultural competence or cultural safety?

The findings from this literature scan and environmental scan show that most of the training and education currently being offered to doctors in Aotearoa and other jurisdictions is within the realm of cultural competence.

Defining cultural safety

There is debate in the literature regarding how cultural safety is differentiated from cultural competence, cultural awareness, cultural sensitivity, and other related areas. Several authors that write specifically about cultural safety posit that the key area of differentiation is that cultural safety is a philosophical orientation (Waitoki, 2012) that requires doctors to develop a critical consciousness (Curtis et al., 2019; Dao et al., 2017; Dargaville, 2020; Kirmayer, 2012; Sjorberg & McDermott, 2016; Truong et al., 2014; Watt et al., 2016).

Curtis et al (2019) provided a seminal definition of cultural safety that is the basis of the 2019 Medical Council of New Zealand Statement on Cultural Safety. This provides a guiding framework for many medical colleges. It states that cultural safety requires that doctors:

- examine themselves and the potential impact of their own culture on clinical interactions and healthcare service delivery
- acknowledge and address their own biases, attitudes, assumptions, stereotypes, prejudices, structures and characteristics that may affect the quality of care provided
- engage in ongoing self-reflection and hold themselves accountable for providing culturally safe care, as defined by the patient and their communities
- influence healthcare to reduce bias and achieve equity within the workforce and working environment.

This focus on developing a critical consciousness and examining power imbalances is particularly emphasised by other authors. Cultural safety training exposes the way in which power relations play a part in shaping health care relationships (Downing et al., 2011), prepares practitioners to challenge these unequal power relationships (Kurtz et al., 2018) and redress this dynamic by making the clinician's cultural underpinning a critical focus for ongoing reflection (Laverty et al., 2017).

In Aotearoa, despite the recent emphasis on cultural safety, researchers and academics have stressed the importance of also retaining a focus on cultural competence and Hauora Māori as core components of medical education (Curtis et al., 2019; Huria et al., 2017; Jones et al., 2010, 2019).

In order to appreciate cultural safety, the rubric overleaf examines definitions, key features, intended outcomes of teaching and assessment of the three areas of 'cultural safety', 'cultural competence', and 'Hauora Māori'. It specifies the key features of training initiatives within each category, demonstrating the similarities, differences and relationships between these three areas.

Table 2: Rubric describing key features of cultural safety, cultural competence and Hauora Māori

CULTURAL SAFETY	CULTURAL COMPETENCE	HAUORA MĀORI
FEATURE: Theoretical/ epistemological basis		
Cultural safety arose from a desire by Māori nurses, led by Irihapeti Ramsden, to improve the health of whānau Māori (Curtis et al., 2019; Ramsden cited in Waitoki, 2012). Building on postcolonial, social justice and critical theory paradigms, cultural safety is centred on "critical consciousness"t in clinical practice (Curtis et al., 2019; Dao et al., 2017; Dargaville, 2020; Kirmayer, 2012; Sjorberg & McDermott, 2016; Truong et al., 2014; Watt et al., 2016). It challenges and aims to displace structures of power that reinforce inequity and oppression (Dargaville, 2020; Downing et al., 2011; Kurtz et al., 2018; Laverty et al., 2017). Cultural safety offers understanding and pragmatic action in the internal, interpersonal (horizontal), and structural (vertical) domains to address the ways in which colonial processes and structures shape and negatively impact Māori health (Downing et al., 2011). Patients and whānau are situated as the definers of culturally safe care (Dargaville, 2020).	Cultural competence has multiple theoretical underpinnings, from ethnography to critical medical anthropology (Dargaville, 2020). It provides a philosophical orientation from where practitioners can recognise, respect and respond to the relevant socio-political dynamics of ethnicity and principles of cultural socialisation (Sue, 2006, cited in Waitoki, 2012). Cultural competence has been critiqued as an 'individualised, knowledge-based approach' towards understanding the cultural 'other' (Dargaville, 2020).	The philosophical underpinnings of Hauora Māori include Mātauranga Māori (traditional Māori knowledge), Māori world views and traditional Māori values. Hauora Māori acknowledges the colonial context of the health circumstances for tāngata whenua, including socio-political factors and structural racism in Aotearoa. Health is considered a property of the collective rather than the individual, and is holistically viewed, incorporating physical, mental, emotional, spiritual, and whānau dimensions, and the relationship with whenua and environment. In a contemporary context, Hauora Māori considers power dynamics, decision-making and resource distribution, as well as the impact of and relationship with the health systems and other systems in Aotearoa. The diversity of individual and whānau Māori is recognised.
FEATURE: Key features of training initiatives		
Examination of the relationships that influence patient-practitioner interactions (e.g., sources of repression, social domination, colonisation, power, privilege and racism) (Curtis et al., 2019). This aspect of the cultural safety training and education curriculum may include the following topics: • Historical context of colonisation, armed conflict, forced assimilation (Jones et al., 2010; Dargaville, 2020; Sundberg et al., 2019) • Contemporary societal, institutional, legal, and political power structures that continue to undermine Māori health equities (Dargaville, 2020; Kurtz et al., 2018; Medical Council of New Zealand, 2019; Sundberg et al., 2019; Waitoki, 2012). • Examination of the power dynamics within health consultations (Downing et al., 2011; Jennings et al., 2018; Kirmayer, 2012; Kurtz et al., 2018).	**Continued acquisition of information about other cultures** This aspect of the cultural competence training and education curriculum may include the following topics: • Acknowledgement of difference (Dargaville, 2020). • Exploring Indigenous (Māori) cultural beliefs, values and practices (Alizadeh & Chavan, 2016; Clifford et al., 2017b; Huria et al., 2017; Waitoki, 2012). • Re-presenting Māori history, colonisation from Māori perspective (Huria et al., 2017). • Understanding the contexts in which Indigenous populations live and the impacts of these contexts on health outcomes (Clifford et al., 2017b).	This aspect includes the following topics: • Knowledge of the contemporary Māori health situation (Clifford et al., 2015; Huria et al., 2017; Jones et al., 2010), inequities in both health and the wider determinants of health. • Using Māori health frameworks within clinical practice and having opportunity to apply these to their clinical practice. e.g. Meihana model, Hui Process. (Huria et al., 2017). • Engaging appropriately with Māori patients, whānau and communities (Jones et al., 2010). • Te reo Māori. • Tikanga Māori, and the diversity of Māori beliefs, values and experiences.

CULTURAL SAFETY	CULTURAL COMPETENCE	HAUORA MĀORI
FEATURE: Key features of training initiatives (Continued)		
• Examination of the power dynamics within health consultations (Downing et al., 2011; Jennings et al., 2018; Kirmayer, 2012; Kurtz et al., 2018). • Strategies that challenge the barriers to clinical effectiveness arising from power imbalances (Kurtz et al., 2018; Laverty et al., 2017). • The sources and impacts of racism (White-Davis et al., 2018). **Acknowledgement of one's own culture, values, beliefs and history and how this influences conscious and unconscious assumptions** (Curtis et al., 2019). This aspect of the cultural safety training and education curriculum may include the following topics: • Awareness of trainees' own ethnic-cultural heritage values and history (Dargaville, 2020; Downing et al., 2011; Medical Council of New Zealand, 2019; Ramsden 2002, cited in Waitoki, 2012). • Acknowledgement of biases, attitudes, assumptions, stereotypes, prejudices, and characteristics (Jennings et al., 2018; Kirmayer, 2012; Watt et al., 2016). • How these values, heritage, attitudes and biases manifest in their practice, potentially affecting the quality of care provided to Māori (Downing et al., 2011; Jennings et al., 2018; Watt et al., 2016). • Reflection on the position of trainees' within a health system complicit in ongoing colonisation and control of Māori (Dargaville, 2020; Jennings et al., 2018)	**Awareness of ones' own views and biases** This aspect of the cultural competence training and education curriculum may include the following topics: • Identifying ethnocentric, biased and prejudiced attitudes and beliefs towards other cultures (Alizadeh & Chavan, 2016; Clifford et al., 2017b; Huria et al., 2017). • Reflections on existing assumptions and stereotypes about Indigenous patients (Barnabe et al., 2021; Huria et al., 2017). • Discussions on the social, cultural and economic benefits of cultural diversity (Clifford et al., 2017b). **Knowledge and skills to work effectively within a cross-cultural context or situation** This aspect of the cultural competence training and education curriculum may include the following topics: • Skills and knowledge to accommodate the cultural preference of patients (Barnabe et al., 2021, 2021, 2021; Dargaville, 2020; Jones et al., 2010; Medical Council of New Zealand, 2019; Watt et al., 2016). • Knowledge of cultural protocols, beliefs, and language to facilitate engagement with patients during clinical encounters (Alizadeh & Chavan, 2016; Clifford et al., 2017b; Huria et al., 2017). • Communication skills and confidence to ask about cultural expectations and traditional practices, including pronouncing names correctly (Alizadeh & Chavan, 2016; Barnabe et al., 2021, 2021).	• Historical events and contemporary factors that contribute to the health situation for Māori (Jones et al., 2010; Dargaville, 2020). • Data sovereignty, data interpretation and the importance of high quality, timely data to determine resource distribution. • Te Tiriti o Waitangi, rights to health including UNDRIP2007.

CULTURAL SAFETY	CULTURAL COMPETENCE	HAUORA MĀORI
FEATURE: Key features of training initiatives (Continued)		
Engagement in ongoing self-reflection and self-awareness (Curtis et al., 2019). This aspect of the cultural safety training and education curriculum may include the following topics: • Development of a critical stance in examining their own identity and the cultural underpinnings that they bring to clinical interactions and healthcare service delivery (Dargaville, 2020; Downing et al., 2011; Laverty et al., 2017b; Medical Council of New Zealand, 2019; Waitoki, 2012). • Assisting trainees to practice reflexivity, undertake ongoing self-reflection, and hold themselves accountable for providing culturally safe care, as defined by the patient and their communities (Dargaville, 2020; Medical Council of New Zealand, 2019; Sjorberg & McDermott, 2016; Waitoki, 2012; Watt et al., 2016). **Recognition that cultural safety praxis requires commitment and action at all levels of the health and disability system (Curtis et al., 2019)** This aspect of the cultural safety training and education curriculum may include the following topics: • Analysis of the culture of the healthcare system and health practitioners themselves (Jennings et al., 2018). • Identifying sites of structural oppression that (re)inscribe the dominant discourse and understanding its influence on one's own social positioning (Dargaville, 2020; Kirmayer, 2012). • Identifying ways to influence healthcare to reduce bias and achieve equity within the clinical environment (Jennings et al., 2018; Watt et al., 2016)		

CULTURAL SAFETY	CULTURAL COMPETENCE	HAUORA MĀORI
FEATURE: Key features of training initiatives (Continued)		
Examination of inequity and disparities This aspect of the cultural safety training and education curriculum may include the following topics: • Acknowledging the existence of ethnic inequalities in health (Jones et al., 2010; Maldonado et al., 2014; Sundberg et al., 2019; Waitoki, 2012). • Critically analysing the social determinants of health (Dargaville, 2020; Jones et al., 2019; Kirmayer, 2012; Sjorberg & McDermott, 2016). • Understanding how to reduce health inequalities (Dargaville, 2020; Jones et al., 2010; Maldonado et al., 2014; Waitoki, 2012).		
FEATURE: Intended Outcomes		
Works to effect systemic change, by exposing and confronting the discourses and assumptions that are used by the dominant structures and systems (Dargaville, 2020; Downing et al., 2011). Aims to develop self-aware health professionals who are culturally safe to practice, as defined by the people they serve (Dargaville, 2020; Kirmayer, 2012; Kurtz et al., 2018).	Empower patients to interact with the formal health care system (Butler et al., 2016; Waitoki, 2012). A reduction in health disparities caused by racial/ethnic discrimination (Truong et al., 2014).	Reduction in health disparities between the two Tiriti partners, Māori and tauiwi. Improved communication with and empowerment of Māori whānau and communities. Greater access for Māori to health care and the determinants of good health. Improved autonomy for Māori whānau and communities.
FEATURE: Assessment		
Assessment focuses primarily on behavioural and attitudinal change (Dargaville, 2020).	Assessment focuses primarily on knowledge and skill-based measures (Dargaville, 2020).	Assessment focuses on behavioural and attitudinal change, and encourages lifelong learning in reo, tikanga, Hauora Māori and communication skills.

Findings from the literature regarding curriculum content

Evidence from the literature related to Aotearoa and comparable jurisdictions (Australia, Canada and the United States) shows that curriculum content primarily sits within the cultural competence domain articulated in the rubric. It focuses on teaching knowledge, skills and behaviour to equip doctors to interact effectively in cross-cultural settings.

Much of the content of medical education and training related to culture focuses on equipping medical professionals with the communication and behavioural ability to interact effectively with culturally different people (Alizadeh & Chavan, 2016). For example, Downing et al. (2011) reviewed cultural training of professional health workers in Australia and found most Indigenous cultural training is based on what is labelled 'cultural awareness'. An Australian-based training programme focuses on awareness of power differentials in doctor-patient communication and techniques for effective communication with Indigenous Australians (Jennings et al., 2018). In Aotearoa, undergraduate and vocational training emphasise use of Māori frameworks such as the Hui Process to engage appropriately with Māori patients in clinical practice (Huria et al., 2017; Jones et al., 2010).

There is also a strong focus in education and training, both in Aotearoa and in overseas jurisdictions, on awareness of the context and determinants of Indigenous People's health status (Horvat et al., 2014; Maldonado et al., 2014). Key aspects of the curricula focus on recognising and deconstructing historical and contemporary colonisation (Huria et al., 2017; Jones et al., 2010; Kurtz et al., 2018). For example, a training programme in the United States examines how historical armed conflict, forced assimilation, and subsequent legal and political policy have shaped health within rural Native American and Alaska Natives communities (Sundberg et al., 2019). Undergraduate medical education in Aotearoa encourages students to consider colonisation from an Indigenous perspective (Huria et al., 2017).

Although typically named as 'cultural competence', there is increasing awareness in the literature of the need to train health practitioners to critically examine power structures, biases and how this manifests in their practice (Downing et al., 2011; Jennings et al., 2018; Kurtz et al., 2018; Maldonado et al., 2014). For example, a cultural competence course delivered by the University of Pennsylvania is centred on critical consciousness in clinical practice in the internal (reflection and understanding of biases, values, and previous experiences), interpersonal (relational communication skills, an appreciation of differing social positions, and a stance of humility and openness), and structural (institutions, norms, and configurations of power) domains (Dao et al., 2017). This may be because the label 'cultural safety' is very much an Aotearoa-specific phenomena and the aspects described above, which align more closely with the cultural safety domain of our rubric, are being absorbed into existing cultural competence programmes.

A recent study completed as part of a Masters of Public Health thesis in Aotearoa, completed under the supervision of Elana Curtis undertook a series of interviews with key informants providing training in primary care and nursing contexts in Aotearoa that transverse cultural competence and cultural safety (Dargaville, 2020). These found that the content aligned to cultural competency, cultural awareness, Te Tiriti o Waitangi, Māori health, health literacy and Culturally and Linguistically Diverse

(eCALD)[4] training. Curriculum design typically catered to individual knowledge and skill, and behaviour change and transformation, which are aspects of cultural competence. Key informants within her study stated that there is an absence or dilution of training content focused on the examination of power, privilege, bias, discrimination, racism and prejudice, which are considered to be critical aspects of cultural safety in Aotearoa. The study participants questioned whether the training content was sufficient to support cultural safety to doctor practice, and called for a stronger focus on interventions to teach critical consciousness.

The current situation in Aotearoa

Interviews with representatives from six medical colleges and a review of college documentation found that education and training is primarily within the cultural competence domain of the rubric. Medical college curricula and training delivery emphasises the acquisition of information about Māori/Aboriginal and Torres Strait Islander cultures and context. In Aotearoa this includes colonisation and its impacts, te Tiriti o Waitangi, Māori models of health such as Te Whare Tapa Whā; and the knowledge and skills to work effectively with Māori (tikanga Māori and cultural protocols, engagement frameworks such as the Meihana model and Hui Process). There is also emphasis within medical college curricula and training programmes on Hauora Māori (including knowledge of health inequities and the social determinants of health).

Where there is a focus on cultural safety within the curriculum and training mechanisms, it typically emphasises doctor engagement in self-reflection and self-awareness. This includes the use of tools to reflect on implicit bias, how this impacts doctor-patient engagement, and techniques for overcoming bias. Reflecting Dargaville's 2020 thesis, there is a gap in training and education related to privilege, discrimination, racism and prejudice. This indicates some aspects of Curtis and colleagues' 2019 definition of cultural safety are not reflected in the teaching and learning activities for cultural safety.

> *The registrars get feedback from their workplace supervisors on performance, including implicit bias. But beyond the Treaty workshops, there isn't any specific training on developing critical consciousness. (Interview, medical college representative).*

The interviews and environmental scan also show that the emphasis tends to be on the individual and their behaviour in a doctor-patient interaction. There is little within the education and training programmes of most colleges to prompt critique, exposure and action to dismantle structural factors that enforce inequities.

The interviews also suggest that there remains a lack of clarity on the definitions and distinctions between cultural safety, cultural competence, Hauora Māori and related topics. The terms were used interchangeably by some interview participants. In some instances, interview participants discussed cultural safety training initiatives that align more closely with the cultural competence rubric description. For example, several interviewees characterised teaching the Hui Process as a cultural safety activity; whereas this involves teaching intercultural engagement skills so based on our rubric

4 eCALD is an organisation that provides courses and resources for the New Zealand health workforce, focused on culturally and linguistically diverse groups who are migrants and refugees from Asian, Middle Eastern, Latin American and African (MELAA) backgrounds.

aligns more with cultural competence. Another college representative stated that their college saw cultural safety in broad terms, not just related to Indigenous populations. On the other hand, two of the college representatives interviewed, and their supporting documentation, indicated that their training and education materials provided a definition of cultural safety, its history and epistemology, and how it differs from cultural competence. Their curricula and training mechanisms included information and activities from both spheres.

The Medical Council NZ's 2019 Statement on Cultural Safety has made an impact on colleges and has prompted several to review or change their curriculum. One college stated that it had used the term cultural competence until 2019, and immediately aligned the language to the Medical Council definition – although noted that the content is still in the process of being reviewed. Representatives from two of the six colleges stated that their institution had undertaken an overhaul of their curriculum. Both reported that the Medical Council statement had been a key input into the review, and that their curriculum and training programmes now explicitly focused on cultural safety as well as Hauora Māori/Indigenous health and cultural competence. However, as noted above, our review of curriculum documents indicated the cultural safety elements primarily focused on bias and self-reflection, rather than dismantling structural oppression. The other three colleges still use 'cultural competence' terminology for their curriculum and do not reference cultural safety explicitly.

3.3 Modes of learning

The findings of two international systematic reviews of education, training or other interventions of enhanced cultural competence of health professionals (Clifford et al., 2015; Truong et al., 2014) found that the majority of education and training sessions were delivered using didactic, interactive and experiential methods. These are discussed below.

Didactic learning

Didactic learning includes class or lecture-based presentations, workshops, seminars and conferences. It can also include online training platforms and educational videos. Dargaville's (2020) research identifies a number of online tools and courses available in Aotearoa, including programmes by Mauri Ora Associates, the Health Quality and Safety Commission's Understanding Bias in Health Care, the Ministry of Health Foundation Course in Cultural Competency and Culturally and Linguistically Diverse training (eCALD). Dargaville's study noted that didactic methods including online tools are often a core component of vocational training and CPD requirements related to cultural safety in Aotearoa. Key informants within her research questioned the quality and efficacy of such training modes. These informants also noted a scarcity of workshops and seminars solely dedicated to cultural safety and that practitioners were more likely to engage in cultural safety learning as part of a plenary session within national and international conferences.

Interactive learning

Learning modes within the interactive domain include peer and group discussions, audit of practice, and simulation techniques such as role play (Barnabe et al., 2021; Dargaville, 2020; Huria et al., 2017). Peer group discussions are often a key component of cultural safety and competence training programmes. These are intended to

prompt self-reflection on recent experiences, consider the underlying assumptions of their decisions and allow for inquiry and critique from peers (Dargaville, 2020). The University of Pennsylvania's cultural competence course includes small-group peer discussion sessions using a facilitation model that emphasizes relational communication, vulnerability, and personal transformation. Peer group discussions are also part of undergraduate Indigenous health programmes in Aotearoa. Feedback shows that students valued the opportunity for interactive discussion and open and honest interactions in a safe learning environment (Huria et al., 2017). Experts in Dargaville's 2020 study recommend peer group sizes of between three and seven members, as this is enough members for diversity of insight and critique; whereas more than seven members risks diluting the intimacy required for authentic reflection.

Simulation techniques, such as role play, are also commonly used in cultural safety and cultural competence education. For example, the 'Educating for Equity (E4E)' programme, a continuing professional development intervention intended to improve Indigenous patient experiences and outcomes in healthcare interactions, facilitates application of related skills through case-based role-play (Barnabe et al., 2021). In undergraduate medical education in Aotearoa, simulated patient interviews provide students an opportunity to apply strategies they have been taught within a clinical scenario (Huria et al., 2017). Through feedback from teachers and peers, and self-reflection, learners are supported to identify and address power dynamics, bias and racism in clinical settings, explore their thought process and reflect on their reactions and decision-making (Dargaville, 2020).

Experiential learning

Experiential learning includes practicum and clinical placements, and excursion and immersion activities. In Aotearoa this generally encompasses immersion in Māori settings, such as noho marae and visits to, or placements in, Māori health providers (Dargaville, 2020; Huria et al., 2017).

Proponents of immersion activities note that it assists health professionals to understand the contexts in which culturally diverse populations live and the impacts of these contexts on health outcomes (Brock et al., 2019; Clifford et al., 2017b; Hart et al., 2015), and that it promotes 'cognitive disequilibrium', prompting trainees to re-evaluate their ideas about the world and better relate to the health needs of that community (Sundberg et al., 2019).

There is some evidence that cultural immersion activities improved students' attitudes towards interacting with Indigenous Peoples, improved knowledge and understanding of cultural differences, increased confidence in providing culturally competent health care, and enhanced ability to examine their own values and privileges (Brock et al., 2019; Clifford et al., 2017b; Hart et al., 2015).
Student feedback from immersed Indigenous health programmes in Aotearoa showed that it broadens their understanding of Māori culture, enables them to see its relevance within a healthcare setting, and increases their understanding of the relevance of Indigenous status to health (Huria et al., 2017; Jones et al., 2010). However, these studies relied on self-reported data from trainees. No evidence is available regarding perceptions of changes to the cultural safety of trainee practice as defined by the people they serve.

Critics of the approach note that immersion activities must be carefully managed and

include a mechanism that encourages trainees to reflect on their biases; otherwise it risks reinforcing 'othering' (Dargaville, 2020). In the context of placements at Indigenous health providers, the majority of learning is informal and takes place experientially; it is often unclear how cultural competence and cultural safety skills are developed and assessed in these placements (Watt et al., 2016).

Most cultural safety/cultural competence training and education programmes described in the literature draw from all three learning modes. For example, an Australian pilot programme providing training to general practitioners used a cultural safety workshop, a health worker toolkit, and partnerships with mentors from Indigenous organisations (Laverty et al., 2017). In the United States, an anti-racism intervention incorporated a didactic presentation, a video depicting racial and gender microaggression within a hospital setting, small group discussion, large group debrief, and presentation of a toolkit (White-Davis et al., 2018).

Training delivery

The literature identifies two key inter-related aspects of education and training delivery: the role of educators and the creation of safe learning spaces. It is vital that that educators, trainers and supervisors have enthusiasm and passion for cultural safety and accord the topic emphasis as a 'real science' on par with clinical aspects of practice (Huria et al., 2017).

Several studies also highlight the need for educators to create safe learning spaces. Cultural safety education requires the development of a critical consciousness and asks students to step into an 'emotionally charged zone' and explore the cultural underpinnings that they bring to the health encounter (Sjorberg & McDermott, 2016; Zaidi et al., 2017). If not managed carefully, this can induce negative emotional reactions such as 'white guilt', resentment, defensiveness and backlash (Shepherd, 2019; Truong et al., 2014). It is vital that educators and trainers avoid a 'shame and blame' approach (Shepherd, 2019) and effectively manage conflict and challenge, support learners in sustained dialogue and introspection; and provide pastoral care through the learning process (Dargaville, 2020; Sukhera & Watling, 2017; Zaidi et al., 2017). This reinforces the need for skilled educators with the ability to create safe learning spaces.

The current situation in Aotearoa

The environmental scan and discussion with representatives from medical colleges in Aotearoa found that cultural safety training and education typically draws from all three modes of learning outlined above. As noted by Dargaville (2020), didactic methods are a core component of vocational training in Aotearoa. Trainee doctors in all colleges are expected to participate in education and training seminars, courses, online learning and/or workshops related to cultural competence and cultural safety. Representatives from two of the six colleges described trainee seminars which define and discuss cultural safety, cultural competence and health equity; and set out their college's expectations for doctors related to these topics.

Online learning is a key didactic learning method for vocational training and CPD, used by most of colleges in Aotearoa. Several of the college representatives interviewed had commissioned the development of bespoke online modules that aimed to equip students to deliver culturally safe care within their speciality area. Modes of learning

include video interviews with doctors, Māori/Indigenous patients, and cultural experts, as well as case studies that reflect 'real life' examples of culturally competent/safe care in practice. Course descriptions suggested that the majority of training was skills-based and aligned with the cultural competence rubric description. One college has developed an online package to prompt trainees to reflect on and assess their cultural competence/safety practice, which is also used to provide guidance for training supervisors on how they can provide meaningful feedback to trainees.

Interactive learning, such as roles plays, peer group discussions, and audit of practice, were typically accorded less emphasis as a training and education mechanism by those interviewed. Role plays were sometimes used to reinforce didactic learning during workshops or seminars. Peer group discussion and practice audits are a core part of training programmes, but the evidence provided by colleges suggests that cultural safety is an aspect of these discussions/audits but not generally the central focus. One college is developing a tool to support registrars and fellows to do equity audits and self-reflection of their practice, which is due for release in early 2022.

Two of the colleges that participated in interviews had mandated the MIHI 501 course, run by Otago University, for their trainees. This combines didactic and interactive learning. Trainees first complete a series of self-directed online learning modules, followed by a face-to-face workshop or noho marae which includes practice with Māori patients and whānau. This course was highly regarded by both colleges as a way of enhancing trainee cultural safety:

> *Some [trainees] found it quite confronting, but positive in that it made them think about their practice with Māori. They really like the ability to immediately apply learning to practice. (Interview, medical college representative).*

Experiential learning is valued as a means to encourage trainees to reflect on their privilege and confront their prejudices and bias. Two of the colleges interviewed mandated participation in noho marae for vocational trainees. One interviewee described this as an important mechanism for orienting trainees to the college's expectations regarding equity and Hauora Māori, participate in cultural practices, learn tikanga, and reinforce the impacts of colonisation on health outcomes.

Representatives from all the colleges also highlighted placements in Māori health providers and/or communities with a high Māori population as a means to get lived experience of the Māori health context, impacts of social determinants on health and practical experience in using Māori models of engagement. The workplace-based training programmes are typically framed around a set of skills or competencies, which include cultural safety and/or cultural competence. Trainees are prompted to reflect on their development of these skills through mechanisms such as supervisor feedback and multisource feedback tools.

3.4 Curriculum structure

Findings from the literature

A seminal paper from Jones et al. (2010) emphasised the importance of using a combination of immersed, integrated and independent teaching and learning approaches. While Jones et al. were writing in the context of teaching Hauora Māori

to undergraduate medical students, their recommendations are highly applicable to cultural safety in vocational training.

In summary, Jones et al. describe three training approaches:

- Immersed: involves time allocated solely for the specified content (in this case, cultural safety), as opposed to teaching within other components of the curriculum.
- Integrated: involves incorporating cultural safety content into other parts of the curriculum. Jones et al. note that the ubiquitous nature of Māori health (and, implicitly, the need to practice in a culturally safe way) requires that it be addressed within learning components in subject areas such as population health, communication skills and quality and safety.
- Independent: encourages self-reflection and provides a supported platform for integrating [cultural safety] theory and concepts with clinical experience.

Jones et al. recommend combining immersed, integrated and independent approaches in a programme of education and training. Other studies have reached a similar conclusion; a systemic review of published evaluations of cultural competence education and training interventions targeting university based health professionals in training found evidence supporting the need for Indigenous health to be integrated within the broader curriculum and not as a stand-alone element (Clifford et al., 2017).

Dargaville (2020) recommended that cultural safety is integrated into vocational and CPD curricula both 'vertically' and 'horizontally'. Horizontal integration is defined as a curriculum that is dispersed across the learning continuum at any one point in time and vertical integration as a curriculum that is structured across grades and levels of competency (Connelly & Connelly 2013, in Dargaville, 2020).

The current situation in Aotearoa

All curricula reviewed include 'immersed' learning modules that focus on Hauora Māori, Indigenous health, health equity, cultural competence and/or cultural safety. For trainees, this typically includes completing mandatory online training modules, workshops or seminars in these topics. For example, one trans-Tasman college has developed a 'suite' of online modules which cover topics such as culturally competent care in [speciality], health literacy, and improving access for Indigenous patients. An Aotearoa-based college requires registrars to a do a masters course, which includes Hauora Māori as a mandatory paper and a two-day Treaty of Waitangi and health workshop. Others have mandated the MIHI 501 course. Another college has recently reviewed its curriculum to align with the Medical Council of New Zealand's Statement on Cultural Safety, adding new immersed learning domains in topics such as Te Tiriti o Waitangi in the context of Hauora Māori. As has been discussed in other sections of this report, college representatives highlighted these as the key mechanisms to build culturally safe practice within their trainee cohort. However, the immersed topics mainly fit within the cultural competence and Hauora Māori domains of the rubric.

All college representatives interviewed emphasised the importance of integrated learning. They stated that the trainee doctor programme embeds consideration of Indigenous health issues across all domain areas, such as delivering clinical care in a culturally safe way.

> *We expect our trainees to consider equitable outcomes for Māori across all*

areas. They are encouraged to ask: What is the state of Māori health in this area? What are our responsibilities in doing something about this to achieve better outcomes? (Interview, medical college representative).
Trainees have to do a dissertation, and there is a requirement to have considered implications for Māori health and health equity. Students have to work alongside a Māori health advisor to ensure cultural safety in the research process. (Interview, medical college representative).

Our review of written materials confirmed that medical college curricula have embedded cultural competency into the broader competency framework, typically under domains such as communication, professionalism, and leadership. For example, specifying intercultural communication development expectations across the learning continuum, or stating that doctors need to be able to demonstrate that clinical interactions take into account the impact of cultural issues.

College representatives also emphasised the importance of workplace placements as an opportunity for integrated cultural safety skill development. This is intended to be formalised through mechanisms such as self-reporting and feedback from supervisors on competency development (including cultural competency).

Training programmes also have provision for independent learning related to cultural safety. This is generally through practice audits and collegial practice reviews, in which cultural competence/safety is considered amongst other aspects. One college stated that it is developing a tool to support registrars and fellows to undertake equity audits and self-reflection, which is expected to be released in early 2022.

Overall, the document review and interviews with college representatives indicate that processes to develop skills within the cultural competence and Hauora Māori domains of the rubric are integrated and immersed within college curricula. The evidence suggests that there is less emphasis within the training and education programme on developing culturally safe practice. College representatives interviewed were largely aware of this gap, and expressed a desire for guidance materials on cultural safety training and education.

3.5 Duration of training

Findings from the literature

The review of literature shows that the didactic and interactive components of the majority of cultural competence/cultural safety education and training initiatives are allocated 36 hours or less of formal learning time. A systematic review of 16 published evaluations of cultural competence education and training of the health workforce found that the duration of training varied from sessions of 60 minutes or less, to workshops of up to two days duration (Clifford et al., 2015). Other studies report similar findings, with a review of seven studies reporting total instructional time ranging from 4.5-36 hours (Kurtz et al., 2018). In the experiential domain, a review of four cultural immersion programmes found that duration ranged from one to five days (Clifford et al., 2017).

These education and training initiatives ranged from one-off interventions, such as a half day workshop (Clifford et al., 2017), to courses that incorporated regular sessions over the full semester (Dao et al., 2017), to multi-day intensive immersion programmes (Huria et al., 2017).

Published evidence supports the use of sequential, long term education and training programmes, rather than single events or short term courses (Dargaville, 2020; Huria et al., 2017; Ramani et al., 2019; Shepherd, 2019). One-off encounters, such as workshops, are criticised as inadequate for attendees to absorb meaningful information that can be implemented into practice, often having little continuation or follow up beyond the initial encounter (Shepherd, 2019). Changing patterns of thinking, behaviour and attitudes requires education and training that are "frequent and ongoing, provide long-lasting exposure to the transformative unlearning process and reinforces a commitment to change" (Dargaville, 2020, p.25).

The current situation in Aotearoa

In Aotearoa the findings of the environmental scan and interviews with college representatives reflect the evidence from the literature scan. The 'immersed' (i.e., time allocated solely for cultural safety/competence) didactic and interactive components of vocational programmes were allocated 3-28 hours. Specific examples given included: a half day (3 hour) presentation on cultural competence and cultural safety; a 9-hour Indigenous health and cultural competency online course; a two-day Treaty of Waitangi and health workshop; and an expected completion time of 22-28 hours for the MIHI 501 course.

However, college representatives emphasised that immersed training and education is accorded less emphasis in vocational training than at undergraduate level; as outlined above, cultural competence/cultural safety is embedded in all workplace-based training. Interviewees stated that the total time trainees spend undertaking reflection and learning related to cultural safety and cultural competence is much higher than the time spent taking formal courses.

CPD requirements are often time-bound. Two of the colleges that participated in interviews have mandated CPD requirements on cultural safety and cultural competence. For example, one college has mandated that fellows complete an approved cultural competence activity of a minimum two hours' duration in every triennial CPD cycle. Other colleges do not have minimum CPD hours or points related to cultural safety, but have allocated 'generous' CPD points to activities such as the MIHI 501 course in the aim of encouraging fellows to undertake these activities.

> *Nothing is mandated or a requirement yet, but CPD in cultural competence is strongly encouraged. The 'gold points' hours are for activities that require self-reflection, including on cultural competence and bias. (Interview, medical college representative).*

3.6 Assessment mechanisms

Focus of assessments

Most of the programmes described in a 2017 systematic review of 16 education and training initiatives were intended to enhance cultural competence. Assessments therefore largely focused on knowledge and skill acquisition (Clifford et al., 2017). Other studies highlight assessments that measure attitudinal change, particularly related to confidence in ability to engage with Indigenous populations, attitudes towards Indigenous or marginalised population groups, or perceived ability to deliver culturally competent care (Dargaville, 2020; Maldonado et al., 2014).

There is very little discussion in the literature around assessment of behavioural change. This aligns with a 2020 study into building a culturally safe and critically conscious health workforce in Aotearoa, which found that despite almost half of the teaching methods reviewed having a specific focus on teaching for behavioural change, very few proposed assessment measures to capture aspects of behavioural transformation (Dargaville, 2020).

It is also noted that behavioural change can be encouraged and reinforced through frequent assessments and feedback, which prompts continued effort and commitment to change (Dargaville, 2020).

Assessment methods

The evidence from the literature scan shows there is a lack of standardised methods and tools to objectively assess doctors on their ability to practice culturally safe or culturally competent care (Maldonado et al., 2014).

Assessment methods rely heavily on the use of self-reported tools, predominantly pre- and post- questionnaires and interviews (Clifford et al., 2015; Dargaville, 2020; Milne et al., 2016; Truong et al., 2014). Many of these tools have not been validated (Truong et al., 2014) and are subject to a range of biases (such as social desirability bias) (Clifford et al., 2017; Dargaville, 2020; Milne et al., 2016; Truong et al., 2014).

Other assessment mechanisms highlighted in the literature include observations, examinations, assignments, case scenarios, reflection journals, informal presentations, group discussions, essays, and critical analysis pieces (Clifford et al., 2017; Dargaville, 2020; Maldonado et al., 2014; Truong et al., 2014). A United States-based accreditation council places emphasis on asking medical educators to objectively evaluate and report on their trainees' ability to practice patient-centred, culturally competent care (Maldonado et al., 2014).

A novel method proposed by an Australian study, and reportedly in use in undergraduate medical education in Aotearoa, tests students' critical analysis via a 'deconstruction exercise'. This asks students to consider a question (such as 'Why are Aboriginal people prone to drug and alcohol addiction?) and identify assumptions, omissions, and racialised language and/or approaches; rather than answer the question itself (Sjorberg & McDermott, 2016).

Despite a key facet of cultural safety emphasising evaluation of practice as defined by the people accessing care, very few assessment methods assess culturally safe practice from a patient perspective. A 2014 'review of reviews' of cultural competence education and training found that while a small number of assessments included patient satisfaction questionnaires, most did not include the patient perspective (Truong et al., 2014). Similarly, interventions reviewed by Dargaville (2020) had an absence of patient experience and patient feedback in assessments for cultural safety.

The current situation in Aotearoa

The environmental scan and interviews found that assessing cultural competence and cultural safety skills in registrar training programmes is usually done as a component of broader assessments. The college representatives who were interviewed stated

that there is currently no specific tool to assess cultural competency/safety but this is an aspect that is assessed during supervisor observation capture, self-completed learning records and logs, oral examinations, and multisource feedback assessments. Online modules and courses for registrars and CPD typically include multichoice questionnaires testing knowledge acquisition and case assignments with a virtual patient. Interviewees highlighted challenges in developing meaningful assessment of cultural safety practices in online courses in a way that doesn't reinforce stereotypes.

In line with the literature scan findings, assessment mechanisms do not currently include feedback from patients and whānau, as the definers of culturally safe care.

3.7 Evidence of effectiveness

Effectiveness in changing knowledge, attitudes and behaviours
There is a small amount of evidence that participation in cultural safety or cultural competence training results in improvements in:

- knowledge of and cultural factors that impact on doctor-patient interaction (Barnabe et al., 2021; Brock et al., 2019; Clifford et al., 2017b; Govere & Govere, 2016; Renzaho et al., 2013)
- attitudes towards Indigenous and culturally diverse Peoples (Brock et al., 2019; Clifford et al., 2017; Govere & Govere, 2016; Kerrigan et al., 2021)
- improved communication and relationship building (Barnabe et al., 2021; Shepherd, 2019)
- reflections on held stereotypes, values and privileges (Barnabe et al., 2021; Brock et al., 2019; Zaidi et al., 2017).

It should be noted that the majority of studies that reported these findings were mainly based on self-reported data from pre- and post-intervention questionnaires, and that the methodological rigor of much of the research is weak (Downing & Kowal, 2011; Shepherd, 2019). In addition, there is a paucity of research and therefore little available evidence regarding whether cultural safety training leads to sustained change because few programmes have been subject to long term evaluation (Laverty et al., 2017).

Impact on health equity

The findings of the literature scan indicate that the evidence base is weak regarding the extent to which cultural safety education results in improved patient-related outcomes. There has been little research on the links between cultural safety training, patient experience or satisfaction, and equity of outcomes (Butler et al., 2016; Downing & Kowal, 2011; Jernigan et al., 2016; Kirmayer, 2012; Renzaho et al., 2013; Shepherd, 2019; Truong et al., 2014).

The review did not identify any studies that directly investigate whether cultural safety training reduces health outcome inequity. The effectiveness of cultural safety training and education as a strategy to eliminate disparities in health outcomes is not well understood (Jernigan et al., 2016)

4. Conclusions

What education and training initiatives in cultural safety are being provided in Aotearoa and other jurisdictions?

The findings of the literature review and environmental scan show that medical colleges in Aotearoa are making efforts to provide education and training to doctors that enables them to interact with a range of cultural groups. In Aotearoa, the emphasis is on supporting doctors to engage effectively with whānau Māori.

The education programme for trainee doctors and CPD typically includes a requirement to participate in education and training using seminars, courses, online learning and/or workshops related to cultural competence and cultural safety. This is often combined with interactive learning such as role plays, peer group discussions, and audit of practice. Several colleges have invested in bespoke online learning modules that aim to equip students to effectively engage with and provide care to Māori and/or Aboriginal and Torres Strait Islander patients. The MIHI 501 training programme is also offered by at least two colleges. This is a well-regarded course that combines self-directed online learning with a face-to-face workshop that includes practice with Māori patients and whānau.

Experiential learning, such as noho marae and placements in Māori health providers and/or communities with a high Māori population, is common in trainee doctor programmes. These opportunities are intended to encourage trainee doctors to participate in cultural practices, learn tikanga, practice Māori models of engagement, reflect on their privilege, confront their prejudices and bias, and reinforce the impacts of colonisation on health outcomes. Doctor training curricula also have provision for independent learning related to cultural safety through practice audits and collegial practice reviews, as well as feedback from supervisors.

This is similar to the training and education arrangement in comparable jurisdictions overseas. The content of the training in these jurisdictions is broadly focused on intercultural competence, anti-racism, and engagement practices with specific Indigenous or minority groups as relevant to the location. The review did not find evidence of training and education initiatives that were particularly innovative or different to that provided in Aotearoa.

To what extent do the education and training initiatives currently available in Aotearoa focus on 'cultural safety' versus 'cultural competence'? What is the place of Hauora Māori teaching in medical colleges?

The findings from this literature scan and environmental scan show that most of the training and education currently being offered to doctors in Aotearoa and other jurisdictions is within the cultural competence and Hauora Māori domains of our rubric (Table 2).

The education and training offered by medical colleges primarily focuses on cultural competency, teaching the knowledge, skills and competencies to equip doctors to interact effectively in cross-cultural settings. In Aotearoa, this prioritises interactions with whānau Māori. The training mechanisms described above, including online modules, the MIHI 501 course, noho marae, presentations and workshops, focus on issues such as the communication and behavioural ability to interact effectively with Māori, cultural protocols, knowledge of health inequities and the social determinants of health.

Hauora Māori is also accorded emphasis in medical college education and training programmes. This includes providing training on Te Tiriti o Waitangi, teaching of Māori health frameworks such as Te Whare Tapa Wha and the Meihana model, knowledge of the contemporary Māori health context, and te reo Māori and tikanga Māori. During interviews, medical college representatives emphasised the importance of Hauora Māori within the curriculum, noting that it is vital the doctors have knowledge related to the drivers of health inequity and the skills to interact with whānau Māori.
However, this research found that there is currently limited focus on training and education in the cultural safety domain of the rubric. The Medical Council of New Zealand's 2019 Statement on Cultural Safety has made medical colleges aware of the need to explicitly include cultural safety as part of their training programmes. The training that is offered in this space typically emphasises doctor engagement in self-reflection and self-awareness. This includes the use of tools to reflect on unconscious bias, how this impacts doctor-patient engagement, and techniques for overcoming bias.

The evidence from the literature scan and interviews with college representatives indicates that there is limited emphasis in college training programmes in aspects of cultural safety such as critically examining power structures that influence patient-practitioner interactions. The emphasis tends to be on the individual doctor and their behaviour in a doctor-patient interaction, with little focus on the need for commitment and action at all levels of the health system The research also found there is an absence or dilution of training content related to discrimination, racism and prejudice, which are considered to be aspects of cultural safety in Aotearoa.

The research also found that there is a lack of clarity on the definitions and distinctions between cultural safety, cultural competence, Hauora Māori and related topics.

What are the characteristics of education and training initiatives and assessment methods that evidence shows best meet the cultural safety training needs of doctors?

The findings from the literature and environmental scan indicate that the following aspects are important to meet the cultural safety training needs of doctors:

- The education and training of doctors is inadequate as a stand-alone strategy to enhance cultural safety in doctor practice and improve equity of health outcomes. Achieving more equitable health outcomes requires structural changes at the organisational level, by embedding cultural safety into policy documents, such as position statements and strategic plans.

- Training needs to include interventions to teach critical consciousness, making the clinician's cultural underpinning a critical focus for reflection. This includes exposing the way in which power relations play a part in shaping health care relationships, and preparing practitioners to challenge these unequal power relationships and redress this dynamic. It is important that training and education also encourages doctors to reflect on privilege, discrimination, racism and prejudice.
- It is recommended to combine immersed, integrated and independent approaches in a programme of education and training.
- Published evidence supports the use of sequential, long-term education and trining programmes, rather than single events or short-term courses. Changing patterns of thinking, behaviour and attitudes requires frequent and ongoing exposure to transformative 'unlearning' processes.
- Didactic, interactive, and emersion are all important learning modes for cultural safety education. Evidence shows that interactive activities such as role play and peer group discussions to prompt self-reflection on experiences and allow for critique from peers are particularly important. Experiential learning, such as noho marae and placements in Māori health providers assists doctors to understand the contexts in which culturally diverse populations live and the impacts of these contexts on health outcomes.
- There is a need for CPD learning opportunities that are directly related to cultural safety in Aotearoa.
- It is vital that educators, trainers and supervisors create safe learning spaces, that they avoid a 'shame and blame' approach, effectively manage conflict and support learners in sustained dialogue and introspection.
- Behavioural change can be encouraged and reinforced through frequent assessments and feedback, which prompts continued effort and commitment to change.
- Assessments need to focus on behavioural transformation, as well as skills and knowledge. There is also value in investigating assessment methods that include the perspective of patients and whānau, as the definers of culturally safe care.
- There is little evidence regarding how and to what extent cultural safety and competency training impacts on disparity. The review has identified that it is not well understood and there is a scarcity of long-term evaluation. It is important that training programmes to produce culturally safe doctors includes a commitment to undertake evaluation of its effectiveness and impacts.

References

Alizadeh, S., & Chavan, M. (2016). Cultural competence dimensions and outcomes: A systematic review of the literature. *Health & Social Care in the Community*, 24(6), e117–e130. https://doi.org/10.1111/hsc.12293

Barnabe, C., Kherani, R. B., Appleton, T., Umaefulam, V., Henderson, R., & Crowshoe, L. (2021). Participant-reported effect of an Indigenous health continuing professional development initiative for specialists. *BMC Medical Education*, 21, 116. https://doi.org/10.1186/s12909-021-02551-9

Berg, K., McLane, P., Eshkakogan, N., Mantha, J., Lee, T., Crowshoe, C., & Phillips, A. (2019). Perspectives on Indigenous cultural competency and safety in Canadian hospital emergency departments: A scoping review. I*nternational Emergency Nursing*, 43, 133–140. https://doi.org/10.1016/j.ienj.2019.01.004

Brock, M. J., Fowler, L. B., Freeman, J. G., Richardson, D. C., & Barnes, L. J. (2019). Cultural immersion in the education of healthcare professionals: A systematic review. J*ournal of Educational Evaluation for Health Professions*, 16, 4. https://doi.org/10.3352/jeehp.2019.16.4

Butler, M., McCreedy, E., Schwer, N., Burgess, D., Call, K., Przedworski, J., Rosser, S., Larson, S., Allen, M., Fu, S., & Kane, R. L. (2016). *Improving Cultural Competence to Reduce Health Disparities*. https://europepmc.org/article/nbk/nbk361126

Clifford, A., Calman, J. M., Jongen, C., & Bainbridge, R. (2017). Cultural Competency Training and Education in the University-based Professional Training of Health Professionals: Characteristics, Quality and Outcomes of Evaluations. *Diversity & Equality in Health and Care*, 14(3). https://doi.org/10.21767/2049-5471.1000104

Clifford, A., McCalman, J., Bainbridge, R., & Tsey, K. (2015). Interventions to improve cultural competency in health care for Indigenous peoples of Australia, New Zealand, Canada and the USA: A systematic review. *International Journal for Quality in Health Care*, 27(2), 89–98. https://doi.org/10.1093/intqhc/mzv010

Curtis, E., Jones, R., Tipene-Leach, D., Walker, C., Loring, B., Paine, S.-J., & Reid, P. (2019). Why cultural safety rather than cultural competency is required to achieve health equity: A literature review and recommended definition. I*nternational Journal for Equity in Health.*

Dao, D. K., Goss, A. L., Hoekzema, A. S., Kelly, L. A., Logan, A. A., Mehta, S. D., Sandesara, U. N., Munyikwa, M. R., & DeLisser, H. M. (2017). Integrating Theory, Content, and Method to Foster Critical Consciousness in Medical Students: A Comprehensive Model for Cultural Competence Training. *Academic Medicine,* 92(3), 335–344. https://doi.org/10.1097/ACM.0000000000001390

Dargaville, K. (2020). W*aiwhakaata: Building a culturally safe and critically conscious health workforce* [Masters of Public Health]. University of Auckland.

Downing, R., & Kowal, E. (2011). A postcolonial analysis of Indigenous cultural awareness training for health workers. *Health Sociology Review*, 20(1), 5–15. https://doi.org/10.5172/hesr.2011.20.1.5

Downing, R., Kowal, E., & Paradies, Y. (2011). Indigenous cultural training for health workers in Australia. I*nternational Journal for Quality in Health Care*, 23(3), 247–257. https://doi.org/10.1093/intqhc/mzr008

Govere, L., & Govere, E. M. (2016). How Effective is Cultural Competence Training of Healthcare Providers on Improving Patient Satisfaction of Minority Groups? A Systematic Review of Literature. *Worldviews on Evidence-Based Nursing*, 13(6), 402–410. https://doi.org/10.1111/wvn.12176

Hart, B., Cavanagh, M., & Douglas, D. (2015). The "Strengthening Nursing Culture Project" – an exploratory evaluation study of nursing students' placements within Aboriginal Medical Services. *Contemporary Nurse*, 51(2–3), 245–256. https://doi.org/10.1080/10376178.2016.1150190

Horvat, L., Horey, D., Romios, P., & Kis-Rigo, J. (2014). Cultural competence education for health professionals. *Cochrane Database of Systematic Reviews*, 5. https://doi.org/10.1002/14651858.CD009405.pub2

Huria, T., Palmer, S., Beckert, L., Lacey, C., & Pitama, S. (2017). Indigenous health: Designing a clinical orientation program valued by learners. B*MC Medical Education*, 17(1), 180. https://doi.org/10.1186/s12909-017-1019-8

Jennings, W., Bond, C., Hill, P. S., Jennings, W., Bond, C., & Hill, P. S. (2018). The power of talk and power in talk: A systematic review of Indigenous narratives of culturally safe healthcare communication. *Australian Journal of Primary Health*, 24(2), 109–115. https://doi.org/10.1071/PY17082

Jernigan, V. B. B., Hearod, J. B., Tran, K., Norris, K. C., & Buchwald, D. (2016). An Examination of Cultural Competence Training in US Medical Education Guided by the Tool for Assessing Cultural Competence Training. J*ournal of Health Disparities Research and Practice*, 9(3), 150–167.

Jones, R., Crowshoe, L., Reid, P., Calam, B., Curtis, E., Green, M., Huria, T., Jacklin, K., Kamaka, M., Lacey, C., Milroy, J., Paul, D., Pitama, S., Walker, L., Webb, G., & Ewen, S. (2019). Educating for Indigenous Health Equity: An International Consensus Statement. *Academic Medicine*, 94(4), 512–519. https://doi.org/10.1097/ACM.0000000000002476

Jones, R., Pitama, S., Huria, T., Poole, P., McKimm, J., Pinnock, R., & Reid, P. (2010). Medical education to improve Māori health. *New Zealand Medical Journal*, 123(1316), 113–122.

Kerrigan, V., McGrath, S. Y., Majoni, S. W., Walker, M., Ahmat, M., Lee, B., Cass, A., Hefler, M., & Ralph, A. P. (2021). "The talking bit of medicine, that's the most important bit": Doctors and Aboriginal interpreters collaborate to transform culturally competent hospital care. *International Journal for Equity in Health*, 20(1), 170. https://doi.org/10.1186/s12939-021-01507-1

Kirmayer, L. J. (2012). Rethinking cultural competence. *Transcultural Psychiatry*, 49(2), 149–164. https://doi.org/10.1177/1363461512444673

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

Laverty, M., McDermott, D. R., & Calma, T. (2017). Embedding cultural safety in Australia's main health care standards. *Medical Journal of Australi*a, 207(1), 15–16. https://doi.org/10.5694/mja17.00328

Lenette, C. (2014). Teaching cultural diversity in first year human services and social work: The impetus for embedding a cultural safety framework. A Practice Report Introduction. T*he International Journal of the First Year in Higher Education*, 5. https://doi.org/10.5204/intjfyhe.v5i1.196

Maldonado, M. E., Fried, E. D., DuBose, T. D., Nelson, C., & Breida, M. (2014). The Role That Graduate Medical Education Must Play in Ensuring Health Equity and Eliminating Health Care Disparities. *Annals of the American Thoracic Society*, 11(4), 603–607. https://doi.org/10.1513/AnnalsATS.201402-068PS

Matheson, A., Bourke, C., Verhoeven, A., Khan, M. I., Nkunda, D., Dahar, Z., & Ellison-Loschmann, L. (2018). Lowering hospital walls to achieve health equity. *BMJ*, 362, k3597. https://doi.org/10.1136/bmj.k3597

Medical Council of New Zealand. (2019). *Statement on cultural safety*. https://www.mcnz.org.nz/assets/standards/b71d139dca/Statement-on-cultural-safety.pdf

Milne, T., Creedy, D. K., & West, R. (2016). Development of the Awareness of Cultural Safety Scale: A pilot study with midwifery and nursing academics. *Nurse Education Today*, 44, 20–25. https://doi.org/10.1016/j.nedt.2016.05.012

Palmer, S. C., Gray, H., Huria, T., Lacey, C., Beckert, L., & Pitama, S. G. (2019). Reported Māori consumer experiences of health systems and programs in qualitative research: A systematic review with meta-synthesis. *International Journal for Equity in Health*, 18(1), 163. https://doi.org/10.1186/s12939-019-1057-4

Ramani, S., McMahon, G. T., & Armstrong, E. G. (2019). Continuing professional development to foster behaviour change: From principles to practice in health professions education. *Medical Teache*r, 41(9), 1045–1052. https://doi.org/10.1080/0142159X.2019.1615608

Renzaho, A. M. N., Romios, P., Crock, C., & Sonderlund, A. L. (2013). The effectiveness of cultural competence programs in ethnic minority patient-centered health care—A systematic review of the literature. I*nternational Journal for Quality in Health Care*, 25(3), 261–269. https://doi.org/10.1093/intqhc/mzt006

Shepherd, S. M. (2019). Cultural awareness workshops: Limitations and practical consequences. *BMC Medical Education*, 19(1), 14. https://doi.org/10.1186/s12909-018-1450-5

Sjorberg, D., & McDermott, D. (2016). The deconstruction exercise: An assessment tool for enhancing critical thinking in cultural safety education. *International Journal of Critical Indigenous Studies*, 9(1), 28–48. https://doi.org/10.5204/ijcis.v9i1.143

Sukhera, J., & Watling, C. (2017). A Framework for Integrating Implicit Bias Recognition Into Health Professions Education. *Academic Medicine : Journal of the Association of American Medical Colleges*, 93. https://doi.org/10.1097/ACM.0000000000001819

Sundberg, M. A., Charge, D. P. L., Owen, M. J., Subrahmanian, K. N., Tobey, M. L., & Warne, D. K. (2019). Developing Graduate Medical Education Partnerships in American Indian/Alaska Native Communities. J*ournal of Graduate Medical Education*, 11(6), 624–628. https://doi.org/10.4300/JGME-D-19-00078.1

Truong, M., Paradies, Y., & Priest, N. (2014). Interventions to improve cultural competency in healthcare: A systematic review of reviews. *BMC Health Services Research*, 14(1), 99. https://doi.org/10.1186/1472-6963-14-99

Waitoki, W. (2012). T*he Development and Evaluation of a Cultural Competency Training Programme for Psychologists Working With Māori: A Training Needs Analysis* [Doctor of Philosophy, University of Waikato]. https://researchcommons.waikato.ac.nz/bitstream/handle/10289/6654/thesis.pdf?sequence=3&isAllowed=y

Watt, K., Abbott, P., & Reath, J. (2016). Developing cultural competence in general practitioners: An integrative review of the literature. *BMC Family Practice*, 17(1), 158. https://doi.org/10.1186/s12875-016-0560-6

White-Davis, T., Edgoose, J., Brown Speights, J. S., Fraser, K., Ring, J. M., Guh, J., & Saba, G. W. (2018). Addressing Racism in Medical Education: An Interactive Training Module. *Family Medicine*, 50(5), 364–368. https://doi.org/10.22454/FamMed.2018.875510

Zaidi, Z., Vyas, R., Verstegen, D., Morahan, P., & Dornan, T. (2017). Medical Education to Enhance Critical Consciousness: Facilitators' Experiences. *Academic Medicine*, 92(11S), S93. https://doi.org/10.1097/ACM.0000000000001907