CULTURAL SAFETY TRAINING PLAN FOR VOCATIONAL MEDICINE IN AOTEAROA

JANUARY 2023

Te Kaunihera o Ngā Kāreti Rata o Aotearoa
COUNCIL OF MEDICAL COLLEGES
NEW ZEALAND

TE OHU RATA O AOTEAROA
MĀORI MEDICAL PRACTITIONERS
TeORA

Foreword

Hauora Māori and cultural competence are education and training approaches that have been taken since the mid-1980s in New Zealand medical schools, and more recently in medical colleges. These approaches aim to increase knowledge and skills around interactions with patients of a different culture, particularly Māori.

The underlying intentions have been high-quality service provision by practitioners and better health outcomes for the (Māori) patient in the consultation. The recent introduction by the Medical Council of New Zealand of cultural safety as a standard for doctors to adhere to requires a different approach. It calls for the practitioner to develop and maintain a critical consciousness - a reflective practice that examines the biases and the power relationships that impede best outcomes for the (Māori) patient.

This Cultural Safety Training Plan for Vocational Medicine in Aotearoa has been prepared as a guide for the Council of Medical Colleges to assist their member colleges in the development of high quality training for registrars and Continuous Professional Development (CPD) packages for Fellows. Because it asks us to turn our critical eye upon ourselves and commit to transformative change, cultural safety is far more challenging than other new programmes of knowledge and skills. The package however promotes learning techniques and assessment modalities that we are all well acquainted with in our usual training and CPD.

Cultural safety is about us as medical practitioners creating a better consultation environment in order to foster optimal patient outcomes, particularly for those most affected by inequities in society. But cultural safety is not confined to individual practitioners. It can also be applied to clinics, services, hospitals and indeed, to the health system itself.

Cultural safety is not the end-game and it will not solve inequitable health outcomes for Māori patients. But it is an essential tool in the provision of excellent health care for Māori and others. We urge a courageous pursuit - of what will one day be a very standard practice – by all.

Nā māua me a māua mihi nui,

David Tipene-Leach
Kaihautū, Te ORA

Samantha Murton
Chair, Council of Medical Colleges

Acknowledgements

The Council of Medical Colleges, Te Ohu Rata o Aotearoa and Allen + Clarke acknowledge the valuable contributions from medical college representatives who participated in the environmental scan of current practice in cultural safety training and education, that has contributed to the development of this training plan. We also thank the peer reviewers, the Interdisciplinary Māori Advisory Group and the members of the consumer reference group who provided valuable advice and feedback to help shape the plan. Ngā mihi nui ki a koutou katoa.

This project was supported with funding from the Council of Medical Colleges and the Choosing Wisely campaign. Professor David Tipene-Leach's participation in the project was funded by the Eastern Institute of Technology.

Suggested citation:

Simmonds S, Carter M, Haggie H, Mills V, Lyndon M, Tipene-Leach D. *A Cultural Safety Training Plan for Vocational Medicine in Aotearoa*. Te ORA and the Council of Medical Colleges, January 2023

ISBN Digital: 978-1-99-117067-5
ISBN Print: 978-1-99-117068-2

Contents

1. Introduction

1.1 Purpose

This document presents a plan for cultural safety training that medical colleges can employ in the development of their own cultural safety training programmes for college registrar training and in continuing professional development (CPD) with college fellows.

This responds to the 2019 statement from the Medical Council of New Zealand (MCNZ) that medical education in Aotearoa should include a focus on cultural safety. Colleges should already have Hauora Māori and cultural competence training well developed. This is in addition to those pieces of work.

Cultural safety applies to diverse population groups, particularly those experiencing inequitable health outcomes. This cultural safety training plan is an integral contribution to the overall vision of optimal health for Māori, moving beyond equity to the aspiration of Māori reaching their full health potential. Therefore, it is envisioned that 'culturally safe practice' by a medical practitioner actively contributes to ongoing progression towards optimal health for Māori.

The purpose of this training plan is to provide the foundation for the development of medical colleges' training programmes that support practitioners to undertake culturally safe practice in their medical specialty, as defined by the people they serve. It is intended that medical colleges will adapt and develop specific training programmes that suit the context of their vocational scope.

This training plan has been designed to reflect the unique context of Aotearoa. Whilst cultural safety is applicable to all cultural, ethnic, religious and other social groups that share a core set of beliefs, behaviours and values, its application to equitable outcomes for Māori is immediately obvious and intentional. This training plan focuses on cultural safety through the lens of Māori health equity and achieving and maintaining full health potential for Māori patients and their whānau.

1.2 Background and context: Hauora Māori, cultural competence, and cultural safety

Medical schools in Aotearoa have offered Hauora Māori as a subject since the mid-1980s. This focusses on developing a knowledge base on the historical and contemporary context of Māori health, an understanding of Māori models of health, and an approach to engagement with whānau Māori. Cultural competence has been a core subject for almost two decades and has sat, for the most part, alongside the Hauora Māori curriculum. These topics have been intended as a pathway for upskilling doctors to support positive health outcomes for Māori and in the provision of high-quality medical care to diverse patient populations. The focus on cultural competence aligns with the Health Practitioners Competence Assurance Act 2003.

In 2006, the MCNZ developed a 'Statement on Cultural Competence' (2006) to guide practitioners' behaviour around health interactions with diverse cultural groups. MCNZ subsequently released a resource called 'Best health outcomes for Māori: Practice Implications' (2008) to provide further guidance on best health outcomes for Māori.
In Australia, the Australian Medical Council (AMC) strengthened its Indigenous health accreditation standards for the binational medical colleges that span Australia and New Zealand. Its revised standards (2015) include five standards that specifically address the health of Aboriginal and Torres Strait Islander peoples in Australia, and Māori in New Zealand. Colleges are expected to demonstrate how they meet these standards.

In pursuit of equitable health outcomes for Māori, the MCNZ and Te Ohu Rata o Aotearoa – the Māori Medical Practitioners Association (Te ORA) developed a work programme called Cultural Competence, Partnership and Health Equity. The outputs of that programme included a journal article entitled 'Why cultural safety rather than cultural competency is required to achieve health equity' (Curtis et al., 2019). In its 2019 'Statement on Cultural Safety' the MCNZ advised that the medical profession should be expanding from training in cultural competence and Hauora Māori, to also deliver training in cultural safety.

By definition, cultural safety emphasises self-reflection upon one's own cultural mores and the likely effect of how bias and prejudice arising from that cultural perspective might affect professional behaviour and equitable health outcomes (MCNZ, 2019a). The MCNZ has also sought to address equitable outcomes for Māori with 'He Ara Hauora Māori: a Pathway to Māori Health Equity' (2019b).

Following this, Te ORA and the Council of Medical Colleges (CMC) published the report 'Choosing Wisely means Choosing Equity' (2020), as part of the Choosing Wisely campaign in Aotearoa. This report identified that cultural safety is vital for enabling an environment where shared decision making and two-way dialogue between health practitioners and patients can take place. Te ORA and the CMC continued to work together to scope how well medical colleges were set up to be culturally safe organisations, that train registrars in cultural safety (Te ORA and Council of Medical Colleges, 2021).

The introduction of cultural safety has not replaced cultural competence, nor has it replaced the need to have an adequate Hauora Māori knowledge base. These are separate but entwined pursuits, and all pertain to equitable outcomes and optimal health for Māori. In line with this aspiration, vocational training in medical colleges now needs to include training in cultural safety as well as cultural competence and Hauora Māori.

To support medical colleges to facilitate this shift, the CMC and Te ORA have developed this cultural safety training plan for vocational medical training in Aotearoa.

This plan focuses on the specific proficiencies that a culturally safe doctor needs to develop. It also provides a cultural safety teaching and assessment rubric for registrars and fellows, to support the ongoing development of their skills and understanding around cultural safety. The intention has been to present new training in a format that is easily recognised by practitioners using teaching and assessment methods that are familiar.

1.3 Audience for the training plan

The audience for this training plan is medical colleges in Aotearoa that provide vocational training and continuous professional development for doctors.

1.4 Key features of the training plan

The cultural safety training plan has been developed to incorporate the following features:

- It offers an overarching **conceptual framework**, citing culturally safe practice alongside the broader context of medical practitioners' role in achieving optimal health for Māori.
- It identifies and **defines the proficiencies** that a culturally safe doctor needs to develop.
- It provides a **teaching and assessment rubric** for registrars and fellows, to support the ongoing development of their skills and understanding around cultural safety.
- It also offers a **self-assessment tool** for monitoring progress.
- The training plan is designed to be used **across medical disciplines**. The proficiencies provided are intended to be contextualised to a range of medical specialities.
- The training plan has been specifically designed to reflect the **unique context of Aotearoa**. The proficiencies focus on developing practitioners' culturally safe practice, through the lens of Māori health equity and achieving and maintaining optimal health for Māori patients and whānau.
- The suggested teaching methods and assessment tasks are offered as guidance for medical colleges, but it is not compulsory for these to be implemented exactly as described in this plan. Colleges can implement teaching methods and assessments that align with their current training programmes and provide context for their particular vocation.
- Ultimate **accountability is to the people served**; culturally safe care is defined by patients, whānau, and communities.
- The plan is designed for Aotearoa but with the potential to adapt to other contexts.

Alongside other education pursuits like Hauora Māori and cultural competence, this will enhance health outcomes for Māori.

1.5 Development of the training plan

This plan has been developed to reflect the findings of a literature and environmental scan that identified the characteristics of training initiatives and assessment methods that evidence shows best meet the cultural safety training needs of doctors (Te ORA and Council of Medical Colleges, 2023). The literature scan incorporated information from 41 articles and reports, prioritising literature from comparable jurisdictions and work by Indigenous authors.

The literature scan was supplemented by interviews with representatives (such as academic advisors or training officers) from a sample of six medical colleges.

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 registrars and fellows, and one with higher Māori representation; and colleges in specialisations that have close contact with patients, and those that do not.

This plan also builds on previous work undertaken by Te ORA, CMC and the MCNZ, including the Cultural Competence, Participation and Health Equity project, the Choosing Wisely Means Choosing Equity report (Te ORA and Council of Medical Colleges, 2020) and the Cultural Safety in Vocational Medical Training report (Te ORA and Council of Medical Colleges, 2021).

This training plan has been developed iteratively, led by a working group with representatives from Te ORA and CMC, a senior Māori clinician and academic, and researchers from Allen + Clarke including a Kaupapa Māori researcher. Advice and peer review has been provided by two senior Māori medical education academics.

The draft plan was tested and refined through workshopping the proficiencies with Māori registrars and fellows of the medical colleges through the CMC's Interdisciplinary Māori Advisory Group; representatives of medical colleges; and a group of Māori consumers. Feedback was also sought from MCNZ leadership.

The advice and feedback received from the peer reviewers, workshops and the consumer group has been incorporated into the final version of the plan.

2. Defining Cultural Safety

2.1 Key definitions

Current definitions of cultural safety owe much to Irihapeti Ramsden and Māori nurses' work in the 1990s, which defined cultural safety as:

> *A focus for the delivery of quality care through changes in thinking about power relationships and patients' rights. (Papps & Ramsden 1996, cited in Curtis et al., 2019)*

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. She refers to those in the medical profession as 'border workers', who work at the interface between the system, and patients and whānau (Koptie, 2009; Ramsden, 2002).

Cultural safety is the topic area of pursuit. Ramsden's work 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.
A recent seminal article by Curtis and colleagues (2019) echoes Ramsden in defining 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.*

The MCNZ has drawn on the above work to produce their own definition of cultural safety, as provided in their Statement on Cultural Safety (2019a):

> *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.

These definitions informed the framing of the literature and environmental scan of cultural safety in vocational medical training that was conducted prior to and as a key input into the development of the proficiencies articulated in this training plan.

2.2 Cultural safety as transformative action

As suggested in the definitions above, culturally safe care requires transformative action from medical practitioners, actively working to normalise and embed practices that contribute to equity for Māori in Aotearoa. This transformative action needs to occur within different spheres of medical practice:

- Internal transformation, which focuses on the practitioner's psychological interior and own culture, and requires addressing their own biases, attitudes, assumptions, stereotypes, prejudices, and holding themselves accountable for providing culturally safe care.
- Horizontal or interpersonal transformation, which emphasises a focus on interactions amongst colleagues and cultural safety within the workforce.
- Vertical or structural transformation of the institution or organisation a practitioner works within, as well as the wider healthcare ecosystem, strategies, policies, protocols, practices, funding models that contribute to achieving health equity.

The proficiencies for culturally safe practice outlined in this training plan prompt transformation within all three spheres.

3. Contextualising Cultural Safety: A Conceptual Framework

3.1 Actively contributing to optimal health for Māori

This training plan posits that the core vision of cultural safety training in vocational medicine in Aotearoa is to support doctors to contribute to optimal health for Māori. Working towards this vision is complex, and cultural safety is one aspect of the broader and multi-layered context of knowledge, skills, competencies and practices that need to be continuously developed by medical practitioners in Aotearoa.

Figure 1 providers a visual summary of a broad conceptual framework for achieving optimal health for Māori in Aotearoa. This illustrates that cultural safety is a contributor, but on its own it is inadequate to achieve this aim.

The components of the conceptual framework were identified through a review of literature, and drew on the broader knowledge of the working group members. The conceptual framework was tested and refined through the process described in section 1.5.

Figure 1: Conceptual framework for optimal health for Māori in Aotearoa

3.2 Components of vocational medical training that support optimal health for Māori

Table 1 below defines the three 'domains' of vocational medical training that contribute to optimal health for Māori: cultural safety, cultural competence and hauora Māori.

While the focus of this training plan is on cultural safety, it is important to note that hauora Māori and cultural competence remain critical to medical college vocational education and training and CPD programmes. It is important that vocational training retains a focus on these areas, as they are a vital part of contributing to optimal health for Māori.

Please note that some of the cultural safety proficiencies detailed below overlap with cultural competency and Hauora Māori, again reinforcing the integrated nature of the proficiencies required for supporting optimal health for Māori.

Table 1: Definitions of Hauora Māori, cultural competence and cultural safety

CULTURAL SAFETY	CULTURAL COMPETENCE	HAUORA MĀORI
Culturally safe medical practitioners engage in ongoing development of critical consciousness, involving self-reflection on their own biases, attitudes, assumptions, stereotypes, prejudices, structures and characteristics that may affect their practice. They examine and redress power relationships in consultations, with colleagues, and within the healthcare ecosystem, and they commit to transformative action internally, horizontally and vertically. They ensure that cultural safety is defined by the patients, whānau, and communities that they serve.	Culturally competent medical practitioners are committed to ongoing development of the knowledge and skills to work effectively within cross-cultural contexts. They recognise that the definition of culture is wider than ethnic understandings, and includes other social groups defined by their behaviours, beliefs and values. They accommodate for the cultural preferences of patients, whānau and communities, and have knowledge of cultural protocols, beliefs, and language, and use this to facilitate engagement with patients during clinical encounters. They have the communication skills and confidence to ask about cultural expectations and traditional practices, including the correct pronunciation of names.	Medical practitioners have knowledge of the historical and contemporary Māori health situation, use Māori health models within clinical practice, engage appropriately with Māori patients, whānau and communities, and are familiar with te reo Māori and tikanga Māori, and the diversity of Māori beliefs, values and experiences. 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.

3.3 Concepts underpinning optimal health for Māori

The conceptual framework is underpinned by eight 'key elements' that serve to facilitate optimal health for Māori, and also as a set of aims to be upheld and honoured. The following provides a brief description of each.

Te Tiriti o Waitangi

Medical practitioners need to be aware of the historical context which led to the development of te Tiriti, understand the content of te Tiriti, how it applies to health contexts, and how they can implement te Tiriti in daily practice at a health service and system level. The recent Waitangi Tribunal Hauora report outlines five key principles of te Tiriti as: partnership, active protection, equity, options, and tino rangatiratanga.[1]

1 https://forms.justice.govt.nz/search/Documents/WT/wt_DOC_152801817/Hauora%20W.pdf

Equity of health outcomes for Māori

Medical practitioners need to recognise that Māori experience "differences in health that are not only avoidable but unfair and unjust" (Reid & Robson, 2007, p.19) and commit to transformative action that supports equity in health outcomes for Māori. Medical practitioners must focus on progressing equity for Māori, working to address the persistent disparities in health, the determinants of poor health, lack of health system responsiveness and the under representation of Māori in the health and disability workforce (Reid & Robson, 2007).

Continuous quality improvement (CQI)

Achieving optimal health for Māori requires a commitment to continuous quality improvement through deliberate, defined actions that improve responsiveness to community needs and enhance population health. Medical practitioners need to take a systems approach to contribute progressively to improvement of processes, safety, health outcomes, and patient care. The 'triple aim' quality improvement approach considers improved quality, safety, experience of care for people and their whānau, improved health and equity for all populations, and best value for public health system and resources.[2]

The right to health

Medical practitioners must acknowledge and support the right to health for all, as first recognized in the 1946 World Health Organization (WHO) constitution, which states that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition." [3]

Indigenous rights

A commitment to optimal health for Māori means that medical practitioners support the rights of Indigenous peoples, as defined in the United Nations Declaration of the Rights of Indigenous Peoples, which establishes a universal framework of minimum standards for the survival, dignity, wellbeing and rights of the world's indigenous peoples.[4]

Equity

Medical practitioners need to be aware of differences in health outcomes in population groups that are avoidable, unfair, and unjust. They must recognise that different people with different levels of advantage require different resources and approaches to achieve equitable health outcomes. This includes taking responsibility for ensuring their actions and decision-making contribute to advancing equity.

Actively challenge racism

There is a need for medical practitioners to uphold the United Nations International Convention on the Elimination of All Forms of Racial Discrimination (CERD)[5] , the main international human rights treaty dealing with racial discrimination. This includes supporting its focus on addressing discrimination or violence, condemning ideas of racial superiority or hatred and protecting human rights in an equitable way, including rights to health and adequate housing, and freedom of expression.

---

2 https://www.hqsc.govt.nz/our-data/health-quality-intelligence/about-us/
3 https://www.who.int/about/governance/constitution
4 OHCHR | UN Declaration on the Rights of Indigenous Peoples

Social justice

Medical practitioners working towards optimal health for Māori actively promote social justice in terms of the distribution of wealth, opportunities, and privileges within Aotearoa. This involves identifying and working to remove barriers that disadvantage people and communities. Culturally safe practitioners maintain a focus on fairness and equity of opportunity, supporting patients and whānau to reach their full potential.

3.4 The role of the medical practitioner as 'navigator and border worker' to the healthcare ecosystem

Irihapeti Ramsden (2002) refers to the role of the healthcare practitioner as that of 'border worker' to the health system, and emphasises the importance of this role in navigating the often differing social, emotional and cultural borders between patients and the health system.

Taking a wider ecosystem approach to healthcare involves considering the interconnected stakeholders, organisations and structures that contribute to the health of individuals and communities.

This approach also positions the medical practitioner as part of the wider health workforce and therefore an integral part of the healthcare ecosystem. Other actors in the healthcare ecosystem include: iwi/mana whenua/hapori (communities); healthcare providers (primary care, hospitals, hauora Māori providers, laboratories and others); policy makers, funders and regulators; suppliers; governance and system structures; NGOs; and education and research institutes. With patients and whānau at the core, the healthcare practitioner is often the main point of connection, ie. the 'navigator and border worker', between patients and whānau and the wider healthcare ecosystem.

This training plan includes proficiencies to enhance medical practitioner advocacy and transformative change actions in the healthcare ecosystem. It is expected that medical practitioners will identify and take actions to apply the proficiencies within their sphere of influence. A practitioner's sphere of influence may extend to their colleagues, workplace, college, the health system, and across sectors.

4. Cultural Safety Proficiencies

While the conceptual framework details the breadth of practices that are required for medical practitioners to work towards optimal health for Māori, this training plan focuses specifically on the cultural safety domain. It outlines four 'key proficiencies', and five 'enabling proficiencies' for each. The four key cultural safety proficiencies are provided in Figure 2.

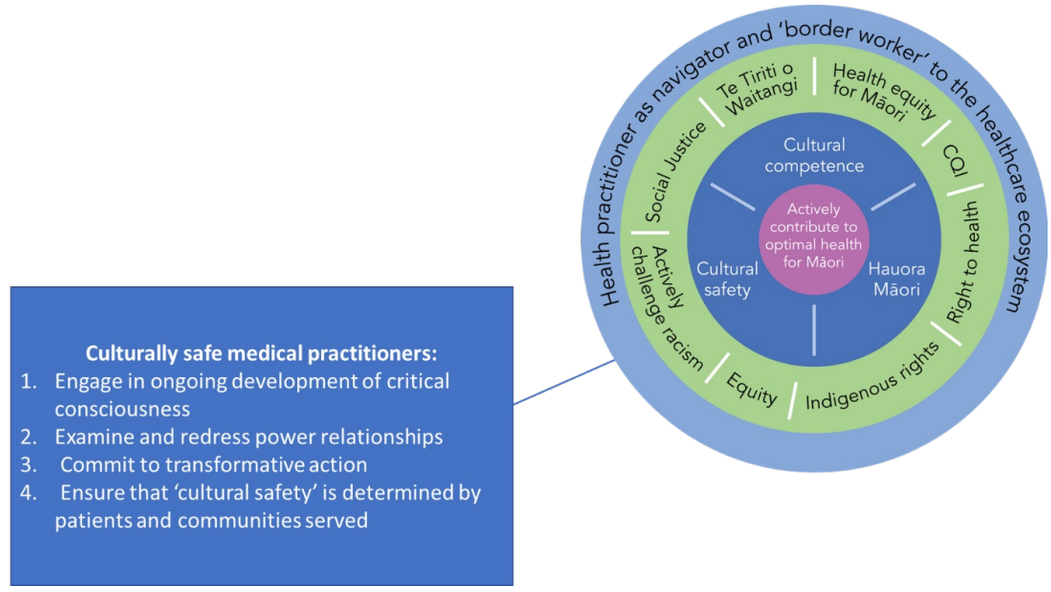

Figure 2: Cultural safety key proficiencies

Key proficiency 1. Culturally safe medical practitioners engage in ongoing development of critical consciousness

Description

Being a culturally safe practitioner requires doctors to first turn the lens on themselves. Doctors need to have knowledge of their own ethno-cultural heritage, and the values and assumptions they bring to clinical interactions (Dargaville, 2020; Downing et al., 2011; Medical Council of New Zealand, 2019a; Ramsden 2002; Sjorberg & McDermott, 2016; Waitoki, 2012; Zaidi et al., 2017).

Culturally safe doctors are aware that they bring conscious and unconscious assumptions and bias to their interactions with patients and colleagues (Downing et al., 2011; Jennings et al., 2018; Kirmayer, 2012; Watt et al., 2016). They work hard to identify these biases, critically consider how this affects their interaction with patients, communities, and colleagues, and commit to transformative action to ensure that their biases do not negatively affect the quality of care they provide to patients.

Critical consciousness is an empowering, strengths-based approach that promotes introspective practices and active engagement in solutions to challenge inequity and oppression. The development of critical consciousness is central to being a culturally safe practitioner. Culturally safe doctors engage in ongoing self-reflection and self-awareness (Curtis et al., 2019). Their practice is also characterised by the knowledge that patients and whānau are the ones who determine and define whether the care they provide is culturally safe. This commitment to reflexive practice is foundational to developing proficiency in the other domains of culturally safe practice.

Enabling Proficiencies

Cultural safety training and education should equip doctors to:

1.1 demonstrate understanding of their own cultural heritage, values and history
1.2 identify and address their own biases, attitudes, assumptions, stereotypes, prejudices, privileges and characteristics that may affect the quality of healthcare provided
1.3 engage in ongoing self-reflection and self-awareness of own conduct and interactions to identify and remedy oppressive practices in interactions with patients, whānau and communities
1.4 engage in ongoing self-reflection and self-awareness of own conduct and interactions with colleagues in the workforce to uphold culturally safe spaces
1.5 commit to transformative change, and identify and implement alternative personal practices that contribute to equity and ongoing progression towards optimal health for Māori.

Key proficiency 2. Culturally safe medical practitioners examine and redress power relationships

Description

Culturally safe doctors are aware of the way in which power dynamics play a part in shaping the doctor-patient relationship (Downing et al., 2011). They recognise historical events and contemporary power structures that undermine Māori health equity (Jones et al., 2010; Dargaville, 2020; Kurtz et al., 2018; Medical Council of New Zealand, 2019a; Sundberg et al., 2019; Waitoki, 2012). Culturally safe doctors know that this context affects their interactions with patients and whānau. They do not accept that doctors should hold the power within the relationship; they deliberately learn, develop and implement strategies to redress this power imbalance.

Authentic power sharing requires relinquishing a level of power from doctor to patient and whānau, and empowering patients with closer involvement in healthcare decision-making. This also serves to build trust, and acknowledges the patient as expert in their own life and situation.

Culturally safe doctors also turn a lens on power relationships within the workplace, particularly regarding their Māori colleagues. They take active steps to embed workplace behaviours, attitudes, policies, and structures that support a safe and equitable work environment for Māori.

Culturally safe doctors are critical allies. They are aware of their sphere of influence, or 'locus of power' (Ramsden, 2002) and consider what they are empowered to do within

that sphere, and in different contexts, in order to effect positive change within their workplace and the broader healthcare ecosystem.

Enabling Proficiencies

Cultural safety training and education should equip doctors to:

- 2.1 recognise and advocate for the rights of patients, whānau, communities and tangata whenua
- 2.2 examine and redress power imbalances between themselves and patients, whānau, the community, and tangata whenua
- 2.3 relinquish and leverage their own power to develop reciprocal relationships with patients and their whānau to foster shared decision making and informed consent throughout treatment
- 2.4 examine and redress power imbalances within the healthcare profession and workforce
- 2.5 examine and influence power imbalances in the institution or organisation they work for, and the wider healthcare ecosystem.

Key proficiency 3. Culturally safe medical practitioners commit to transformative action

Description

Culturally safe doctors understand that achieving health equity requires changing the conditions that create systematic differences in health experiences and outcomes. They identify structural and environmental barriers that influence their ability to provide culturally safe care, and advocate for and contribute to positive change (Dargaville, 2020; Jennings et al., 2018; Watt et al., 2016).

Culturally safe doctors embrace their role as an agent of change (Ramsden, 2002). They take a critical look at the healthcare ecosystem, and their role within it, and challenge the status quo. They commit to transformative action, demonstrating creativity, courage, passion and leadership to affect positive change. A key aspect of this proficiency is the need for doctors to support and critique their colleagues and peers on their journey to culturally safe practice.

Enabling Proficiencies

Cultural safety training and education should equip doctors to:

- 3.1 analyse and critique the healthcare ecosystem and its structures and processes that reinforce health advantage and disadvantage
- 3.2 identify structural barriers to equitable, culturally safe care within the institution or entity where they work
- 3.3 analyse and critique the culture and relationships amongst colleagues in their workplace and identify oppressive elements in workplace culture, and support their colleagues on the journey of cultural safety
- 3.4 examine health outcomes for Māori patients in clinical audit and case reviews, and identify interventions to eliminate inequities, and progress towards optimal health
- 3.5 identify solutions to structural and institutional barriers, and contribute to, implement and embed transformative change.

Key proficiency 4. Culturally safe medical practitioners ensure that 'safety' is determined by patients and communities

Description

Culturally safe doctors know that patients, whānau and communities define what culturally safe care means and looks like (Curtis et al., 2019; Dargaville 2020; Truong et al., 2014). They make time and space for open and authentic discussions, and listen to and action feedback and recommendations. An important facet of seeking feedback and input to ensure cultural safety in healthcare is to consult and engage with tangata whenua and mana whenua, and follow their advice and recommendations. The mechanisms for this engagement will depend on the context in which the practitioner is operating – for example, engagement with mana whenua may be at the organisational level, and the individual doctor's responsibility is to familiarise themselves with and act upon the resultant advice.

Culturally safe doctors know that power dynamics come into play when seeking patient feedback and are careful to balance obtaining feedback in a way that does not put pressure on, or overburden patients, whānau and communities. They also seek out, critique, and draw on research on patient perspectives and experiences, specifically including kaupapa Māori research and including a diverse range of voices and perspectives.

Enabling Proficiencies

Cultural safety training and education should equip doctors to:

- 4.1 make provision for regular feedback and input from patients, whānau and communities on the cultural safety of the healthcare environment, interactions and care provided
- 4.2 advocate for their organisation to ensure regular feedback and input from tangata whenua/mana whenua on the cultural safety of the healthcare environment and interactions
- 4.3 implement recommendations from patients, whānau, and communities, and tangata whenua, in personal practice
- 4.4 identify and critique research and information that draws on a diverse range of patient perspectives and experiences, to shape policy, practice and healthcare interactions
- 4.5 identify kaupapa Māori research that presents tangata whenua perspectives and experiences, to shape policy, practice and healthcare interactions.

5. Teaching and Assessment Rubric and Self-Assessment Tool

Assessing the development of culturally safe practice requires a focus on changes in the knowledge, skills, attitudes and behaviours of practitioners (Clifford et al., 2017; Dargaville, 2020; Maldonado et al., 2014). A key facet of cultural safety emphasises evaluation of practice as defined by the people accessing care. It is vital to include patient experience and patient feedback in assessments for cultural safety (Dargaville, 2020; Truong et al., 2014). This section provides guidance for medical colleges on **teaching methods** and activities, and **assessment methods** that can be used to evaluate practitioner development of cultural safety practice. Also provided is a **self-assessment and reflection tool.**

5.1 Teaching and assessment rubric

The table on the following spread (Table 2) provides guidance on how the cultural safety proficiencies described in this plan can be taught and assessed through a cultural safety education and training programme.

It is important to note that while it is intended that the cultural safety key and enabling proficiencies remain constant and unchanged, the suggested teaching methods and assessment tasks are provided as guidance only. Medical colleges can adapt the specific teaching methods, activities and assessment tasks or CPD activities to suit the context of their own vocational training curriculum and their exisiting training and assesment structure, provided each of the proficiencies is reflected in the teaching and assessment activities. Similarly, the suggested teaching methods and activities and assessment tasks can also be applied to the delivery of Hauora Māori and cultural competence training, which can be delivered together with cultural safety training.

There are three types of teaching methods suggested. These are:

1. **self-directed learning** (individual learning such as through online courses, collation and critique of research, analysing guidance materials and resources, or critical analysis of case studies)
2. **didactic learning** (workshops, seminars, wānanga or presentations)
3. **peer group** (sharing, discussions, analysis, group work, mentoring or tuakana/teina relationships)

The assessment methods (e.g., journals, case studies, clinical audit, and personal development plans) are suggested so as to be familiar to learners and therefore more likely to be met without apprehension. As is the habit of CPD plans, these assessments will be systematically filed and audited by the College. It is expected, as is presently the practice, that completion of cultural safety work is compulsory.

5.2 Adapting the teaching and assessment rubric

Aside from the competencies, the rubric outlined above is intended to be adaptable. The suggested teaching methods and activities and assessment/CPD tasks are designed as a guide, and not all activities or assessments need to be incorporated into the curriculum.

It is intended that the colleges have the flexibility to design assessment methods and CPD tasks that align with their current assessment/CPD framework. For example, colleges that use Workplace Based Assessment tools could incorporate assessment of the cultural safety proficiencies into Case Based Discussions and Mini-CEX observations. Similarly, colleges that offer Entrustable Professional Activities (that is, work tasks that trainees need to be able to perform with supervision at a distance by the end of their vocational training) can require the proficiencies to be demonstrated through clinical practice tasks.

5.3 Cultural safety practice self-assessment tool

Cultural safety is not something that can be 'achieved': it is a lifelong journey of continual reflection and development. The new knowledge, skills, and behaviours learned through the cultural safety training programme need to be regularly reflected upon, embedded, normalised and maintained.

In addition, understanding of cultural safety and best practice approaches to culturally safe care will develop over time and the evidence base will grow. It is therefore important to recognise that the development of culturally safe practice must continue beyond the formal 'training' period. Accordingly, completing these learning activities to develop cultural safety proficiencies is ongoing and not a "one off" event. Longitudinal assessment should be incorporated into the implementation of the training plan.

The following continuum provides a model of the stages of progress in developing culturally safe practice (Table 3). This can be used as a tool for self-assessment of practitioners, and can also serve as both a needs analysis to identify teaching and learning needs of a group, and as an evaluation for teaching, in order to demonstrate progress and further training requirements. It is based on the idea of an ever-increasing awareness of cultural safety. To utilise this tool, practitioners can self-rate 'where they are at' with respect to each of the enabling proficiencies in the training plan. This requires self-reflection on existing practice, and identifying areas for change and progression.

Table 3: Self-assessment continuum

I'M AWAKE TO THIS	I'M ONTO THIS	I'VE GOT THIS
This signifies an awakening or raising of awareness and understanding, and early stages of the development of knowledge and skills, and of identifying transformative changes needed.	This indicates deeper understanding and the beginning of transformative action, putting into practice behaviours and actions that support and promote cultural safety.	This signifies normalising and habitualising practices that promote cultural safety, and that these practices have become embedded. It does not signal an 'end point' but indicates the continuing pursuit of advancement and growth.
Practices observed at this stage of development include: • Developing critical analysis skills • Recognising and identifying where change is needed (internal, interpersonal, structural).	Practices observed at this stage of development include: • Acting on opportunities to create change (internal, interpersonal, structural) • Initiating and contributing to transformative change	Practices observed at this stage of development include: • Embedding transformative change as normalised practice (internal, interpersonal, structural) • Regularly reflecting on, reviewing and refining practices.

Table 2: Suggested teaching methods and assessment tasks/CPD activities

CULTURAL SAFETY PROFICIENCIES	SUGGESTED TEACHING METHODS AND ACTIVITIES	ASSESSMENT TASKS/CPD ACTIVITIES
Proficiency 1. Culturally safe medical practitioners engage in ongoing development of critical consciousness		
1.1 Demonstrate understanding of their own cultural heritage, values and history 1.2 Identify and address their own biases, attitudes, assumptions, stereotypes, prejudices, privileges and characteristics that may affect the quality of healthcare they provide 1.3 Engage in ongoing self-reflection and self-awareness of own conduct and interactions to identify and remedy oppressive practices in interactions with patients, whānau and communities 1.4 Engage in ongoing self-reflection and self-awareness of own conduct and interactions with colleagues in the workforce to uphold culturally safe spaces 1.5 Commit to transformative change, and identify and implement alternative personal practices that contribute to equity and ongoing progression towards optimal health for Māori.	**Self-directed learning:** • Research practitioner's own cultural background • Undertake critical analysis of a case study within own medical specialty to recognise stereotyping and discrimination that create barriers for Māori to high quality health care. **Didactic learning:** Workshops, seminars or presentations on implicit bias, stereotypes, privilege, racism and strategies to counter own biases. **Peer group learning:** Discussions to reflect on interactions with patients and colleagues, identify biases within these interactions, discuss case critical analysis, reflect on workshops and develop strategies to implement equity enhancing practices.	Assessment/CPD task 1: **Self-reflection journal** This assessment should focus on the practitioner's critical and honest reflections on a clinical encounter (or encounters). The journal should include evidence of self-reflection against the proficiencies, including the biases they brought to the clinical encounters and interactions with colleagues, and the identification of transformative change strategies they will implement within their scope of practice and in their workplace.
Proficiency 2. Culturally safe medical practitioners examine and redress power relationships		
2.1 Recognise and advocate for the rights of patients, whānau, communities and tangata whenua 2.2 Examine and redress power imbalances between themselves and patients, whānau, the community, and tangata whenua 2.3 Relinquish and leverage their own power to develop reciprocal relationships with patients and their whānau to foster shared decision making and informed consent throughout treatment 2.4 Examine and redress power imbalances within the healthcare profession and workforce 2.5 Examine and influence power imbalances in the institution or organisation they work for, and the wider healthcare ecosystem	**Self-directed learning:** • Online course, guidance sheets and/or readings on power relationships in clinical encounters • Case studies within own medical specialty that provide examples of redressing power imbalance, shared decision making and informed consent in clinical interaction. **Didactic learning:** Workshops, seminars, wānanga or presentations on the context of colonisation, rights to health, indigenous rights, social justice and Te Tiriti o Waitangi. **Peer group learning:** Simulation techniques, in CPD/ peer group such as role play, to practice techniques for redressing power imbalances with patients and in the workplace.	Assessment/CPD task 2: **a) Case study repor**t that allows the practitioner to demonstrate practical application of strategies to redress power imbalances in a clinical case. **b) Presentation** on case study report. This short presentation to be delivered to peer group, providing a wider range of case studies for peer learning experience.

Proficiency 3. Culturally safe medical practitioners commit to transformative action		
3.1 Analyse and critique the healthcare ecosystem and its structures and processes that reinforce health advantage and disadvantage 3.2 Identify structural barriers to equitable, culturally safe care within the institution or entity they are employed by 3.3 Analyse and critique the culture and relationships amongst colleagues in their workplace and identify oppressive elements in workplace culture, and support their colleagues on the journey of cultural safety 3.4 Examine health outcomes for Māori patients in clinical audit and case reviews, and identify interventions to eliminate inequities, and progress towards optimal health 3.5 Identify solutions to structural and institutional barriers, and contribute to, implement and embed transformative change.	**Self-directed learning:** • Online course, guidance sheets and/or readings on structural barriers to equitable care. **Didactic learning:** • Workshops, seminars, wānanga or presentations on ethnic inequalities in health (focusing on Māori health), the social determinants of health, and strategies to reduce health inequalities • Guest speaker presentation to relate a personal experience of transformative action in medical specialty. **Peer group learning:** • Analysis of workplace culture • Clinical audit of health outcomes for Māori patients • Monitor clinical pathways for factors that facilitate or act as barriers for achieving equity and optimal health for Māori • Discussions to critically reflect on healthcare ecosystem, identify transformative actions to address structural barriers in the healthcare environment, and solutions to create an equity-supporting environment for patients and whānau.	Assessment/CPD task 3: **Clinical audit report and transformative change plan** This should detail the outcomes of clinical audit, proposed transformative actions to address inequity within own spheres of influence in the healthcare ecosystem, review of previous transformative actions implemented, and evidence of progress towards equity.
Proficiency 4. Culturally safe medical practitioners ensure that 'safety' is determined by patients & communities		
4.1 Make provision for regular feedback and input from patients, whānau and communities on the cultural safety of the healthcare environment, interactions and care provided 4.2 Advocate for their workplace to ensure regular feedback and input from tangata whenua/mana whenua on the cultural safety of the healthcare environment and interactions 4.3 Implement recommendations from patients, whānau, and communities, and tangata whenua, in personal practice 4.4 Identify and critique research and information that draws on a diverse range of patient perspectives and experiences, to shape policy, practice and healthcare interactions 4.5 Identify kaupapa Māori research that represents tangata whenua perspectives and experiences, to shape policy, practice and healthcare interactions.	**Self-directed learning:** Collation and critique of research on patient perspectives, including kaupapa Māori research and research from other diverse perspectives, on culturally safe practice within their medical specialty. **Didactic learning:** Workshops, seminars or presentations on tools and techniques for gathering feedback from patients, whānau, communities and tangata whenua. **Peer group learning:** Discussion and sharing of strategies to collect and implement patient perspectives and needs.	Assessment/CPD task 4: **Strategy development plan** Development of a process (or refresh existing process) to gather perspectives from patients, whānau and communities, the process for implementing recommendations, evidence of implementation of previous recommendations, and any evidence of improvement in cultural safety as defined by patients and communities.

6. Implementing the Training Plan

This section provides guidance for colleges for implementing the training plan to develop cultural safety education and training.

6.1 Jurisdictional context

This training plan has been designed to reflect the unique context of Aotearoa, and therefore focuses on cultural safety through the lens of Māori health equity and achieving and maintaining full health potential for Māori patients and whānau.

Australasian colleges will need to consider how the plan can be adapted to ensure that it meets the needs of registrars and fellows, and the individual institutes, in both jurisdictions, without 'diluting' the core focus on educating Aotearoa-based practitioners to work towards optimal health of Māori.

The focus of cultural safety education and training is on self-reflection and transformative action, rather than acquiring knowledge and skills. Therefore, the key proficiencies and enabling proficiencies are likely to remain relevant in an Australian context and can be applied across indigenous and other cultural groups. Similarly for cultural competence, which focuses on skills required for cross-cultural communication. However, the specifics of cultural safety curriculum development, training methods, learning activities and assessment methods will need to be tailored to the context of Aboriginal and Torres Strait Islander health equity and achieving full health potential, for its application in the Australian context.

6.2 Cultural safety of the college environment

It is vital for medical colleges and accredited training providers to be culturally safe at the organisation level, and develop an organisational approach to culturally safe practice (Berg et al., 2019; Clifford et al., 2015, 2017; Curtis et al., 2019; Dargaville, 2020; Downing et al., 2011; Laverty et al., 2017; Lenette, 2014; Matheson et al., 2018; Palmer et al., 2019; Shepherd, 2019; 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, including medical colleges, 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.

Prior to implementing this plan, medical colleges need to demonstrate commitment to health equity and achieving optimal health for Māori. Cultural safety should be made explicit within the organisational vision, mission statements, strategic priorities, and strategies. The content of the cultural safety training and education will need to align with the cultural safety statement or policy of the college.

6.3 Curriculum development

6.3.1. Context of the medical specialty

This training plan has been designed so that the vision, aim, domains, cultural safety key proficiencies and enabling proficiencies remain constant across the medical colleges.

The delivery of the educational programme for each college requires operationalising this plan into a curriculum that aligns with the context of the college's medical specialisation. This requires consideration of the resources available that are relevant to its context (including academic resources, community resources, relevant case studies, teaching staff and guest speakers with relevant expertise and experience, locations for experiential learning, development and strengthening of relationships with locations). It may also entail developing specific resources where none are available to support the teaching and learning of a particular proficiency.

The role of the health practitioner as a border worker and navigator between patients and whānau and the health ecosystem is a central focus of the cultural safety proficiencies, and the details of the healthcare ecosystem will differ for each medical specialty. The specifics of the healthcare ecosystem will need to be identified for each medical specialty, including key stakeholders and their roles, interactions and relationships, and lines of power and decision-making.

In addition, while there are no specific proficiencies directly related to the eight key elements that underpin cultural safety training (Te Tiriti o Waitangi, health equity for Māori, continuous quality improvement, right to health, indigenous rights, equity, actively challenging racism and social justice, see Figure 2), these are topics worthy of pursuit by the practitioner, and provide much of the rationale for cultural safety training.

It is intended that, in implementing the training plan, each college will contextualise the content to ensure it is relevant to its vocational scope. Colleges can orientate the training and education programme to the medical specialty area by tailoring the training methods, activities, assessment and self-assessment tool to the context and range of interactions for the medical specialty. This may include:

- peer group discussions, case study presentations, group assessment work and scenarios based in the medical specialty area
- online learning resources and guest speakers with experience in the medical specialty area
- academic research and resources relevant to the medical specialty, including Kaupapa Māori research, and research from diverse population groups, and including research and resources incorporating community and patient voice
- tailoring the self-assessment tool to include detailed proficiencies for the medical specialty.

6.4 Delivering the training

6.4.1. Educator workforce

It is vital 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). A key competency of educators is the ability to create safe learning spaces. Cultural safety education asks practitioners 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, and support learners in sustained dialogue and introspection; and provide pastoral care through the learning process (Dargaville, 2020; Sukhera & Watling, 2017; Zaidi et al., 2017).

6.4.2. Avoiding cultural loading

While cultural safety is the practice of self-reflection with the view to improving interactions, and ultimately improving outcomes for Māori and other population groups, the teaching and delivery of cultural safety must be delivered by those with appropriate skills and expertise on guiding self-reflection and transformative change. This is not necessarily the responsibility of Māori educators, and of particular importance, both during curriculum development and delivery, is the need to avoid 'cultural loading' of Māori fellows, practitioners and educators. The skill and expertise of any Māori involved in the curriculum development and delivery needs to be recognised and remunerated appropriately.

Delivery of cultural safety education also needs to be carefully considered to ensure the safety of Māori clinicians. For example, during teaching sessions or peer group discussions, expecting Māori clinicians to lead discussions on power imbalances with non-Māori colleagues could result in compromised safety for Māori. A more appropriate structure may be for Māori educators to work with Māori practitioners, and non-Māori educators to work with non-Māori practitioners on these issues, in order to maintain the cultural safety of the learning environment itself.

7. Evaluation Plan

The CMC and Te ORA will undertake an evaluation of the cultural safety training plan. The parameters of the evaluation are described below

7.1 Evaluation questions

The following questions are proposed to frame the evaluation:

1. How well is the cultural safety training plan supporting medical colleges to deliver cultural safety training?
2. To what extent are the suggested training and assessment activities relevant to the needs of medical practitioners?
3. How effective and appropriate are the cultural safety proficiencies in enhancing the culturally safe practice of trainees and fellows?
4. To what extent has the delivery of the cultural safety training plan resulted in observable changes in the cultural safety practice of trainees and fellows?
5. What changes could be made to the cultural safety training plan to enhance its effectiveness?

Table 4: Evaluation methods and data sources

METHOD	DATA SOURCE	DESCRIPTION
Survey	All CMC member colleges	The survey offers an opportunity to gather quantitative information from colleges. It is recommended that one response per college be sought. The survey instrument should be based on the evaluation questions, seeking specific information on aspects of interest (for example, respondents could be asked to rate the relevance of four cultural safety proficiencies, or the appropriateness of the teaching methods). It is recommended that the survey include mainly closed questions using Likert scales and ordinal variables, with a small number of free text responses.
Key informant interviews	A sample of personnel from 4-6 colleges involved with the delivery of cultural safety training	Key informant interviews will provide an opportunity to gather qualitative data on the experience of those who are delivering the training. The interviews should be semi-structured, and seek perceptions on successes and challenges implementing the training plan, and views on aspects that could be improved.
Focus group hui	Māori fellows and trainees Non-Māori fellows and trainees	It will be important to seek the views of the intended audience for the training plan. The use of focus group hui allows for efficient data collection, and can create additional insights as listening to others' views can spark new thoughts. The focus group discussion should be guided by a series of prompts based on the evaluation questions.

Table 4: Evaluation methods and data sources (contiunued)

METHOD	DATA SOURCE	DESCRIPTION
Document and data review	College materials such as curricula, training resources, data on training delivery and uptake	This will provide evidence on how colleges have operationalised and delivered the cultural safety training plan, including what changes and adaptations have been made.

7.3 Timing

It is recommended that the evaluation be conducted within four years of the training plan being launched.

7.4 Use of evaluation findings

The findings of the evaluation should be used to inform adaptions to the training plan to ensure it remains relevant, fit-for-purpose and in line with current research.

Bibliography

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

Australian Medical Council (2015). S*tandards for assessment and accreditation of specialist medical programs and professional development programs*. https://www.amc.org.au/wp-content/uploads/accreditation_recognition/specialist_edu_and_training/assessment/standards_for_assessment.pdf

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. B*MC Medical Education*, 21(1), 1-8. 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. *International 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. *Journal of Educational Evaluation for Health Professions*, 16. 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/10.21767/2049-5471.100010

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. I*nternational 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. *International Journal for Equity in Health,* 18(1), 1-17.

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). Waiwhakaata: 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 Revie*w, 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. *International 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. *BMC 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. *Journal 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

Koptie, S. (2009). "Irihapeti Ramsden: The Public Narrative on Cultural Safety". F*irst Peoples Child & Family Review*, 4(2), 30-43. https://fpcfr.com/index.php/FPCFR/article/view/136

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 Australia*, 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. *The International Journal of the First Year in Higher Education*, 5(1), 117-123. 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. (2008). *Best health outcomes for Māori: Practice implications*. http://www.indigenouspsych.org/Resources/Best_Health_Outcomes_for_Maori.pdf

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

Medical Council of New Zealand. (2019b). *He Ara Hauora Māori: A Pathway to Māori Health Equity*. https://www.mcnz.org.nz/assets/standards/6c2ece58e8/He-Ara-Hauora-Maori-A-Pathway-to-Maori-Health-Equity.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 Teacher*, 41(9), 1045–1052. https://doi.org/10.1080/0142159X.2019.1615608

Ramsden, I.M. (2002). C*ultural safety and nursing education in Aotearoa and Te Waipounamu*. [Doctor of Philosophy in Nursing]. Victoria University of Wellington.

Reid P & Robson B (2007). *Understanding Health Inequities*. Chapter 1 in Hauora: Māori Standards of Health IV, a study of the years 2000-2005. Wellington: Te Rōpū Rangahau Hauora a Eru Pōmare.

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), 1-10. 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. (2018). A Framework for Integrating Implicit Bias Recognition into Health Professions Education. *Academic Medicine*, 93(1), 35-40. 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. *Journal of Graduate Medical Education*, 11(6), 624–628. https://doi.org/10.4300/JGME-D-19-00078.1

Te ORA and Council of Medical Colleges. (2020). *Choosing wisely means choosing equity*. Choosing-Wisely-July-2020.pdf (teora.maori.nz)

Te ORA and Council of Medical Colleges. (2021). *Cultural safety within vocational medical training*. final-te-ora-cmc-cultural-safety-report-20210512.pdf

Te ORA and Council of Medical Colleges. (2022). *Literature scan and environmental scan of cultural safety in medical training* [unpublished].

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). *The 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