Indigenous Health and Cultural Safety
The Social Accountability Framework

Report of Task Group 8 to the CURE Steering Committee
November 8, 2011

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1. INTRODUCTION

The social accountability task group #8 was asked to bring forward recommendations on what to teach, how to teach and how to evaluate students and curriculum in the following areas: indigenous health, cultural safety, social accountability, interprofessional education and practice, and advocacy. These topics are interrelated in some, but not all, aspects.

The need for a focus on indigenous health and cultural safety cannot be overstated. It must find a place in the new curriculum. Cultural safety is related to the historical context of Canada and individuals’ socio-political, linguistic, economic and spiritual realms. Cultural safety requires health care providers to be respectful of nationality, culture, and other social attributes. Cultural safety also includes self reflection as a necessary tool for the learner.

The importance in the medical curriculum of First Nations, Métis and Inuit health has been demonstrated in the development of the Associate Dean and a Section in the Department of Community Health Sciences of the same name. The intent is to engage the faculty and students in understanding and addressing aboriginal health. On October 27, 2011, Dr. David Barnard, President and Vice Chancellor of the University of Manitoba, spoke publicly by giving an apology to aboriginal peoples about the University's failure to intervene in tragedies such as the residential schools issues. He committed the University to doing more in the future.

Social accountability and responsibility are core values for physicians to recognize and practice from an individual to a global scale, for the well being of all members of the community. It has been articulated in the medical literature over the past decade. ¹

The topics of interprofessional education and practice and health advocacy also need to find a place in the new curriculum. There is a University wide initiative on interprofessional education in which the faculty of medicine will be participating in March 2012. Health advocacy has been demonstrated by many individual faculty members through voluntary work and international contributions to medical education research and practice.

This task group recognizes that teaching in these areas is needed to assure medical students are skilled, competent physicians. Teaching must have continuity from undergraduate through postgraduate education. There needs to be better integration of teaching across the four year undergraduate curriculum Students need to understand the impact of the social and environmental context on people’s health and the impact of health on the overall community.

Critical thinking and increasing competency in these areas is as important as in clinical skills. They will serve students well in their future practice of medicine.

2. TASK GROUP MEMBERS

Regular meetings were held between July 22 and October 28, 2011. Meetings were also held in smaller groups around specific topic areas. All members of the group contributed to the final report and to the power point presentation.

• Julie Beaulac – Psychology – co-chair
• Anne Durcan - Community Health Sciences
• Lauren Garbutt- Med 2
• Pol Gomez – Med 2
• Barry Lavallee – Centre for Aboriginal Health Education
• Sharon Macdonald - Community Health Sciences – co-chair
• Janice Linton - Neil John Maclean Health Sciences Library
• Nelson Oranye – School of Medical Rehabilitation
• Mahwash Saeed – PGY 2
• Alex Singer - Family Medicine
• Ian Whetter - Family Medicine

3. KEY CONCEPTS

During discussions in the task group meetings, several concepts and themes emerged that are worthy of clarification. There is leadership through the UM central administration around community engagement and service learning, with recommendations forthcoming from there.

3.1 Engaged scholarship

Engaged Scholarship is a concept described in the literature and practice by many universities. It conveys two concepts. The first is engagement with the community and the second is scholarly activities performed in partnership with community. Medicine seems naturally suited to this: research and clinical training invariably involves patients who live in communities. In considering a competency based UGME curriculum, outcomes in many domains could be matched against community needs and the teaching program should involve community members and organizations. Social medicine is one approach to linking social inequalities to disease processes and to develop the means to improve health. This seems to define the “What We Teach” component, but more specific objectives would need to be derived.

3.2 Service learning

Service Learning is a structured experience that combines defined learning outcomes, service to address specific community needs, and structured reflection exercises to
promote deep understanding. It provides an opportunity to link theory to practice – which is basically the concept behind clerkship and residency. It is also an approach to answer the “How We Teach” question when bringing the social determinants of health to life in the community setting. How can service learning be incorporated into a curricular framework? Some of the questions to be answered are posed here.

- Discrete block(s) versus sessions spread throughout pre-clerkship/clerkship?
- Mandatory components, elective options for students, or optional program(s)?
- How much curricular time should be explicitly devoted to service learning?
- How are students evaluated? How is progress reported?
- How do we ensure student buy-in? How effective is service learning if it’s not voluntary?

There are already some starting points for using a service learning approach in teaching. They include the following activities.

- Rural week
- Clerkship rotations
- Sessions at Winnipeg Harvest, Nine Circles, etc
- SWEAT program, Early Exposures
- WISH Clinic, interest groups

3.3 Indigenous health and cultural safety

As noted in the introduction, indigenous health and cultural safety are key components of a revised curriculum. If the faculty is going to tackle institutional racism, we need to begin with an understanding of the socio-political influences on the health of First Nations, Métis and Inuit people in Manitoba and Canada and the need for cultural safety.

3.4 Power relationships

To ensure student wellness and cultural safety the power relationships between students and faculty members needs to be acknowledged and discussed. More mechanisms need to be in place for students to come forward in regards to issues that arise during medical training. The use of power in relationships is part of the hidden curriculum. In the context of patient-physician relationships, understanding the two-sided nature of power relations improves the learner’s ability to work together with patients.

3.5 Student wellness

Student wellness needs to be supported and modeled through the wellness of their role models. The hidden curriculum again emerged as an issue when evaluation was discussed. Student evaluations need to be explicit. For instance, students who put in the most hours may be viewed preferentially. Student fatigue and family responsibilities need to be acknowledged and not negatively weighted in evaluation. Evaluations are taken seriously by students and need to be taken seriously by faculty members. At the same time students want to be assured of the opportunity to provide confidential, useful, and
sometimes critical, evaluations of faculty members. Mechanisms to address this should also be strengthened in the new curriculum.

3.6 Safe learning environment

The need for a safe learning environment was discussed in the group. It is related to the concepts of cultural safety, power relationships and student wellness.

3.7 Celebrating diversity in community, staff and students

The Faculty of Medicine needs to explicitly celebrate diversity in all aspects. This needs to be a part of student life, faculty activities, and community engagement.

3.8 Self reflection as a learning tool

Self reflection is an important tool for learners and providers and should be used more widely. Students and faculty require instruction on how to use it. Preparation, implementation and feedback on self reflection activities are required.

4. TOPICS (What to teach, How to teach and How to Evaluate)

4.1 Indigenous health education

What to Teach

The advancement of Indigenous health content within the medical school curriculum stems from the Social accountability framework document published by Health Canada.(1) This document outlines the social contract that medical learners and practitioners have in delivering care to all communities but especially non-traditional communities. Further work with the Indigenous Physician’s Association of Canada helped clarify this framework in the context of focusing on the health and healing needs of First Nations, Inuit and Métis communities. This led to the creation of the document titled First Nations, Inuit, and Métis Health CORE COMPETENCIES: A Curriculum Framework for Undergraduate Medical Education which provides a set of core competencies framed after the CANMEDS framework.(2) These competencies assist medical schools in developing curriculum that reflects local Indigenous health and cultural needs.

How to Teach

Opportunities to incorporate First Nations, Inuit and Metis health exist across the medical curriculum, from the didactic lecture format to problem based learning. Adapting a non-deficit approach and incorporating strength based analysis assists educators and learners to guard against stereotyping. Because of the unequal knowledge base of entering first year medical students, a common educational intervention to bring basic knowledge about the historical and current relationships between the diverse First Nations, Inuit and Metis communities is important. This information should then be delivered in the context of advancing cultural safety as a skill for the learner.(3) Experiential learning through community engagement, small group learning, and reflective learning environment gives
students a chance to deepen their knowledge and skills and to be challenged in facing common stereotypes that remain as barriers to therapeutic encounters.

**How to Evaluate**

Evaluation strategies may employ content testing, observational skills and demonstrating respectful clinical encounters, advancing community centered advocacy behaviours and as well engaging in inter professional health care delivery. Attitudinal skills are more of a challenge to evaluate. Writing exercises with a self-reflective domain may assist here. It is important is to make sure that feedback to students is strengthened with both formative and summative evaluations in the educational life of medical learners.

**References**


2. First Nations, Inuit, Métis Health CORE COMPETENCIES A Curriculum Framework for Undergraduate Medical Education 2009


**4.2 Cultural Safety in Medical Education**

- Cultural Competence: can be seen as “a set of congruent behaviors, attitudes and policies that come together in a system, agency, or among professionals and enable that system, agency, or those professionals to work effectively in cross cultural situations”.

- Cultural safety analyzes power imbalances, institutional discrimination, colonization and colonial relationships as they apply to health care and health education.

Cultural Safety is a teachable skill and one main component of it is self-reflection. The National Aboriginal Health Organization published an information sheet on cultural safety that summarizes this concept. Teaching this skill to medical learners in the context of Aboriginal health is mandatory. In order to redress the continuing impact of racism, stereotyping and discrimination and other social residue left over from the unequal sharing of power for First Nations, Inuit and Metis communities in Canada, medical learners must become adept at recognizing their influences. Cultural safety offers medical learners a chance to interrupt, advocate about and address the invisible barriers that prevent the advancement of health and well being First Nations, Metis and Inuit people in our community.

At the patient-physician relationship level, the employment of cultural safety improves therapeutic outcomes for patients. This is important for all communities as patients come from diverse conditions of oppression, violence and suppression of individual, religious and racial rights. Cultural safety facilitates listening skills for medical learners, thus assisting them to hear...
about and empathize within the sometimes about painful lived experiences and unbelievable conditions in which patients live. This type of skill constitutes a therapeutic tool. (NAHO)

Teaching cultural safety provides some challenges that may only be addressed through appropriate faculty education and support. Lecture formats help define what cultural safety is about, but more importantly, active employment and support of this skill may improve its retention. Protected time for self-reflection is required. Faculty must be trained in basic skills related to debriefing at all levels in the medical life of learners.


4.3 Social Accountability

The WHO definition of Social Accountability of Medical Schools is:

“The obligation to direct their education, research and service activities towards addressing the priority health concerns of the community, region, and/or nation they have a mandate to serve. The priority health concerns are to be identified jointly by governments, health care organizations, health professionals and the public.”

Social Accountability partnership pentagram (1)

The fundamental principle of social accountability is that society’s needs must always be central and medical school’s education, service and research must always strive to meet these diverse and ever changing needs. An important aspect of social accountability, reflected in the WHO definition, is that education, research and service activities should be jointly identified by the stake holders (governments, health organizations, health professionals and the public). Social accountability essentially means that the community should be involved at every stage in the process, beginning with identification of the needs. The service providers (government, health care organizations, and health professionals) should always get back to the community as

Indigenous Health, Cultural Safety, Social Accountability, Interprofessional Education and Practise and Advocacy
partners to give feedback and get their inputs. Community partnership, involvement and providing regular updates to the community should be seen as the hallmark of social accountability.

Social accountability should go hand-in-hand with social responsibility. Social accountability deals with community involvement, rendering regular accounts to the community on what is being done and why, and seeking their approval/cooperation; social responsibility relates to the fact that service providers have a legal and social obligation to the community. The activities must be seen as an obligation and not an act of favour to the community. The two principles of collaboration and obligation (legal, moral, and social) should be integrated into the teaching and practice of medicine, along with the four values of social accountability noted by WHO.

The four values of social accountability are declared in “Canadian Medical Schools: A Vision for Social Accountability”, a document endorsed by the Association of Faculties of Medicine in Canada in 2001. (2) These values are:

1. **Equity**. - We must assure there is quality health care available to all people. Medical schools can define populations with specific or increased need, support community driven research, and educate students in environments in which they are exposed to those in need. (2) Equitable care can be enhanced by engaging students with underserved populations, such as inner city communities, ethnic and racial minorities, to learn of their specific needs, and encourage future work with these communities. (3)

2. **Relevance** – Medical education must address priority health needs, including access, distribution of physicians to meet needs of communities, & give attention to communities with higher rates of illness or greater barriers to health. (4)

3. **Quality** – Medical education must be evidence based, comprehensive, community responsive. Care must be culturally safe and sensitive.

4. **Cost effectiveness** – Use human and material resources for the public interest in the most cost efficient and effective way.

A social accountability conference was held in 2010 with 65 representatives from medical schools and accrediting bodies globally. Similar concepts were expressed in the document Global Consensus for Social Accountability of Medical Schools, as discussed in the previous section. The committee recommended medical education curriculum should:

- Be guided by the four principles of equity, relevance, quality and cost effectiveness to meet society’s needs.
- Recognize the determinants of health and direct education, research and service to address these factors.
- Work with stakeholders in design, implementation, and evaluation.
- Recognize local community as primary stakeholder and share responsibility for a comprehensive set of health services, using population and individual health activities.
- Recruit a diverse student population to medical school.
• Give priority to primary care health.
• Early and longitudinal approach to community based learning.
• Act on determinants of health and gain appropriate clinical skills, organized to benefit the community concerned.
• Engage medical school and student body to address health challenges and needs of society.
• Recognize academic excellence as ability to deliver education, research and service that respond to health challenges and needs in society and have a positive impact on health.
• Identify health need in partnership with community, implement intervention, and measure impact on health, both individual and population-wide.
• Assess medical students’ career choices in relation to societal priority health needs. (6)

What to Teach

The medical student will be able to:

• Define concepts and describe the importance of social accountability and social responsibility, community responsiveness and partnership, individual and community empowerment in addressing health issues, community capacity building, and community based participatory research.
• Describe a community’s health using a population health and determinants of health framework.
• Link learning to community specific needs.
• Contextualize health issues of specific communities, and reflect on quality and equity of care, cost effectiveness and relevance for communities (including immigrant/refugee health, global health, inner city health, rural/remote health, mental health, health of the elderly, gay/lesbian/bisexual/transgender/two-spirited health, health for persons with disabilities).
• Use a CanMed framework to work with stakeholders for design, implementation and evaluation.

How to Teach

• Lecture
• Early and longitudinal community service learning with reflection and group debriefing at multiple community based organizations and community health centers throughout Winnipeg, Manitoba, and globally (consider program such as University of Saskatchewan’s Making the Links)
• Web based learning
• Problem based learning – with input and feedback from communities for community responsiveness, relevance, quality
• Build on standardized patient scenarios
• Debriefing monthly with faculty mentor during clerkship
• Each program leader should include specific objectives addressing social accountability:
Are there elements in the course content contextualized? Large group, small group, problem solving, community based?
Are stakeholders consulted for input on planning, implementation and evaluation of contextualized content?
Are principles of population health and determinants of health addressed?
Are there community based learning opportunities?
Is there a process to allow students to consider changing health issues in at risk populations, and possible multifaceted ways to intervene?
Is a strengths based approach used?
Does the course allow for interprofessional learning on current health needs of the community?
Is community driven research discussed and done?

How to Evaluate

- Written examinations
- Logbook with reflections on community member’s narratives of experience with health issue, health system throughout four years. Include narrative of a positive encounter with health professional or community leader, and how it helped the person’s health.
- OSCE
- Logbook entries with reflective component
- Host organizations to provide feedback on knowledge, attitude and skills gained by participating students.
- Evaluate student and host organizations satisfaction with educational experience.

How to design, implement, evaluate curriculum

- Create a process for ongoing input and feedback from stakeholders
- Community specific objectives should follow the process used by IPAC AFMC core competencies for FN, Inuit, Metis Health

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References

4.4 Interprofessional Education and Collaboration

Interprofessional Education (IPE): “Occasions when two or more professions learn with, from and about each other to improve collaboration and the quality of care. This includes all such learning in health, social, academic, work and community based settings adopting an inclusive view of “professional” to include all those who provide, care/ service as well as patients/ clients, families and communities who are integral components of the education continuum (CIHC National Competency Framework, 2010).

Interprofessional Collaboration (IPC): “The process of developing and maintaining effective interprofessional working relationships with learners, practitioners, patients/clients/ families and communities to enable optimal health outcomes. Elements of collaboration include respect, trust, shared decision making, and partnerships.” (CIHC National Competency Framework, 2010).

Research on IPE is in its infancy but has been linked to more collaborative practice and improved service delivery (CIHI, 2008).

What to Teach: IPE Competencies (from CIHC National Competency Framework, 2010)

Recently, the Canadian Interprofessional Health Collaborative (CIHC) has developed a national competency framework for IPC that is to cut across health professions and contexts (CIHC National Competency Framework, 2010). This framework (see Appendix A) identifies six competency domains related to knowledge, skills, attitudes and values for IPC. These domains reflect the what to teach in terms of IPE and include:

1. Interprofessional communication
2. Patient/client/family /community-centred care
3. Role clarification
4. Team functioning
5. Collaborative leadership
6. Interprofessional conflict resolution

How to Teach

A developmental approach from: 1) Exposure; 2) Immersion; and, 3) Mastery is recommended. The University of Manitoba has an IPE Initiative, which has been developing a “Blueprint” for the development of an IPE curriculum. The Faculty of Medicine should consult with this committee on the specific methods recommended for teaching IPE across different levels of learning. An initial IPE demonstration project took place at the University of Manitoba in 2007 (Anderson et al., 2008). Further pilots are planned including an IPE case study on health promotion for March 2012, which will focus on the domain of interprofessional communication. In brief, IPE should begin early in training and should be integrated throughout curriculum across training years rather than being one-off events. Teaching of IPE should include both classroom- and practice-based methods. It is important to note that small group and interactive
approaches to learning are likely to be favoured more by students than large didactic approach (Rosenfield, Oandasan, & Reeves, 2011). Some examples of relevant classroom-based methods for IPE: small group exercises involving problem-based learning or case studies, reflective exercises, and interactive skills labs. Some relevant practice-based methods for IPE include: placement opportunities with IPE /IPC learning goals, interprofessional student run health clinics or community initiatives.

**How to Evaluate:**

An evaluation of IPE should include an evaluation of learners and their learning environments. Learners should be evaluated across attitudes, knowledge, behaviours and skills. MCQs will be applicable but not the most relevant method of evaluation; rather, observation and short-answer assignments will be more important methods. Learners should be evaluated according to competencies listed in the CIHI National Competency Framework CIHC, 2010). Learning environments would be evaluated by learners and could also be evaluated externally.

**References:**

1. BC Competency Framework for Interprofessional Collaboration
2. CIHI (2008). The Synthesis of Review Evidence for Interprofessional Education:
   www.cihc.ca/resources/publications.html
3. CIHC (2010). National Competency Framework
   http://www.umanitoba.ca/faculties/medicine/education/iecpcp/
Appendix A

National Interprofessional Competency Framework

Goal: Interprofessional Collaboration
A partnership between a team of health providers and a client in a participatory, collaborative and coordinated approach to shared decision-making around health and social issues.

(Figure from CIHC National Competency Framework, 2010)
4.5 Health Advocacy

The material for this section is drawn directly from the handbook developed by the Royal College of Physicians and Surgeons of Canada to promote a train the trainer health advocates across the country. A summary is provided here. It is recommended that the handbook be used in its entirety. The handbook contains the core competencies, teaching methods, teaching materials and bibliography. A summary is provided here for easy reference. This material is consistent with the large literature available on advocacy.

Source: CanMEDS Train-The-Trainer Health Advocate
The Royal College of Physicians and Surgeons of Canada 2008

What to Teach

Core Competencies CanMEDS Health Advocate Role.

A Health Advocate responds to the needs of patients they serve.

Physicians are able to:

1. Respond to individual patient health needs and issues as part of patient care;
2. Respond to the health needs of the communities that they serve;
3. Identify the determinants of health of the populations that they serve;
4. Promote the health of individual patients, communities and populations.

A Health Advocate responds to the health needs of the communities they serve.

Physicians are able to:

1. Describe the practice communities that they serve;
2. Identify opportunities for advocacy, health promotion and disease prevention in the communities that they serve, and respond appropriately;
3. Appreciate the possibility of competing interests between the communities served and other populations.

How to Teach

1. Preclerkship Invite guest speakers who are community and/or patient advocates; use case studies in tutorials and/or self study; undertake a community service learning project such as a community agency visit, home visit or Personal Care Home visit with a briefing or debriefing.

2. Clerkship 500 word essay – integrate with Family Medicine or Public Health. A 500 word essay each quarter would detail:
   - An interaction during which they have identified an advocacy issue
   - Identify which key or enabling competency is reflected in the interaction
- What role the resident played in the interaction
- What lessons were learned or changed resulted from the interaction.
- Identify community advocacy activities addressing health and wellness, including social justice

**How to Evaluate**

Written Tests
- Contextual interventions (CIWA Scale, domestic Violence)

Direct Observation
- Use of Video
- ITERs

Multi-Source Feedback
- Nurses, clerical staff, consultant staff, patient/client

OSCE (TOSCE, ITOSCE)
- Risk factors, interventions (counselling)

Chart Review/audit
- Risk factors, preventative care

**5. FACULTY DEVELOPMENT**
The working group concluded that faculty development would be required across a number of the topics discussed here. Where there already exist training materials, such as in health advocacy, it is recommended that these be used. Faculty development should start now and continue as an ongoing part of academic professionalism in education.

**6. RELEVANCE TO CLINICAL TEACHING**
Early in their clinical practice, physicians begin to understand that the social circumstances and the lived environment of their patients has an important impact on their health and hence on the work of the physician. Doctors may not have recognized this during medical school.

**7. CONCLUSION**
The topics and concepts discussed here should be incorporated into the new Faculty of Medicine curriculum. It is particularly important that indigenous health and cultural safety is well understood and well practiced, not only by students but also by faculty members and other practicing physicians. In medical school, the relevance of these topics may not seem immediately relevant to students. Teaching them can be a challenge. The opportunity is to make the material interesting, relevant, and reflected in role modeling by their teachers. There is much to discover in our communities. Scholarship needs to be applied, as in any other subject area.

The University of Manitoba can draw on current materials used by other organizations in other universities. This document represents a summary of the hot topics assigned to this working
group. Discussion papers providing more background and bibliographies are listed below and posted on the CURE website for easy reference.

Linked or posted to the CURE website are the following resources related to this document.


5. Social Accountability - A background paper for CURE authored by Dr. Anne Durcan and Mahwash Saeed. October 2011.
