Cultural Safety in Practice

A Curriculum for Family Medicine Residents and Physicians

IPAC-RCPSC

March 2009
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Introduction

Family physicians play a pivotal role in advancing the health and healing of Indigenous peoples in Canada. While many Indigenous peoples have experienced challenges with the health care system in Canada, family physicians can continue to act within their scope of professional capacity to help address the persistent health disparities in these diverse communities. The purpose of this work is advance cultural safety as a pedagogical format and a specific skill-set to improve the quality and quantity of care delivered to First Nation, Inuit and Métis patients by family physicians in Canada.

The roots of cultural safety in the health-care system lie in the education of its health-care providers. The Indigenous Physicians Association of Canada (IPAC) and the Royal College of Physicians and Surgeons of Canada (RCPSC) have thus collaborated to produce this training module for family medicine residents and physicians.

The material has been developed by the IPAC–RCPSC Family Medicine Curriculum Development Working Group and is based on the original frameworks of First Nations, Inuit, and Métis Health Core Competencies for Undergraduate, Postgraduate and Continuing Medical Education.

The Undergraduate Core Competencies, developed by the Indigenous Physicians Association of Canada in partnership with the Association of Faculties of Medicine of Canada (AFMC), prompted the development and extension of such Core Competencies into Postgraduate Medical Education (PGME) and Continuing Medical Education (CME) by IPAC in partnership with the Royal College.

A clinical scenario with a presenting complaint that is common in a family practice setting is a springboard to guide learners through a consideration of cultural safety, particularly as it relates to First Nations, Inuit and Métis patients.

The goal of the preparation, seminar and homework is to increase the likelihood that the participant will establish a culturally safe environment for Indigenous patients in their family practice. Learners will employ self reflection as a key skill within the paradigm of cultural safety and leading to the provision of a culturally safe clinical environment.

The success of this curriculum will be dependent upon creating a learning milieu in which participants can begin to reflect on their world view, observe how it might be different from that of their patients, and to engage in a therapeutic encounter that is Indigenous centered.
Culturally unsafe care or teaching:

Culturally unsafe care or teaching may occur when the values, ethics, knowledge or epistemologies of a First Nations, Inuit and Métis person are not valued or respected during a clinical encounter.

Culturally unsafe care or teaching often results from a negative portrayal of Indigenous people in curricula, a lack of acknowledgement of the historical experience of Indigenous people and the resulting impact on the health and health behaviours of these communities. As well, culturally unsafe can be perpetuated through acts of racism and discrimination at the various levels of the health care system.

Additionally, a lack of inclusion of the determinants of health for Indigenous peoples (such as access to health services due to geography and a lack of linguistic and cultural support) further define some milieus where culturally unsafe care can be perpetuated.

The material in this module is meant to be the first step in a long process. Each physician who uses the module, whether he or she is an educator or a learner, will bring his or her own perspectives and experiences to the material. We hope that users will share their views of the material with us and suggest ways to improve it; their generosity will enrich the module for the benefit of those who come after them.
Teaching requirements

Time
This session will require approximately 1-2 hours of teaching time.

It is intended to provide a training simulated office oral (SOO) experience within a family medicine residency training program.

Materials
- Room/space:
  - A training room that allows visual observation, either with a one-way mirror or with video equipment
- Internet connection: recommended
  - Facilitators may wish to search for information beneficial to the learner during the teaching session.
- DVD player: optional
  - A facilitator or training program may choose to tape two sessions for further review by the learners.
- Flip chart
- Whiteboard
- Paper, pencils

Resources
Fact sheets and information materials are included in summary form in this package; however, access to websites through an internet connection will enhance the session.

Resource lists and a bibliography are also included. Facilitators should be sure to review all resources before the session.

Teaching format
This module can be utilized for either small group or individual training sessions.

If learners are engaged in practice oral exams, this SOO will give them the opportunity to build their skills in conducting a patient interview and to reflect on their skills levels.
Cultural Safety in Practice
A Curriculum for Family Medicine Residents and Physicians

Glossary
Note: Publication details for all works cited in this glossary are available in the list of Resources.

**Indigenous knowledge:** Indigenous knowledge is a complete knowledge system with its own epistemology, philosophy and scientific and logical validity… which can only be understood by means of pedagogy traditionally employed by the people themselves” (Battiste and Henderson, 2000, p. 41). In other words, Indigenous knowledge is Indigenous people’s collective understanding of how the social, spiritual, political and economic ways of understanding the universe and their place within it as a community or nation interact. These ways of knowing are based on and guided by traditional interpretations of these ways of understandings in everyday contexts.

**Inuit knowledge or Inuit Qaujimaningit:** “[Inuit Qaujimaningit] (or traditional knowledge) results from our age-old connection to our land and its living resources, and the inseparable relationship that exists between our land, resources and culture. Attachment to the land through personal histories, stories and place names is just as important as more functional attachments based on areas of good hunting, travel routes and specific knowledge about the physical environment and living resources.” (Inuit Tapiriit Kanatami, 2007)

**Traditional knowledge:** Traditional knowledge is considered to be synonymous with Indigenous knowledge, but this term is generally used to refer to the history, ceremonies, practices and beliefs of a particular group that have been passed down from previous generations.

**Family:** Family can be defined by First Nations, Inuit or Métis to mean persons in one’s immediate family, such as a parent or child, who are related by blood or by adoption. The term may also be used to refer to extended family members, such as aunts, uncles and cousins, who are related either by both blood or by marriage. Family may also include persons related by clan, kinship lines, shared lands or ceremonial or traditional adoptions.

**Knowledge transfer:** Knowledge transfer is a process by which two different entities share knowledge. This process is neither hierarchal nor lateral but rather an interaction in which information is shared between individuals or groups in a way that is easily understood by both. It is sometimes referred to as knowledge exchange.

**Culturally unsafe care or teaching:** Culturally unsafe care or teaching may occur when the values, ethics, knowledge or epistemologies of a First Nations, Inuit and Métis person are different from those of their health-care provider. Culturally unsafe care or teaching often results from a negative portrayal of Aboriginal peoples in curricula, a lack of acknowledgement of the historical experience of Aboriginal Peoples and the effects of colonization on them, and basic access barriers (geographic, linguistic or cultural).
Cultural sensitivity: Cultural sensitivity is an acknowledgement by the health practitioner or educator that the patient or student is of a different culture than their own and therefore may have a different way of understanding the world. It is possible for a practitioner or teacher to be culturally sensitive without necessarily being culturally competent or providing a culturally safe environment. Cultural sensitivity can be thought of as the first step toward learning about oneself within the context of one’s interaction or relationship with people of a different culture.

Epistemology: Epistemology is the study of the nature and scope of knowledge. It is a branch of philosophy.

Protocol: A protocol is the set of defined methods or procedures or both for completing a task. Ceremonial or spiritual protocols are the traditionally prescribed ways in which items are handled; protocols may indicate which individuals can participate in a ceremonial or spiritual event, roles and responsibilities, and where and when the event will take place. These protocols may vary by nation, culture, language group, geographic area, and gender.

Sacred: This term may refer to specific ceremonial items (drums, medicine bundles, pipes, tobacco and other plants, etc.) as well as particular locations; in some traditions it may also refer to the body or body parts. Although the term may refer to specific items similar to the religious artifacts of “formal” religions (crucifixes, icons, the Koran, rosaries, etc.), Indigenous conceptions of the sacred tend to be broader than they are in a church, temple, synagogue or mosque.

Ceremony: Ceremonies are central to many Indigenous conceptions of health and healing. Ceremonies may also be seen as necessary in the preparation for, and recovery from, specific medical procedures. They may include songs, prayers, pipe ceremonies and smudge (cleansing) ceremonies, among others. Ceremonies vary by nation, culture, language group, geographic area, and gender. Conversely, many First Nations, Inuit and Métis people may not observe traditional practices or share in the traditional beliefs or customs so learners are cautioned to avoid stereotyping based on Indigenous heritage.
Goal and Objectives

Goal
The module has been developed with a focus on the development of skill sets that will enable the learner to provide culturally safe care.

Objective 1:
The learner will be able to identify three features of a culturally safe interview with a First Nations, Métis or Inuit patient. (Communicator, Professional)

Objective 2:
The learner will be able to identify the range of healing and wellness practices available within the local community for a First Nations, Métis or Inuit patient. (Medical expert)

Objective 3:
The learner will be able to identify resources and services available to support First Nation, Inuit and Métis patients in achieving optimal health. (Manager, Collaborator)

Objective 4:
The learner will be able to describe an effectively integrated care plan for the First Nations, Métis or Inuit patient in a rural, urban or remote location. (Collaborator, Manager, Medical expert)
Learning activities

The module has been developed as a simulated office oral (SOO) for family medicine postgraduate and continuing medical education training.

Each objective provides teaching and learning points, with weighted points granted to each identified point.

A faculty member should do the role playing, with the learner in the inquiry role. A standardized format for delivery of the SOO will allow for a basic script and training to be developed, and the faculty member will be able to develop local content and resources for the specific area of the training program.

Source: National Aboriginal Health Organization, 2008b
Simulated Office Oral (SOO)

(Role playing: 5 minutes; teaching and discussion: 30 minutes)

You are Anna McDonald, a 26-year-old First Nations (Anishinabe) woman, an Ontario university student (pursuing a degree in anthropology, with plans to continue on to law school), and this is your first visit to the clinic. You are here because you are worried about your blood pressure.

You have been under quite a bit of stress with school and have been experiencing some headaches. You took your blood pressure (BP) at the pharmacy and found it to be 140/95, which read as “high.” The headaches occur 1-2 times a week, are bilateral and frontal in location, and feel like a tight band around your head. They are not accompanied by visual symptoms, nausea or photophobia. They come on gradually over the course of the day and respond reasonably well to OTC analgesics. They do not interfere with activity, except that you have opted out of some recreational team sports activities recently.

You were not concerned about the headaches, as you have had similar problems occasionally in the past, until you noted the elevated BP. You would like to know what this means for your health and what you can do about it.

You have no other health problems as far as you know. You do not experience chest pain or shortness of breath with activity. You do not have dizziness, palpitations, sweating or fever. You have no urinary symptoms and have not had bladder infections. Your exercise tolerance is good, and you play volleyball twice a week with a recreational team when your studies allow and you do not have a headache. Your weight has been stable and your appetite is fine.

You are fatigued, and you often miss hours of sleep because of studying, but your mood is okay. Although your studies are going well, you feel out of place, as if you don’t fit in with the university crowd. You have been hurt by comments from fellow students who alluded to their mistaken belief that you “got in easy” and don’t have to pay for your education. Additionally, you have had to challenge racist beliefs by some of your professors and fellow students. This has been particularly painful since you did not experience this in your community of origin. At times, you describe feeling “caught between two worlds” and crave the company of people who understand you and who share your feelings.

You have recently signed up to be a mentor at the Aboriginal Students’ Association. You want to have an opportunity to be supported in your educational experience and wonder if other First Nation students have experienced the same negative stereotypes as you have at the university.

You drink alcohol once every 2 weeks, one or two beers with friends on a weekend, and smoke socially. You have coffee daily, 2-3 cups in the morning. You do not use any illicit drugs or over the counter (OTC) medications except for acetaminophen or ibuprofen, and you take no prescription medications. You have never taken the Birth Control Pill (BCP) and are not currently involved in an intimate relationship. You have never been pregnant and have had no surgeries. You have no allergies.

You do have a family history of high blood pressure through your father, who suffered a myocardial infarction (MI) in his early 50s, and your grandmother, who had a stroke at 63. There is no diabetes in the family.
You have been living in the city for 2 years to attend university. Originally you come from **Poplar River First Nation**, a small, remote reserve approximately 400 km north of Winnipeg. Your mother was a professor in the faculty of social work at the University of Manitoba and had encouraged you to pursue your studies. Both she and your father are residential school survivors. Although your mother credits this experience with sparking her interest in school, your father does not discuss it. Your parents are now retired and living back home. You do not have family in the city, which made the adjustment difficult. You have met several friends through the activities mentioned above. You have become interested in traditional healing practices as a result of these new contacts and have begun to make use of them to help lower your stress levels, blood pressure and to deal with the racism, overt and otherwise you continue to experience. (Specific examples may be provided according to location.) This has caused some strain between yourself and your parents, as they are devout Pentecostals.

You have 2 younger sisters, who live in Winnipeg. The older one has a new baby, whom you haven’t yet had a chance to meet. This has been hard on you. You would like a baby yourself one day, and occasionally you wonder whether you have made the right choice by delaying family life for your education.

**On examination:**

BP 150/100  
BMI 27

**Blood pressure acting tip:**

“My blood pressure is high.”

**You are confident and self-assured. You dress neatly and are well groomed.**

**You have the following lifestyle issues:**

- You believe your headaches are normal because of your busy life.
- You believe in the benefits of traditional healing.
- You do not go to church, and this has been a great strain between you and your parents, who are devout Pentecostals.
- Your parents are survivors of the residential school era. Your father does not want to discuss his residential school experience and your mother credits her experience with residential school with sparking her interest in school. You will only bring this up when specifically asked about your relationship with her.
- You will not disclose anything further about your family or your own feelings if you feel the doctor is not empathic or is judgmental.
- You feel anxious and are questioning your choice to steer clear of relationships, delaying marriage and children in your quest for higher education.

**10 minutes remaining:**

If the candidate has not found out that you are of Indigenous heritage:

“**I used traditional healing.**”
7 minutes remaining:
The prompt is usually the cue to bring the candidate back to the management of the first problem, if it has not yet been dealt with: “So what about my BLOOD PRESSURE AND HEADACHES?”

3 minutes remaining:
“You have 3 minutes left.” Verbal and visual.

0 minutes remaining:
“Your time is up.”

Evaluation

The learner must:

- conduct the patient encounter in a culturally safe manner:
  - using clear and understandable language
  - paying attention to non-verbal cues
  - allowing sufficient time
  - demonstrating respect for the values and beliefs of the patient
  - providing opportunities for questions
  - checking for understanding and seeking common ground
  - having a non-judgmental attitude
- take a thorough history (presenting complaint, past medical history, family history, social history)
- address FIFE (feelings, ideas, function, expectations of the patient)
- make a clear statement to the patient that communicates understanding of their situation and empathy
- plan for help for the patient:
  - providing resources (e.g., student health/psychology services, private insurance, FNIHB)
  - counseling regarding lifestyle changes (e.g., smoking, alcohol, exercise, diet, etc.)
  - reassures and supports, and conducts appropriate follow-up including PHE next visit, tests if appropriate
## Score sheet

<table>
<thead>
<tr>
<th>1. Identification: Problem 1</th>
<th>Illness Experience</th>
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<tbody>
<tr>
<td>Superior Certificant</td>
<td>Superior Certificant</td>
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<tr>
<td>Certificant</td>
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<th>Illness Experience</th>
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<th>4. Management: Problem 1</th>
<th>Finding Common Ground</th>
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<th>5. Management: Problem 2</th>
<th>Finding Common Ground</th>
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| 6. Overall Interview Process and Organization | |
|-----------------------------------------------||
| Superior Certificant                         | |
| Certificant                                   | |
| Non-certificant                               | |
Objectives and Evaluation Points

Learning points and resources for each objective have been compiled for participants and are available in the appendices.

Objective 1

The learner will be able to identify three features of a culturally safe interview with a First Nations, Métis or Inuit patient. (Communicator, Professional)

**Evaluation points:**

- Communicates competently with the patient or client in that person’s social, political, linguistic, economic and spiritual realm.
- Awareness of power imbalances and measures taken to minimize, eliminate or reduce
- Uses plain language relevant to the patient or client in a way that makes the person feel engaged in the encounter.
- Respects the patient or client’s culture, age and beliefs
- Offers explanations to the client or patient and involving him or her in decisions about his or her care.
- Clarifies important directions clearly to the patient or client.
- Respect the need for the patient or client to negotiate the course of action
- Ensures agreement and comprehension about plans for care
- Recognizes that the beliefs of the patient or client may not fit with established medical views and must work with these beliefs

See Appendix A:

- Student fact sheet
- Resources
Objective 2
The learner will be able to identify the range of healing and wellness practices available within the local community for a First Nations, Métis or Inuit patient.
(Medical expert)

Evaluation points:
• Understands that there is a range of practices across the country and within communities; avoids making assumptions about those practices and which ones a patient may choose
• Demonstrates openness in interview style to other health practices
• Is aware of 2-3 local healing resources and practices common in the population served (e.g., sweat lodge, fasts, smudging ceremony, elders, going into bush, attending ceremonies, sundance, potlatch, natural remedies, church)

See Appendix B:
• Overview of Indigenous spiritual and cultural care
• Resources
Objective 3
The learner will be able to identify resources and services available to support First Nations, Inuit and Métis patients in achieving optimal health. (Manager, Collaborator)

Evaluation points:
• Is aware that resources vary for medical services (e.g., FNIHB for status First Nations and Inuit but not for Métis and non-status First Nations people) (See summary of non-insured health benefits in Appendix C)
• Is aware that all of the usual provincial services apply and private plans may also exist and must be used first
• Understands some of the barriers to care within the system (e.g., finding a dentist who will accept a patient receiving social assistance since this pays less than private plans; having less access to care because of fewer resources or transportation challenges)

See Appendix C:
• Summary of non-insured health benefits
• Lists of insured, core and non-insured health services
• Resources
Objective 4:
The learner will be able to describe an effectively integrated care plan for the First Nations, Métis or Inuit patient in a rural, urban or remote location. (Collaborator, Manager, Medical expert)

Evaluation points:
- Advises the patient appropriately regarding elevated BP, gives lifestyle advice
- Confirms the diagnosis of HTN using accepted means (24 hr BP monitor, return office visit x 2, home BP machine)
- Orders appropriate lab tests (may include TSH, cre/lytes, F lipid profile, FBS, EKG)
- Discusses counseling options and/or stress management strategies
  1. University health/psychology services
  2. Private plan
  3. Aboriginal Students’ Association FNIHB (crisis only)

See Appendix D:
- Resources
Case-specific Evaluation Points

Identification:
Elevated blood pressure
Areas to be covered:

1. **History of elevated blood pressure**
   - BP 140/95 at local pharmacy
   - No previous BP measurement
   - Bilateral and frontal headaches 1-2 times per week
   - OTC analgesics – acetaminophen or ibuprofen. No oral contraceptives
   - Fondness for salty foods
      i. Review of other health practices
      ii. Offer of ongoing support
   - Father has high blood pressure and a heart attack in his early 50s, grandmother had a stroke at age 63

2. **Concern regarding high blood pressure**
   - May have premature heart attack or stroke if not treated
   - Wants to see whether she needs medications
   - Wants to know if she can do anything herself to reduce the risk of heart attack or stroke

3. **Use of traditional healing**
   - Has resulted in lowered stress levels
   - Learnt of the availability of traditional healing from friends at university

4. **Strained relations with parents:**
   - not practising Pentecostal religion

**Superior Certificant:** Covers 1-4
**Certificant:** Covers 1-3
**Non-certificant:** Does not cover 1-3

Illness experience
Areas to be covered:

**Feelings**
- Worried about the high blood pressure
- Confident about traditional healing

**Ideas**
- She might have high blood pressure
- She may experience premature MI/stroke

**Impact on function**
- None

**Expectations for this visit**
- The doctor will help her with managing her blood pressure
- The doctor will sanction continued use of traditional healing

**Superior Certificant:**
Actively explores the illness experience to arrive at an in-depth understanding of it. This is achieved through the purposeful use of verbal and non-verbal techniques, including both effective questioning and active listening.

**Certificant:**
Inquires about the illness experience to arrive at a satisfactory understanding of it. This is achieved by asking appropriate questions and using non-verbal skills.

**Non-certificant:**
Demonstrates only minimal interest in the illness experience and so gains little understanding of it. There is little acknowledgment of the patient’s verbal and non-verbal cues, or the candidate cuts the patient off.
Section A

Identification: Stress
Areas to be covered

1. Current issues
   - Has to study hard and does not have time for exercise
   - Wonders if she has made the right decision to go to university and delay having a family
   - Not easy to go home to visit family
   - Had difficulty in finding friends initially
   - Parents think she should go to church every Sunday

2. Parents’ current situation
   - Retired
   - Survivors of residential school
   - Father does not talk about his residential school experience
   - Mother a retired professor social work; supports her daughter’s attending university

3. Life in university
   - Enjoys university
   - Mentors at Aboriginal Students’ Association
   - Two beers and cigarettes when socializing every 1-2 weeks
   - Not seeing anyone

4. Parents are devout Christians and believe she should attend church every Sunday. The patient is not sure about this and is too busy with studying.

Superior Certificant: Covers 1-4
Certificant: Covers 1-3
Non-certificant: Does not cover 1-3

Illness experience
Areas to be covered:

Feelings
- Annoyed
- “I’m trying to do the best I can”

Ideas
- Patient can’t manage parents on her own

Impact on function
- Patient doesn’t have more time to spend on looking after her parents

Expectations for this visit
- The doctor will solve the crisis for her

Superior Certificant:
Actively explores the illness experience to arrive at an in-depth understanding of it. This is achieved through the purposeful use of verbal and non-verbal techniques, including both effective questioning and active listening.

Certificant:
Inquires about the illness experience to arrive at a satisfactory understanding of it. This is achieved by asking appropriate questions and using non-verbal skills.

Non-certificant:
Demonstrates only minimal interest in the illness experience and so gains little understanding of it. There is little acknowledgment of the patient’s verbal and non-verbal cues, or the candidate cuts the patient off.
Social and developmental context: Context identification

Areas to be identified:

1. Family
   - Two younger sisters
   - 2nd sister has a new baby
   - Has not met baby but wishes she had
   - Wonders if she made the right choice by delaying having a family
   - Mother is a retired professor of social work
   - Grew up in a remote community

2. School
   - Adjustment to the city was difficult
   - Studying takes up most of her time and has limited the frequency of her visits back home
   - Has made friends
   - Mentors at Aboriginal Students’ Association once a month

3. Relationship with parents
   - Both parents are survivors of residential school
   - Father does not talk about residential school
   - Mother believes in schooling; father does not discuss this
   - Parents expects her to attend church every Sunday
   - They live in a remote community

Superior Certificant: Covers 1-3
Certificant: Covers 1 & 2
Non-certificant: Does not cover 1 & 2

Social and developmental context: Context integration

Context integration measures the candidate’s ability to:

- integrate issues pertaining to the patient’s family, social structure and personal development with the illness experience; and
- reflect observations and insights back to the patient in a clear and empathic way.

This step is crucial to the next phase of finding common ground with the patient to achieve an effective management plan.

The following is a certificant-level statement:

“You seem caught in a common and stressful situation for Indigenous students: having to adapt to new and big city, feeling the pressure of having to study hard for your future, missing home and feeling pressure from your parents to do well.”

Superior Certificant:
Demonstrates initial synthesis of contextual factors and an understanding of their impact on the illness experience. Empathically reflects observations and insights back to the patient.

Certificant:
Demonstrates recognition of the impact of the contextual factors on the illness experience.

Non-certificant:
Demonstrates minimal interest in the impact of the contextual factors on the illness experience or cuts the patient off.
Management: Elevated blood pressure
Plan
1. Arrange for BP measurement in office
2. Recommend repeating BP measurement at least yearly even if BP is normal
3. Discuss importance of lifestyle changes:
   - regular exercise for at least 30 minutes 4 times a week
   - cut down on salt
   - stop smoking
4. Discuss ambulatory BP monitoring or home BP monitoring with approved BP monitors; normal being below 135/85

Superior Certificate: Covers 1-4
Certificant: Covers 1-3
Non-certificant: Does not cover 1-3

Finding common ground
Behaviours that indicate efforts to involve the patient include:
1. Encouraging discussions.
2. Providing the patient with opportunities to ask questions.
3. Encouraging feedback.
4. Seeking clarification and consensus.
5. Addressing disagreements.

This list is meant to provide guidelines, not a checklist. The points listed should provide a sense of the kind of behaviours for which the examiner should look.

Actively inquires about the patient’s ideas and wishes for management.
Purposefully involves the patient in the development of a plan and seeks his feedback about it.

Superior:
Encourages the patient’s full participation in decision making.

Certificant:
Involves the patient in the development of a plan.
Demonstrates flexibility.

Non-certificant:
Does not involve the patient in the development of a plan.
Management: Stress

Plan

1. Help patient reflect on her achievements (university and mentoring).

2. Acknowledge her concern about her BP reading at the pharmacy and family history of MI and stroke.

3. Encourage the patient to maintain a healthy lifestyle.

4. Encourage the patient to continue with traditional healing practice.

**Superior Certificant:** Covers 1-4

**Certificant:** Covers 1-3

**Non-certificant:** Does not cover 1-3

Finding Common Ground

Behaviours that indicate efforts to involve the patient include:

1. Encouraging discussions.

2. Providing the patient with opportunities to ask questions.

3. Encouraging feedback.

4. Seeking clarification and consensus.

5. Addressing disagreements.

This list is meant to provide guidelines, not a checklist. The points listed should provide a sense of the kind of behaviours for which the examiner should look.

Actively inquires about the patient’s ideas and wishes for management.

Purposefully involves the patient in the development of a plan and seeks his feedback about it.

**Superior:**

Encourages the patient’s full participation in decision making.

**Certificant:**

Involves the patient in the development of a plan.

Demonstrates flexibility.

**Non-certificant:**

Does not involve the patient in the development of a plan.
Interview process and organization

The other scoring components address particular aspects of the interview. However, evaluating the interview as a whole is also important. The entire encounter should have a sense of structure and timing, and the candidate should always take a patient-centered approach.

The candidate should demonstrate cultural safety by communicating competently with a patient in that patient’s social, political, linguistic, economic, and spiritual realm. The candidate should be respectful of the culture, age, sex, political and religious beliefs, and sexual orientation of the patient. The candidate should not diminish, demean or disempower the cultural identity and well-being of an individual.

1. Good direction with a sense of order and structure.
3. Flexibility and good integration of all interview components; the interview should not be piecemeal or choppy.
4. Appropriate prioritisation with an efficient and effective allotment of time for the various interview components.

Superior Certificant:
Demonstrates advanced ability in conducting an integrated interview with clear evidence of a beginning, a middle, and an end. Promotes conversation and discussion by remaining flexible and by keeping the interview flowing and balanced. Very efficient use of time with effective prioritization. Demonstrates clear understanding of the cultural context for the patient.

Certificant:
Demonstrates average ability in conducting a culturally safe and integrated interview. Has a good sense of order, conversation, and flexibility. Uses time efficiently.

Non-certificant:
Demonstrates limited or insufficient ability to conduct an integrated interview. Interview frequently lacks direction or structure. May be inflexible and/or overly rigid, with an overly interrogative tone. Uses time ineffectively. The interaction diminishes or demeans or disempowers the patient.
## Self-reflection Exercise

At the end of the module, learners are asked to complete the following reflective exercise that will focus on the following core components.

### Communication

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am confident that I am able to communicate competently with the patient taking into consideration the social, political, linguistic, economic and spiritual realm of that patient.</td>
<td></td>
</tr>
<tr>
<td>I am confident that I am able to use plain language relevant to the patient or client in a way that makes the person feel engaged in the encounter.</td>
<td></td>
</tr>
<tr>
<td>I am confident that I am able to respect the patient or client’s culture, age and beliefs.</td>
<td></td>
</tr>
<tr>
<td>I am confident that I am able to recognize that I bring my own culture and attitudes to the relationship.</td>
<td></td>
</tr>
</tbody>
</table>

### Decision-making

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am confident that I am able to show respect for the individual by offering explanations to the client or patient and involving him/her in decisions about his or her care.</td>
<td></td>
</tr>
<tr>
<td>I am confident that I am able to provide important information to the patient using explanations that are clear and easily understood.</td>
<td></td>
</tr>
<tr>
<td>I am confident that I am able to be respectful of the need for the patients or clients to negotiate the course of action.</td>
<td></td>
</tr>
</tbody>
</table>

### Areas of possible misunderstanding

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am now confident that I am able to explain medical requirements and procedures and ask if the patient or client understands and agrees with the integrated treatment plan.</td>
<td></td>
</tr>
</tbody>
</table>

### Beliefs

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am now confident that I am able to recognize that the beliefs of the patient or client may not fit with established medical views and that I must work with these beliefs.</td>
<td></td>
</tr>
</tbody>
</table>
Appendix A

Cultural Safety in Practice
A Curriculum for Family Medicine Residents and Physicians

Objective 1:
The learner will be able to identify three features of a culturally safe interview with a First Nations, Métis or Inuit patient. (Communicator, Professional)

Contents:
1. Learning points
2. Student fact sheet
3. Resources

I. Learning points
In a culturally safe interview the health-care provider should focus on the following core components.

- Communication:
  - The health-care provider must be able to communicate competently with the patient or client in that person’s social, political, linguistic, economic and spiritual realm.
  - The health-care provider must use plain language relevant to the patient or client in a way that makes the person feel engaged in the encounter.
  - The health-care provider must respect the patient or client’s culture, age and beliefs.
  - The health-care provider must recognize that he or she brings his or her own culture and attitudes to the relationship.

- Decision-making:
  - The health-care provider must show respect for the individual by offering explanations to the client or patient and involving him or her in decisions about his or her care.
  - Important directions will require specific explanations that are clear to the patient or client.
  - The health-care provider must be respectful of the need for the patient or client to negotiate the course of action.

- Areas of possible misunderstanding:
  - The health-care provider must explain medical requirements and procedures and ask if the patient or client understands and agrees with the integrated treatment plan.

- Beliefs:
  - The health-care provider must recognize that the beliefs of the patient or client may not fit with established medical views and must work with these beliefs.
Section C

2. Student fact sheet

Note: Publication details for all works cited in this appendix are available in the list of Resources.

Background

- The term cultural safety was developed in the 1980s in New Zealand in response to the Maori people's discontent with nursing care. Maori nursing students and Maori national organizations supported the theory of cultural safety, which upholds political ideas of self-determination and decolonization of the Maori people and is based within a framework of dual cultures.

- In understanding cultural safety as a theoretical and methodological approach originating with colonized Indigenous peoples, the importance of its application across the health-care spectrum becomes clear. Cultural safety moves beyond the concept of cultural sensitivity to analyzing power imbalances, institutional discrimination, colonization and colonial relationships as they apply to health care.

- Cultural safety within an Indigenous context means that the educator, practitioner or professional, whether Indigenous or not, can communicate competently with a person in their social, political, linguistic, economic and spiritual realm. Culturally unsafe practices can be understood to mean "any actions that diminish, demean or disempower the cultural identity and well-being of an individual" (Nursing Council of New Zealand, 2005, p. 7).

- Cultural safety requires that health-care providers respect nationality, culture, age, sex, political and religious beliefs and sexual orientation. This notion is in contrast to transcultural or multicultural health care, which encourages providers to deliver service irrespective of these aspects of a patient. Cultural safety involves recognizing that the health-care provider brings his or her own culture and attitudes to the relationship.

Rationale for providing culturally safe care

- There is growing recognition of the need for culturally safe care to improve the health of First Nations, Inuit and Métis in Canada. The experience of many Aboriginal people with the mainstream health-care system has been negative, often because of cultural differences between the patient and their health-care provider(s). Cultural differences and the inability of health-care providers to appropriately address these differences have frequently contributed to high rates of non-compliance, reluctance to visit mainstream health-care facilities even when service is needed and feelings of fear, disrespect and alienation among Aboriginal people (National Aboriginal Health Organization, 2003, pp. 39-41).

- Misunderstandings can exist between health-care professionals and their clients and patients; these can affect the ability of health-care professionals to help their clients and patients achieve optimal health. For example, health-care professionals may view clients and patients who are culturally different from themselves as unintelligent or of differing intelligence, irresponsible or disinterested in their health (Dowling, 2002, p. 4). This can result in poor health status, marginalization within the health-care system, increased risk of poor outcomes and experiences of racism for a First Nations, Inuit or Métis patient. This can contribute to greater inefficiency in the operation of the health-care system, a decrease in staff morale, an increase in health-care costs as patients return with
progressed illness, an increase in wait times, overburdening of health-care centres and a decrease in the overall ethical standard of care (Fortier, 2004, 15).

- Adopting a culturally safe approach to health care can benefit individuals, providers and health-care systems. When culturally appropriate care is provided, patients respond better to care. Health-care providers can benefit from learning the skills needed to provide culturally safe care: their confidence on the job may increase because their ability to address the needs of various groups in society has improved.

**How does a health-care provider treat someone in a culturally safe way?**

**Communication:**

- Recognizing that the language of care may not be the patient's first language, the health-care provider should conduct discussions and offer explanations in plain language. Health-care providers must learn to not use jargon, technical or academic terms and to explain things simply and clearly. However, it is important that plain language not be used in a way that makes the patient feel they are considered less intelligent.

- Non-verbal behaviour varies among cultures and people. Some patients may feel uncomfortable maintaining eye contact, especially in stressful situations or with strangers. A health-care provider should not make assumptions about what a patient's non-verbal behaviour means but should simply accept that the patient is behaving in a way that is comfortable or important to him or her. The caregiver should also try to adapt his or her own non-verbal behaviour to the patient's in appropriate ways. For example, a caregiver working with Inuit patients and their families should be aware that many Inuit use blinking as a confirmation of understanding.

- Patients are more likely to feel safe and empowered to tell caregivers about their needs and concerns if the caregivers encourage them to ask questions. Health-care providers who come across as more concerned with patients' questions than with time constraints are more likely to provide safe care.

**Decision-making:**

- A health-care worker can show respect for the individual by offering the client or patient explanations and involving them in decisions about their care rather than making demands on them or issuing unexplained directives. For example, the health-care worker can have the clients or patients go through their situation and the advice they’ve received with him or her to see if it "makes sense" to them and for them. People need information to be able to decide if they want and need to follow through or if a course of action fits with their context, needs or abilities. For example, the health-care worker could say something like, “There are a couple of things I can suggest that might work. You could try … This can be helpful because … How does that sound to you?”

- If it is important that the patient do a specific thing, the health-care worker should give them a specific explanation. For example, if a patient must take medication several times a day for a period, rather than just saying, “Take one pill every four hours for a week,” the health-care worker should explain the reasoning behind the direction: “It’s really important that you take all of it according to the schedule. You’ll probably start to feel better after a couple of days. However, even though you feel better, the germs are still in your body. It takes all this medication, spread out over a week, to kill all the germs. If any of them are left, they’ll multiply and you’ll get sick again.”
If the health-care worker presents a course of action and the patient or client responds that she cannot do that without first discussing it with her husband, the health-care worker needs to respect her response. The course of action may not require a spouse’s approval, but the health-care worker must understand the patient’s life context and values, in spite of their differences: “Good, you discuss it with him. Can you come by again tomorrow and let me know? Then we can discuss the details.”

Areas of possible misunderstanding:

- People do not want to look silly and may feel uncomfortable questioning authority. For many reasons, they may say yes when in fact they mean no, or no when in fact they mean yes. For example, when a health-care worker has explained medical requirements and procedures and asks, “Any questions? Anything you don’t understand?” the patient may say no even when they do not understand. The use of clear and plain language can help avoid problems. It may be helpful to write down information and instructions so the person can think about it in private. However, keep in mind the client’s literacy level. Further explanation may be helpful, such as “We doctors don’t always explain things too well. I really would appreciate if you’d get back to me if you have any questions. It will help both of us. I’ll know what I missed, and you’ll get the right information.”

Beliefs:

- Clients or patients may have beliefs about causes and cures that do not fit with established medical views. For example, if a client or patient explains that the full moon makes him or her act in strange ways (the moon is still widely believed to play a role in mental illness and aberrant behaviour around the world), the health-care provider should simply accept the explanation and work with and around it: “Yes, the moon is said to affect people. Let’s look at what’s happening in your situation. There may be ways we can reduce the effects.”

Culturally safe practice involves building health-care providers’ communication skills so they:

- are aware of the needs their client or patient may have and the issues he or she might face;
- are able to ask questions to get the information they need to best serve their client or patient; and
- pay close attention to and do not negatively judge verbal and non-verbal information that patients provide.

Examples of culturally safe or unsafe practice

- It is well known among health-care providers at the Wabano Centre for Aboriginal Health in Ottawa that many of their Métis and non-status First Nations patients do not have access to insured health benefits.1 Thus, when the nurse practitioners at the centre give out a prescription, they know that the patient may not be able to get it filled. The nurse practitioners take alternative actions to ensure that their patients receive the care they need to maintain good health or fight illness. They may offer free drug samples to patients or refer them to employment search services and food banks or engage in other patient advocacy activities.

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1 If a patient has insured health benefits it means that have access to pharmaceuticals as part of the treatment plan. This can include non-insured health benefits, a private insurance plan or even basic access to pharmacy services in the patient’s home community.
Browne, Fiske and Thomas (2001) give the following example of a culturally unsafe experience in their article on First Nations women’s encounters with mainstream health care: *An Indigenous woman comes into the hospital with a black eye and a wailing child. Health-care workers immediately apprehend the child to child and welfare services without first checking the patient’s medical or personal history. Culturally unsafe assumptions about abuse and the woman’s ability to take care of her child underlie these actions.*

Because of the prevalence of sexual abuse in communities, some First Nations, Inuit or Métis women may be reluctant to seek out health-care encounters involving bodily exposure to avoid feeling invalidated or shamed. They do not want to draw attention to their bodies or are afraid of having a doctor or nurse examine or touch their bodies, especially if the health-care provider is male. A health-care worker who communicates effectively with the patient to ensure their comfort during the examination would be acting in a culturally safe way.

**Does culturally safe care work?**

Once changes in practice and delivery occur, there are ways to measure whether or not they have had positive effects. According to Schyve (2002), there are three signs of positive cultural change, as follows.

- **Leadership**—there must be a proactive risk-reduction program in the organization that enables leaders to pay attention to communication throughout the organization.
- **Information**—if something does go wrong, the patient must be informed that this result was not what was planned or anticipated.
- **Education**—the patient and his or her family must be informed about their treatment in a way that they can understand.

Another key way by which to assess cultural safety is to look for improvements in the following measures:

- patient satisfaction;
- patient comprehension;
- adherence to treatment recommendations;
- appropriate utilization;
- accurate diagnosis;
- appropriate treatment;
- organizational improvements;
- self efficiency;
- cost–benefit;
- clinical outcomes and disparity reduction;
- cost containment;
- clinical and organizational quality; and
- relationships between key stakeholders, patients and caregivers (Fortier, 2002, Slides 6-8).

If positive changes occur in any of these measures through practice and delivery, i.e., increased patient safety, we can say that cultural safety was a factor in bringing about these changes. The positive changes in practice and delivery should be continually applied and evaluated.
Cultural safety and competency in a First Nations, Inuit and Métis context

Cultural safety is rooted in the education of health-care providers. If the health-care professional or paraprofessional is able to create a culturally safe environment, then we can assume that they are able to be sympathetic, sensitive and empathic and are willing to do what is necessary to bridge the gap between giver and receiver. We can also assume that they have learned that often the one who believes he or she is the giver is in fact the receiver. This knowledge can help individuals to bridge the gap between staff members and their organization and between patients and students.

The foundational principles of cultural safety discussed earlier are applicable to interactions with First Nations, Inuit and Métis. However, it is imperative that the educator or practitioner recognize that although they share a common history and have been subject to similar constraints of colonialism, First Nations, Inuit and Métis populations are similar to yet different from each other. In addition, there is great diversity within each of these populations. This is not to say that the tools provided in this text are not useful but rather that the educator or provider has a responsibility to learn, acknowledge and appreciate the Indigenous knowledge of the group with which they are working, when feasible. When thinking about how to best meet a population’s health priorities, the educator or provider needs to take into account the determinants of health for each population, such as geography, economy, community cohesion, access and capacity and educational attainment.

3. Resources

Organizations that can provide further information on cultural competency and safety

- National Aboriginal Health Organization
- Accreditation Canada
- Canadian Patient Safety Institute
- Ontario Ministry of Health and Long-term Care
- Meno-Ya-Win Health Centre (Sioux Lookout)
- First Nations and Inuit Health Branch, Health Canada
- Nishnawbe-Aski Nation
- Indigenous Physicians Association of Canada
- Health Human Resource Strategy - Vision 2020
- Aboriginal Nurses Association of Canada
- U.S. Department of Health and Human Services, Health Resources and Services Administration
- U.S. Department of Health and Human Services, Office of Minority Health

Other sources of information

- www.diversityRx.org (website resource dedicated to culturally safe health practices)
- the documents in the list of suggested readings (Appendix F), in particular four documents published by the National Aboriginal Health Organization (National Aboriginal Health Organization, 2006a, 2006b, 2008a, 2008b)
Appendix B

Cultural Safety in Practice
A Curriculum for Family Medicine Residents and Physicians

Objective 2: The learner will be able to identify the range of healing and wellness practices available within the local community for a First Nations, Métis or Inuit patient.

Contents:
1. Learning points
2. Overview of Indigenous spiritual and cultural care
3. Resources

1. Learning points

Beliefs:

- The health-care worker must recognize that the patient’s beliefs may not fit with established medical views and must work with these beliefs.

Areas of possible misunderstanding:

- The health-care worker must explain medical requirements and procedures.
- The health-care worker must recognize that the patient or client may wish to access healing practices other than those recommended by the physician and must ask if the patient or client has other options available to them.
- The health-care worker must show a willingness to integrate options recommended by the patient or client into their treatment plan.
- The health-care worker must ensure that the patient or client understands the medical requirements, must agree to include the patient or client’s requirements and recommended options in the treatment plan and must ensure that the patient or client agrees with the integrated treatment plan.

2. Overview of Indigenous spiritual and cultural care

Encounters with the health-care system can be stressful for First Nations, Inuit or Métis patients and their families. Patients require access to culturally relevant resources to assist them to meet their physical, emotional and spiritual needs. To effectively meet the spiritual needs of all Indigenous people within the health-care system, the health-care system should provide access to traditional elders, Christian elders, healers and other spiritual-care providers.

Traditional Indigenous spirituality is based on the belief that all natural things are interconnected. There are three general belief systems within First Nations, Inuit or Métis cultures:

- traditional spirituality that is based on the ancient teachings of the nation or culture and usually passed down orally by elders;
- an integration of Christian and other Western faiths with traditional teachings; and
- Christianity and other faiths.
Section C

**First Nations, Inuit and Métis ceremonies**

Ceremonies are often part of the work performed by healers and elders. There are a variety of healing ceremonies within traditional Indigenous cultures; some of the more common ones are smudging, end of life and prayer ceremonies. Each ceremony is unique and has its own purpose, but all ceremonies are part of a holistic approach to healing. It is appropriate to ask an elder or traditional healer to teach you about a ceremony in which you are interested to understand. Sacred medicines or other sacred items may be used in ceremonies.

**The four sacred medicines**

Four sacred medicines were given to the First Nations people. They are used in everyday life and in ceremonies. All of the sacred medicines are used for smudging and other medicinal purposes, such as cleansing and to help in healing. Traditional healers or elders may give other medicines as well. Alcohol or drugs should not be taken when using the sacred medicines.

Tobacco: Tobacco is always the first medicine to be used in ceremonial or cultural work. It is used as an offering for everything and in every ceremony. Tobacco opens the door to allow communication with the spirit world.

Sage: Sage is used to prepare people for ceremonies and teachings. It is used to cleanse the mind while removing negative energies and to cleanse homes and sacred items, among other medicinal uses.

Cedar: Cedar has restorative medicinal uses. It is used to purify homes and it is often used to protect a person against negative energies.

Sweetgrass: Sweetgrass is the sacred hair of Mother Earth. It is used to cleanse and to invite in positive energies. It is used along with sage and cedar for smudging and purification. When it is used in a healing circle, it has a calming effect.

**The role of traditional healers and elders**

Traditional healers and elders are people who carry Indigenous knowledge and teach traditional customs, ceremonies and culture and the language of their people.

In spiritual healing, the traditional healers and elders work with all inter-related aspects of an individual – spiritual, emotional, mental and physical – according to the teachings they have received. Healers may work with plants, they may use some form of doctoring or healing or they may counsel. They may work with ceremonies, such as the sweat lodge. Healers will use one or more of the four sacred medicines.

Healers: A healer’s purpose is to help people and bring healing. There are similarities in all healing practices, but each healer has their own approach and their own way with the medicines that they use in their work.

Elders: A traditional elder will teach and share the wisdom of his or her culture and history. An elder is someone who has many teachings and who has earned the respect of his or her community by contributing to its spiritual development.

Within the health-care system, traditional healers and elders provide culturally appropriate and holistic treatment for any person requesting their services. They can also work closely with a patient’s family and health-care providers as part of the health-care team.
Approaching traditional healers and elders

Individuals, patients or families requesting the services of a First Nations traditional healer or elder, would follow cultural protocols as such:

- When one is with a healer or elder, one should be respectful of them and practice humility.
- One should explain the request to the healer or elder
- It is important for a patient to refrain from taking alcohol or drugs before going to a healer. The patient’s body and spirit should be free of alcohol and drugs so that the medicine will have its strongest impact.
- It is also important for a patient to let the healer or elder know if they are taking any medications prescribed by a doctor or nurse.
- One should give tobacco to the elder or healer as an offering. Tobacco is one of 4 sacred plants Ceremonial Tobacco is preferred but not always available. Often it is acceptable in other forms, such as a cigarette from a pack, a pack of cigarettes, a pouch of tobacco or loose tobacco wrapped in a small square of cloth.
- Other gifts can be given to express ones gratitude for the help one has received.

3. Resources

The National Aboriginal Health Organization has published an informative overview of traditional knowledge as it relates to medicine and public health (National Aboriginal Health Organization, 2008a) and its website provides information on the traditional healing and cultural practices of various Aboriginal populations: http://www.naho.ca/english/tk.php
Appendix C

Cultural Safety in Practice

A Curriculum for Family Medicine Residents and Physicians

**Objective 3:**
The learner will be able to identify resources and services available to support First Nations, Inuit and Métis patients in achieving optimal health. (Manager, Collaborator)

**Contents:**
1. Learning points
2. Summary of non-insured health benefits
3. Lists of insured, core and non-insured health services
4. Resources

**1. Learning points**
- The health-care worker should be aware of the basic insured, core and non-insured health services available for his or her patients or clients.
- The health-care worker should be aware of how to access local or regional resources within the patient or client’s environment to obtain additional support for him or her.

**2. Summary of non-insured health benefits**
The Non-Insured Health Benefits Program (NIHB) provides extended medical coverage (similar to private health insurance) for eligible First Nations and Inuit Canadians.

**Who is covered?**
Status First Nations (Registered Indians under the Indian Act), Inuk recognized by one of the Inuit Land Claims organizations and infants under 1 year of age whose parent is an eligible recipient.

**Who is not covered?**
Non-Status First Nations, Métis

**When are benefits covered?**
**To be considered for coverage, an item or service must:**
1. be a listed benefit;
2. be for use at home or in another ambulatory care setting (i.e., not in a hospital or institution);
3. be approved in advance if required;
4. NOT be covered by any other program (i.e., an individual must first try to access funding from other sources, such as provincial or private insurance programs, for which he or she is eligible);
Section C

5. be prescribed by a physician or other authorized health-care professional;

6. be provided by a recognized provider.

**How are benefits provided?**

Either service providers can bill NIHB directly or patients can pay themselves and seek reimbursement from NIHB within one year.

**What is covered?**

**Crisis counselling** – Benefits are provided for the initial assessment, development of treatment plan and, if cost effective, travel for the professional to provide the services in a community. Therapists generally need to be registered clinical psychologists or clinical social workers. Only short-term crisis intervention is covered.

**Dental benefits** – Benefits are provided for diagnosis, treatment, cleanings, fillings, dentures, bridges and oral surgery. A number of types of services require preapproval. The rates paid are not always competitive, so not all dentists are willing to provide services at NIHB rates.

**Drug benefits** – These benefits cover drugs listed on the NIHB formulary (drug benefit list) and some approved over-the-counter medications. Patients must use other drug plans first if available to them. Patients bring their prescription to a pharmacy and the pharmacy can bill NIHB directly. Most listed drugs can be dispensed without preapproval. Drugs with limited use criteria, maximum allowable amount criteria, “no-substitution” drugs and unlisted drugs require preapproval. Physicians must submit written requests for coverage for these drugs.

**Eye and vision care** – These benefits cover eye examinations if not insured by the province or territory, corrective lenses (new and repairs), eye prostheses and other specific benefits as medically indicated. Examinations must be provided by an optometrist or ophthalmologist and prescriptions filled by a recognized vision-care provider. Preapproval for benefits is required.

**Medical supplies and equipment** – These benefits cover items such as hearing aids, wheelchairs, walkers, orthotics and custom footwear, oxygen, pressure garments, bandages and dressings. A prescription from a physician or other authorized health-care professional is required. Owing to interprovincial variability in the types of authorized providers, regional offices maintain lists of approved providers for each region.

**Medical transportation** – These benefits cover the costs required to access medically required health services not available in the patient’s home community. Coverage may include ground, water and air travel and includes costs for accommodation while travelling. If the patient is unable to care for himself or herself, funding for an able-bodied person (an escort) to travel with and assist him or her may also be provided. A variety of arrangements exist whereby these services are provided locally or regionally. Preapproval is required and access to this benefit is made by contacting the local health or band office or local First Nations or Inuit health authority if the patient lives in a First Nations or Inuit community or by contacting their regional office or his or her responsible First Nations or Inuit health authority if he or she lives elsewhere.
**What can I do if a request for coverage is denied?**

There is a defined appeals process for each category of benefit. Details are available on the NIHB website.


For more information for providers, including links to forms: [http://www.hc-sc.gc.ca/fniah-spnia/nihb-ssna/provide-fournir/index-eng.php](http://www.hc-sc.gc.ca/fniah-spnia/nihb-ssna/provide-fournir/index-eng.php)


### 3. Lists of insured, core and non-insured health services

**Insured health services:**

- Physician services (salaried or fee-for-service physicians)
- In-hospital services
- Diagnostic and laboratory services

**Core health services:**

- Home care
- Public health
- Mental health care

**Non-insured health services (requiring coverage by private insurance, such as Blue Cross, Great-West Life, or Health Canada’s plans for non-insured health services benefits):**

- Dental health
- Prescription drugs on the provincial formulary
- Medical supplies and equipment
- Medical transportation

### 4. Resources

National organizations that can direct health-care providers to regional centres or organizations that deal with Indigenous healing and wellness (both Western and traditional)

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>NAHO</td>
<td>National Aboriginal Health Organization</td>
</tr>
<tr>
<td>NIICHRO</td>
<td>National Indian and Inuit Community Health Representatives Organization</td>
</tr>
<tr>
<td>ANAC</td>
<td>Aboriginal Nurses Association of Canada</td>
</tr>
<tr>
<td>IPAC</td>
<td>Indigenous Physicians Association of Canada</td>
</tr>
<tr>
<td>*NWAC</td>
<td>Native Women’s Association of Canada</td>
</tr>
<tr>
<td>*AFN</td>
<td>Assembly of First Nations</td>
</tr>
<tr>
<td>*MNC</td>
<td>Métis National Council</td>
</tr>
<tr>
<td>*ITK</td>
<td>Inuit Tapiriit Kanatami</td>
</tr>
<tr>
<td>*CAP</td>
<td>Congress of Aboriginal Peoples</td>
</tr>
<tr>
<td>Acronym</td>
<td>Full Name</td>
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<tr>
<td>---------</td>
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</tr>
<tr>
<td>NAFC</td>
<td>National Association of Friendship Centres</td>
</tr>
<tr>
<td>AHF</td>
<td>Aboriginal Healing Foundation</td>
</tr>
<tr>
<td>AHRNetS</td>
<td>Aboriginal Health Research Networks Secretariat</td>
</tr>
<tr>
<td>IAPH</td>
<td>Institute of Aboriginal Peoples’ Health</td>
</tr>
<tr>
<td>NEAHR</td>
<td>Network Environments for Aboriginal Health Research</td>
</tr>
<tr>
<td>AWHHHRG</td>
<td>Aboriginal Women’s Health and Healing Research Group</td>
</tr>
<tr>
<td>Pauktuutit</td>
<td>Pauktuutit Inuit Women’s Association of Canada</td>
</tr>
<tr>
<td>CAAN</td>
<td>Canadian Aboriginal AIDS Network</td>
</tr>
<tr>
<td>AHWS</td>
<td>Aboriginal Healing and Wellness Strategy</td>
</tr>
<tr>
<td>NMHAC</td>
<td>Native Mental Health Association of Canada</td>
</tr>
<tr>
<td>NADA</td>
<td>National Aboriginal Diabetes Association</td>
</tr>
</tbody>
</table>

*These are the five federally recognized national Aboriginal organizations of Canada. Each one has regional or territorial offices and health committees that can direct queries regarding their specific populations to appropriate respondents.*
Appendix D

Cultural Safety in Practice

A Curriculum for Family Medicine Residents and Physicians

Objective 4
The learner will be able to describe an effectively integrated care plan for the First Nations, Métis or Inuit patient in a rural, urban or remote location. (Collaborator, Manager, Medical expert)

Contents:
1. Learning points
2. Resources

1. Learning points
The health-care worker should be able to identify an integrated care plan for the patient or client that includes general access to resources.

2. Organizational Resources
National organizations that can direct health-care providers to regional centres or organizations that deal with Indigenous healing and wellness (both Western and traditional)

- NAHO National Aboriginal Health Organization
- NIICHRO National Aboriginal Health Organization
- ANAC Aboriginal Nurses Association of Canada
- IPAC Indigenous Physicians Association of Canada
- *NWAC Native Women's Association of Canada
- *AFN Assembly of First Nations
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- AHF Aboriginal Healing Foundation
- AHRNetS Aboriginal Health Research Networks Secretariat
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- NEAHR Network Environments for Aboriginal Health Research
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- CAAN Canadian Aboriginal AIDS Network
- AHWS Aboriginal Healing and Wellness Strategy
NMHAC Native Mental Health Association of Canada

* Federally recognized National Aboriginal Organizations (NAOs) of Canada having regional or territorial offices and health committees that can direct queries regarding their specific populations to appropriate respondents.
Appendix E

Cultural Safety in Practice

A Curriculum for Family Medicine Residents and Physicians

Additional Readings and Resources


Leininger, M. (1998); Leininger’s theory of nursing: Cultural care diversity and universality. *Nursing and Health Care, 1*, 152–160.


National Aboriginal Health Organization. (2003). *Analysis of aboriginal health careers education and training opportunities*. Ottawa:


