

Indigenous Peoples' Experiences with Culturally Safe Health Care

by

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Diploma in Nursing, University College of the Fraser Valley, 1999

Bachelor of Science in Nursing, University of British Columbia, 2002

Master of Nursing – Nurse Practitioner, University of British Columbia, 2009

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We acknowledge and respect the Lək'wəŋən (Songhees and Esquimalt) Peoples on whose  
territory the university stands, and the Lək'wəŋən and WSÁNEĆ Peoples whose historical  
relationships with the land continue to this day.

## **Supervisory Committee**

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## Abstract

It is widely recognized that Indigenous peoples have a lower life expectancy and higher rates of chronic health conditions and infectious diseases than non-Indigenous people do. Factors contributing to such health inequities include the impact of colonization on Indigenous peoples' health and racism that Indigenous peoples often endure in mainstream health care settings. To promote Indigenous peoples' health and reduce stigma and discrimination in health care, cultural safety is a promising approach. Although there is a substantial body of literature and research on cultural safety, there is a lack of resources to guide health care providers in practicing cultural safety effectively.

The overarching purpose of this dissertation was to gain insight into Indigenous peoples' experiences with culturally safe health care. Two research questions guided the research process:

1. What are Indigenous peoples' experiences with culturally safe health care encounters?
2. How is cultural safety enacted in health care as described by Indigenous peoples?

Two methodologies were used to explore these questions. For the first question, I used the Joanna Briggs Institute meta-aggregative approach to conduct a qualitative systematic literature review. For the second question, I used a descriptive qualitative methodology informed by relational inquiry, which is a nursing approach that is grounded in critical theoretical perspectives, hermeneutic phenomenology, and pragmatism. While the systematic review provided a synthesis of existing evidence, the qualitative study explored the 'how' of cultural safety, specifically, how health care providers created positive and safe health care experiences as described by Indigenous peoples, in contrast to much of the existing research that mainly focuses on the 'what' of cultural safety.

This publication-based dissertation is organized into three papers. The first paper is a published protocol for the qualitative systematic review. The second paper is the completed qualitative systematic review. The third paper is a practice-oriented paper aimed at assisting nurse practitioners in implementing culturally safe practice at the point of care through the creation of a mnemonic. The mnemonic was intended to provide a way for nurse practitioners to think about culturally safe care and enhance their ability to provide that care in specific health care situations.

*Keywords:* Indigenous, cultural safety, health inequities, relational inquiry, systematic review, nurse practitioners

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I would like to acknowledge the traditional, ancestral, and unceded territories of the x<sup>w</sup>məθk<sup>w</sup>əyəm (Musqueam), Sk<sup>w</sup>xwú7mesh (Squamish), and səlilwətał (Tsleil-Waututh) Nations, where I lived and learned during my doctoral studies.

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## **Dedication**

To my partner James, who always encouraged me to push on because this was important work, no matter how hard it seemed, who was a sounding board for many of the shifts happening in my thinking, who took the full weight of looking after our family, driving the kids to soccer, back from swimming, up to skiing, making lunches, making dinner, folding laundry, the list is endless, and I recognize and appreciate everything you have done to make this possible.

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I dedicate this work in loving memory of my father, Don Hay. From you, I learned the value of a calm, quiet, strong presence, doing the right thing, and a love of the outdoors, all of which continue to provide me with solid direction, grounding, and happiness. I miss you.

## **Chapter One: The Foreword**

When seeking health care, not everyone experiences high-quality care (Pauly et al., 2009). In Canada, examples of culturally unsafe care are widespread. In 2008, Brian Sinclair, an Indigenous man, died while being ignored in a hospital waiting room after waiting 34 hours for treatment of a treatable urinary tract infection (Brian Sinclair Working Group, 2017). As his condition progressed towards sepsis, health care providers assumed that Brian was homeless, sleeping, or intoxicated, rather than investigating his symptoms of lethargy, vomiting, and slurred speech (Brian Sinclair Working Group, 2017). Thus, he died “in plain sight” (Brian Sinclair Working Group, 2017, p. 3) of health care providers, including nurses and nurse practitioners (NPs). In 2015, Keegan Combes, a 29-year-old Indigenous man, accidentally ingested windshield wiper fluid, which resulted in methanol poisoning (First Nations Health Authority, 2022). The health care providers felt they knew Keegan from previous interactions related to his disabilities, and overlooked the diagnosis of methanol poisoning, despite confirmation from a urinalysis (First Nations Health Authority, 2022). Health care providers’ delay in diagnosis and treatment (more than 12 hours) led to his preventable death (First Nations Health Authority, 2022). More recently, Joyce Echaquan’s untimely death in 2020 also points to the fatal consequence of culturally unsafe health care (Kamel, 2021). Joyce Echaquan was a 37-year-old Indigenous woman and mother who sought health care for ongoing medical issues, including diabetes and heart failure (Kamel, 2021). Falsely stereotyped as someone addicted to narcotics, Joyce Echaquan was met with prejudice, including derogatory remarks from the nursing staff (Kamel, 2021). In spite of being in pain and with her health deteriorating, Joyce Echaquan was able to video record and broadcast the culturally unsafe care she experienced on social media just before she died in the hospital (Kamel, 2021).

## **Situatedness**

I want to begin by locating myself in relation to the work demonstrated in my dissertation. I was born and raised on the traditional, ancestral, and unceded territory of the Stó:lō Nation in Chilliwack, British Columbia, Canada, in a White, middle-class, heteronormative, and able-bodied family. As a result of my social position, I was afforded unearned privileges at the expense of others. While some of my friends growing up self-identified as Indigenous, I unknowingly internalized negative and harmful stereotypes that were prevalent in my home, school, community, and the media.

Although Canada has a long history of harming Indigenous peoples through colonial policies and practices, that history was not included in my primary or secondary education, nor was it included in my initial nursing education. It was troubling for me, having spent my entire life in Canada, to learn (as an adult) of the harmful and lasting effects of the colonial history of Indigenous peoples. Despite practicing as a nurse for decades, I was unaware of the historical and ongoing harms Indigenous peoples continue to encounter when seeking health care. During my doctoral studies, the more I learned of our history of colonization, the more I became aware that my nursing practice was deeply embedded in the dominant biomedical, Westernized, and liberalist health care system in Canada (Browne, 2001; Doane & Varcoe, 2021; Pauly et al., 2009; Reutter & Kushner, 2010). I was a product of my environment, and the scariest part for me to reflect on was that I did not know it. I had no insight into my unearned privilege (McGibbon et al., 2014) and made no connection between the Indigenous people I knew and the harmful stereotypes I held. Because of my own ignorance and unconscious bias, I failed to recognize how damaging stereotypes harmed Indigenous peoples through culturally unsafe care (Doane & Varcoe, 2021).

My PhD journey has had a significant influence on me as a White settler, NP, educator, and researcher. I have had the profound opportunity to deeply reflect on my values and biases, and the harmful ways I showed up in health care interactions with Indigenous peoples due to my lack of awareness and self-reflection. Addressing culturally unsafe health care for Indigenous peoples is especially important considering the Truth and Reconciliation Commission's Calls to Action, which provides recommendations to address Indigenous-specific racism and discrimination (Truth and Reconciliation Commission of Canada, 2015). In particular, Calls to Action 18, 19, 23, and 24, related to the health and education of health care providers, are very important (Truth and Reconciliation Commission of Canada, 2015) (see Chapter 5 for details).

### **Finding Focus**

In the early days of my doctoral program, I had the opportunity to work as a research assistant. The study was looking at health equity within emergency departments, and my role was to administer surveys to people waiting to receive health care. After my first day, the focus of my research topic was etched into my mind. Chapter 4 provides the details of my observations during this time of an Indigenous person's encounter with culturally unsafe care. Thinking back on that experience almost daily over the course of my doctoral work, I can now see my role in perpetuating culturally unsafe health care by failing to act. Because of my doctoral education, I have been able to critically examine and disrupt my biased assumptions, reflect on how I showed up (or failed to show up) as a nurse and later NP, and became aware of how I perpetuated harmful stereotypes in health care encounters with Indigenous peoples. This has driven me, as an NP, educator, researcher, and human, to promote socially just, equity-oriented action to bring about positive changes in the health care system.

## Significance

Indigenous peoples comprise five percent of Canada's overall population (Public Health Agency of Canada, 2018). As such, providing culturally safe care is a significant part of our professional obligations as nurses and NPs (British Columbia College of Nurses and Midwives, 2022; Canadian Nurses Association, 2017). Culturally safe care is not only significant because many clients presenting for health care self-identify as Indigenous, but also because Indigenous peoples experience significantly worse health outcomes than non-Indigenous people (Public Health Agency of Canada, 2018). For instance, Inuit peoples living in Canada have a life expectancy that is up to 12 years lower than non-Indigenous people (Public Health Agency of Canada, 2018). Additionally, Indigenous peoples in Canada have infant mortality rates up to 3.9 times higher (Public Health Agency of Canada, 2018). Furthermore, in areas with higher numbers of Indigenous peoples, suicide rates are up to 6.5 times higher (Public Health Agency of Canada, 2018). The growth of Indigenous populations (Public Health Agency of Canada, 2018), the well-documented enactment of culturally unsafe health care (Truth and Reconciliation Commission of Canada, 2015; Turpel-Lafond, 2020) and the professional responsibility of nurses and NPs to provide culturally safe care (British Columbia College of Nurses and Midwives, 2022; Canadian Nurses Association, 2017) all underscore the dire need for research in the area of culturally safe care for Indigenous peoples.

Nurses and NPs often play a significant role in their clients' health care experiences; and thus, Indigenous health and health care inequities are critical issues for nursing. However, research has shown that Indigenous peoples frequently encounter negative attitudes and judgmental behaviors from nurses when seeking care in mainstream health care settings, leading to stigma, discrimination, and culturally unsafe care (Browne & Fiske, 2001; Browne et al.,

2016; Goodman et al., 2017; Turpel-Lafond, 2020). Poor treatment causes Indigenous peoples to leave without receiving the health care they originally sought (Goodman et al., 2017), which in turn discourages them from seeking future care (O'Donnell et al., 2016). Worse, as demonstrated in the earlier examples, Indigenous individuals such as Brian Sinclair, Keegan Combes, and Joyce Echaquan have been ignored to death, highlighting the fatal consequence of culturally unsafe health care (Brian Sinclair Working Group, 2017; First Nations Health Authority, 2022; Kamel, 2021).

Moreover, it is an ethical obligation for all nurses and NPs to confront stigma and discrimination (Canadian Nurses Association, 2017). The Canadian Nurses Association's *Code of Ethics* (Canadian Nurses Association, 2017) outlines seven core nursing values and ethical responsibilities that nurses and NPs must uphold. There are three key points that are worth highlighting in relation to my research. Firstly, nurses will “not discriminate on the basis of a person's race, ethnicity, culture, political and spiritual beliefs, social or marital status, gender, gender identity, gender expression, sexual orientation, age, health status, place of origin, lifestyle, mental or physical ability, socio-economic status, or any other attribute” (Canadian Nurses Association, 2017, p. 15). Secondly, nurses must demonstrate respect for the unique histories and interests of Indigenous peoples (Canadian Nurses Association, 2017). Thirdly, nurses must avoid engaging in judgmental or stigmatizing behaviors towards people receiving care (Canadian Nurses Association, 2017). As a result of these ethical obligations, it is the responsibility of all nurses and NPs to promote culturally safe care and improve the health and health care experiences of Indigenous peoples.

## **Existing Knowledge of Cultural Safety**

Cultural safety is a promising approach that has been used to address Indigenous-specific racism in health care (Pauly et al., 2015). The concept has been in existence for several decades, having originated in a nursing classroom in New Zealand in the late 1980s (Wepa, 2015). Māori nurse leaders, who sought to address the health inequities experienced by Māori peoples, developed the concept (Papps & Ramsden, 1996; Ramsden, 2000; Wepa, 2015). It has been characterized as “an example of Māori resistance to dominant western ways of thinking, seeing, and carrying out health care” (Robinson et al., 1996, p. 371). Cultural safety was defined early on as “the effective nursing of a person/family from another culture by a nurse who has undertaken a process of reflection on (their) own cultural identity and recognises the impact of the nurse’s culture on (their) own nursing practice” (as cited in Papps & Ramsden, 1996, p. 491). Others went on to define what cultural safe care was not, “any actions which diminish, demean, or disempower the cultural identity and well-being of an individual” (Wood & Schwass, 1993, p. 5).

Cultural safety also draws on critical theoretical perspectives, including critical social justice, and postcolonial feminism (Anderson et al., 2003; Browne et al., 2009; Papps & Ramsden, 1996; Pauly et al., 2015; Ramsden, 2000; Richardson et al., 2017; Richardson et al., 2009; Smye et al., 2010). Although cultural safety was initially developed within the nursing discipline, it has since been used in other health care fields, including medicine, social work, physical therapy, and occupational therapy (Smye et al., 2010).

Cultural safety is grounded in several key assumptions. The first is that the client, not the health care provider, defines when care is culturally safe (Papps & Ramsden, 1996). This shifts power from the health care provider to the client, thus addressing the traditional power

imbalance in health care relationships (Blanchet Garneau et al., 2018; Papps & Ramsden, 1996; Robinson et al., 1996). The second assumption of cultural safety is that everyone has culture (Bourque Bearskin, 2011) and calls for health care providers to critically examine their own cultural backgrounds and biases to understand how they impact the nursing care they provide (Anderson et al., 2003). And the third assumption of cultural safety highlights how social, economic, and political factors impact health and health care (Doane & Varcoe, 2021). As such, it is important to shift our understanding from individual-level explanations of health and illness to the broader societal structures that greatly influence health (Browne, 2001; Reutter & Kushner, 2010).

The literature presents cultural safety as a framework, approach, continuum, process, outcome, and paradigm shift (Brascoupé & Waters, 2009; Curtis et al., 2019). As such, there are many conceptualizations of this concept. For the purposes of this doctoral project, I began this research by defining cultural safety as the experience of positive, safe, and affirming health care encounters or their perceptions or feelings of being in culturally safe health care encounters (Harding et al., 2021).

Although there have been numerous studies on Indigenous peoples' experiences with racism in health care (Allan & Smylie, 2015; Browne et al., 2016; Goodman et al., 2017; Turpel-Lafond, 2020), there is a limited amount of research describing Indigenous peoples' experiences with culturally safe health care (Hadjipavlou et al., 2018; Hole et al., 2015; Jennings et al., 2018). While it is widely accepted that racism in health care negatively impacts Indigenous peoples' well-being, there is an opportunity to shift the focus towards strengths-based approaches that emphasize the strength and resilience of Indigenous peoples. Highlighting the positive experiences of Indigenous peoples will add to nursing's knowledge of culturally safe

care. As culturally safe care must be named as such by the person receiving care (Curtis et al., 2019), it is crucial to seek the perspectives of Indigenous peoples about their positive and safe health care experiences. Thus, their stories can serve as educational examples of culturally safe care and help “translate this concept” (Reimer Kirkham et al., 2007, p. 37) into something tangible that nurses and NPs can use in their practice. Stories or examples can demonstrate how culturally safe care can be enacted in nursing practice, potentially promoting positive health care encounters rather than the negative ones that Indigenous peoples often experience.

### **Purpose and Research Questions**

The United Nations (2007) describes Indigenous groups as people who self-identify, are self-sustaining, and have experienced multiple forms of discrimination and violence upon and since the arrival of settlers. In Canada, the term Indigenous includes First Nations, Métis, and Inuit Peoples (Parrott, 2023). In this dissertation, the term Indigenous is used, as defined by Martinez-Cobo (1983):

Indigenous communities, peoples and nations are those which, having a historical continuity with pre-invasion and pre-colonial societies that developed on their territories, consider themselves distinct from other sectors of the societies now prevailing on those territories, or parts of them. They form at present non-dominant sectors of society and are determined to preserve, develop and transmit to future generations their ancestral territories, and their ethnic identity, as the basis of their continued existence as peoples, in accordance with their own cultural patterns, social institutions and legal system (p. 50).

The overarching purpose of this dissertation was to gain insight into Indigenous peoples’ experiences with culturally safe health care. The specific objectives to achieve my research purpose were: 1) to conduct a qualitative systematic review of Indigenous peoples’ experiences

with culturally safe health care encounters; 2) to learn from Indigenous peoples who shared their stories about culturally safe health care experiences and; 3) to disseminate the findings among nurses and NPs as a means of promoting cultural safety in their nursing practice.

Two questions guided the research process:

1. What are Indigenous peoples' experiences with culturally safe health care encounters?
2. How is cultural safety enacted in health care as described by Indigenous peoples?

Two methodologies were used to explore these questions. For the first question, I used the Joanna Briggs Institute (JBI) meta-aggregative approach (Aromataris & Munn, 2020) to conduct a qualitative systematic literature review. For the second question, I used a descriptive qualitative methodology (Polit & Beck, 2021) informed by a relational inquiry approach (Doane & Varcoe, 2021) that guided the study design, development of the research question, and data collection. Relational inquiry is a nursing approach based on critical theoretical perspectives, hermeneutic phenomenology (HP), and pragmatism (Doane & Varcoe, 2021) and is explored in detail in the following section. The study findings were presented within the framework of the findings from our systematic review.

## **Theoretical Perspectives**

Critical theoretical perspectives (including postcolonial feminism and critical social justice) and relational inquiry significantly shaped my thinking and underpinned my doctoral research into culturally safe health care from Indigenous peoples' perspectives.

### ***Critical Theoretical Perspectives***

“There is no single critical theory. Rather, it includes many perspectives” (Stevens & Hall, 1992, p. 3), such as postcolonial feminism and critical social justice. Together these critical

perspectives focus on power structures, domination, and oppression; strive towards emancipation and social change; and have been identified as effective lenses for critiquing health and health care inequities (Anderson, 2000; Anderson et al., 2009; Browne, 2000; Kirkham & Browne, 2006; McGibbon et al., 2014). They have also attracted increasing attention in nursing and research with Indigenous peoples over the past several decades (Anderson et al., 2009; Browne, 2000, 2005; Browne & Varcoe, 2006; Doane & Varcoe, 2021; Kirkham & Browne, 2006).

The following key assumptions, as articulated by Stevens and Hall in their seminal paper on critical theories (1992), underpin this research: (a) there is no apolitical research, as it is widely known that Indigenous peoples and their communities have been harmed by researchers (Macdonald et al., 2014); (b) oppressive and unequal power relations are ever present, including in health care (Foucault, 1973); (c) history influences social, economic, and political situations; and (d) emancipation is vital to well-being. These key assumptions shaped the way I undertook the research, highlighting the importance of seeking Indigenous consultation, learning about the history of colonization, and carefully scrutinizing my own actions while paying particular attention to power relations. Considering these assumptions in relation to Indigenous peoples' health and cultural safety, I hope my doctoral work has been *with* Indigenous peoples and not *on* Indigenous peoples.

### ***Postcolonial Feminism***

Within this critical perspective, postcolonial feminism focused my attention on the importance of centering the voices of those who have experienced marginalization and oppression (Anderson, 2000, 2004; Anderson & McCann, 2002; Kirkham & Anderson, 2002; Kirkham & Anderson, 2010) because “it is from those who have suffered the sentence of history—subjugation, domination, diaspora, displacement—that we learn our most enduring

lessons for living and thinking” (Bhabha et al., 2004, p. 172). In Canada, Indigenous peoples have been marginalized, and their voices have often been silenced in research and mainstream health care settings. As Kirkham and Anderson (2010) write, the central tenet of postcolonial feminism

calls for the inclusion of voices silenced in the social production of knowledge and disrupts the history of the categorization of people according to their presumed race. It analyzes how historical and racialized relations have contributed to structural inequities along the axes of race, class, gender, and other social relations (p. 198).

Informed by postcolonial feminism, I designed this research to ask Indigenous peoples about their experiences with culturally safe health care, as opposed to privileging health care providers’ perspectives (the more common approach in the cultural safety literature).

Another key objective of postcolonial feminism is to disrupt essentialized knowledge (Wesp et al., 2018). For instance, in Canada, the prevalent biomedical, Westernized, and disease-focused model of health has historically excluded Indigenous health and healing practices. Postcolonial feminism exposes the dominance of the White, middle-class perspective as ‘normal’ and anything else as ‘other’ or inferior (Van Herk et al., 2011). In my doctoral work, I attempted to expose such knowledge by showing how alternative models of health care were positively regarded. I was interested in learning from Indigenous peoples about culturally safe health care experiences, and thus I needed access to a health care setting where people were likely to have positive care experiences. For this reason, I partnered with an Indigenous-led clinic that merged conventional primary care services with traditional Indigenous medicine and wellness practices to emphasize the significance of diverse approaches to health care. By listening to the

perspectives of Indigenous peoples from this type of clinic, we were able to recognize the immense value of delivering health care in more than just the dominant way.

Another important point about postcolonial feminism is how it centers on emancipation and positive social change (Kirkham & Browne, 2006; Kirkham & Anderson, 2010). Doctoral work is an enormous project that may or may not do anything in the way of improving health care once it has been completed. It is important to me that my doctoral work contributes to positive health care experiences for people. I hope this research prompts nurses and NPs (myself included) to address the negative health care experiences that Indigenous peoples endure. Promoting cultural safety in nursing practice is one approach to improve health care experiences for Indigenous peoples and work towards positive social change (Pauly et al., 2015).

### ***Critical Social Justice***

The idea of critical social justice was initially introduced by Kirkham & Browne (2006). These authors aimed to provide critical interpretations of social justice “to mobilize socially transformative efforts that shift the root causes of social and health inequities” (Kirkham & Browne, 2006, p. 21). Unequal power relations at the societal level result in poor health for some and good health for others (Fraser, 2007; Young, 1990). Feminist scholars, such as Nancy Fraser and Iris Marion Young, broadened understandings of social justice by highlighting its political nature (Kirkham & Browne, 2006).

Many nursing scholars have drawn on critical social justice as an approach that highlights the power dynamics behind health inequities (Anderson et al., 2009; Browne & Reimer-Kirkham, 2014; Browne & Tarlier, 2008; Kirkham & Browne, 2006; Pauly et al., 2013). Critical social justice has been applied to examine the root causes, or the sociopolitical causes, of health inequities and the underlying reasons for disproportionately lower health outcomes in certain

groups (Anderson et al., 2009; Browne & Tarlier, 2008; Pauly et al., 2013). For example, critical social justice has been useful in understanding the root causes of Indigenous health inequities in Canada (Browne, 2005). It is clear that Indigenous health inequities are related to the removal of land and resources, the inability to carry out traditional food practices, and the rise in substance use and violence in response to physical, emotional, and sexual trauma inflicted upon Indigenous peoples by the government and the churches in Canada (Kim, 2019). A critical social justice perspective shifts attention from the individual level to the societal level and scrutinizes the policies and practices that continue to underlie Indigenous health inequities (Browne & Tarlier, 2008).

Critical social justice also supports a health equity orientation, rather than health equality (Kirkham & Browne, 2006). Health equity is seen as a key aspect of social justice in health care aimed at “reducing the gap between those who are healthy and those who are less healthy by shifting the health and social equity gradient upward” (Browne & Reimer-Kirkham, 2014, p. 22). On the other hand, health equality refers to equal shares for all, regardless of their circumstances (Braveman, 2022). For example, a health equality approach provides the same dominant model of health care to everyone. In contrast, a health equity approach is more nuanced and considers the historical colonial practices that have suppressed Indigenous peoples’ traditional medicine and wellness practices. It aims to challenge and transform the colonial system to incorporate Indigenous models of health and healing within the existing health care system. A critical social justice perspective led me to understand that delivering health care in the same way for everyone may be equal, but it is not equitable. This was another reason that I sought to partner with a particular Indigenous-led clinic for this study: because they are moving health care beyond the

dominant biomedical medical model to incorporate traditional Indigenous medicine and wellness practices.

Additionally, critical social justice focuses on collectivism as a way forward rather than individualism (Browne & Tarlier, 2008). Individualism is a political ideology grounded in liberalism that claims that taking personal responsibility for one's health is what makes people healthy, and it dominates current discussions on health (Browne, 2001). This individualistic mindset shifts the burden of responsibility from political and social spheres, places the blame on individuals, and disregards the importance of the collective well-being of society (Browne, 2001). By concentrating on personal, rather than collective responsibility, individualism works against the overall health of society (Reutter & Kushner, 2010). It also restricts our capacity to reduce health inequities, which are influenced mainly by broader social, historical, and political contexts (Reutter & Kushner, 2010). Individualistic discourses continue to blame Indigenous peoples for the health inequities they face, rather than taking into consideration the detrimental effect of colonial policies and practices in Canada on Indigenous peoples' health (Poirier et al., 2022). By way of example, it is widely known that Indigenous peoples in Canada experience higher rates of diabetes, tuberculosis, and HIV, as well as a lower life expectancy than non-Indigenous people (Public Health Agency of Canada, 2018). The proximal explanations that are commonly given, as well as the dominant narratives, tend to emphasize neoliberal and individualist ideologies that attribute such health inequities to bad choices, poor eating habits, lack of self-care, and irresponsible behavior. However, this explanation reflects a colonial mindset and fails to acknowledge the structural factors contributing to such health inequities. A critical social justice lens shifts the focus from the individual to the societal level and recognizes

the responsibility of institutions in creating and perpetuating health inequities (Kirkham & Browne, 2006).

Combining postcolonial feminism and critical social justice in my doctoral work has been a valuable way to look at culturally safe nursing practice. Together, they decentered dominant health care perspectives and voices (Anderson, 2000, 2004; Anderson & McCann, 2002; Kirkham & Anderson, 2002; Kirkham & Anderson, 2010), pushed me beyond individual level health orientations (Browne, 2001; Reutter & Kushner, 2010), highlighted the importance of historical, political, and social factors constraining Indigenous peoples' health (Browne & Tarlier, 2008), and brought awareness about the need for positive social change (Kirkham & Browne, 2006; Kirkham & Anderson, 2010).

### ***Relational Inquiry***

In addition to the critical perspectives discussed above, relational inquiry also informed this research project. Doane and Varcoe (2021) contend that relational inquiry is a form of culturally safe practice. As a culturally safe health care process, this involves three levels of inquiry. Intrapersonal inquiry focuses on what is happening *within* people (Doane & Varcoe, 2021): considering the inner values, beliefs, practices and concerns of both people receiving health care and those providing health care. Interpersonal inquiry examines what is happening *between* people for the purpose of ensuring positive health care encounters through authentic, meaningful, responsive, “power-with” relationships (Doane & Varcoe, 2021). Contextual inquiry considers the systemic elements that might be shaping people and health care encounters, and in turn how systemic elements might be shaped by people, including socio-historical elements (Doane & Varcoe, 2021). Together, these three levels of inquiry draw attention to what is required for culturally safe and responsive health care.

Relational inquiry assumes that everyone is interconnected with everyone and everything (Doane & Varcoe, 2021). In other words, “people are contextual beings who exist in relation with others and with social, cultural, political, and historical processes” (Doane & Varcoe, 2007, p. 198). This approach to nursing practice acknowledges the intricate nature, complexity, and uniqueness of each health care encounter (Doane & Varcoe, 2021). Relational inquiry is also a way of paying attention to the specifics of each unique health care encounter, while also considering what is occurring at three levels: the intrapersonal (within), the interpersonal (among and between), and the contextual (around) (Doane & Varcoe, 2021). This involves asking questions of oneself (as a nurse or NP), of clients (the Indigenous person or their families) and engaging in the hard work of critical self-reflection to best guide nursing actions (Doane & Varcoe, 2021).

Relational inquiry is informed by critical theoretical perspectives (as discussed above), as well as HP and pragmatism (Doane and Varcoe, 2021). The HP lens adds a focus on the significance of people’s lived experiences and interpretations (Doane & Varcoe, 2021). Also, a fundamental grounding of relational inquiry, pragmatism further assumes that knowledge is uncertain and constantly needs re-evaluation, and emphasizes the importance of the usefulness of knowledge or ideas (Doane & Varcoe, 2021). This pragmatic orientation to knowledge emphasizes (a) the importance of critically questioning and tracking the consequence of any knowledge and/or approach, and (b) enlisting knowledge for the purpose of promoting the well-being of people and situations (Doane & Varcoe, 2021).

Using relational inquiry, I was able to bring together the critical theoretical perspectives of postcolonial feminism and critical social justice, while also attending to the meaning of experience for each individual at varying levels of inquiry (Doane & Varcoe, 2021). Using

relational inquiry as a framework for my qualitative research study offered a way for Indigenous participants to share their unique stories and experiences, while also emphasizing the structural factors that nurses and NPs must address for culturally safe nursing practice. This is crucial when studying Indigenous health inequities (Browne et al., 2012).

Together, postcolonial feminism, critical social justice, relational inquiry, and cultural safety informed and shaped the way I approached and conducted this research project. All of these perspectives either have origins in nursing or have been applied within a nursing context and are thus valuable for examining issues related to nursing practice. Both relational inquiry and cultural safety promote social justice and health equity (Browne et al., 2009; Doane & Varcoe, 2021; Pauly et al., 2015; Smye et al., 2010), and highlight the importance of non-judgmental relationships and shifting power dynamics in health care relationships from nurses and NPs to clients (Blanchet Garneau et al., 2018; Doane & Varcoe, 2021; Papps & Ramsden, 1996; Robinson et al., 1996).

Also, the above perspectives helped me recognize how certain knowledge is favored for specific reasons. For instance, portraying Indigenous peoples in a deficit-based way has been one of the many tools of colonialism (Mackay & Feagin, 2022). As such, it was important for me to adopt a strengths-based approach (Doane & Varcoe, 2021). Instead of focusing on unsafe care, I aimed to provide examples of culturally safe care that nurses and NPs could understand and use. Additionally, the above perspectives highlighted that it is essential to understand how Indigenous peoples' experience health care and how they prefer to receive it. I firmly believe that the perspectives of Indigenous peoples who receive care are the most crucial when studying cultural safety. Their perspectives are often overlooked and silenced, which is why I designed this study to privilege Indigenous voices.

## **Overview of the Publication-Based Dissertation and Manuscript Chapters**

Given the increasing complexity of nursing knowledge, innovative methodological approaches are essential (Benner et al., 2010). As a result, researchers must think creatively to develop new ways of generating knowledge that is beneficial for nursing and the people cared for by nurses and NPs. Nursing knowledge can stem from multiple ways of knowing and be grounded in various paradigms and modes of inquiry (Benner et al., 2010; Fawcett et al., 2001; Reimer Kirkham et al., 2007; Weaver & Olson, 2006).

In this dissertation, I applied two methodologies to approach my research questions: a JBI meta-aggregative approach to evidence synthesis (Aromataris & Munn, 2020) and a descriptive qualitative study (Polit & Beck, 2021). This dissertation is the partial fulfillment of the requirements for a PhD in Nursing at the University of Victoria and is composed of five chapters. It includes a Foreword, three manuscripts, and an Afterword. Chapters 2, 3, and 4 are manuscripts, all of which explore Indigenous peoples' experiences with culturally safe health care.

### ***Systematic Review Manuscripts***

The first and second manuscripts of this dissertation are the JBI qualitative systematic review protocol (see Chapter 2) (Harding et al., 2021) and the subsequent JBI systematic review (see Chapter 3). The purpose of this systematic review was to answer the following question: What are Indigenous peoples' experiences with culturally safe health care encounters?

A systematic review of the literature, which is a form of secondary research (Jordan et al., 2018), is just one type of research synthesis approach among the various available approaches (Schick-Makaroff et al., 2016). The objective of a systematic review is to synthesize primary research studies to provide recommendations for policy and practice (Aromataris & Munn, 2020;

Hannes & Lockwood, 2011) and to determine whether or not current health care interventions are appropriate (Munn et al., 2018). Alan Pearson, the founder of JBI, developed the qualitative synthesis review methodology, despite the approach's origins in the post-positivist paradigm (Butcher, 2017).

The JBI meta-aggregative approach is grounded in two perspectives: Husserlian phenomenology and pragmatism (Hannes & Lockwood, 2011; Pearson et al.). Phenomenology is the first of these, focusing on lived experiences and the experiences of human life (Pearson et al., 2011). According to Husserlian phenomenology, researchers can set aside any preconceived biases that may impact their research (Pearson et al., 2011), although there are criticisms regarding the challenges of bracketing, or the ability to separate the researcher from the research (Hamill & Sinclair, 2010; LeVasseur, 2003). Given the critical theoretical perspectives and relational inquiry approach outlined above, in contrast to the JBI approach, I do not believe that it is possible to objectively set aside who you are at any time of the day, including when conducting research. However, I engaged in ongoing critical self-reflection to be aware of how my own preconceived understandings and history may be limiting me as a researcher. As per Doane and Varcoe (2021), the idea of reference points was instrumental in helping me identify how and where and why I focused my attention. I had to continually scrutinize these reference points throughout the research process. The second philosophical assumption of the JBI meta-aggregative approach is pragmatism, which is centered on the usefulness of an idea. JBI's pragmatic orientation is intended to provide useful findings for policy and practice (Aromataris & Munn, 2020; Hannes & Lockwood, 2011).

Like many others who have gone through graduate education, I did not want my doctoral dissertation to sit and gather dust on the proverbial shelf. Investing a significant amount of time

and energy that doctoral studies require, I wanted my work to contribute to something good. I wanted it to be useful for nurses and NPs. And I wanted it to help ensure positive health care experiences for Indigenous peoples when they present for health care. As such, the critical perspectives, relational inquiry, and the JBI approach offered me a way to do this and gave me a pragmatic plan for using the results of my systematic review. Also, as someone who was schooled in concrete thinking, the structure and formatting of the JBI methodology appealed to me.

Adhering to JBI guidelines, the systematic review was carried out by a review team (Aromataris & Munn, 2020). The team included myself as the lead reviewer, my supervisor, Dr. Esther Sangster-Gormley; my committee member Dr. Karen MacKinnon; and University of Victoria research librarian Dr. Carol Gordon. Three of the four co-authors completed the JBI Comprehensive Systematic Review Training program. It is a JBI requirement to have at least one review team member with this training (Aromataris & Munn, 2020). Additionally, two of the four team members had experience in conducting JBI systematic reviews.

As per JBI requirements, an a priori protocol was published in the JBI Evidence Synthesis journal (see Chapter 2) (Harding et al., 2021). The third chapter of this dissertation is a completed qualitative systematic review that adheres to the requirements set forth by JBI (Aromataris & Munn, 2020). As a doctoral student, I served as the lead reviewer for the project and consulted regularly with the rest of the team throughout the review process.

In addition to the co-authors on the JBI protocol, we also included two more team members for the systematic review: Christine Huel, a University of Victoria PhD candidate and JBI-trained reviewer, and Shannon Rooney, a University of British Columbia nursing faculty member. Despite receiving two rounds of peer-reviewed feedback and completing major

revisions, the systematic review was not accepted for publication by the journal JBI Evidence Synthesis. Upon reflection, the methodological tensions that we experienced in undertaking this systematic review may not have made this the most appropriate journal for our qualitative systematic review (see Chapter 5 for details). Our plan is to resubmit the systematic review manuscript to another journal.

### ***Substantive Paper***

The second part of my dissertation research was a descriptive qualitative study to learn from Indigenous peoples about culturally safe health care, which constitutes the third manuscript of my dissertation (see Chapter 4). This study aimed to address research question two: “How is cultural safety enacted in health care as described by Indigenous peoples?” The interview questions were designed based on relational inquiry (Doane & Varcoe, 2021). By incorporating this perspective into the study, we hoped to make it more beneficial for the nursing audience we were trying to reach. While the systematic review provided a comprehensive synthesis of existing evidence, the qualitative study aimed to explore the ‘how’ of cultural safety: specifically, how health care providers created positive and safe interactions as described by Indigenous peoples, in contrast to much of the existing research that mainly focuses on the ‘what’ of cultural safety.

In Chapter 4, I begin by reflecting on cultural safety within the context of critical theoretical perspectives and relational inquiry, as well as examining my own deeply ingrained colonial biases. I then summarize the key findings from the systematic review, coupled with examples from the qualitative interviews that I did which supported those findings. In an effort to assist NPs in operationalizing culturally safe practice at the point of care, Chapter 4 presents a mnemonic that was created. This mnemonic was intended as a tool, as a way for NPs to think

about enacting culturally safe care and to enhance their ability to provide that care in specific health care situations. This mnemonic was informed by what I learned from Indigenous peoples when reading about (the systematic review) and listening to (the qualitative interviews) their experiences with culturally safe health care. By sharing real-life examples from Indigenous peoples about their positive care experiences, I hoped to support nurses and NPs in responding to the Truth and Reconciliation Commission's Calls to Action, and to promote culturally safe health care experiences for Indigenous peoples.

As the Foreword chapter comes to a close, the subsequent three chapters of the dissertation contain the manuscripts described above. The fifth and final chapter of this dissertation is the Afterword, where I reflect on the advantages, limitations, and methodological tensions experienced within this doctoral project, as well as the implications for nursing and NP practice, education, and research.

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## Chapter Two: Systematic Review of Qualitative Evidence Protocol

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This is a final version of the accepted manuscript (before copyediting and publication).

### **Review title**

Indigenous peoples' positive experiences with culturally safe health care: A qualitative systematic review protocol

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# **Indigenous Peoples' Positive Experiences with Culturally Safe Health Care: A Qualitative Systematic Review Protocol**

## **Abstract**

**Objective:** The purpose of this systematic review is to explore what is known about Indigenous peoples' positive experiences with culturally safe health care.

**Introduction:** Research demonstrates that Indigenous people often experience stigma and discrimination from non-Indigenous health care providers when accessing health care services. One approach that has been put forward to address Indigenous health inequities is cultural safety. Studies have been conducted to identify what comprises culturally safe care for Indigenous people, but many of these studies target the health care provider's perspective, rather than the perspective of the Indigenous person who is receiving the care.

**Inclusion criteria:** This review will consider studies that involve Indigenous peoples' positive experiences with culturally safe health care from any study setting. Studies that present relevant qualitative findings including descriptions, examples, or stories about how a health care provider enacted cultural safety from Indigenous perspectives will be considered.

**Methods:** MEDLINE, CINAHL, Embase, PsycINFO, First Nations Periodical Index, the Native Health Database, the Indigenous Studies Portal, and the Arctic and Antarctic Regions Database will be searched for published studies. The search for unpublished studies will include Google and Google Scholar, ProQuest Dissertations and Theses, and opengrey.eu. Databases will be searched from 1988 onwards and only studies published in English will be included. The JBI systematic review guidelines will be followed. The JBI process of meta-aggregation will be used

to identify categories and synthesize findings. The ConQual approach will be used to assess confidence in the review findings.

**Systematic review registration number:** PROSPERO CRD42020173003

**Keywords:**

cultural safety; experience; health care; Indigenous; nursing

**Introduction**

Around the world, there are approximately 476 million Indigenous peoples spanning more than 90 countries.<sup>1</sup> Although Indigenous people constitute six percent of the worldwide population,<sup>1</sup> they score much lower on numerous indicators of health.<sup>1-8</sup> For example, Indigenous people worldwide experience disproportionately higher rates of chronic illnesses and infectious diseases, such as diabetes, cardiovascular illnesses, tuberculosis, and HIV/AIDS.<sup>2</sup> Additionally, life expectancy is up to 20 years lower for Indigenous people in Australia and Nepal compared to non-Indigenous people.<sup>2</sup> Furthermore, the suicide rates in regions of Canada where many people self-identify as Indigenous are more than six times higher than areas where not many people self-identify as Indigenous.<sup>6</sup>

The health inequities that Indigenous people face are well documented in the literature.<sup>1-8</sup> Health equity “means that all persons have fair opportunities to attain their full health potential”<sup>9(p.271)</sup> In contrast, health inequities are differences in health or health care spread systematically across groups, produced by unfair and modifiable social factors.<sup>10</sup> Social factors that influence a person’s health have been extensively described as the social determinants of health (SDoH).<sup>11</sup> These include things such as education,<sup>11</sup> employment, food security, health care services, housing, and social exclusion.<sup>11</sup> Moreover, racism, stigma, and oppression have also

been identified as social determinants of health that consistently create and sustain health inequities.<sup>12</sup>

Racism contributes to the health and health care inequities Indigenous people continue to endure, profoundly affecting their health and well-being.<sup>7</sup> Researchers have demonstrated that Indigenous people often experience stigma and discrimination from non-Indigenous health care providers when accessing mainstream health care services.<sup>4,13</sup> Indigenous people are sometimes treated so poorly during health care encounters that they leave prior to receiving medical attention.<sup>3</sup> Racism occurs at structural levels and is embedded in many institutional policies and practices.<sup>7</sup>

It has been said that the “systematic neglect of culture in health is the single biggest barrier to advancement of the highest attainable standard of health worldwide”.<sup>14(p.1630)</sup> In efforts to promote health equity, many conceptual models and frameworks have been proposed.<sup>8,15</sup> The particular framework that informs our understanding of health equity is from a nursing lens that is deeply rooted in social justice and health equity.<sup>15</sup> This health equity framework describes three approaches, including trauma and violence informed care, contextually-tailored care, and cultural safety.<sup>15</sup> For the purposes of this review, our focus will be on cultural safety.

Cultural safety is a promising concept that can be used to examine health and nursing practice and has been put forward as one approach to address Indigenous health inequities. Cultural safety emerged from nurse leaders who were concerned with the health inequities facing Māori peoples of New Zealand as a result of colonialism and racism.<sup>16</sup> It began as “an example of Maori resistance to dominant western ways of thinking, seeing, and carrying out health care”<sup>17(p.371)</sup> Culturally unsafe care was described as “any actions which diminish, demean, or disempower the cultural identity and well-being of an individual,”<sup>18(p.5)</sup> while the principles of

culturally safe care included the 3 R's (recognize, respect, rights)<sup>18</sup>. It is well documented that a culturally safe encounter must be identified by the person receiving care.<sup>16</sup> Further, cultural safety requires a shifting of power in the health care relationship from the provider to the person receiving care.<sup>16</sup> Cultural safety pushes the provider to reflect on their health care practices and shift the gaze onto themselves to critically examine their assumptions, biases and prejudices, and reflect on dominant health care practices.<sup>16</sup>

There are numerous other concepts of culture care, such as cultural sensitivity, cultural awareness, and cultural competence. However, they tend to define culture as race or ethnicity and purport that once a health care provider learns about another group's culture, they can provide care that is sensitive to or tolerant of that culture.<sup>19,20</sup> Conversely, cultural safety is grounded in critical theoretical perspectives,<sup>16,21</sup> and linked to goals of social justice<sup>21</sup> and health equity.<sup>22</sup> Although these culture care terms have been used interchangeably, they represent very different conceptualizations of culture and concepts of care. It is not our intention to define each of these concepts related to culture care, as we are only interested in the concept of cultural safety.

For the purposes of this review, we understand cultural safety as positive, safe, and affirming health care interactions as identified by the patient. We will be looking to include only positive examples of cultural safety as stated here. We believe that providing living examples from Indigenous perspectives on what culturally safe care looks like in particular situations will help health care providers understand how to enact culturally safe care.

A preliminary search of PROSPERO, CINAHL, MEDLINE, Epistemonikos, the Cochrane Database of Systematic Reviews, and the JBI Evidence Synthesis was conducted. A qualitative systematic review exploring the experiences of accessing health care from Indigenous

people in Australia was found.<sup>23</sup> Although some of the findings from this existing systematic review may overlap with the proposed systematic review, they differ in that the existing systematic review focused only on Australian respondents and centered around experiences related to health care access,<sup>23</sup> rather than experiences of cultural safety.

An additional systematic review protocol was found on the experiences of Indigenous people in health care encounters in Westernized settings.<sup>24</sup> This protocol was published in 2012,<sup>24</sup> however, to date there has been no systematic review to follow. The authors of the protocol were contacted in 2019 and were still planning to publish the systematic review. Although there may be some overlap between the review in progress and the proposed review, they differ because the authors are not focusing explicitly on cultural safety but rather exploring both positive and negative experiences in health care.<sup>24</sup> This proposed review will focus only on positive health care encounters, in order to capture examples of cultural safety as it is enacted.

Finally, a scoping review was found which explored culturally safe health initiatives for Indigenous people in Canada.<sup>25</sup> However, the scoping review looks at “any form of medical care, health promotion program, or health intervention”.<sup>25(p.203)</sup> The proposed systematic review will focus only on encounters in health care settings between an Indigenous person receiving care and a health care provider. The proposed review will exclude programs, training, and the evaluation of interventions.

The objective of this review is to understand positive experiences with culturally safe health care from Indigenous perspectives, with the ultimate goal of providing health care providers with suggestions and examples about how to enact culturally safe health care.

## **Review question**

What do we know about Indigenous peoples' positive experiences with culturally safe health care?

The aim is to include studies focusing on Indigenous peoples' positive experience of culturally safe health care as a guide for improving health care practice.

## **Inclusion criteria**

### **Participants**

This review will consider studies involving people who self-identify as Indigenous regardless of age, gender, or sex. As Indigenous people self-identify in diverse ways, we will include various terms, including but not limited to Indigenous, Aboriginal, Métis, First Nations, Inuit, Māori of New Zealand, the Aborigines and Torres Strait Islanders of Australia.

We will include studies that focus on the perspectives and experiences of Indigenous people, their family, or community member where the recipient of care is identified as Indigenous.

We will exclude studies that focus on the perspectives and experiences of health care providers (including students and educators).

### **Phenomena of interest**

This review will consider studies describing Indigenous peoples' positive experiences with culturally safe health care. For this review, cultural safety is defined as positive, safe, and affirming interactions with health care providers in any health care setting as experienced by the recipient(s) of care, their family, or community. We will only include findings that relate to a particular or specific health care encounter. A health care encounter is defined as any interaction

between a person receiving care and a health care provider occurring in a health care environment.

Since the terminology used to describe culturally safe care varies considerably in the international literature, we will search using terms that may be synonymous or include examples of cultural safety in a global context. We will then screen papers using our inclusion and exclusion criteria. Only research findings describing positive, safe, and affirming interactions with health care providers in any setting from the perspective of the care recipient will be included in this review.

We expect there will be many qualitative research reports with both positive and negative examples of health care interactions from Indigenous perspectives. We will not exclude studies that describe both positive and negative examples of health care interactions; we plan to deal with this at the extraction phase and will only extract those findings that match our operational definition of positive examples of cultural safety. We will exclude studies only describing negative, unsupportive, stigmatizing, discriminatory, or racist interactions with health care providers in any health care setting as experienced by the recipient(s) of care, their family, or community.

We will exclude studies that focus only on the cultural practices of the recipient(s) of care, their family, or community members, as this is essentializing and does not align with the critical, emancipatory focus of cultural safety.

## **Context**

The context of this review will consider all studies from any geographic location and all health care settings such as acute care, primary care, and community care. Studies that pertain to

training, professional education, and students will be excluded as this review is focused on applicability to health care and nursing practice.

### **Types of studies**

This review will consider studies presenting qualitative findings including, but not limited to, designs such as phenomenology, grounded theory, ethnography, action research, feminist research, Indigenous health research, and Indigenous methodologies. Descriptive qualitative studies describing the experience or describe the effects of the experience will also be considered. We anticipate that findings will primarily be the descriptive and interpretive themes identified by the researchers of the primary studies. We will only extract findings that include participant quotations, examples, or stories of cultural safety as illustrations of these findings.

We will exclude studies with only general comments about health care encounters that lack specific details as an illustration (such as most blogs and editorials).

### **Methods**

The proposed systematic review will be conducted in accordance with the JBI methodology for systematic reviews of qualitative evidence.<sup>26</sup> The review has been registered in PROSPERO (CRD42020173003).

### **Search strategy**

The search strategy will aim to find both published and unpublished studies. An initial limited search of MEDLINE (PubMed) and CINAHL (EBSCO) was undertaken to identify articles on the topic. The text words contained in the titles and abstracts of relevant articles, and of the index terms used to describe the articles were used to develop a full search strategy for CINAHL (see Appendix I). The search strategy, including all identified keywords and index

terms, will be adapted for each included information source. The reference list of all studies selected for critical appraisal will be screened for additional studies.

Studies published in English will be included. Due to resource limitations as a PhD student, translation of papers in languages other than English will not be possible. If a detailed English abstract is provided, studies published in other languages will be recorded for future consideration. Studies published from 1988 to the present will be included as “the formalisation of the concept of cultural safety began in 1988.”<sup>16</sup> (p. 492)

The databases to be searched include MEDLINE (PubMed), CINAHL (EBSCO), Embase, and PsycInfo. A grey literature search strategy was developed incorporating grey literature databases such as ProQuest Dissertations and Theses, opengrey.eu, and relevant organizational websites. We will also search Google and Google Scholar using keywords based on those found in our preliminary database searches. These searches will be iterative, as is typical for grey literature searching. Conference abstracts and blogs will be excluded. For literature related to Indigenous peoples, the search will include the First Nations Periodical Index, the Native Health Database, the Indigenous Studies Portal, and the Arctic and Antarctic Regions Database.

### **Study selection**

Following the search, all identified citations will be collated and uploaded into EndNote X9 (Clarivate Analytics, PA, USA) and duplicates removed. Following a pilot test, titles and abstracts will be screened by two independent reviewers for assessment against the inclusion criteria for the review. Potentially relevant studies will be retrieved in full and their citation details imported into the JBI System for the Unified Management, Assessment and Review of Information (JBI SUMARI; JBI, Adelaide, Australia).<sup>27</sup> The full text of selected citations will be

assessed in detail against the inclusion criteria by two independent reviewers. Reasons for exclusion of full text studies not meeting the inclusion criteria will be recorded and reported in the systematic review. Any disagreements that arise between the reviewers at each stage of the study selection process will be resolved through discussion, or with a third reviewer. The results of the search will be reported in full in the final systematic review and presented in a Preferred Reporting Items for Systematic Reviews and Meta-analyses (PRISMA) flow diagram.<sup>28</sup>

### **Assessment of methodological quality**

Eligible studies will be critically appraised by two independent reviewers for methodological quality using the standard JBI Critical Appraisal Checklist for Qualitative Research.<sup>26</sup> Authors of papers will be contacted to request missing or additional data for clarification, where required. Any disagreements that arise between the reviewers will be resolved through discussion, or with a third reviewer. The results of critical appraisal will be reported in narrative form and in a table.

All studies, regardless of the results of their methodological quality, will undergo data extraction and synthesis (where possible). The quality of included studies will be considered and reported on in this review.

### **Data extraction**

Data will be extracted from studies included in the review by two independent reviewers using the standardized JBI data extraction tool.<sup>26</sup> The data extracted will include specific details about the populations, context, culture, geographical location, study methods and the phenomena of interest relevant to the review objective. The data extracted will include quotations, examples, or stories from Indigenous peoples of positive health care experiences with cultural safety as illustrations of these findings. Findings, and their illustrations, will be extracted and assigned a

level of credibility. Any disagreements that arise between the reviewers will be resolved through discussion, or with a third reviewer. Authors of papers will be contacted to request missing or additional data, where required.

### **Data synthesis**

Qualitative research findings will, where possible, be pooled using JBI SUMARI with the meta-aggregation approach.<sup>26</sup> This will involve the aggregation or synthesis of findings to generate a set of statements that represent that aggregation, through assembling the findings and categorizing these findings on the basis of similarity in meaning. These categories will then be subjected to a synthesis in order to produce a single comprehensive set of synthesized findings that can be used as a basis for evidence-based practice. Where textual pooling is not possible, the findings will be presented in narrative form. Only unequivocal and credible findings will be included in the synthesis.

### **Assessing confidence in the findings**

The final synthesized findings will be graded according to the ConQual approach for establishing confidence in the output of qualitative research synthesis and presented in a Summary of Findings.<sup>29</sup> The Summary of Findings includes the major elements of the review and details how the ConQual score is developed. Included in the Summary of Findings will be the title, population, phenomena of interest and context for the specific review. Each synthesized finding from the review will then be presented along with the type of research informing it, score for dependability and credibility, and the overall ConQual score.

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**Conflicts of interest**

The authors declare no conflict of interest.

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## Appended materials

### Appendix I: Search strategy

CINAHL (via EBSCO)

Search conducted on Oct 6, 2020.

Search	Query	Records retrieved
S1	(MH “Cultural Safety”)	659
S2	“cultural safety” OR “culturally safe”	1,069
S3	S1 OR S2	1,069
S4	MH cultural competence	10,074
S5	“cultural competenc*”	11,012
S6	S4 or S5	11,012
S7	MH cultural sensitivity	7,545
S8	“cultural sensitivity”	7,995
S9	S7 OR S8	7,995
S10	“cultural awareness”	682
S11	“cultural humility”	229
S12	S3 OR S6 OR S9 OR S10 OR S11	18,736
S13	Indigenous* OR “First Nation*” OR Metis* OR Inuit* OR Aborigin* OR “Native*” OR “North American Indian*” OR Maori OR “Torres Strait Islanders” OR “First Nations of Australia” OR “Aboriginal Canadians” OR “First Nations of Canada”	43,928
S14	(MH “Indigenous Peoples+”) OR (MH “Health Services, Indigenous”) OR (MH “Indigenous Health”) OR (MH “Native Americans”)	22,123
S15	S13 OR S14	44,060
S16	qualitative or experience* or perception* or interview* or “focus group*” or “talking circle*” or yarn* or stor* or listen* or hear* or ethnograph* or phenomenol* or narrat* or ethnonurs* or “grounded theory” or “indigenous methodolog*” or “indigenous epistemolog*”	1,243,621
S17	(MH “Qualitative Studies+”) OR (MH “Phenomenology”)	151,847

<b>Search</b>	<b>Query</b>	<b>Records retrieved</b>
S18	S16 OR S17	1,250,037
S19	nurs* OR “healthcare” OR “health care” OR “healthcare provider*” or “health care provider*” or physician* or doctor* or medic* or clinic* or hospital or “healthcare worker*” or “health care worker*” or midwi* or “social worker*” or “occupational therap*” or “physical therap*” or pharmac* or “allied health” or dietic*	2,303,874
S20	(MH “Nurses+”) OR (MH “Health Personnel+”) OR (MH “Physicians+”)	582,853
S21	S19 OR S20	2,434,073
S22	S12 AND S15 AND S18 AND S21	793

## Chapter Three: Systematic Review of Qualitative Evidence Manuscript

*Harding, J., MacKinnon, K., Sangster-Gormley, S., Huel, C., Rooney, S. & Gordon, C. (2023). Indigenous peoples' experiences with culturally safe health care encounters: A qualitative systematic review. Unpublished*

This manuscript has been submitted to JBI Evidence Synthesis but is unpublished.

### Review title

Indigenous peoples' experiences with culturally safe health care encounters: A qualitative systematic review

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The authors declare no funding.

## **Conflicts of interest**

There is no conflict of interest in this project.

## **Declarations**

We declare that the co-authors on this review identify as White (all) nurses and nurse practitioners (JH, KM, CH, SR, ES), academics (JH, KM, CH, SR, ES), and researchers (JH, KM, CH, ES, CG). We are all committed to working to address and redress Indigenous health and health care inequities, and their harms.

## **Author Contributions**

JH, KM, CH, and SR completed the screening of citations, full-text review, critical appraisal, and data extraction. JH, KM, CH completed the analysis and synthesis of the review. CG assisted with the search strategies for the review. JH, KM, CH, SR, and ES contributed to editing the manuscript.

# **Indigenous Peoples' Experiences with Culturally Safe Health Care Encounters: A Qualitative Systematic Review**

## **Abstract**

**Objective:** The objective of this systematic review was to synthesize the best available evidence about Indigenous peoples' experiences with culturally safe health care encounters to inform the responsiveness of health care providers to the needs of Indigenous peoples.

**Introduction:** Studies have been conducted to identify what comprises culturally safe care for Indigenous peoples from the perspective of health care providers, but few have focused on the perspectives of Indigenous care receivers. It is important to learn from Indigenous peoples how they describe culturally safe health care encounters as a way to promote health equity and confront stigma and discrimination.

**Inclusion criteria:** This review included studies examining Indigenous peoples' experiences with culturally safe health care encounters within any setting. Relevant study findings, with descriptions of how a health care provider enacted cultural safety from Indigenous perspectives, were included.

**Methods:** The following databases were searched for published qualitative studies in 2021 and updated in 2022: MEDLINE, CINAHL, Embase, PsycINFO, the Native Health Database, the Indigenous Studies Portal, and the Arctic and Antarctic Regions Database. The search for unpublished studies included Google Scholar, ProQuest Dissertations and Theses, Opengrey.eu, and relevant organizational websites. Databases were searched from 1988 onwards. No language limitations were applied. All the studies identified in the search were examined against the inclusion criteria. Studies that met the inclusion criteria were assessed for methodological

quality. Qualitative research findings were extracted and the JBI process of meta-aggregation was used to identify categories and synthesize the findings. The ConQual approach was used to assess confidence in the review findings.

**Results:** Thirty qualitative studies of high methodological quality were included in this review, describing Indigenous peoples' experiences with culturally safe health care encounters in Canada, the United States, Australia, and New Zealand. A total of 758 participants were included in the review. The 77 findings were grouped into 10 categories and synthesized into the following three findings: 1) building and maintaining relationships that respect and acknowledge Indigenous peoples, families, communities, and cultures; 2) embodying caring, non-judgmental, and supportive ways of being; and 3) promoting shared care and collaborative decision-making, sharing power, and speaking up when the person's autonomy is jeopardized or when additional services are required; and including Indigenous providers, knowledge, wellness practices, and Indigenous cultural and spiritual spaces in the health care system.

**Conclusions:** Engaging in culturally safe health care requires attention to several factors. The findings emphasize the importance of building and maintaining positive relationships with Indigenous peoples, where health care providers share power with them and engage in shared care and shared decision-making. Acknowledging and respecting their Indigenous culture was key to culturally safe health care encounters in addition to acknowledging their unique personal identity, knowledge, and experiences. Health care providers contribute to culturally safe health care encounters when they are caring, kind, non-judgmental, and supportive. The findings indicate the need to incorporate Indigenous health traditions and practices, and Indigenous health care providers, into health care.

**Systematic review registration number:** PROSPERO (CRD42020173003)

**Keywords:** cultural safety; experiences; health care encounters; health care providers;

Indigenous

## Summary of Findings

### Indigenous peoples' experiences with culturally safe health care: A qualitative systematic review

Bibliography: *Harding, J., MacKinnon, K., Sangster-Gormley, S., Huel, C., Rooney, S. & Gordon, C. (2023). Indigenous peoples' experiences with culturally safe health care encounters: A qualitative systematic review. Unpublished.*

Synthesized finding	Type of research	Dependability	Credibility	ConQual score	Comments
Synthesized Finding 1. To engage with cultural safety, health care providers build and maintain relationships that respect and acknowledge Indigenous peoples, families, communities, and cultures.	Qualitative	High	High	High	Dependability: 19/20 studies scored 4 or 5; 1/20 studies scored 3. Therefore, rating remains high.  Credibility: 33/33 findings ranked unequivocal. Therefore, score remains high and ConQual score is high.
Synthesized Finding 2. To engage with cultural safety, health care providers embody caring, non-judgmental, and supportive ways of being with Indigenous clients, families, and communities.	Qualitative	High	High	High	Dependability: 19/20 studies scored 4 or 5; 1/20 studies scored 3. Therefore, rating remains high.  Credibility: 26/26 findings ranked unequivocal. Therefore, score remains high and

					ConQual score is high.
Synthesized Finding 3. To engage with culturally safety, health care providers walk beside Indigenous clients, families, and communities on their path to health and health equity. This journey involves promoting shared care and collaborative decision-making, sharing power, and speaking up when the person’s autonomy is jeopardized or when additional services are required, and including Indigenous providers, knowledge, and wellness practices. Indigenous cultural and spiritual spaces in the health care system are also required.	Qualitative	High	High	High	Dependability: 11/11 studies scored 4 or 5. Therefore, rating remains high.  Credibility: 18/18 findings ranked unequivocal. Therefore, score remains high and ConQual score is high.

## Introduction

Globally, 476 million Indigenous peoples live across 90 countries.<sup>1</sup> Indigenous peoples face significant health inequities,<sup>2</sup> experiencing disproportionately higher rates of chronic health conditions and infectious diseases such as diabetes, cardiovascular disease, hypertension, tuberculosis, HIV/AIDS, depression, and anxiety than non-Indigenous people.<sup>3-5</sup> The life expectancy of Indigenous peoples is considerably lower than that of non-Indigenous people in many countries including Canada, Australia, New Zealand, Mexico, Panama, Guatemala and Nepal.<sup>2</sup>

The term Indigenous has been used to describe the earliest known peoples of a geographic area. However, the diversity of Indigenous peoples worldwide has led to the use of various terms to name such groups. For example, English-speaking countries used the names “Aboriginal” and “Native American” to describe Indigenous peoples. According to the United Nations Declaration on the Rights of Indigenous Peoples, “Indigenous peoples have the right to determine their own identity or membership in accordance with their customs and traditions.”<sup>6(p.24)</sup> As such, there is no universal definition of Indigenous peoples.<sup>7</sup> One of the earlier and more widely cited definitions of Indigenous communities states:

peoples and nations are those which, having a historical continuity with pre-invasion and pre-colonial societies that developed on their territories, consider themselves distinct from other sectors of the societies now prevailing on those territories, or parts of them. They form at present non-dominant sectors of society and are determined to preserve, develop and transmit to future generations their ancestral territories, and their ethnic identity, as the basis of their continued existence as peoples, in accordance with their own cultural patterns, social institutions and legal system.<sup>8 (p.17)</sup>

For the purposes of this review, these are the sources we draw upon when reflecting on Indigenous identity.

The loss of many Indigenous languages, cultural practices, and traditional lands continues to have an intergenerational impact on Indigenous people's health worldwide.<sup>2</sup> It has been noted that the “systematic neglect of culture in health is the single biggest barrier to advancement of the highest attainable standard of health worldwide.”<sup>9</sup> (p. 1630) Racism is one of several factors that contributes to the health and health care inequities Indigenous people continue to endure.<sup>10</sup> There is a strong body of evidence describing racism in health care.<sup>3, 10-13</sup> For example, a recent scoping review summarized the findings of 213 studies across various national contexts. The authors found that experiences of racism were common in health care, including Indigenous-specific racism.<sup>14</sup> Experiences of racism resulted in Indigenous peoples leaving health care settings prior to having their health care needs addressed<sup>13</sup> and avoiding seeking care altogether.<sup>11</sup>

Numerous approaches to reducing racism and preventing health inequities have been identified in the literature.<sup>15, 16</sup> However, there is variability in the terminology used to describe these approaches, including but not limited to cultural awareness, cultural sensitivity, cultural competency, cultural humility, and cultural safety. Although there are similarities among the approaches, there are also differences. Therefore, we first discuss each individual approach, followed by an operational definition of the approach used in this review.

Cultural awareness focuses on health care providers cultivating awareness of the differences among groups of people.<sup>17, 18</sup> Similarly, cultural sensitivity encourages health care providers to learn about a group's cultural characteristics and use their knowledge to provide sensitive or tolerant care.<sup>19, 20</sup> An underlying assumption of both is that health care providers can simply learn the common or essential cultural traits of groups of people and apply that

knowledge during health care encounters.<sup>17-20</sup> At face value, cultural awareness and cultural sensitivity seem to address racism in health care. However, both approaches have been criticized for overlooking diversity within cultural groups and promoting stereotyping.<sup>17, 18</sup>

Cultural competence encourages health care providers to know the common traits and practices of a group and to respectfully acknowledge them while working with group members.<sup>21</sup> A critique of cultural competence is the assumption that knowing a group's traits and practices equates to health care providers' competence in another person or group's culture.<sup>17</sup> Despite this criticism, some suggest that cultural competency can be used as a tool on the continuum towards cultural safety.<sup>15</sup>

Cultural humility is a lifelong practice of learning and self-reflection.<sup>16</sup> It aims to shift the traditional power differential that has existed between health care providers and clients.<sup>16</sup> Health care providers learn from individual clients about what is important for them in their health care experience, rather than assuming based on a person's culture.<sup>16</sup>

Cultural safety is an empowering approach for exploring Indigenous peoples' experiences of health care, which became formalized in 1988.<sup>22</sup> As a result of health inequities affecting Māori peoples of New Zealand stemming from colonialism and racism, in 1990, Ramsden, in collaboration with Māori nurse leaders, published the first standards for teaching the practice of cultural safety.<sup>23</sup> Initially, early definitions of cultural safety focused on culturally unsafe care, described as “any actions which diminish, demean, or disempower the cultural identity and well-being of an individual.”<sup>24 (p. 9)</sup> By 1992, cultural safety was adopted in nursing and midwifery education in New Zealand.<sup>22</sup> At that time, the Nursing Council of New Zealand defined cultural safety as “the effective nursing of a person/family from another culture by a nurse who has undertaken a process of reflection on (their) own cultural identity and recognises the impact of

the nurses' culture on (their) own nursing practice."<sup>22</sup> (p. 491) Historically, cultural safety has been embedded in critical social theory, postcolonial theory, and feminist theory<sup>22, 25-31</sup> and has been linked to health care goals related to social justice and health equity.<sup>27, 32</sup>

There are several assumptions underpinning the concept of cultural safety. Firstly, the client is the one who defines what culturally safe care is, not the health care provider, thus shifting the power differential from the health care provider to the client.<sup>22, 27, 28, 33-35</sup> Secondly, health care providers must critically reflect upon their cultural beliefs and biases to illuminate how these influence the care they provide.<sup>22, 27, 34, 36</sup> Thirdly, cultural safety attends to how social, economic, and political forces affect health and health care.<sup>17, 26, 33, 35, 37, 38</sup> As one of the main premises of cultural safety is that the person receiving care is the one who defines an interaction as culturally safe,<sup>22, 27, 8, 33-35</sup> we were interested in synthesizing qualitative research findings exploring health care encounters between an Indigenous person and a health care provider. Based on our initial review of the literature (JH) and for the purposes of this review, we define cultural safety as an Indigenous person's experience of positive, safe, and affirming health care encounters or their perceptions or feelings of being in culturally safe health care encounters.<sup>39</sup> Later on, we used this operational definition for the extraction of findings and to provide examples that reflect cultural safety.

Despite Wilson<sup>40</sup> arguing that researchers should place greater emphasis on exploring Indigenous peoples' experiences of culturally safe health care, studies have largely focused on negative and/or culturally unsafe experiences. Since most of the literature on cultural safety reflects the perspectives of health care providers or Indigenous people's negative experiences as receivers of health care, we wanted to examine Indigenous people's experiences with culturally safe, rather than unsafe, care. This approach is congruent with the founding perspective of Māori

nurses who wanted to shift power relations towards the receivers of care.<sup>22</sup> Thus, we believe that establishing what culturally safe care experiences look like and how culturally safe care is enacted will help to guide health care providers and shift health care to a more accessible, equitable, and comfortable place for Indigenous peoples. We also wanted to identify research that might provide examples of culturally safe care from the perspective of Indigenous peoples to inform the responsiveness of health care providers to the needs of Indigenous peoples receiving health care.

At the time of publication of our protocol, and to the best of our knowledge, there were no qualitative systematic reviews addressing our review question. We conducted a preliminary search of PROSPERO, CINAHL, MEDLINE, Epistemonikos, the Cochrane Database of Systematic Reviews, and JBI Evidence Synthesis. Although there were similar reviews, including one published systematic review that focused on Australia<sup>41</sup> and one published scoping review from Canada,<sup>17</sup> none of these reviews attempted to synthesize findings from a broader group of countries. We also located one published systematic review protocol that pertained to the experiences of Indigenous peoples in health care encounters in Westernized settings.<sup>42</sup> This protocol was published in 2012, but there was no published systematic review. Therefore, we contacted the remaining authors of the protocol in 2019 and again in 2023 and were informed that it was unlikely that the review would be completed. More recently, two additional reviews were located; however, they focused on strategies and services surrounding palliative care for Indigenous peoples.<sup>43, 44</sup> The main differences between the aforementioned reviews and our review is that we focused on health care encounters, rather than health care services, programs, or strategies, and included studies across all countries from within any setting.

The objective of this systematic review was to synthesize the best available evidence of Indigenous peoples' experiences with culturally safe health care encounters to inform the responsiveness of health care providers to the needs of Indigenous peoples (care receivers).

### **Review question**

What are Indigenous peoples' experiences with culturally safe health care encounters?

### **Keywords**

cultural safety; experiences; health care encounters; health care providers; Indigenous

### **Inclusion criteria**

#### **Participants**

This review considered studies that included participants who self-identified as Indigenous, regardless of age, gender, or sex. As Indigenous people self-identify in diverse ways, we included (but did not limit to) various terms: Indigenous, Aboriginal, Métis, First Nations, Inuit, Māori of New Zealand, the Aborigines and Torres Strait Islanders of Australia, American Indians, and Alaskan Natives.

We included studies that focused on the experiences of Indigenous peoples, their families, or community members, where the recipient of care identified as Indigenous and their experiences could be identified in the findings. We ensured that all illustrations were from an Indigenous care receiver. We excluded studies that focused on the experiences of health care providers only, such as physicians, nurses, midwives, educators, and students.

#### **Phenomenon of interest**

This phenomenon of interest is culturally safe health care. We defined cultural safety as “positive, safe, and affirming interactions with health care providers in any care setting as experienced by the recipient of care, their family or community.”<sup>39</sup> (p. 2436) These were descriptive words commonly found in the literature when cultural safety in health care settings is discussed.

For transparency and reproducibility, we operationalized these three terms. Positive care is perceptions of receiving good care, or of being treated fairly or equally. Safe care is experiences of feeling safe and respected in interactions with a health care provider. Affirming care is experiences receiving care that recognizes and responds to the person, their family, community, and culture. In the full-text stage, each study had to contain at least one finding that reflected positive, safe, or affirming care. If the phenomenon of interest in the qualitative study focused more broadly on the Indigenous person's experiences of receiving care, we identified the concepts and philosophical perspectives framing culture care and then looked for findings that reflected positive, safe, or affirming care and reflected the perspective of the Indigenous care receiver.

Examples of other terms taken into account that were used in an international qualitative research context include cultural awareness, cultural humility, cultural sensitivity, or cultural competence as perceived by the receiver of care.

We excluded studies with findings that: described only negative perceptions or experiences; reflected unsafe, demeaning, or disrespectful care; or did not recognize the Indigenous person as an individual, or their cultural identity as a member of an Indigenous community.

## **Context**

This review considered studies on health care encounters, regardless of the type of health care provider, from any geographic location and health care setting, including but not limited to acute care, primary care, and community care.

For this review, a health care encounter is defined as an interaction between an Indigenous person receiving care and a health care provider (Indigenous or non-Indigenous)

occurring in a health care context. We excluded studies with only general comments about health care encounters that lacked specific details regarding the experiences of a particular encounter.

### **Types of studies**

This review considered studies with primary qualitative data, including but not limited to designs such as phenomenology, grounded theory, ethnography, action research, feminist research, Indigenous health research, and Indigenous methodologies. In addition, mixed-methods studies with separate findings for the qualitative arm were considered for inclusion.

Editorials, blogs, literature reviews, and conference abstracts are not primary research reports, so were ultimately not included in the review. Conference abstracts were screened to identify relevant primary studies, and presenters were contacted by email in an effort to locate the associated studies.

### **Methods**

This systematic review was conducted in accordance with the JBI methodology for systematic reviews of qualitative evidence<sup>45</sup> and an a priori protocol published in 2021.<sup>39</sup> The review has been registered in PROSPERO (CRD42020173003).

### **Search strategy**

The search strategy was aimed at locating both published and unpublished studies. A three-step search strategy was used in this review. First, an initial limited search of MEDLINE (PubMed) and CINAHL (EBSCO) databases was performed to identify articles on the topic. The text words contained in the titles and abstracts of relevant articles and the index terms were used to develop a full search strategy (see Appendix 1). We aimed to locate studies from various countries by considering research reports using synonyms for cultural safety, such as cultural awareness, cultural sensitivity, cultural humility, or cultural competence. Our search also

reflected the diverse ways in which Indigenous people self-identify, including but not limited to: Indigenous, Aboriginal, Métis, First Nations, Inuit, Māori of New Zealand, and the Aborigines and Torres Strait Islanders of Australia.

Second, a search strategy was adapted for each included information source. The initial full search was completed in February 2021, and the second full search was performed in January 2022. Appendix I provides the full search strategy. These search strategies were developed through consultation with a research librarian (CG) at the University of Victoria.

Finally, the reference lists of studies selected for inclusion in this review<sup>46-75</sup> were screened for additional studies, and forward citation searching was used to identify potential studies arising from our included studies. We also screened the references of systematic reviews, scoping reviews, and associated protocols on similar topics for additional studies.<sup>17, 41-44, 76-82</sup>

We searched for studies published from January 1988 onwards as this date was identified in one of the foundational documents as when “the formalization of the concept of cultural safety began.”<sup>22 (p.492)</sup> No language limitations were included in the search.

The databases searched were MEDLINE (EBSCO), CINAHL (EBSCO), Embase (Ovid), and PsycInfo (EBSCO). For literature related to Indigenous peoples, the search included the Native Health Database, the Indigenous Studies Portal, and the Arctic and Antarctic Regions Database (EBSCO). We intended to search the First Nations Periodical Index; however, we reached out to appropriate sources and confirmed that this index was no longer available. Sources of unpublished studies and gray literature searched included ProQuest Dissertations and Theses, Opengrey.eu, and relevant organizational websites. We also searched Google Scholar using keywords based on those found in our preliminary database search. As the number of Google Scholar search results and some organizational website search results were very high (in

the tens of thousands) and had little relevance beyond the first 50 results, we decided not to review more than 50 results. Our protocol stated that we would use both Google and Google Scholar to search for relevant reports; however, after receiving a large number of hits in the Google Scholar search, we determined that further searching in Google would not be necessary.

### **Study selection**

Following the search, all identified citations were collated and uploaded to Covidence (Veritas Health Innovation, Melbourne, Australia) and EndNote 20 (Clarivate Analytics, PA, USA), and duplicates were removed. Following a pilot test of ten studies to assess the clarity of the review's inclusion criteria, titles and abstracts were screened by two or more independent reviewers (JH, KM, CH, and SR). During the screening stage, we considered studies that used terms that were synonymous or equivalent to cultural safety in the title, abstract, or keywords. Potentially relevant studies were retrieved, and their citation details were imported into the JBI System for the Unified Management, Assessment and Review of Information (JBI SUMARI) (JBI, Adelaide, Australia).<sup>83</sup>

We pilot tested the review of the first ten studies as a review team, then the full text of selected citations was assessed in detail against the inclusion criteria by two or more independent reviewers (JH, KM, CH, and SR).

Full-text studies that did not meet the inclusion criteria were excluded. The reasons for their exclusion are provided in Appendix II. Any disagreements between the reviewers at each stage of the selection process were resolved through a discussion or by a third reviewer.

### **Assessment of methodological quality**

The review team met to discuss critical appraisal and complete a pilot test of three studies, followed by critical appraisal of all eligible studies for methodological quality by two

independent reviewers (JH, KM, CH, and SR) using the standard JBI Critical Appraisal Checklist for Qualitative Research.<sup>45, 83</sup> We did not need to contact any authors of the papers due to missing information or additional data for clarification. Any disagreements between the reviewers were resolved through discussion or by a third reviewer.

All studies, regardless of their methodological quality, underwent data extraction (JH, KM, CH) and synthesis (JH, KM, CH). When this review was conceptualized in 2018, the number of studies on cultural safety was still relatively small. Thus, we decided not to exclude any studies at the protocol stage based on their methodological quality.

### **Data extraction**

Following a pilot test of three studies, data were extracted from the studies included in the review by two independent reviewers using the standardized JBI data extraction tool<sup>45, 83</sup> (JH, KM, CH). The extracted data included specific details about the participants, context, culture, geographical location, study methods, the phenomenon of interest, and the study results relevant to the review objective (see Appendix III).

Only findings relevant to our review question were extracted. Since Indigenous peoples' perspectives are essential to definitions of cultural safety, we looked for findings within an illustration to identify an example in the Indigenous participants' own words. Findings were extracted when they reflected our operational definition of positive, safe, or affirming care, as identified by the Indigenous care receiver. The extracted findings also reflected health care encounters between an Indigenous care receiver and a health care provider or providers (over a course of care). General descriptions or advice not grounded in the Indigenous care receivers' experiences were not extracted.

The findings and their illustrations were extracted by repeatedly reviewing the results section of each study. Accurately representing the meaning of each finding is central to the integrity of the qualitative systematic review. Therefore, we carefully extracted the theme, sub-theme, or interpretive description at the same level within each study, along with a verbatim quotation that described the findings for clarity of meaning.

The extracted findings were assigned a level of credibility (unequivocal, credible, or unsupported), which was based on the reviewer's interpretation of how closely the illustration was related to the finding. Any disagreements between the reviewers were resolved through discussion or by a third reviewer.<sup>45</sup> We did not need to contact any of the authors of the studies for missing or additional data.

### **Data synthesis**

Qualitative research findings were pooled using JBI SUMARI with the meta-aggregation approach (JH, KM, CH).<sup>45</sup> This involved the aggregation or synthesis of findings to generate a set of statements that represented that aggregation through assembling the findings and categorizing these findings on the basis of similarity in meaning. Categories were derived by carefully reading and re-reading the findings and illustrations to ensure that we understood the primary researcher's meaning. Finally, these categories were subjected to a synthesis to produce a single comprehensive set of synthesized findings that could be used as a basis for evidence-based practice.

### **Assessing confidence in the findings**

The final synthesized findings were graded according to the ConQual approach for establishing confidence in the output of qualitative research synthesis and presented in a Summary of Findings table.<sup>84</sup> The Summary of Findings includes the major elements of the

review and details of how the ConQual score was developed. The titles, participants, phenomena of interest, and context of the specific review are included in the table. Each synthesized finding from the review is presented, along with the type of research informing it, scores for dependability and credibility, and the overall ConQual score.

## **Results**

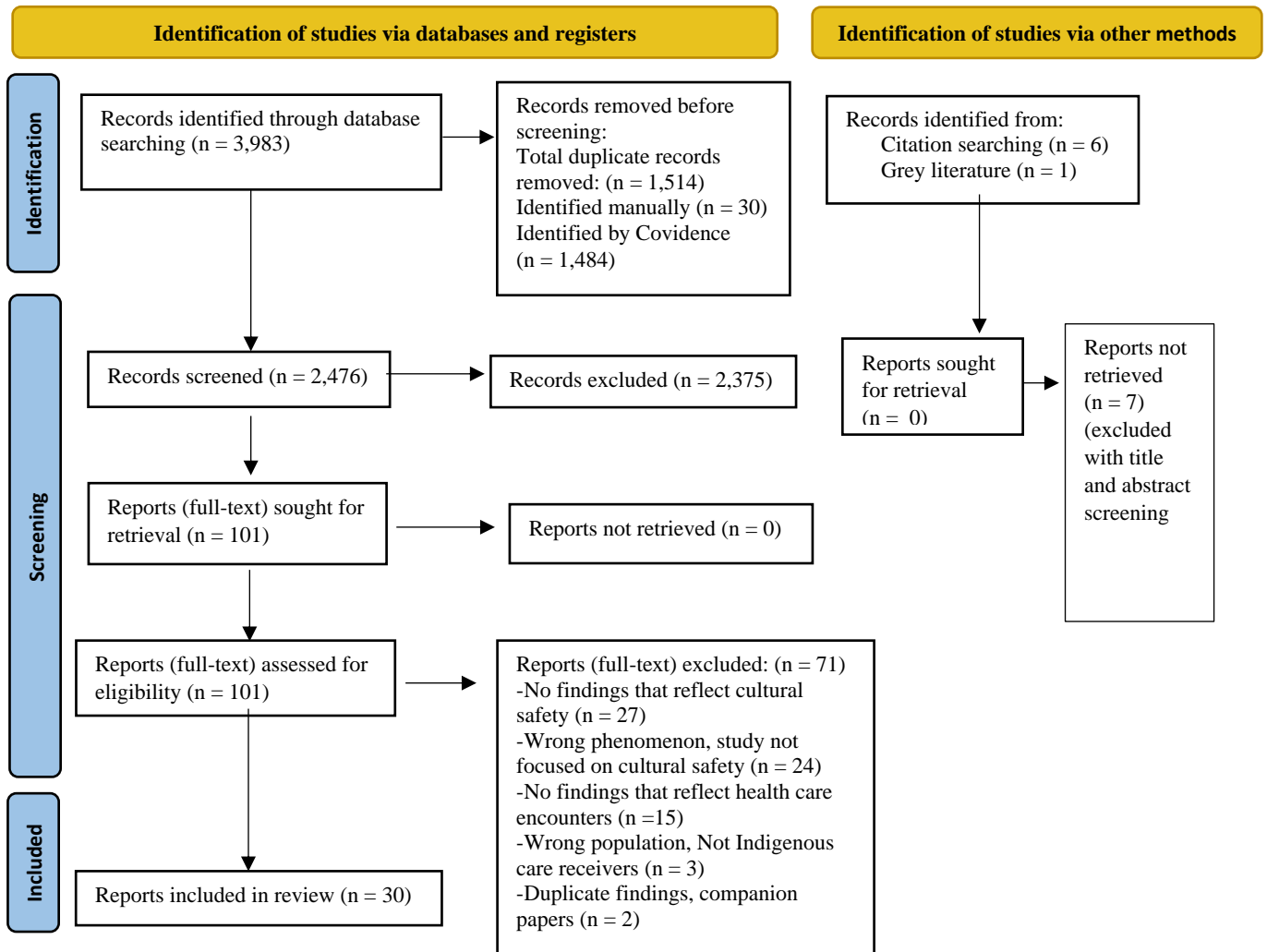
### ***Study inclusion***

The number of citations identified from all sources was 3,990, with 3,983 from databases and registers and seven from other sources, including citation searching. Studies were imported into Covidence, and 1,514 duplicates were removed, leaving 2,476 studies to be screened. During the title and abstract screening stage, 2,375 irrelevant studies were excluded. We retrieved only two non-English research reports (one in Spanish and the other in French). After using Google Translate to read the abstracts, it was determined that neither addressed the phenomenon of interest in this review.

This left 101 studies for full-text screening. During the full-text review, 71 studies were excluded; the reasons for exclusion are provided in Appendix II. Full-text studies were excluded if the phenomenon of interest for the study was not cultural safety, because the findings did not reflect positive, safe, or affirming care as identified by the Indigenous care receiver, or if the findings did not reflect a health care encounter between an Indigenous care receiver and a health care provider or providers over a course of care (see Appendix II).

Following the full-text review, 30 studies were eligible for inclusion. For details of the search results and screening process, refer to Figure 1 containing the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) flow chart.<sup>85</sup>

Figure 1: Search results and study selection and inclusion process<sup>85</sup>



### ***Methodological quality***

The methodological quality of the included studies was high with critical appraisal scores ranging from 8 to 10 (out of a total of 10) overall, and 22 out of the 30 included studies (73%) scoring 10 out of 10.<sup>46-48, 50-55, 58-62, 66-69, 71, 73-75</sup> All included studies demonstrated congruence between the research methodology and the research question or objectives; the methods used to collect data; and the representation and analysis of the data and interpretation of the results.<sup>46-75</sup> In three of the 30 included studies, there was no statement to determine the researcher's cultural or theoretical orientation.<sup>49, 63, 72</sup> In six of the 30 included studies, a clear statement about the influence of the researcher on the research, and vice-versa, was missing or it was unclear.<sup>56, 57, 63, 65, 70, 72</sup> Additionally, one study was given an unclear score because it lacked a statement about the philosophical perspective underpinning the research.<sup>64</sup> All studies showed adequate representation of participants and their voices; evidence that the research was ethical; and that the conclusions drawn in the studies flowed from the analysis or interpretation of the data.<sup>46-75</sup>

All 10 questions listed in the standard JBI Critical Appraisal Checklist for Qualitative Research<sup>45</sup> scored over 80%, with 9 of the 10 questions scoring over 90%; therefore, we can confidently say that the methodological quality of the included studies was high (see Table I for a summary of the completed critical appraisal).

**Table 1: Critical Appraisal Results of Eligible Qualitative Studies (n=30)**

<b>Study</b>	<b>Q1</b>	<b>Q2</b>	<b>Q3</b>	<b>Q4</b>	<b>Q5</b>	<b>Q6</b>	<b>Q7</b>	<b>Q8</b>	<b>Q9</b>	<b>Q10</b>	<b>Total</b>
Adcock et al. <sup>46</sup>	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10
Adcock et al. <sup>47</sup>	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10
Baker and Daigle <sup>48</sup>	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10
Brown et al. <sup>49</sup>	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	9

<b>Study</b>	<b>Q1</b>	<b>Q2</b>	<b>Q3</b>	<b>Q4</b>	<b>Q5</b>	<b>Q6</b>	<b>Q7</b>	<b>Q8</b>	<b>Q9</b>	<b>Q10</b>	<b>Total</b>
Browne and Fiske <sup>50</sup>	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10
Burns et al. <sup>51</sup>	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10
Butler et al. <sup>52</sup>	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10
Churchill <sup>53</sup>	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10
Cook et al. <sup>54</sup>	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10
Fretts <sup>55</sup>	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10
Gott et al. <sup>56</sup>	Y	Y	Y	Y	Y	Y	U	Y	Y	Y	9
Hohl et al. <sup>57</sup>	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	9
Hole et al. <sup>58</sup>	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10
Jensen-Ross <sup>59</sup>	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10
Laczko <sup>60</sup>	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10
Lipsett <sup>61</sup>	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10
Lottis <sup>62</sup>	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10
Ludeke et al. <sup>63</sup>	Y	Y	Y	Y	Y	N	N	Y	Y	Y	8
Maar et al. <sup>64</sup>	U	Y	Y	Y	Y	Y	Y	Y	Y	Y	9
Moeke-Maxwell et al. <sup>65</sup>	Y	Y	Y	Y	Y	Y	U	Y	Y	Y	9
Monchalin <sup>66</sup>	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10
Pearce et al. <sup>67</sup>	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10
Seear et al. <sup>68</sup>	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10
Slater <sup>69</sup>	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10
Strobel et al. <sup>70</sup>	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	9
Tipa <sup>71</sup>	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10
Wiebe and Young <sup>72</sup>	Y	Y	Y	Y	Y	N	N	Y	Y	Y	8
Williams et al. <sup>73</sup>	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10

<b>Study</b>	<b>Q1</b>	<b>Q2</b>	<b>Q3</b>	<b>Q4</b>	<b>Q5</b>	<b>Q6</b>	<b>Q7</b>	<b>Q8</b>	<b>Q9</b>	<b>Q10</b>	<b>Total</b>
Wilson <sup>74</sup>	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10
Wright et al. <sup>75</sup>	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10
<b>%</b>	96.6	100	100	100	100	90	80	100	100	100	

Y = Yes, N = No, U = Unclear; JBI Critical Appraisal Checklist for Qualitative Research Q1 = Is there congruity between the stated philosophical perspective and the research methodology? Q2 = Is there congruity between the research methodology and the research question or objectives? Q3 Is there congruity between the research methodology and the methods used to collect data? Q4 = Is there congruity between the research methodology and the representation and analysis of data? Q5 = Is there congruity between the research methodology and the interpretation of results? Q6 = Is there a statement locating the researcher culturally or theoretically? Q7 = Is the influence of the researcher on the research, and vice-versa, addressed? Q8 = Are participants, and their voices, adequately represented? Q9 = Is the research ethical according to current criteria or, for recent studies, is there evidence of ethical approval by an appropriate body? Q10 = Do the conclusions drawn in the research report flow from the analysis, or interpretation, of the data?

### *Characteristics of included studies*

Of the 30 studies included in this review, 21 were published primary research and nine were dissertations and theses. The dates of the included studies ranged from 2000 to 2023, with the majority of the studies published after 2010 (n=23). Most of the identified studies were conducted in Canada (n=14), followed by New Zealand (n=10), Australia (n=4), and the United States (n=2). The total number of participants was 758, ranging in age from 17 to their 80s. Participants self-identified as Indigenous, including Aboriginal, First Nations, Métis, Mi'kmaq, Torres Strait Islander, Māori, Pacific peoples of New Zealand, American Indians, and Alaska Natives. The study settings varied from large urban tertiary hospitals to rural and remote community health care clinics. The qualitative methodologies employed included descriptive approaches, phenomenology, grounded theory, ethnography, participatory action research,

interpretive description, narrative inquiry, case study, hermeneutic, Two-eyed Seeing, and Māori centered approaches. Most studies utilized interviews for data collection.

Across the studies, the health care providers included doctors, nurses, midwives, therapists or counselors, and consultants or specialists. The majority of the studies did not state whether the health care provider was Indigenous or non-Indigenous, although this detail was usually provided at the findings or illustration level. Most studies reflect both Indigenous and non-Indigenous health care providers in health care encounters. One study conducted within an Indigenous midwifery context included non-Indigenous midwives in the care team<sup>53</sup> (see Appendix III for the characteristics of the included studies).

### ***Review findings***

A total of 77 findings were allocated into 10 categories, which we further developed into three synthesized findings (see Appendix IV, Table 2, 3, 4, and 5): 1) to engage with cultural safety, health care providers build and maintain relationships that respect and acknowledge Indigenous peoples, families, communities, and cultures; 2) to engage with cultural safety, health care providers embody caring, non-judgmental, and supportive ways of being with Indigenous clients, families, and communities; and 3) to engage with cultural safety, health care providers walk beside Indigenous clients, families, and communities on their path to health and health equity. This journey involves promoting shared care and collaborative decision-making, sharing power, and speaking up when the person's autonomy is jeopardized or when additional services are required, and including Indigenous providers, knowledge, and wellness practices; and Indigenous cultural and spiritual spaces in the health care system. Of the 77 findings included in this review, all were rated as unequivocal; none were rated as credible or unsupported (see Appendix IV and Table 2).

**Table 2: Results of meta-synthesis of qualitative findings**

<b>Synthesized Finding</b>	<b>Categories</b>	<b>Findings</b>
1. To engage with cultural safety health care providers build and maintain relationships that respect and acknowledge Indigenous peoples, families, communities, and cultures.	1.1 Building and maintaining relationships	13 Unequivocal findings
	1.2 Acknowledging and respecting Indigenous culture	13 Unequivocal findings
	1.3 Acknowledging and respecting personal knowledge, identity, and experience	7 Unequivocal findings
2. To engage with cultural safety, health care providers embody caring, non-judgmental, and supportive ways of being with Indigenous clients, families, and communities.	2.1 Being caring and kind	9 Unequivocal findings
	2.2 Being non-judgmental	4 Unequivocal findings
	2.3 Being supportive	9 Unequivocal findings
	2.4 Providing accessible and timely information	4 Unequivocal findings
3. To engage with culturally safety, health care providers walk beside Indigenous clients, families, and communities on their path to health and health equity. This journey involves promoting shared care and collaborative decision-making, sharing power, and speaking up when the person’s autonomy is jeopardized or when additional services are required, and including Indigenous providers, knowledge, and wellness practices; and Indigenous cultural and spiritual spaces in the health care system.	3.1 The importance of shared care and decision-making	7 Unequivocal findings
	3.2 Being an advocate	4 Unequivocal findings
	3.3 Including and incorporating Indigenous providers, knowledge, and wellness practices; and Indigenous cultural and spiritual spaces into the health care system	7 Unequivocal findings

**Synthesized Finding 1. To engage with cultural safety, health care providers build and maintain relationships that respect, and acknowledge Indigenous peoples, families, communities, and cultures.**

This synthesized finding was created from the aggregation of three categories with similar meanings and was supported by 33 findings (see Appendix IV and Table 3). Indigenous peoples’ experiences of positive health care encounters highly reflect the importance of genuine, authentic, and meaningful relationships with health care providers. Health care providers who acknowledged and were respectful of Indigenous peoples’, families’, and communities’ cultural identities contributed to positive health care experiences. In addition, Indigenous participants expressed the importance of respect for and acknowledgement of their unique personal identity, knowledge, and experiences. Each category is described in detail below.

**Table 3: Synthesized finding 1**

Synthesized finding	Categories	Findings
1. To engage with cultural safety, health care providers build and maintain relationships that respect and acknowledge Indigenous peoples, families, communities, and cultures.	1.1 Building and maintaining relationships	“Affirming encounters frequently arose out of <b>long-term, positive relationships</b> with family doctors or community health nurses.” <sup>50(p.141)</sup> (U)
	This category focuses on the importance of having positive relationships with health care providers, described as kinship or kin-like, similar to a family-like relationship.	“ <b>Building relationships</b> with Pacific patients was important in overcoming language barriers.” <sup>63(p.125)</sup> (U)
		“ <b>Spending time with the patient</b> was viewed as an indicator of quality of care, and important in developing rapport.” <sup>63(p.126)</sup> (U)
		“The importance of positive relationships... was prominent in the participant's stories.” <sup>68(p.572)</sup> (U)
		“Connections between women and clinicians who had consistently provided care were

Synthesized finding	Categories	Findings
		<p>spoken about by women as part of <b>an extended kinship</b>.<sup>54(p.24)</sup> (U)</p> <hr/> <p>“Developing a <b>good personal rapport</b> and <b>understanding</b> was also seen as important. Displaying an interest in the whanau (family) and personal life was described as a way of establishing rapport.”<sup>75(p.76)</sup> (U)</p> <hr/> <p>“Several participants discussed how it was important to them to <b>get to know a health care provider</b> and to develop a personal relationship with them.”<sup>60(p.30)</sup> (U)</p> <hr/> <p>“Many of the women voiced their desire to have a <b>deep, personal</b>, kin-based, and/or reciprocal <b>relationship</b> with their midwife.”<sup>53(p.111)</sup> (U)</p> <hr/> <p>“<b>Additional time was also needed early in the relationships</b> in order for women to feel safe to divulge. A young woman described the power of a nurse's sharing.”<sup>54(p.24)</sup> (U)</p> <hr/> <p>“<b>Building relationships</b> with their infants’ nurses in the NICU was repeatedly emphasized by mothers as important to their feeling safe and cared for.”<sup>75(p.4)</sup> (U)</p> <hr/> <p>“When the women felt that they had <b>enough time to establish trusting relationships</b> with their midwives and obtain knowledge without being made to feel guilty or rushed, they felt more comfortable and safe in their care.”<sup>53(p.107)</sup> (U)</p> <hr/> <p>Importance of a <b>positive and long-term GP and patient/whānau relationship</b>.<sup>69</sup> (U)</p> <hr/> <p>“<b>Feeling connected</b>... represents the <b>relationships</b> required for culturally responsive ways of working with whānau.”<sup>71(p.117)</sup> (U)</p>

Synthesized finding	Categories	Findings
	1.2 Acknowledging and respecting Indigenous culture	“Being visible and <b>being acknowledged as Aboriginal</b> in the health care relationship promoted a sense of cultural safety.” <sup>58(p.1666)</sup> (U)
	These findings imply learning from and with Indigenous peoples about their history and their culture.	“The importance of <b>respect for families and their ceremonies.</b> ” <sup>58(p.1666)</sup> (U)
		“Participants acknowledged and appreciated caregivers who had conveyed a tolerance of family visiting, the <b>native custom</b> that seemed to be particularly problematic for staff but important to participants.” <sup>48(p.20)</sup> (U)
		“Many of the women were not <b>asked</b> by their midwives <b>about their cultural needs</b> around birth. Shelley was asked and she described how this made her feel respected as a person.” <sup>49(p.355)</sup> (U)
		“ <b>Validation of self-identity and cultural pride</b> signaled a willingness to listen to the patient and to understand her health within the social and cultural dimensions that she defined as most important to her.” <sup>50(p.141)</sup> (U)
		“Of great important to many [participants] was <b>provider acceptance of clients’ beliefs</b> , religions, backgrounds, and history, and a focus on building on the strengths of Aboriginal people.” <sup>64(p.9)</sup> (U)
		“Some women spoke of their non-Aboriginal care provider <b>demonstrating cultural awareness</b> , which contributed to women feeling comfortable.” <sup>68(p.572)</sup> (U)
	“Provider awareness and comfort with AI/AN (American Indian and Alaska Natives) <b>cultural healing traditions</b> was an important influence on satisfaction.” <sup>57(p.2441)</sup> (U)	

Synthesized finding	Categories	Findings
		<p data-bbox="834 260 1408 369">Respect for cultural beliefs and traditions. “Josie explained how her cultural beliefs and traditions were respected.”<sup>51(p.151)</sup> (U)</p> <hr/> <p data-bbox="834 401 1408 590">“<b>Communicating cross-culturally</b> is more than a dialogue between individuals... It is an attempt to convey particular meaning, meaning that finds validity in a particular cultural context.”<sup>61(p.237)</sup> (U)</p> <hr/> <p data-bbox="834 621 1408 890">“<b>Listening differently</b> can be a difficult challenge because much listening tends to be an unconscious, passive activity... In these instances, practitioners tend to unconsciously succumb to the particular and conditioned listening skills appropriate to the context.”<sup>61(p.251)</sup> (U)</p> <hr/> <p data-bbox="834 921 1408 1031">Bridging between cultures through <b>accommodating Indigenous beliefs</b> and healing practices.<sup>61</sup> (U)</p> <hr/> <p data-bbox="834 1062 1408 1331">“The diverse experiences and influences Māori are exposed to highlights the need for nurses to <b>reject adopting a universal approach.</b>”<sup>74(p.181)</sup> “Some Māori women noted how a change toward universal approaches [standardized] missed their culturally related needs.”<sup>74(p.182)</sup> (U)</p>
	<p data-bbox="558 1373 764 1642">1.3 Acknowledging and respecting personal knowledge, identity, and experience</p>	<p data-bbox="834 1362 1408 1551">“Some individuals framed their positive health care experiences in ways that reflected the importance of <b>being treated like others</b>, rather than as someone who was different.”<sup>58(p.1666)</sup> (U)</p> <hr/> <p data-bbox="834 1583 1408 1692">“Clinicians who prioritized <b>communication</b> made substantial differences to women’s experiences.”<sup>54(p.24)</sup> (U)</p> <hr/> <p data-bbox="834 1724 1408 1793">“Participants also appreciated having their <b>experiences acknowledged.</b>”<sup>55(p.56)</sup> (U)</p>

Synthesized finding	Categories	Findings
	<p>This category describes the importance of acknowledging and respecting each Indigenous client as a unique individual, and as an expert in their own personal experiences.</p>	<p>“Although every respondent had experienced one “bad apple” among the caregivers, they all singled out an individual staff member who <b>made them feel understood</b>.”<sup>48(p.19)</sup> (U)</p> <hr/> <p>“On one hand, participants felt that caregivers created understanding by acknowledging and accepting certain cultural differences; on the other, they felt that understanding was created when caregivers ignored social differences by <b>treating them the same as everyone else</b>.”<sup>48(p.20)</sup> (U)</p> <hr/> <p>“All of the women wanted their midwives to <b>respect them as individuals</b> and honour their diversity.”<sup>53(p.106)</sup> (U)</p> <hr/> <p>Trusted providers were <b>willing to take the time</b> needed to discuss a medical situation. “This sense of being respected and heard by providers who were willing to take the time and review tests, to actually sit and discuss a medical situation and offer counselling arose repeatedly.”<sup>62(p.99)</sup> (U)</p>

U, unequivocal

### Category 1.1: Building and maintaining relationships

This category consisted of 13 unequivocal findings reflecting the importance of health care providers building and maintaining relationships.<sup>54, 63, 69, 71, 73, 75</sup> Indigenous care receivers wanted relationships that were positive,<sup>50, 68, 69</sup> long-term,<sup>50, 60, 69</sup> reciprocal,<sup>53</sup> and kin-based (family-like).<sup>53, 54</sup> Part of building relationships involves taking the time needed to understand the person and their needs. Indigenous care receivers appreciated health care providers who took the time to get to know them<sup>53, 54, 63, 68</sup> and develop a personal relationship that moved beyond their medical needs.<sup>53, 54, 60</sup>

An excerpt from Cook<sup>54</sup> provides a quote from a study participant:

I recommend this clinic to everyone and because ... they make you feel comfortable and you grow a close relationship with the staff ... [nurse] and [nurse], they're both mothers and you feel comfortable because you're a mother and they make you feel comfortable with your body and you feel like you can open up to them about anything. We've been coming here since we were sexually active so we have a close bond with them, we can talk to them on the street and feel comfortable seeing them and they're always lovely and nice and want to know how we are. So we keep coming back.<sup>54 (p.24)</sup>

### Category 1.2: Acknowledging and respecting Indigenous culture

Category 1.2 included 13 unequivocal findings. Indigenous care receivers appreciated when their culture was acknowledged, recognized, and affirmed.<sup>49-51, 58, 64, 68</sup> Simply put, "being visible and being acknowledged as Aboriginal in the health care relationships promoted a sense of cultural safety."<sup>58 (p.1666)</sup> When health care providers asked about their cultural wants and needs, it contributed to "feeling respected as a person."<sup>49 (p. 355)</sup> Wilson noted that Māori women described how universal or standardized approaches towards health care overlooked their

cultural needs.<sup>74</sup> Some Māori women remembered a time when nurses were able to accommodate more practices that reflected Indigenous cultural needs:<sup>74</sup>

“Nurses used to do ‘things’, but they do not do these now. The ‘things’, such as old values and practices, contribute to spiritual well-being.”<sup>74</sup> (p. 182)

Part of acknowledging and respecting their cultural identity meant there was respect for families,<sup>48, 58</sup> ceremonies,<sup>58</sup> and traditional ways of healing.<sup>57</sup> Moreover, an approach that centered building the strengths of Indigenous peoples was important,<sup>64</sup> and the ways in which health care providers listened and communicated to Indigenous care receivers was paramount.<sup>61</sup> The participant excerpts below provide examples of the importance of acknowledging and respecting cultural identity:

“I told them I needed my eagle feather hanging from my IV thing, and he asked me what it was for and I says, ‘Well, the eagle feather is my protection. It’s my power, my healing.’ So he understood that.”<sup>57</sup> (p. 2441)

“When my mom passed on I thought it was just great that staff members had let us do smudging in the room she was in [and] that we didn't have to go someplace else. And they respected what we wanted to do.”<sup>58</sup> (p. 1666)

A participant from Brown’s study<sup>49</sup> provided an example of how respect and acknowledgement made them feel:

“The first person that has ever asked about respecting the wishes of my Aboriginal [culture] and I was, I was shocked about it and I was, I was amazed and that was a good feeling.... Well, I liked it, I was like wow ... I felt so good and it’s good to know that somebody is respecting you in that way and if, especially if you’re like a native woman, for you know, but it’s just understanding.”<sup>49</sup> (p. 355)

Category 1.3: Acknowledging and respecting personal knowledge, identity, and experience

This category was constructed using seven unequivocal findings describing how Indigenous care receivers felt when their personal knowledge and individual experiences were acknowledged and respected. They described their health care experience as positive if the health care provider acknowledged, respected, and cared about who they were as unique and distinct individuals, in addition to acknowledging their Indigenous cultural identity.

This included feeling understood,<sup>48</sup> and being respected and heard.<sup>62</sup> Indigenous care receivers appreciated feeling validated when their experiences were acknowledged.<sup>55</sup> More specifically, “respecting and honoring diversity of identity, of experience”<sup>53 (p. 106)</sup> contributed to positive health care experiences. Further, being treated equally and receiving individualized care with responsive listening from the health care provider was noted to be of significant value.<sup>48, 58</sup>

“She was very genuine. She challenged me. She acknowledged what I’d been through, what I had accomplished up to this point, my addiction, and where I came from.”<sup>55 (p.56)</sup>

“I told her I didn’t want to breastfeed, and she respected that instead of constantly, ‘you gotta breastfeed, you gotta breastfeed.’”<sup>53 (p. 106)</sup>

**Synthesized Finding 2. To engage with cultural safety, health care providers embody caring, non-judgmental, and supportive ways of being with Indigenous clients, families, and communities.**

This synthesized finding was derived from the aggregation of four categories and a total of 26 unequivocal findings (see Appendix IV and Table 4). Indigenous care receivers appreciated caring, kind, and supportive health care providers who did not judge them. Health care providers

who provided timely and accessible information also contributed to positive health care experiences. Each category is described in detail below.

**Table 4: Synthesized finding 2**

Synthesized finding	Categories	Findings
<p>2. To engage with cultural safety, health care providers embody caring, non-judgmental, and supportive ways of being with Indigenous clients, families, and communities.</p>	<p>2.1 Being caring and kind</p>	<p>“Participants described caregivers who <b>created understanding as kind.</b>”<sup>48(p.19)</sup> (U)</p>
	<p>Being caring is associated with empathy, compassion, and hospitality, and results in being perceived as trustworthy.</p>	<p>“Participants shared stories of health providers who demonstrated an outstanding ability to <b>convey a caring attitude.</b>”<sup>50(p.139)</sup> (U)</p>
		<p>“In practice cultural safety means demonstrating <b>trustworthiness, compassion and hospitality.</b>”<sup>54(p.23)</sup> (U)</p>
		<p>“The strongest theme that emerged from the interviews with parents was the importance of feeling that NICU staff and physicians <b>genuinely cared</b> about their infant.”<sup>72(p.79)</sup> (U)</p>
		<p>“When health practitioners were <b>loving and empathetic</b>, caring for parents and whanau (family) as well as their infant/s, whanau felt comfortable and confident to participate in hospital routines.”<sup>46(p.13)</sup> (U)</p>
		<p>“The survivors and caregivers further widely reported that care providers’ <b>empathic communication practices</b> contributed to satisfaction.”<sup>57(p.2440)</sup> (U)</p>
		<p>Trusted providers were willing to help as needed and regularly participated in community events.<sup>62</sup> (U)</p>
		<p>“Trusting relationships were very important to women, and many had</p>

Synthesized finding	Categories	Findings
		<p>searched hard to find a HCP (health care provider) they could trust.”<sup>52(p.8)</sup> (U)</p> <hr/> <p>Issues of trust were addressed by demonstrating care for the Indigenous community.<sup>61</sup> (U)</p>
	<p>2.2 Being non-judgmental</p> <p>Being non-judgmental is associated with being respectful, not making assumptions, and having an open mind.</p>	<p>“Safe attitudes were demonstrated by doctors who respected patient autonomy and held <b>non-judgmental, strengths-based perspectives</b> on substance use.”<sup>67(p.56)</sup> (U)</p> <hr/> <p>“When the midwives <b>supported</b> the women in their <b>choices</b> and did not make assumptions, the women felt comfortable and respected.”<sup>53(p.105)</sup> (U)</p> <hr/> <p>“The women shared how service providers at SGMT (clinic) were <b>non-judgmental</b> and <b>compassionate</b>.”<sup>66(p.103)</sup>(U)</p> <hr/> <p>“Several participants also reported feeling understood by White therapists and were able to verbalize that they felt were important components to feeling understood ... openness and validation.”<sup>55 (p. 55)</sup> (U)</p>
	<p>2.3 Being Supportive</p> <p>Being supportive is associated with offering emotional support, and being present, positive, and affirming. Providing supportive care that recognizes the impact of past trauma is also being supportive.</p>	<p>“Reassurance was provided in the form of a <b>supportive presence from a caring person</b>. It was reassuring to know that they had somewhere to go and someone to trust if they had any problems especially with their new babies.”<sup>60(p.31)</sup> (U)</p> <hr/> <p>“When the women <b>felt supported</b> they had more positive experiences of their births.”<sup>49(p.354)</sup> (U)</p> <hr/> <p>“Health care delivery that had a strong focus on <b>supporting the emotional</b></p>

Synthesized finding	Categories	Findings
		<p><b>well-being</b> of the older person was considered important.”<sup>65(p.184)</sup> (U)</p> <hr/> <p>“There were many stories that emphasized the importance of the midwives <b>being present</b> in the stressful situations to calm the women down and make them feel comfortable.”<sup>53(p.113)</sup> (U)</p> <hr/> <p>“For some women, having a midwife that approached the entire care experience with a <b>positive attitude</b> and outlook was highly important.”<sup>53(p.106)</sup> (U)</p> <hr/> <p>“Sensitive HCP communication and <b>empathetic, trauma-informed care</b> was central to one woman’s recent positive experiences of screening after a 24-year interval following experience of sexual violence.”<sup>52(p.10)</sup> (U)</p> <hr/> <p>“Participants’ positive interactions focused on <b>being “treated well” and “respected”</b> by staff who were particularly attentive and responsive.”<sup>58(p.1666)</sup> (U)</p> <hr/> <p>“Participants also expressed that AACC staff had done all they could, were culturally appropriate and sensitive, liaised with their Aboriginal health teams, ensured participants were kept informed and provided the best possible care by <b>being responsive and caring</b>.”<sup>70(p.100)</sup> (U)</p> <hr/> <p>“Health practitioner champions, like this doctor, became an important part of the lives of whānau, and were <b>remembered for their support long</b></p>

Synthesized finding	Categories	Findings
		after whānau returned home.” <sup>47(p.567)</sup> (U)
	<p data-bbox="581 363 878 468">2.4 Providing Accessible and Timely Information</p> <p data-bbox="581 562 878 867">Although providing information could also be considered part of being supportive, it focuses on answering questions and providing understandable information.</p>	<p data-bbox="919 363 1412 678">“Regardless of their initial level of understanding of cancer care, the survivors and caregivers who were satisfied with care said their care providers mitigated this multi-level burden by <b>offering informational support</b> and building health literacy.”<sup>57(p.2440)</sup> (U)</p> <p data-bbox="919 699 1412 972">“The participants described feeling well cared for when they were able to <b>have all their questions answered</b>. It was important that staff asked the women if they had any questions or concerns and then were willing to respond.”<sup>60(p.30)</sup> (U)</p> <p data-bbox="919 993 1412 1266">“When the women were <b>told what was happening and what they should expect</b> in ways that were easy to understand, they regained their sense of control, their confidence, and their ability to manage uncertainties.”<sup>53(p.113)</sup> (U)</p> <p data-bbox="919 1287 1412 1444">“The need for <b>simple, non-medical, easily understood language</b> and pictorial representations was reinforced.”<sup>59(p.111)</sup> (U)</p>

U, unequivocal

## Category 2.1: Being caring and kind

This category was assembled with nine unequivocal findings that reflected examples of health care providers being caring and kind. Indigenous care receivers reported positive experiences when their health care provider was kind, compassionate, attentive, responsive, and trustworthy.<sup>48, 54, 72</sup> Feeling genuinely cared about was critical to positive health care experiences<sup>72</sup> for Indigenous care receivers as well as their family members.<sup>46</sup>

“The nurses up there and radiation and the whole crew there were very friendly and, you know, talk to you all the time, you know, and it made you feel like somebody cared.”<sup>57</sup> (p. 2441)

“She was so kind to me—she seemed to understand what I was feeling. She was always there for me.”<sup>48</sup> (p. 19)

“They just seemed really friendly and really warm and they were joyful ... and when they talked to me it felt like they put all the attention on me, not anything else.... I had their attention when I needed it and if anything would go wrong they would be there for me and that they would look after me and be there to help me for any reason.”<sup>54</sup> (p. 23)

Being caring can be associated with empathy, compassion, and hospitality, and results in being perceived as trustworthy. Trusted providers were very important<sup>52</sup> and were described as those who participated in local community events<sup>62</sup> and learned the names of children in the community.<sup>61</sup>

Below is a quote describing a registered nurse (RN) who was identified as being a trusted provider:

Multiple accounts shared the implicit trust with which those living on-reserve spoke of one particular outpost RN, who had many years of experience serving remote communities. She was described as always attentive to the needs of the people, and was

respected in return for her skill as an RN. Examples given included her willingness to drive her boat across the bay to the village for emergencies, explain to patients or family members when there was confusion regarding a diagnosis or treatment plan, advocate for some with the physicians, and perhaps most importantly show respect by regularly participating in community events such as potlatches and other celebrations.<sup>62</sup> (p. 101)

#### Category 2.2: Being non-judgmental

This category encompassed four unequivocal findings describing Indigenous peoples' positive experiences when their health care provider was non-judgmental. Many participants described how their health care provider withheld judgment and avoided making assumptions.<sup>53, 66, 67</sup> Having an open mind<sup>55</sup> and supporting people in the choices they made<sup>53</sup> was also regarded as important. This led to Indigenous peoples feeling comfortable and respected with their health care providers.<sup>53</sup>

“They’re so client centered and non-judgmental and supportive ... even when I told them ... I smoke cigarettes and I’m having a really, really hard time even cutting down. I didn’t feel an ounce of judgment.”<sup>66</sup> (p.103)

“She was so easy to relate to, so easy to talk to, and she didn’t make me feel bad about any of my past and I’ve done some ... I’m an ex-drug addict, prostitute slash, you know? [Laughs]... But she ... that never phased her.”<sup>53</sup> (p. 105)

#### Category 2.3: Being supportive

This category was supported by nine unequivocal findings describing Indigenous peoples' descriptions of feeling supported. Being supportive is associated with offering emotional support, and being present, positive, and affirming. Feeling supported by a health care provider was reassuring<sup>60</sup> and contributed to positive health care experiences, for instance, during

childbirth.<sup>49</sup> Similarly, Indigenous peoples identified that having their emotional health supported was important, in addition to having their physical needs met.<sup>47, 53, 65</sup> Likewise, health care providers with a positive and affirming approach were regarded as important.<sup>53</sup>

“I was at a place where I didn’t want to be giving birth, cuz she was coming early. I was, you know, emotional about it. I was in the hospital and really didn’t want to be in the hospital, and ... she was just there emotionally for me, that she just provided such great emotional support.”<sup>53</sup> (p. 113)

Providing supportive care that recognizes the impact of past trauma is also being supportive. Several Indigenous participants noted that empathetic communication and a trauma-informed approach were key to their positive health care experience.<sup>46, 52</sup> A trauma- and violence-informed approach to care is about creating “a safe environment for all based on an understanding of the traumatic effects of historical and ongoing violence and discrimination.”<sup>12</sup> (p. 5)

#### Category 2.4: Providing Accessible and Timely Information

This category was supported by four unequivocal findings describing Indigenous participants' appreciation for health care providers providing timely and accessible information. Although providing information could also be considered part of being supportive, it focuses on answering questions and providing understandable information. Several participants described positive encounters as receiving easy to understand information with limited medical jargon.<sup>53, 59</sup> It was important for participants to have their questions answered,<sup>60</sup> receive clear information about what was happening and what to expect in relation to their health and health care.<sup>53</sup> As a result, some Indigenous people felt they were being well-cared for,<sup>60</sup> they regained a sense of control<sup>53</sup> and their health literacy improved.<sup>57</sup>

“The doctors really made a big difference. They worked to break it down into terms that we could understand, and it was really reassuring as far as how the outcome would be, and it just felt (like) he really cared about his patients.”<sup>57</sup> (p. 2440)

“It’s really good because [my doctor will] even do a drawing ... [For example, when discussing contraceptives, my doctor explained] ‘The blood vessel is like this, so if you had a clot ... it makes a thickening in the blood vessel.’ She really explains it to you so that you don’t walk out of there still wondering, you know.”<sup>59</sup> (p. 112)

**Synthesized Finding 3. To engage with cultural safety, health care providers walk beside Indigenous clients, families, and communities on their path to health and health equity.** This journey involves promoting shared care and collaborative decision-making, sharing power, and speaking up when the person’s autonomy is jeopardized or when additional services are required, and including Indigenous providers, knowledge, and wellness practices; and Indigenous cultural and spiritual spaces in the health care system.

This synthesized finding was built around the aggregation of three categories and 18 unequivocal findings (see Appendix IV and Table 5). Indigenous care receivers wanted their health care providers to walk alongside them on their journey to health and health equity. This involved encouraging and supporting their active participation, collaboration and shared decision-making that also involved families in care. Most importantly, including and incorporating Indigenous knowledge and wellness practices into health care is crucial. Further, Indigenous cultural and spiritual spaces were important to integrate into the health care system. Each category is described in detail below.

**Table 5: Synthesized finding 3**

Synthesized finding	Categories	Findings
<p>3. To engage with culturally safety, health care providers walk beside Indigenous clients, families, and communities on their path to health and health equity. This journey involves promoting shared care and collaborative decision-making, sharing power, and speaking up when the person’s autonomy is jeopardized or when additional services are required, and including Indigenous providers, knowledge, and wellness practices; and Indigenous cultural and spiritual spaces in the health care system.</p>	<p>3.1 The importance of shared care and decision-making</p> <p>Walking beside Indigenous people on their path the health and health equity involved encouraging and supporting their active participation, collaboration and shared decision-making that also involved families in care.</p>	<p>“Being able to speak openly and to <b>participate in health care decisions</b> through sharing knowledge and power were seen as extremely important.”<sup>50(p.139)</sup> (U)</p>
		<p>“Another young woman spoke of <b>participating as an active and respected member of the health care team</b> during the hospitalization of a young relative.”<sup>59(p.110)</sup> (U)</p>
		<p>“Providers’ ability to listen and invite questions, thereby <b>involving respondents as decision-makers</b> in their own treatment, emerged as a key element for satisfaction.”<sup>57(p.2440)</sup> (U)</p>
		<p>“Similar to other minority groups with communalistic values, <b>involving family members</b> emerged as an important factor in how care providers increased satisfaction and helped ease the burden.”<sup>57(p.2441)</sup> (U)</p>
		<p>“Families appreciated <b>being involved in health care planning</b> initiatives.”<sup>65(p.183)</sup> (U)</p>
		<p>“When women <b>felt included</b> in what was happening they reported positive experiences.”<sup>49(p.353)</sup> (U)</p>
		<p>“Being included refers to the ways whānau see themselves within a service and are <b>involved in the decision-making</b> processes.”<sup>71(p.119)</sup> (U)</p>
	<p>3.2 Being an advocate</p>	<p>“HCPs at the community health centre provided <b>advocacy</b> for participants in their interactions with these other agencies and</p>

Synthesized finding	Categories	Findings
	<p>Being an advocate involved speaking up collaboratively with the person when their autonomy was jeopardized, advocating and for needed services and seamless care, and sharing power while creating opportunities for change.</p>	<p>this was important to the participants and to their relationships with HCPs.”<sup>60(p.31)</sup> (U)</p> <p>“Some of the women told stories about how their midwives <b>advocated</b> for them in mainstream health care context (e.g. in hospital, with doctors) when their autonomy was threatened or taken away.”<sup>53(p.105)</sup> (U)</p> <p>“One participant shared her admiration of the <b>collaborative, seamless approach</b> experienced by her grandmother.”<sup>59(p.113)</sup> (U)</p> <p>“Feeling safe consists of service humility, understanding <b>power sharing</b> and creating opportunities for feedback and change.”<sup>71(p.122)</sup> (U)</p>
	<p>3.3 Including and incorporating Indigenous providers, knowledge, and wellness practices; and Indigenous cultural and spiritual spaces into the health care system.</p> <p>This category focuses more on health service and system level change including incorporating Indigenous providers, knowledge and wellness practices into health services. It also involves physical changes to create cultural and spiritual spaces in the health care settings.</p>	<p>“Several participants verbalized that they would have liked to <b>incorporate traditional American Indian practices</b> into their therapy.”<sup>55(p.53)</sup> (U)</p> <p>“For the women who did not know what to ask for, <b>IK &amp;P [Indigenous Knowledge &amp; Practice]</b> was only included in their care when the midwives <b>offered it</b> to them, or directed them towards the appropriate resources.”<sup>53(p.119)</sup> (U)</p> <p>“Good physical care also included the physical health care environment and infrastructure as <b>medical places were transformed into cultural and spiritual spaces</b> that helped families carry out their care practices and death customs.”<sup>65(p.187)</sup> (U)</p> <p>“Health care delivery that had a <b>strong cultural and spiritual health care focus</b> appeared to support older people and their families.”<sup>65(p.185)</sup> (U)</p>

Synthesized finding	Categories	Findings
		<p data-bbox="859 260 1412 449">“Participants suggested that they and their family felt <b>more comfortable</b> when dealt with by <b>Māori health professionals</b> because of the cultural understandings they share.”<sup>73(p.76)</sup> (U)</p> <p data-bbox="859 478 1412 709">“A pair of sisters talked about the care preferences their mother had for their father. This included a <b>preference for Māori nurses</b>, especially those with a whakapapa (genealogical) connection to their whānau.”<sup>56(p.5-6)</sup> (U)</p> <p data-bbox="859 739 1412 844">“Non-indigenous allies could provide support to create safe spaces and resources.”<sup>56(p.6)</sup> (U)</p>

U, unequivocal

### Category 3.1: The importance of shared care and decision-making

This category was built around seven unequivocal findings, reflecting descriptions of shared care and decision-making. Many Indigenous care receivers described positive health care experiences as being active participants in decisions pertaining to their health.<sup>50, 57, 59</sup> The inclusion of family members and caregivers was also of particular importance in positive health care experiences.<sup>57, 65</sup> Furthermore, several Indigenous care receivers noted that feeling included was central to positive health care experiences.<sup>49, 71</sup> Feeling included in what was happening with their health and feeling that they were a part of the decisions made about their health contributed to positive experiences.<sup>49, 71</sup>

“My doctor, he was really good and he showed me three different plans I could follow and gave us great statistics for each plan. And even though we took the more lengthy route, there was a better chance of survival rate than the other routes.”<sup>57 (p. 2440)</sup>

“There was no time limit, and she helped me to become more in control of my own health, which was the big thing. So I didn’t feel uncomfortable asking questions or [saying] ‘okay, well no, I don’t want to do that, can you try something different?’ ... I wasn’t just a piece of meat.”<sup>50</sup> (p. 139)

### Category 3.2: Being an Advocate

This category holds four unequivocal findings that identify Indigenous peoples’ positive experiences with health care providers as advocates. Advocacy included speaking up with the client or “acting as bridges or mitigators in mainstream health care settings.”<sup>53</sup> (p.105) Similarly, when health care providers worked to ensure a seamless approach to care, participants regarded this as a positive health care experience.<sup>59</sup> Further, feeling safe in the relationship was critical and was described as power sharing,<sup>71</sup> where the health care provider shifted the power in the relationship to the Indigenous care receiver.

She said that if child protections, because I’ve been coming to the programs and they see that I’m doing good, she’s like a support for me like when, because there will, because of my previous history dealing with child protections, they will come and talk to me after baby is born and that’s what she said, she’ll like help me, to make sure I understand, that I’m not just signing random papers, that I know what’s going on and like if there’s no reason for them to take baby then she’ll make sure she’ll speak up for me, and like help me.<sup>60</sup> (p. 31)

Category 3.3: Including and incorporating Indigenous providers, knowledge, and wellness practices as well as Indigenous cultural and spiritual spaces into the health care system

The final category comprises seven unequivocal findings. This category focuses more on health service and system-level change, including incorporating Indigenous providers,

knowledge, and wellness practices into health services. It also involves physical changes to create cultural and spiritual spaces in the health care settings.

Many Indigenous care receivers wanted their health care to be focused on and incorporate cultural and spiritual traditions.<sup>55, 65</sup> Care was regarded as positive when “medical places were transformed into cultural and spiritual spaces.”<sup>65 (p. 187)</sup> This included a strong presence of Indigenous health care providers involved in their care.<sup>56, 70, 73</sup>

Indigenous care receivers wanted to see Indigenous ways of knowing and healing incorporated into their health care.<sup>53, 55, 65</sup> Participants wanted health care providers to help to “ease initiation of access to Indigenous knowledge and practice.”<sup>53 (p. 119)</sup>

“It wouldn’t have been something that we would have asked. Whereas my midwife just took it upon herself to say, ‘Hey do you wanna smudge?’ And we’re like, ‘Yeah, that’s great, like we didn’t even know that was an option,’ because of, you know, you’re in a hospital.”<sup>53 (p. 119)</sup>

“He was White. The good thing for me was that he ran a sweat lodge, he knew people from my reservation. They [tribal spiritual leaders] showed him how to run a sweat lodge. He knew a lot about my tribe. He knew more about my own tribe’s ceremonies than I did. I really liked that. The sweat lodge was every week and that was part of the treatment. I guess my overall experience with that was great. It was really, really great. It was life changing, honestly.”<sup>55 (p. 53-54)</sup>

## **Discussion**

This qualitative systematic review was completed to synthesize the available evidence regarding Indigenous peoples’ experiences with culturally safe health care encounters. Thirty studies were included, and qualitative data was synthesized from Indigenous participants across

four countries.<sup>46-75</sup> The confidence of the evidence was assessed as high for the three synthesized findings, using the ConQual approach.<sup>84</sup> A total of 77 findings formed 10 categories and three synthesized findings. The synthesized findings provided information on how health care providers engage in providing care to Indigenous peoples in culturally safe ways.

To the best of our knowledge, this systematic review is the first qualitative synthesis of studies of Indigenous peoples' experiences of culturally safe health care encounters within a variety of health care settings across a variety of countries. The ultimate goal of this review was to provide examples of culturally safe care from the perspective of Indigenous peoples in order to inform the responsiveness of health care providers to the health care needs of Indigenous peoples. This review highlights elements for health care providers to draw upon to promote culturally safe health care practices. Understanding the perspectives of Indigenous peoples about culturally safe health care is vital for promoting the health of Indigenous peoples.

Several systematic and scoping reviews have explored culturally safe practices, interventions, and initiatives.<sup>17, 41, 43, 44, 77, 79, 86</sup> Overall, our review findings are consistent with the broader literature on culturally safe health care. Consistent with our review findings, previous research has highlighted the importance of building and maintaining relationships,<sup>17, 41, 77, 79</sup> being kind,<sup>44, 79</sup> being non-judgmental,<sup>17, 79</sup> and involving family in care.<sup>43, 44, 77, 79</sup> Additionally, shared decision-making and being an active participant in health care were noted in another review as being key factors in culturally safe care.<sup>43</sup> A further finding that echoes those in our review was the importance of acknowledging and respecting Indigenous culture, identity, values, beliefs, and practices within health care.<sup>17, 43, 44, 77, 79</sup> Our findings are supported by these examples from evidence that describe Indigenous peoples' experiences of health care encounters in a variety of contexts across several countries. However, literature on this topic has

predominantly focused on health care providers' perspectives, or is centred on Indigenous peoples' negative, culturally unsafe, health care experiences.

Our review findings are not intended to provide a prescriptive list of actions, attributes, or a checklist for practice that health care providers can 'do' when providing culturally safe care. Congruent with our first synthesized finding, Indigenous participants described difficulties when experiencing standardized care practices that applied to all clients.<sup>74</sup> Therefore, we are not suggesting that these findings be taken up as a limiting "one size fits all" approach for culturally safe care<sup>17, 87</sup> or "a universal pan-Indigenous health care"<sup>41 (p. 114)</sup> model for enacting culturally safe practice. Rather, we share these review findings as examples from Indigenous peoples as situated in a particular place and time in the world as a way for health care providers to begin considering how to enact cultural safety in their practice, in partnership with their Indigenous clients and communities.

As previously mentioned in the data synthesis section, we drew upon a relational inquiry approach as a way to frame our discussion of culturally safe health care encounters as informed by the synthesized findings of this review. Doane and Varcoe described three domains of inquiry: the intrapersonal, the interpersonal, and the contextual.<sup>19</sup> The intrapersonal level focuses on inquiry into the health care provider's beliefs, assumptions and biases that influence the care they provide.<sup>19</sup> The interpersonal level requires inquiry into the relationships (or lack thereof) that play out between people, including a health care provider and a care receiver.<sup>19</sup> Finally, the contextual level asks about the historical, social, and political forces that impact health care.<sup>19</sup> Therefore, as others have done in a similar manner,<sup>86, 88</sup> in the next section we will discuss the review findings in relation to these three domains of relational inquiry (intrapersonal, interpersonal, and contextual).

### Intrapersonal Inquiry: Asking about the impact of health care providers

Our second synthesized finding was built upon categories that demonstrated the need for health care providers to be caring and kind, non-judgmental, and supportive. Cultivating these attributes in order to provide culturally safe care involves health care providers engaging in critical self-reflection.<sup>90</sup> Self-reflection is defined as the process of examining one's own beliefs, assumptions, and biases.<sup>17</sup> Health care providers need to be self-aware and reflective in order to provide culturally safe care.<sup>16, 17, 19, 43, 86, 89</sup> Examples include strategies such as reflective journaling, cultural safety education, ongoing professional development training, and participating in Indigenous cultural and community events.<sup>90</sup> Congruent with the principles of cultural safety, this kind of lifelong critical reflective practice will help to foster meaningful connections and relationships with Indigenous clients in health care settings.<sup>90</sup>

Indigenous participants in many of the included studies were clear they wanted to be acknowledged and respected for their Indigenous cultural identity and as individuals with unique life experiences and needs.<sup>49-51, 53, 55, 57, 58, 61, 64</sup> Valuing both cultural identity and personal knowledge avoids making unwarranted assumptions about Indigenous peoples.<sup>19</sup> Health care practice based on assumptions and stereotypes puts health care providers in the falsely assumed position of thinking they know everything there is to know about a client.<sup>19</sup> Assuming that a health care provider can know about a person based on their cultural identity ultimately limits the care they provide.<sup>19, 61</sup> The findings from our review confirm that rather than operating on assumptions (which can lead to stereotyping), health care providers should get to know their clients as unique individuals while acknowledging and respecting their Indigenous culture to enhance the health care that is provided.<sup>17, 53, 58</sup>

It is clear that some of our findings have shown that to engage in culturally safe care, health care providers walk beside Indigenous clients, families, and communities on their path to health and health equity. However, in order to do this, health care providers need to engage in a process of learning about the history of colonization and subsequent Indigenous health and health care inequities.<sup>3</sup> For example, in Canada, the intergenerational effects of Canadian government and church-sanctioned Residential Schools continues to this day.<sup>10</sup> Indigenous children were forcibly removed from their homes and families with the intent to assimilate them into the dominant White culture.<sup>10</sup> This negative colonial legacy is responsible for the unparalleled health and health care inequities that Indigenous peoples in Canada and other parts of the world still endure today.<sup>2</sup> Without an understanding of the health impacts of colonialism and racism, it is unlikely that health care providers will engage in cultural safety.<sup>90, 91</sup> In Canada, addressing the negative impacts of the country's colonial legacy is being facilitated through the Truth and Reconciliation Commission's *Calls to Action*.<sup>91</sup> In parallel with synthesized finding 3, this commission has recommended that to facilitate cultural safety training, health care providers and medical and nursing students receive (or are required to take) historical awareness courses.<sup>91</sup>

Moreover, to prevent perpetuation of harm, it is crucial that health care providers learn about the history of colonization and how it persists in institutional policies and practices.<sup>17, 35, 88</sup> One example identified in this review was about the importance of involving families in the health care experience<sup>57, 65, 71</sup> and of being accepting of family and community visitors in health care settings.<sup>48</sup> Sharing power with and speaking up for Indigenous peoples to challenge practices that restrict family visitation requires that health care providers are aware of the potential traumatizing impact that these kinds of restrictions may have on Indigenous care receivers.<sup>6, 10</sup> Developing the skill of ongoing critical awareness and self-examination required to

provide culturally safe care today will also require knowledge about Indigenous-specific history and generational experiences of racism and health inequities.<sup>90</sup>

Interpersonal Inquiry: Asking about the impact of health care encounters

The importance of building and maintaining relationships between Indigenous clients and health care providers was the finding from this review with the strongest evidence to support it.<sup>50, 52-54, 60, 61, 68, 69, 73</sup> Doane and Varcoe emphasize,

relating in itself has the ability to promote well-being or potentiate harm. If you listen to anyone who's had a "bad" health care experience, you can hear the remnants of that experience and how people continue to carry the wounds from those experiences.

Similarly, if you listen to anyone who has had a particularly positive experience, you can hear the impact that experience had and continues to have.<sup>19 (p.99)</sup>

As such, our strongest finding points to how positive relational experiences are, in themselves, a health intervention. In two of our included studies, the language of kin-based (meaning family-like) was used to describe their relationship with their health care provider and seemed to reflect a desire for ongoing health care relationships where people felt like they were connecting with family.<sup>53, 54</sup>

Despite Indigenous peoples expressing a wish for close, ongoing relationships with their health care providers, research has demonstrated that health care encounters for Indigenous peoples can also be traumatizing because of discriminatory and stigmatizing practices.<sup>11, 13, 50</sup> Therefore, even marginal improvements from a traumatizing level of care may be regarded as being a positive health care encounter by some Indigenous peoples.<sup>69, 92</sup> Our team grappled with determining what findings and illustrations from the studies most closely reflected culturally safe

care rather than only a positive experience. We were particularly careful not to deem care as culturally safe when it was simply just good enough health care.

Our second synthesized finding describes ways of being in culturally safe health care encounters. It includes being caring and kind, being non-judgmental, and being supportive. However, this alone is not the full scope of what a culturally safe health care encounter entails. Without synthesized findings one and three being included in a health care provider's practice, the care provided would be missing critical aspects that make it a culturally safe experience, not merely a positive encounter. For instance, our synthesized findings demonstrated that building relationships, acknowledging a person's cultural identity; respecting their unique personal identity, shared care and decision-making; and incorporating Indigenous health care providers, practices, and knowledge into health care were needed in combination with supportive ways of being for health care providers to practice in a culturally safe way.

Questions about the impact of health care encounters are important for cultural safety. Studies have demonstrated that certain aspects of a provider-client relationship could lead Indigenous peoples to describe their experiences as positive.<sup>69, 92</sup> While engaging with this literature, our review team noticed that positive can mean "good enough" care, safe care can just mean "not disrespectful or demeaning," and affirming can simply mean "recognizing the Indigenous person as a human being." In some contexts, cultural safety can be taken up as a pretty low bar. This kind of care is quite different from positive, safe, and affirming care, which has an impact on the Indigenous person's experiences of cultural safety.

Another important finding was that in order for health care providers to 'be' in a relationship that results in culturally safe health care experiences with Indigenous peoples, power needs to be shifted from the health care provider to the care receiver.<sup>17, 37, 71, 86, 88, 93</sup> Being an

advocate, one of the categories in our third synthesized finding, highlighted that sharing power in the health care relationships was important in contributing to positive experiences.<sup>71</sup> Attention needs to be directed towards the unequal power distribution that health care providers have traditionally held in health care encounters.<sup>22</sup> For example, power can show up in health care encounters in negative ways such as being talked down to, being excluded, and through experiences of racism.<sup>41</sup> On the other hand, power differentials can be shifted towards the Indigenous care receiver when health care providers enact shared care and shared decision-making.<sup>17, 43, 50, 57, 59</sup> Power shifts were also reported in studies when a health care provider lacked knowledge about a particular illness or treatment and humbly admitted this to an Indigenous care receiver.<sup>94</sup> As well, the focus and process of conceptualizing this review led our team to pay attention to Indigenous peoples' experiences, and this was done intentionally as a way to actively shift the power differential by centring on Indigenous experiences about a health care encounter where the power distribution was in their favor.<sup>41</sup>

Contextual Inquiry: Asking about the impact of health care settings and systems

Although building relationships with Indigenous clients was the strongest finding supported in our review and other literature,<sup>19, 50, 52-54, 60, 61, 68, 69, 73</sup> in many ways, the findings from our review do not fit within the realities of the current health care system. The history of neoliberalism is playing out in full force in health care settings where time, efficiency, and the ability to decrease health care expenditures are prioritized.<sup>95</sup> Health care providers are working in systems that have had reductions in workforce funding alongside significant increases of people in need of care.<sup>95</sup> Those at the point of care are consistently being asked to do exponentially more with much less.<sup>95</sup> As such, in the context of being short-staffed and under-resourced, taking the time to build meaningful relationships in health care has become difficult.<sup>89, 96</sup>

Further, health care providers around the world are experiencing burnout and moral distress.<sup>97</sup> Stress can occur when the health care provider's time, along with other resources, is managed in a way that requires them to limit their time by only addressing one need or presenting problem per visit, rather than by providing more holistic, culturally safe, and responsive care. Therefore, the abrupt, fast-paced model of health care delivery erects significant barriers to building connections, and does not allow time for meaningful and authentic relationships to be cultivated.<sup>89</sup> Without a supportive environment and organization, it is difficult for health care providers to consistently contribute to positive health care experiences for Indigenous peoples. As such, it is challenging for culturally safe practice to reach its full potential.

Another contextual reason why it is challenging to build and maintain relationships in health care is that mainstream health care institutions are deeply rooted in a biomedical orientation. A criticism of the biomedical way of thinking is that relationships are not viewed as important<sup>89</sup>; instead, the work of diagnosing and treating illnesses is prioritized.<sup>98</sup> As Horrill and colleagues described, such environments have “competed with nurses’ attempts at providing culturally safe and trauma-and-violence-informed care by discounting the relational work of nurses.”<sup>89</sup> (p. 292) We are not saying that the biomedical treatment work is any less important; however, it obscures the fact that building trusting relationships is foundational for all health care providers and their work. Providing culturally safe care to Indigenous people requires competence in the medical aspect of care and in building and maintaining authentic, meaningful relationships.<sup>99</sup> Strategies to promote meaningful and trusting relationships in health care settings need to be prioritized, including an overall reframing within health care that prioritizes meaningful relationships as an important health care intervention.<sup>19, 89</sup>

At the contextual level, creating health care spaces that are inclusive of Indigenous culture is critical.<sup>43, 44, 53, 55, 65, 73</sup> The findings in this review have highlighted that Indigenous peoples want culturally and spiritually focused health care. Many Indigenous care receivers described how they wanted Indigenous ways of healing, knowledge and practices incorporated in the health care system.<sup>53, 55, 56, 65</sup> Creating an inclusive health care space involves the support, recruitment, and welcoming of Indigenous health care providers into the health care system.<sup>17</sup> Although a biomedical orientation continues to be the dominant approach within mainstream health care settings, this one-size fits all approach to delivering health care has not been meeting the needs of Indigenous peoples.<sup>74</sup> A dramatic shift towards embracing Indigenous knowledge and practices of health and healing will contribute to further positive health care encounters for Indigenous peoples.<sup>87</sup>

Finally, all of the synthesized findings in our review highlight what Indigenous peoples have said about culturally safe health care encounters. Yet, to engage with cultural safety, health care providers need to learn about the significant influence of the social determinants of health, including racism, on constraining opportunities for health.<sup>100</sup> Cultural safety attends to how the social, economic and political forces affect health and health care.<sup>20, 89</sup> This shifts our understanding from individual-level explanations of health and illness, which reflects a liberal political ideology<sup>101</sup> to the broader societal structures that play a larger role in influencing health.<sup>102</sup> Without a health equity lens, cultural safety can be taken up in ways that lose the focus on improving health outcomes for Indigenous peoples, particularly by health systems administrators.<sup>44</sup>

## Summary and Reflection

The 10 categories that make up our three synthesized findings demonstrate that health care providers cannot act in isolation to provide culturally safe care; it must be supported in multiple ways.<sup>79</sup> As De Zilva pointed out, “The scope of cultural safety is beyond the interface of patient-provider interactions (communication, relationships, and Indigenous health staff) and includes the health care system.”<sup>79</sup> (p. 81) At the time that this systematic review was conceptualized, we intended to focus on the interpersonal domain as our site of inquiry. This was because it was previously documented that negative interactions with health care providers deter Indigenous peoples from seeking health care or cause them to avoid it altogether,<sup>13</sup> and because of personal experience as a nurse practitioner (JH) who observed stigma, discrimination, and negative experiences in a health care setting. Thus, we were interested in interpersonal inquiry, or what happened between a health care provider and an Indigenous care receiver that led to positive health care experiences. However, it has become apparent to us that it is equally important to look beyond the interpersonal level of the health care encounter to also consider the intrapersonal and contextual domains of engaging with culturally safe health care.

### *Study limitations*

This review had several limitations. First, although a rigorous and systematic search strategy was closely followed, it is possible that we were unable to locate all published studies and unpublished dissertations on this topic. The varying synonymous terms for cultural safety in the international qualitative literature means that it is possible we may have missed some studies due to those variations in terms. However, we utilized the expertise of a highly skilled research librarian (CG) on our review team who helped to craft and refine our search strategy.

This systematic review is part of a doctoral dissertation (JH), which also includes a small-scale qualitative research study exploring Indigenous participants' positive health care experiences. The qualitative study was conducted in partnership with Indigenous Elders. However, we recognize that the systematic review findings would have been strengthened with Indigenous consultation, similar to the approach used in the qualitative study. This review can be considered as a preliminary review on the experiences of Indigenous peoples with culturally safe health care encounters, and future reviews should be in partnership with Indigenous peoples.

In conceptualizing this review, we felt strongly about centring our inquiry at the practice level to help foster culturally safe health care practitioners. Therefore, we excluded studies that did not focus on a specific interaction with a health care provider to inform cultural safety at the practice level. However, in reviewing the literature, we realized that there is more to cultural safety than just the interaction between the care receiver and the health care provider. There were important participant observations made about culturally safe health care environments that were not included in this review because they did not pertain to an interaction with a health care provider. Nor did we include important participant observations about health care providers who had an awareness of colonization and historical violence, which contributed to participants' experiences of cultural safety. By only focusing on the interpersonal level, we may have overlooked other important aspects of cultural safety such as those intrapersonal and contextual factors.

All studies included in our review were from English-speaking settings (Canada, the USA, Australia, and New Zealand) that were colonized by Britain. Therefore, the findings represent culturally safe health care encounters in those four Westernized countries, and may not

be generalizable to Indigenous peoples living outside of these countries represented in this review.

As with most qualitative research, the findings from this review may not be generalizable to all Indigenous populations. In this review, we identified two reasons. First, we understand culture to be dynamic and relational, as opposed to fixed and static<sup>19</sup>; the participants' descriptions of cultural safety may change from person to person, place to place, and over time. "What may be read as good or as culturally safe care by one person may not be read as such by another."<sup>92</sup> (p. 191) Second, the review findings may have limited transferability due to the diversity within Indigenous cultures.<sup>17</sup> Namely, illustrations of culturally safe care from one Indigenous participant in a qualitative study may not hold true for another.

A final potential limitation of this review is that most studies did not disclose whether the health care provider in the encounter was Indigenous or non-Indigenous. Therefore, this review did not capture or highlight the positive elements pertaining to when care was received from Indigenous health care providers.

### ***Conclusion***

Cultural safety is a complex phenomenon that can be studied in many ways. This qualitative systematic review synthesized the evidence from thirty studies about the experiences of Indigenous peoples and reinforced what is already known about culturally safe health care. This review offers synthesized knowledge by describing Indigenous care receivers' experiences in health care encounters rather than focusing on the health care provider perspectives. A qualitative understanding of Indigenous peoples' experiences provides the necessary evidence for health care providers, health care leaders, administrators, and policy-makers to understand the assumptions that underpin their practices and identify ways to cultivate culturally safe health

care encounters. As our findings indicate, cultural safety is something that is enacted; it is a way of being in relation with Indigenous peoples. The aim of this review was to mobilize health care providers to imagine providing care to Indigenous peoples in a better way. This review also highlights a relational inquiry framework that health care providers can draw upon to promote culturally safe health care practice.

### ***Recommendations for practice or policy***

The Summary of Findings for this review reported high dependability and high credibility of the findings. The confidence levels for the synthesized findings were reported as high using the ConQual approach.<sup>84</sup> The following recommendations have been graded according to the JBI Grades of Recommendation.<sup>104</sup>

We recommend that health care providers prioritize building meaningful, long-term relationships with Indigenous clients and understand that this is integral to promoting the health of Indigenous peoples. (Grade A)

We recommend that health care providers acknowledge and respect Indigenous cultures while simultaneously acknowledging and respecting the personal knowledge and experience that each Indigenous client brings. (Grade A)

We recommend that health care providers adopt strategies that promote a culturally safe health care encounter with Indigenous people, including being non-judgmental, supportive, caring, and kind. (Grade A)

We recommend that Indigenous understandings and models of health and health care are incorporated into all health care contexts, and that access to Indigenous ways of healing and giving and receiving care is facilitated in practice across all health disciplines. This includes a

strong presence of Indigenous health care providers across all health disciplines and health care settings. (Grade A)

We recommend that health care providers work towards shared care and shared decision-making, including welcoming families into the health care experience across all contexts.

(Grade A)

### ***Recommendations for research***

Based on the characteristics of the included studies and the findings of this review, we recommend the following for future research.

There is limited research from the perspectives of Indigenous peoples receiving care, and further research should focus on centring the experiences of Indigenous peoples.

Further research that is led by Indigenous health care providers, Elders, knowledge keepers, and community members would illuminate the best way to ask about, understand, incorporate, and facilitate Indigenous understandings of health and ways of healing into health care practice.

Further research could be conducted specifically inquiring about cultural safety within health care settings that focus on Indigenous models of health care to evaluate the impact those settings have on positive health care experiences and health outcomes.

Further research to learn about cultural safety from the perspectives of an Indigenous client and an Indigenous health care provider would highlight the importance of recruiting and retaining Indigenous health care providers.

Further research conducted outside of Westernized settings (Canada, United States, Australia, New Zealand) with Indigenous peoples should be synthesized to better understand their experiences of culturally safe health care encounters. It is important to explore cultural

safety across many geographic settings in future research, and beyond these English-speaking countries.

It is important in future reviews and research to pay attention to how health care providers' understanding of colonization and racism contributes to culturally safe encounters.

As we have learned from this review, concerns about cultural safety occur at all levels throughout the health care system. It is imperative that future research continues to examine Indigenous health inequities from all levels within the health care system.

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## Appended Materials

### Appendix I: Search strategy

Databases were initially searched in February 2021, with updated searches conducted in January 2022. The total number of records from all databases was 3,983. After removing 1,514 duplicates, 2,476 results were scanned for possible inclusion.

CINAHL (via EBSCO)

Search conducted on Jan 19, 2022

Limited to 1988 onwards

Search	Query	Records retrieved
S1	(MH "cultural safety")	749
S2	"cultural safety" OR "culturally safe"	1,264
S3	S1 OR S2	1,264
S4	(MH "cultural competence")	10,965
S5	"cultural competenc*"	12,015
S6	S4 or S5	12,015
S7	(MH "cultural sensitivity")	7,794
S8	"cultural sensitivity"	8,300
S9	S7 OR S8	8,300
S10	"cultural awareness"	744
S11	"cultural humility"	353
S12	S3 OR S6 OR S9 OR S10 OR S11	20,164
S13	Indigenous* OR "First Nation*" OR Metis* OR Inuit* OR Aborigin* OR "Native*" OR "North American Indian*" OR Maori OR "Torres Strait Islanders" OR "First Nations of Australia" OR "Aboriginal Canadians" OR "First Nations of Canada"	48,377
S14	(MH "Indigenous Peoples+") OR (MH "Health Services, Indigenous") OR (MH "Indigenous Health") OR (MH "Native Americans")	22,997

<b>Search</b>	<b>Query</b>	<b>Records retrieved</b>
S15	S13 OR S14	48,470
S16	qualitative or experience* or perception* or interview* or "focus group*" or "talking circle*" or yarn* or stor* or listen* or hear* or ethnograph* or phenomenol* or narrat* or ethnonurs* or "grounded theory" or "indigenous methodolog*" or "indigenous epistemolog*"	1,359,582
S17	(MH "Qualitative Studies+") OR (MH "Phenomenology")	167,019
S18	S16 OR S17	1,366,176
S19	nurs* OR "healthcare" OR "health care" OR "healthcare provider*" or "health care provider*" or physician* or doctor* or medic* or clinic* or hospital or "healthcare worker*" or "health care worker*" or midwi* or "social worker*" or "occupational therap*" or "physical therap*" or pharmac* or "allied health" or dietic*	2,364,434
S20	(MH "Nurses+") OR (MH "Health Personnel+") OR (MH "Physicians+")	600,907
S21	S19 OR S20	2,499,410
S22	S12 AND S15 AND S18 AND S21	911

MEDLINE (via EBSCO)

Search conducted on Jan 20, 2022

Limited to 1988 onwards

<b>Search</b>	<b>Query</b>	<b>Records retrieved</b>
S1	"cultural safety" OR "culturally safe"	880
S2	(MH "cultural competency") OR (MH "culturally competent care")	7,975
S3	"cultural competenc*"	8,820
S4	S2 or S3	10,483
S5	"cultural sensitivity"	1,236
S6	"cultural awareness"	686
S7	"cultural humility"	382

<b>Search</b>	<b>Query</b>	<b>Records retrieved</b>
S8	Indigenous* OR “First Nation*” OR Metis* OR Inuit* OR Aborigin* OR “Native*” OR “North American Indian*” OR Maori OR “Torres Strait Islanders” OR “First Nations of Australia” OR “Aboriginal Canadians” OR “First Nations of Canada”	271,434
S9	(MH “Indigenous Peoples+”) OR (MH “Health Services, Indigenous”) OR (MH “Indigenous Canadians+”) OR (MH “Alaskan Natives+”) OR (MH “Indians, South American”) OR (MH “Indians, North American+”) OR (MH “Indians, Central America”) OR (MH “American Natives”) OR (MH “American Native Continental Ancestry Group+”)	20,719
S10	S8 OR S9	277,793
S11	qualitative or experience* or perception* or interview* or “focus group*” or “talking circle*” or yarn* or stor* or listen* or hear* or ethnograph* or phenomenol* or narrat* or ethnonurs* or “grounded theory” or “indigenous methodolog*” or “indigenous epistemolog*”	3,600,617
S12	(MH “Qualitative Research+”)	71,219
S13	S11 OR S12	3,600,664
S14	nurs* OR “healthcare” OR “health care” OR “healthcare provider*” or “health care provider*” or physician* or doctor* or medic* or clinic* or hospital or “healthcare worker*” or “health care worker*” or midwi* or “social worker*” or “occupational therap*” or “physical therap*” or pharmac* or “allied health” or dietic*	17,084,441
S15	(MH “Nurses+”) OR (MH “Health Personnel+”) OR (MH “Physicians+”)	464,625
S16	S14 OR S15	17,109,271
S17	S1 OR S4 OR S5 OR S6 OR S7	12,496
S18	S10 AND S13 AND S16 AND S17	1,088

Notes: no MeSH for “cultural safety” or “cultural sensitivity” or phenomenology.

APA PsycInfo (via EBSCO)

Search conducted on Jan 19, 2022

Limits: 1988 onwards

<b>Search</b>	<b>Query</b>	<b>Records retrieved</b>
S1	“cultural safety” OR “culturally safe”	434
S2	(SU “cultural sensitivity”)	8,221
S3	“cultural sensitivity”	9,181
S4	S2 or S3	9,181
S5	“cultural competen*”	7,460
S6	“cultural awareness”	1,354
S7	“cultural humility”	581
S8	Indigenous* OR “First Nation*” OR Metis* OR Inuit* OR Aborigin* OR “Native*” OR “North American Indian*” OR Maori OR “Torres Strait Islanders” OR “First Nations of Australia” OR “Aboriginal Canadians” OR “First Nations of Canada”	53,623
S9	(SU “Indigenous Populations”) OR (SU “Alaska Natives ») OR (SU “American Indians”) OR (SU Inuit) OR (SU “Pacific Islanders”) OR (SU “Hawaii Natives”)	15,957
S10	S8 OR S9	56,744
S11	qualitative or experience* or perception* or interview* or "focus group*" or “talking circle*” or yarn* or stor* or listen* or hear* or ethnograph* or phenomenol* or narrat* or ethnonurs* or “grounded theory” or “indigenous methodolog*” or “indigenous epistemolog*”	1,989,454
S12	(SU “Qualitative Methods”) OR (SU Phenomenology)	30,665
S13	S11 OR S12	1,989,545
S14	nurs* OR "healthcare" OR "health care" OR “healthcare provider*” or “health care provider*” or physician* or doctor* or medic* or clinic* or hospital or “healthcare worker*” or “health care worker*” or midwi* or "social worker*" or "occupational therap*" or “physical therap*” or pharmac* or “allied health” or dietic*	2,135,761
S15	(DE “Nurses” OR DE “Psychiatric Nurses” OR DE “Public Health Service Nurses” OR DE “Physicians” OR DE “Family Physicians” OR DE “General	124,089

<b>Search</b>	<b>Query</b>	<b>Records retrieved</b>
	Practitioners” OR DE “Gynecologists” OR DE “Internists” OR DE “Neurologists” OR DE “Obstetricians” OR DE “Pathologists” OR DE “Pediatricians” OR DE “Psychiatrists” OR DE “Surgeons”) OR (DE “Personnel” OR DE “Allied Health Personnel” OR DE “Medical Personnel” OR DE “Mental Health Personnel”)	
S16	S14 OR S15	2,144,679
S17	S1 OR S4 OR S5 OR S6 OR S7	15,948
S18	S10 AND S13 AND S16 AND S17	551

ProQuest Dissertations and Theses Global

Search conducted on Jan 19, 2022.

Limits: no language or date restrictions were applied

<b>Search</b>	<b>Query</b>	<b>Records retrieved</b>
S1	NOFT("cultural safety" OR "culturally safe")	90
S2	SU("cultural competence")	777
S3	NOFT ("cultural competen*")	2,654
S4	S2 or S3	2,654
S5	NOFT("cultural sensitivity")	864
S6	NOFT("cultural awareness")	1,545
S7	NOFT("cultural humility")	162
S8	S1 OR S4 OR S5 OR S6 OR S7	4,928
S9	NOFT (Indigenous* OR "First Nation*" OR Metis* OR Inuit* OR Aborigin* OR "Native*" OR "North American Indian*" OR Maori OR "Torres Strait Islanders" OR "First Nations of Australia" OR "Aboriginal Canadians" OR "First Nations of Canada")	93,546
S10	(SU "Indigenous Peoples") OR (SU "Native Americans") OR (SU "Native North Americans") OR (SU "Native Peoples") OR (SU "American Indians") OR (SU Inuit) OR (SU Metis)	3,560
S11	S9 OR S10	93,554

<b>Search</b>	<b>Query</b>	<b>Records retrieved</b>
S12	NOFT (qualitative or experience* or perception* or interview* or “focus group*” or “talking circle*” or yarn* or stor* or listen* or hear* or ethnograph* or phenomenol* or narrat* or ethnonurs* or “grounded theory” or “indigenous methodolog*” or “indigenous epistemolog*”)	1,175,325
S13	(SU "Qualitative Research") OR (SU Phenomenology)	11,513
S14	S12 OR S13	1,175,325
S15	NOFT (nurs* OR "healthcare" OR “health care” OR “healthcare provider*” or “health care provider*” or physician* or doctor* or medic* or clinic* or hospital or “healthcare worker*” or “health care worker*” or midwi* or “social worker*” or “occupational therap*” or “physical therap*” or pharmac* or “allied health” or dietic*)	809,482
S16	(SU “Nurses”) OR (SU “Physicians”) OR (SU “health care”)	41,664
S17	S15 OR S16	809,482
S18	S8 AND S11 AND S14 AND S17	118

#### Native Health Database

Search conducted on Jan 19, 2022.

Limits: 1988 onwards

<b>Search</b>	<b>Query</b>	<b>Records retrieved</b>
S1	“cultural safety” OR “culturally safe”	5
S2	“cultural competency”	38
S3	“cultural sensitivity” OR “culturally sensitive”	106
S4	“cultural awareness”	8
S4	“cultural humility”	1
S5	S1 OR S2 OR S3 OR S4	159
S6	Indigenous* OR "First Nation*" OR Metis* OR Inuit* OR Aborigin* OR “Native*” OR “North American Indian*” OR Maori OR “Torres Strait Islanders” OR "First Nations of Australia" OR "Aboriginal Canadians" OR “First Nations of Canada”	3,856

<b>Search</b>	<b>Query</b>	<b>Records retrieved</b>
S7	(qualitative or experience* or perception* or interview* or “focus group*” or “talking circle*” or yarn* or stor* or listen* or hear* or ethnograph* or phenomenol* or narrat* or ethnonurs* or “grounded theory” or “indigenous methodolog*” or “indigenous epistemolog*”)	1,845
S8	(nurs* OR “healthcare” OR “health care” OR “healthcare provider*” or “health care provider*” or physician* or doctor* or medic* or clinic* or hospital or “healthcare worker*” or “health care worker*” or midwi* or “social worker*” or “occupational therap*” or “physical therap*” or pharmac* or “allied health” or dietic*)	4,022
S9	S5 AND S6 AND S7 AND S8	33

Notes: no MeSH for “cultural safety” or “cultural sensitivity”

Arctic and Antarctic Regions Databse (EBSCO)

Through UVIC library

Conducted on Jan 19, 2022

Limits: 1988 onwards

<b>Search</b>	<b>Query</b>	<b>Records retrieved</b>
S1	“cultural safety” OR “culturally safe”	6
S2	“cultural sensitivity”	8
S3	“cultural competen*”	9
S4	“cultural awareness”	29
S5	“cultural humility”	0
S6	Indigenous* OR “First Nation*” OR Metis* OR Inuit* OR Aborigin* OR “Native*” OR “North American Indian*” OR Maori OR “Torres Strait Islanders” OR “First Nations of Australia” OR “Aboriginal Canadians” OR “First Nations of Canada”	68,433
S7	(SU “Indigenous Australians”) OR (SU “Indigenous Peoples”)	8,896
S8	S6 OR S7	71,871
S9	qualitative or experience* or perception* or interview* or “focus group*” or “talking circle*” or yarn* or stor* or listen* or hear* or ethnograph* or	74,964

<b>Search</b>	<b>Query</b>	<b>Records retrieved</b>
	phenomenol* or narrat* or ethnonurs* or “grounded theory” or “indigenous methodolog*” or “indigenous epistemolog*”	
S10	(SU “qualitative research”)	75
S11	S9 OR S10	74,980
S12	nurs* OR “healthcare” OR “health care” OR “healthcare provider*” or “health care provider*” or physician* or doctor* or medic* or clinic* or hospital or “healthcare worker*” or “health care worker*” or midwi* or “social worker*” or “occupational therap*” or “physical therap*” or pharmac* or “allied health” or dietic*	20,987
S13	(SU health)	11,262
S14	S12 OR S13	29,345
S15	S1 OR S2 OR S3 OR S4 OR S5	51
S16	S8 AND S11 AND S14 AND S15	8

Notes: no MeSH for headings available

Embase (via Ovid)

Search conducted on Feb 18, 2022

Limits: 1988 onwards

<b>Search</b>	<b>Query</b>	<b>Records retrieved</b>
S1	(SH “cultural safety”)	318
S2	“cultural safety”	707
S3	S1 OR S2	707
S4	(SH “cultural competence”)	7,281
S5	“cultural competenc*”	9,390
S6	S4 OR S5	9,390
S7	(SH “transcultural care”)	4,784
S8	“cultural sensitivity”	2,285

<b>Search</b>	<b>Query</b>	<b>Records retrieved</b>
S9	“cultural awareness”	854
S10	“cultural humility”	439
S11	S3 OR S6 OR S7 OR S8 OR S9 OR S10	16,309
S12	Indigenous* OR “First Nation*” OR Metis* OR Inuit* OR Aborigin* OR “Native*” OR “North American Indian*” OR Maori OR “Torres Strait Islanders” OR “First Nations of Australia” OR “Aboriginal Canadians” OR “First Nations of Canada”	341,923
S13	(SH “Indigenous People”)	7,833
S14	S12 OR S13	341,923
S15	qualitative or experience* or perception* or interview* or “focus group*” or “talking circle*” or yarn* or stor* or listen* or hear* or ethnograph* or phenomenol* or narrat* or ethnonurs* or “grounded theory” or “indigenous methodolog*” or “indigenous epistemolog*”	5,856,439
S16	(SH “Qualitative Research”)	96,906
S17	S15 OR S16	5,856,439
S18	nurs* or “healthcare” or “health care” or “healthcare provider” or “health care provider*” or physician* or doctor* or medic* or clinic* or hospital or “healthcare worker*” or “health care worker*” or midwi* or "social worker*" or “occupational therap*” or “physical therap*” or pharmac* or “allied health” or dietic*	18,918,895
S19	(SH “Nurse”)	136,760
S 20	(SH "Health Care Personnel")	195,906
S 21	(MH “Physician”)	910,707
S 22	S18 OR S19 OR S20 OR S21	18,918,895
S 23	S11 AND S14 AND S17 AND S22	979

Indigenous Studies Portal (via University of Saskatchewan)

Search conducted on Jan 19, 2022

No language or date restrictions were applied.

<b>Search</b>	<b>Query</b>	<b>Records Retrieved</b>
#1	“cultural safety”	80
#2	“cultural competence” health	26
#3	“cultural sensitivity” health	39
#4	“cultural awareness” health	17
#5	“cultural humility” health	0
1 OR 2 OR 3 OR 4 OR 5		99

Google Scholar

Search conducted on Jan 25, 2022

<b>Search</b>	<b>Query</b>	<b>Records Retrieved</b>
#1 – combined key words	“cultural safety” health	15,500
#2 – combined key words	“cultural safety” health “qualitative research”	4,840
#3 - combined key words	Indigenous “cultural safety” experience health	749,000
#4 - combined key words	“Indigenous experiences” “cultural safety” “qualitative research:	3,990

Open Grey

Search conducted on Jan 24, 2022

<b>Search</b>	<b>Query</b>	<b>Records Retrieved</b>
#1 – key words	“cultural safety”	0
#2 – key words	“cultural sensitivity”	1
#3 – key words	“cultural awareness”	1
#4 – key words	“cultural competency”	1

<b>Search</b>	<b>Query</b>	<b>Records Retrieved</b>
#5 – key words	“cultural humility”	0

Relevant organizational websites

Search conducted on Jan 26, 2022

<b>Organizational Website</b>	<b>Search</b>	<b>Query</b>	<b>Records Retrieved</b>
National Collaborating Centre for Indigenous Health <a href="https://www.nccih.ca/en/">https://www.nccih.ca/en/</a>	key words	“cultural safety”	2
First Nations Health Authority <a href="https://www.fnha.ca">https://www.fnha.ca</a>	combined key words	“cultural safety” research	73
British Columbia Center for Disease Control  <a href="http://www.bccdc.ca/health-professionals/clinical-resources/covid-19-care/education-and-training/culturally-safe-care">http://www.bccdc.ca/health-professionals/clinical-resources/covid-19-care/education-and-training/culturally-safe-care</a>  <a href="https://en.unesco.org/">https://en.unesco.org/</a>	key words	“cultural safety”	5
UNESCO <a href="https://en.unesco.org/">https://en.unesco.org/</a>	combined key words	“cultural safety” research	24,700
World Health Organization  <a href="https://www.who.int">https://www.who.int</a>	key words	“cultural safety”	0
Canadian Nurses Association <a href="https://www.cna-aic.ca/en/home">https://www.cna-aic.ca/en/home</a>	Key words	“cultural safety”	78

## Appendix II: Studies ineligible following full-text review

1. Arnaert A, Schaack G. Cultural awareness of Inuit patients' experiences with emergency nursing care. *Accid Emerg Nur*. 2006;14(2):97–103.  
Reason for exclusion: Wrong phenomenon, study not focused on cultural safety
2. Barlow K, Loppie C, Jackson R, Akan M, Maclean L, Reimer G. Culturally competent service provision issues experienced by Aboriginal people living with HIV/AIDS. *Pimatisiwin*. 2008;6(2):155–80.  
Reason for exclusion: No findings that reflect cultural safety
3. Bassett SF, Tango SM. Maori people's experiences of being physiotherapy patients: a phenomenological study. *N. Z. J. Physiother*. 2002;30(1):30–40.  
Reason for exclusion: Wrong phenomenon, study not focused on cultural safety
4. Benoit C, Carroll D, Chaudhry M. In search of a healing place: Aboriginal women in Vancouver's Downtown Eastside. *Soc Sci Med*. 2003;56(4):821–33.  
Reason for exclusion: No findings that reflect health care encounters
5. Browne AJ, Varcoe C, Lavoie J, Smye V, Wong ST, Krause M, et al. Enhancing health care equity with Indigenous populations: evidence-based strategies from an ethnographic study. *BMC Health Serv Res*. 2016;16:544–544.  
Reason for exclusion: Wrong population, not Indigenous care receivers
6. Bucharski D, Reutter LI, Ogilvie LD. "You need to know where we're coming from": Canadian Aboriginal women's perspectives on culturally appropriate HIV counseling and testing. *Health Care Women Int*. 2006;27(8):723–47.  
Reason for exclusion: No findings that reflect cultural safety
7. Cameron BL, Plazas M del PC, Salas AS, Bearskin RLB, Hungler K. Understanding inequalities in access to health care services for Aboriginal people. *ANS Adv Nurs Sci*. 2014;37(3):E1–16.  
Reason for exclusion: No findings that reflect health care encounters
8. Canuto K, Brown A, Harfield S, Wittert G. "I feel more comfortable speaking to a male": Aboriginal and Torres Strait Islander men's discourse on utilizing primary health care services. *Int J Equity Health*. 2018;17(1):N.PAG  
Reason for exclusion: No findings that reflect health care encounters
9. Churchill ME, Smylie JK, Wolfe SH, Bourgeois C, Moeller H, Firestone M. Conceptualising cultural safety at an Indigenous-focused midwifery practice in Toronto, Canada: qualitative interviews with Indigenous and non-Indigenous clients. *BMJ open* [Internet]. 2020;10(9):e038168.

Reason for exclusion: Duplicate study

10. Dalach P, Savarirayan R, Baynam G, McGaughran J, Kowal E, Massey L, et al. “This is my boy’s health! Talk straight to me!” Perspectives on accessible and culturally safe care among Aboriginal and Torres Strait Islander patients of clinical genetics services. *Int J Equity Health*. 2021;20(1):1–13.

Reason for exclusion: No findings that reflect cultural safety

11. Davis R. Voices of Native Hawaiian kupuna (elders) living with chronic illness: “Knowing who I am.” *J Transcult Nurs*. 2010;21(3):237–45.

Reason for exclusion: Wrong phenomenon, study not focused on cultural safety

12. Dudley M, Wilson D, Barker-Collo S. Cultural invisibility: Māori people with traumatic brain injury and their experiences of neuropsychological assessments. *NZ J Psychol*. 2014;43(3):14–21.

Reason for exclusion: No findings that reflect cultural safety

13. Enuaraq S, Gifford W, Ashton S, Al Awar Z, Larocque C, Rolfe D. Understanding culturally safe cancer survivorship care with Inuit in an urban community. *Int J Circumpolar Health*. 2021;80(1):1949843.

Reason for exclusion: No findings that reflect cultural safety

14. Farnbach S, Fernando J, Coyte J, Simms M, Hackett ML. “It’s hard for me to tell my story”: The experiences of Aboriginal and Torres Strait Islander male clients at a residential drug and alcohol rehabilitation centre using primary health care. *Health Promot J Austr*. 2021;32(S2):87-94.

Reason for exclusion: Wrong phenomenon, study not focused on cultural safety

15. Fraser SL, Nadeau L. Experience and representations of health and social services in a community of Nunavik. *Contemp Nurse: A Journal for the Australian Nursing Profession*. 2015;51(2-3):286–300.

Reason for exclusion: Wrong phenomenon, study not focused on cultural safety

16. Gerlach AJ, Browne AJ, Greenwood M. Engaging Indigenous families in a community-based Indigenous early childhood programme in British Columbia, Canada: A cultural safety perspective. *Health Soc Care Community*. 2017;25(6):1763–73.

Reason for exclusion: No findings that reflect health care encounters

17. Gregory D, Whalley W, Olson J, Bain M, Harper GG, Roberts L, et al. Exploring the experience of type 2 diabetes in urban aboriginal people. *Can J Nurs Res*. 1999;31(1):101–15.

Reason for exclusion: Wrong phenomenon, study not focused on cultural safety

18. Hartz DL, Blain J, Caplice S, Allende T, Anderson S, Hall B, et al. Evaluation of an Australian Aboriginal model of maternity care: The Malabar Community Midwifery Link Service. *Women Birth*. 2019;32(5):427–36.

Reason for exclusion: No findings that reflect health care encounters

- 19.** Hastings HD. Tsartlip First Nations analysis of primary care Equity and access [master's thesis on the Internet]. Victoria, Canada: Royal Roads University; 2020. [cited 2023 May 30]. Available from: <https://www.proquest.com/docview/2392001372?pq-origsite=gscholar&fromopenview=true>

Reason for exclusion: Wrong phenomenon, study not focused on cultural safety

- 20.** Joe E. Bridging cultural barriers through relational approaches: Supporting trauma informed emergency care at West Coast General Hospital [master's thesis on the Internet]. Victoria, Canada: Royal Roads University; 2019. [cited 2023 May 30]. Available from: <https://www.proquest.com/docview/2320934607?pq-origsite=gscholar&fromopenview=true>

Reason for exclusion: No findings that reflect cultural safety

- 21.** Kelly J, Luxford Y. Yaitya tirka madlanna warratinna: exploring what sexual health nurses need to know and do in order to meet the sexual health needs of young Aboriginal women in Adelaide. *Collegian*. 2007;14(3):15–20.

Reason for exclusion: No findings that reflect health care encounters

- 22.** Kelly L, Linkewich B, Cromarty H, Pierre-Hansen NS, Antone I, Gilles C. Palliative care of first nations people a qualitative study of bereaved family members. *Can Fam Physician*. 2009;55(4):394.

Reason for exclusion: Wrong phenomenon, study not focused on cultural safety

- 23.** Kerrigan V, McGrath S, Majoni SW, Walker M, Ahmat M, Lee B, et al. From stuck to satisfied. aboriginal people's experience of culturally safe care with interpreters embedded in renal ward rounds in a northern territory hospital. *Nephrology*. 2021;26(SUPPL 2):36.

Reason for exclusion: No findings that reflect health care encounters

- 24.** Krichauff S, Hedges J, Jamieson L. "There's a wall there and that wall is higher from our side": Drawing on qualitative interviews to improve Indigenous Australians' experiences of dental health services. *Int J Environ Res Public Health*. 2020;17(18).

Reason for exclusion: Wrong phenomenon, study not focused on cultural safety

- 25.** Lauziere J, Fletcher C, Gaboury I. Factors influencing the provision of care for Inuit in a mainstream residential addiction rehabilitation centre in Southern Canada, an instrumental case study into cultural safety. *Subst Abuse Treat Prev Policy*. 2021;16(1):55.

Reason for exclusion: No findings that reflect cultural safety

- 26.** Levack WM, Jones B, Grainger R, Boland P, Brown M, Ingham TR. Whakawhanaungatanga: the importance of culturally meaningful connections to improve uptake of pulmonary rehabilitation by Māori with COPD - a qualitative study. *Int J Chron Obstruct Pulmon Dis*.

2016;11:489–501.

Reason for exclusion: No findings that reflect cultural safety

- 27.** Liddell JL, Burnette CE, Roh S, Lee Y-S. Healthcare barriers and supports for American Indian women with cancer. *Soc Work Health Care*. 2018;57(8):656–73.

Reason for exclusion: Wrong phenomenon, study not focused on cultural safety

- 28.** Lokken JM. Native American Indian perspective of Euro-American therapists' behaviors [dissertation on the Internet]. North Dakota, US: University of North Dakota; 1996. [cited 2023 May 30]. Available from: <https://www.proquest.com/docview/304267119?pq-origsite=gscholar&fromopenview=true>

Reason for exclusion: Wrong population, Not Indigenous care receivers

- 29.** Loyola-Sanchez A, Richardson J, Wilkins S, Lavis JN, Wilson MG, Alvarez-Nemegyei J, et al. Barriers to accessing the culturally sensitive healthcare that could decrease the disabling effects of arthritis in a rural Mayan community: a qualitative inquiry. *Clin Rheumatol*. 2016;35(5):1287–98.

Reason for exclusion: No findings that reflect cultural safety

- 30.** Marcusson-Rababi B, Anderson K, Whop LJ, Butler T, Whitson N, Garvey G. Does gynaecological cancer care meet the needs of Indigenous Australian women? Qualitative interviews with patients and care providers. *BMC Health Serv Res*. 2019;19(1):N.PAG.

Reason for exclusion: No findings that reflect cultural safety

- 31.** Masters-Awatere B, Rarere M, Gilbert R, Manuel C, Scott N. He aha te mea nui o te ao? He tĀngata! (What is the most important thing in the world? It is people!). *Aust J Prim Health*. 2019;25(5):435–42.

Reason for exclusion: No findings that reflect health care encounters

- 32.** Mbuvi V, Fulbrook P, Jessup M. Indigenous cardiac patients' and relatives' experiences of hospitalisation: A narrative inquiry. *J Clin Nurs*. 2017;26(23–24):5052–64.

Reason for exclusion: No findings that reflect cultural safety

- 33.** McBride KF, Franks C, Wade V, King V, Rigney J, Burton N, et al. Good heart: Telling stories of cardiovascular protective and risk factors for Aboriginal Women. *Heart Lung Circ*. 2021;30(1):69–77.

Reason for exclusion: Wrong phenomenon, study not focused on cultural safety

- 34.** McCalman J, Searles A, Bainbridge R, Ham R, Mein J, Neville J, et al. Empowering families by engaging and relating Murri way: a grounded theory study of the implementation of the Cape York Baby Basket program. *BMC Pregnancy Childbirth*. 2015;15(1):119–119.

Reason for exclusion: No findings that reflect cultural safety

- 35.** McLellan KM, McCann CM, Worrall LE, Harwood MLN. Māori experiences of aphasia therapy: “But I’m from Hauiti and we’ve got shags.” *Int J Speech Lang Pathol*.

2014;16(5):529–40.

Reason for exclusion: No findings that reflect cultural safety

- 36.** Natalie C, Patrick W, Julie D, Tara T, Georgia J, Talicia M, et al. Melq'ilwiye: Coming together -- Intersections of identity, culture, and health for urban Aboriginal youth. *Can J Nurs Res.* 2013;45(2):36–57.

Reason for exclusion: No findings that reflect cultural safety

- 37.** Nelson SE, Wilson K. Understanding barriers to health care access through cultural safety and ethical space: Indigenous people's experiences in Prince George, Canada. *Soc Sci Med.* 2018;218:21–7.

Reason for exclusion: No findings that reflect cultural safety

- 38.** Nelson SE. They seem to want to help me: Health, rights, and Indigenous community resurgence in urban Indigenous health organizations [dissertation on the Internet]. Toronto, Canada: University of Toronto; 2020. [cited 2023 May 30]. Available from: <https://www.proquest.com/docview/2303838570?pq-origsite=gscholar&fromopenview=true>

Reason for exclusion: No findings that reflect cultural safety

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Reason for exclusion: No findings that reflect health care encounter

### Appendix III: Characteristics of Included Studies

Author/Year	Methodology/ Methods	Country	Phenomena of interest	Setting/Context/ Culture	Participant characteristics/ Sample size	Description of main results
Adcock et al., 2021 <sup>46</sup>	Kaupapa Māori research framework, focused life story interviews, interpretive phenomenology for analysis, themes developed.	Aotearoa New Zealand	Study framed as cultural safety.  Purpose: To hear the experiences relating to preterm birth and the neonatal intensive care from families of Indigenous infants.	Neonatal intensive care in a hospital setting. Health care encounters with NICU staff, including midwives.	19 whānau (family) of Indigenous infants.	The findings highlighted that when health care providers were loving, empathetic, and caring, this contributed to feelings of culturally safe care.
Adcock et al., 2022 <sup>47</sup>	Kaupapa Māori research interviews; Interpretive phenomenology for analysis, themes developed.	New Zealand	Study framed as cultural safety.  Purpose: To give voice to the experiences of parents and whānau (family), of Māori preterm infants to inform service transformation. Whānau (family) were interviewed at their 12 month birthdays to reflect on the last year	All parents, whānau (family), and health practitioners (recommended by whānau) of preterm Māori pēpi (born 24+0–36+6 weeks gestation) admitted to NICU in four health districts (Manukau, Waikato, Capital & Coast, Southern) were eligible to participate. Health care encounters	15 mothers, 3 fathers, 3 grandmothers, and 1 great grandmother took part in the final ‘first birthday’ interviews for the 16 whānau or family units.	The findings show that health practitioner champions were thought of like whanau (family) as a result of their culturally responsive care, which included being non-judgemental, providing information, and engaging in shared decision-making.

Author/Year	Methodology/ Methods	Country	Phenomena of interest	Setting/Context/ Culture	Participant characteristics/ Sample size	Description of main results
			from birth to 12 months.	with midwives, hospital and NICU staff, social workers and doctors.		
Baker, 2000 <sup>48</sup>	Interpretive interactionism qualitative methodology; in-depth interviews. Recurring themes in the narratives were identified.	Canada	Framed as cultural sensitivity and cross-cultural hospital care.  Purpose: To explore the hospitalization experiences of Mi'kmaq First Nation Community members to understand cultural sensitivity.	Mi'kmaq Big Cove First Nation Community, Northeast coast of New Brunswick Health care encounters with staff at 2 hospitals, including nurses.	10 participants had been hospitalized in New Brunswick within 3 years; 2 were mothers of young children who had been hospitalized.	Participants valued encounters when: they felt understood; health care providers were kind to them; customs of family visiting were accepted; they were treated as equals. Identified compassion and a non-discriminatory attitude as more important than cultural knowledge.
Brown et al., 2016 <sup>49</sup>	Interpretive Heideggerian phenomenology; semi-structured interviews (narrative storytelling); thematic analysis.	Australia	Framed as cultural safety.  Purpose: To explore the lived experiences of Indigenous women who gave birth at a public hospital.	A large tertiary public maternity teaching hospital in South Australia. Health care encounters with doctors, midwives and staff. This centre employed Aboriginal Maternity Care	14 participants who had all given birth in standard hospital care (13 identified as Aboriginal and one as Torres Strait Islander);	The findings demonstrate that when women felt supported, included in what was happening regarding their care, and felt that their culture was recognized, this contributed to positive

Author/Year	Methodology/ Methods	Country	Phenomena of interest	Setting/Context/ Culture	Participant characteristics/ Sample size	Description of main results
				Workers to assist women and midwives.	6 lived in rural or remote areas; 8 lived in metropolitan area.	health care experiences, specifically around birth.
Browne and Fiske, 2001 <sup>50</sup>	Qualitative study drawing on critical and feminist ethnographic approaches; in-depth interviews, interpretive thematic analysis.	Canada	Framed as cultural safety.  Purpose: To examine First Nation women's encounters with their local health care services, and how those encounters are influenced by social, political, and economic factors.	Research done in partnership with a First Nation reserve community in the northern region of a Western Canadian province. Health care encounters with doctors or nurses.	10 First Nations women participated.	Encounters with mainstream services that contributed to affirming experiences included: affirmation of personal and cultural identity; positive, long-term relationships with their health care providers; shared decision-making; and receiving exceptional care (conveying a caring attitude).
Burns et al., 2019 <sup>51</sup>	Qualitative study design using participatory action research principles and a Two-Eyed	Canada	Framed as cultural safety.  Purpose: To better understand Mi'kmaq women's experiences	A First Nations community in rural Nova Scotia. Health care encounters with community health nurses. Also had	4 participants who were Mi'kmaq women over 19 years of age; living in the Mi'kmaq nation	Findings showed that respect for cultural beliefs and traditions contributed to the participants experiences of culturally safe health care.

Author/Year	Methodology/ Methods	Country	Phenomena of interest	Setting/Context/ Culture	Participant characteristics/ Sample size	Description of main results
	Seeing approach; in-depth interviews; thematic analysis.		of accessing prenatal care.	Mi'kmaq Support Workers.	who had received prenatal care within the last 5 years.	
Butler et al., 2022 <sup>52</sup>	Yarning (Indigenous qualitative research method) and thematic analysis.	Australia	Study framed as cultural safety.  Purpose: To explore Aboriginal and Torres Strait Islander women's perspectives on cervical screening.	Five communities across three states/territories in Australia Aboriginal and Torres Strait Islander women. Health care encounters with primary health care providers.	29 Aboriginal and Torres Strait Islander women who were under-screened.	In the context of cervical screening, trusting relationships with a health care provider were fundamental to engaging in this type of care. Health care provider communication that was sensitive, empathetic, and trauma-informed were identified as key in contributing to positive cervical screening experiences.
Churchill, 2015 <sup>53</sup>	Qualitative study design using participatory action research	Canada	Framed as cultural safety.  Purpose: To understand how women who self-	Seventh Generation Midwives Toronto (program) which provides Indigenous focused midwifery	9 participants who were Indigenous women living in Toronto;	Four thematic pillars with 12 themes: Culturally safe Indigenous midwifery care meant (1)

Author/Year	Methodology/ Methods	Country	Phenomena of interest	Setting/Context/ Culture	Participant characteristics/ Sample size	Description of main results
	principles and a Two-Eyed Seeing approach; in-depth interviews; thematic analysis Dissertation		identified as Indigenous understood cultural safety and to explore if their experiences with this program were felt to be culturally safe.	care in an urban setting. This setting was designed as an Indigenous alternative to the mainstream biomedical culture. Health care encounters with Indigenous and non-Indigenous midwives. All participants had an Aboriginal midwife on their team with most (7/9) as their primary midwife.	average age was 33.8 years, 4 were first time mothers; while the rest had a least 1 other child.	"culturally continuous care", (2) access to Indigenous knowledge and practices (3) connection to the community, and (4) feeling "at home" in a health care setting.
Cook et al., 2014 <sup>54</sup>	Generic qualitative design; semi-structured interviews; part of a larger study; thematic analysis.	New Zealand	Framed as cultural safety. Purpose: To identify examples of cultural safety in practice from Māori women undergoing gynaecological exams.	Community clinic setting – 2 sexual health clinics. Health care encounters with nurses and doctors.	10 interviews with women who self-identified as Māori; age 18-54.	In the context of gynaecological exams, women felt cultural safety was optimized when: important relationships were built and maintained; communication and collaboration were prioritized, and trustworthiness,

Author/Year	Methodology/ Methods	Country	Phenomena of interest	Setting/Context/ Culture	Participant characteristics/ Sample size	Description of main results
						compassion, and hospitality were shown.
Fretts, 2016 <sup>55</sup>	Phenomenology; interviews with open-ended questions; themes.  Thesis	USA	Framed as cultural competence & humility.  Purpose: To better understand the lived experiences of American Indian clients who saw a White therapist for mental health reasons.	Most participants resided near Missoula, a city in western Montana. Health care encounters with white therapists or counsellors.	11 participants who were American Indian; had received treatment from White therapists; age range was 19-51.	The findings describe cultural competence and cultural humility when participants had their experiences validated and acknowledged, and when health care providers had an open mind. A desire to incorporate spiritual traditions into their health care and treatment was demonstrated.
Gott et al., 2023 <sup>56</sup>	Kaupapa Māori qualitative research methodology; interviews, the analysis is grounded within Māori knowledge and worldviews;	New Zealand	Framed as cultural safety.  Purpose: To explore the perspectives of Māori health practitioners and whānau (family) caregivers about culturally safe	From palliative care settings in four areas of the North Island of Aotearoa New Zealand. Health care encounters with both Māori traditional and biomedical health practitioners (including nurses).	17 whānau family meetings with between one and seven people, total of 103 Māori participants including health care providers.	Māori health practitioners promote culturally safe care. Non-Māori allies can support this work by creating safe spaces and resources. Participants identified a preference for Māori health care providers.

Author/Year	Methodology/ Methods	Country	Phenomena of interest	Setting/Context/ Culture	Participant characteristics/ Sample size	Description of main results
	core themes developed.		palliative and end-of-life care.			
Hohl et al., 2016 <sup>57</sup>	Qualitative portion of a large multi-state study on cancer care among Indigenous Peoples; interviews with open-ended questions; inductive content analysis and core themes.	USA	Framed as cultural competence & sensitivity.  Purpose: To understand the relationship between the client and the health care provider, and how that relationship relates to satisfaction of care as experienced by American Indian and Alaska Native Peoples with cancer.	Washington and Oregon States; cancer survivors. Stories about health care encounters with doctors and nurses.	71 participants who self-identified as American Indian or Alaska Natives; who lived in Washington or Oregon; and were over 21 years of age.	Findings show that participants were satisfied with care when health care providers: engaged with family; communicated empathically; provided informational support; engaged in shared decision-making; and demonstrated sensitivity to cultural traditions and ways of healing.
Hole et al., 2015 <sup>58</sup>	Participatory action research utilizing Indigenous methods; interviews; interlocking analysis of	Canada	Framed as cultural safety.  Purpose: To examine the hospital practices to better understand how Aboriginal patients' experiences	One community hospital in an urban setting in the Okanagan, B.C.; Aboriginal people who had received health care at this particular hospital Stories about health care encounters	28 participants who were Aboriginal community members; 5 men and 23 women; ages	Positive culturally safe experiences were described as: interactions between the health care provider and the client with feelings of visibility and being acknowledged as Aboriginal; being

Author/Year	Methodology/ Methods	Country	Phenomena of interest	Setting/Context/ Culture	Participant characteristics/ Sample size	Description of main results
	narrative summaries.		could be more culturally safe.	with hospital staff (nurses).	ranged from 19-75 years.	treated equally; being treated well and feeling respected; and having respect for families and cultural and spiritual traditions.
Jensen-Ross, 2006 <sup>59</sup>	Qualitative ethnography; focus groups using semi-structured interviews; thematic analysis.  Thesis	Canada	Culture framed as a determinant of health with cultural safety as an outcome.  Purpose: To better understand First Nations women's needs in relation to cervical cancer screening.	Sothern Alberta; women who identified as First Nations; living off-reserve, residing in Chinook. Stories about health care encounters with clinic and hospital staff (including doctors & nurses).	13 participants who self-identified as First Nations: all women; age range from 18-69 years; residing off-reserve, in Chinook, Southern Alberta.	Findings show that, in relation to cervical screening, positive health care experiences meant: ensuring a collaborative, seamless approach to care transitions; providing information; and enabling active participation in the health care team.
Laczko, 2016 <sup>60</sup>	Interpretive descriptive design and a postcolonial perspective. Interviews, thematic analysis.	Canada	Framed as cultural safety.  Purpose: To explore the perspectives of Aboriginal women about the significance of cultural safety during the first	Participants recruited from a community health centre and other community agencies for families with young children in Saskatchewan; inner-city. Health care	6 participants who self-identified as Aboriginal women; age range 20–38, either were pregnant or	Research findings show that positive experiences with health care happened for these participants when: familiar, personal relationships were prioritized; health care

Author/Year	Methodology/ Methods	Country	Phenomena of interest	Setting/Context/ Culture	Participant characteristics/ Sample size	Description of main results
	Thesis		thousand days of their child's life, from conception to age two.	encounters with staff including doctors and nurses.	have a child less than two years of age.	providers acted as advocates; reassurance, support, and information were provided.
Lipsett, 2007 <sup>61</sup>	Qualitative hermeneutics research; Interviews with hermeneutics; thematic analysis  Dissertation	Canada <sup>i</sup>	Framed as culturally sensitive care.  Purpose: To better understand how the individual's worldview greatly influences health and to give health care providers insight into how to better support both the client and themselves in the quest for health and healing.	Coast Salish and Nuu-chah-nulth nations near Victoria, BC. Health care encounters with health care providers including doctors and nurses.	30 First Nation participants.	Finding show that trusting relationships can be established with non-Indigenous health care providers by demonstrating care for the community. Accommodating Indigenous beliefs and healing practices is described as a way of bridging between cultures.
Lottis, 2011 <sup>62</sup>	Narrative inquiry within an overarching critical ethnographic framework; semi-structured interviews and participant	Canada	Framed as cultural safety.  Purpose: To explore experiences among First Nations people of coastal BC with health care system.	Remotely situated First Nations people; coastal British Columbia. Health care encounters with rotating (fly in & out) physicians and outpost RNs.	15 First Nations participants; ages ranged from 21-mid 80s; had a previous interaction with	Participants who had developed relationships of trust with health care providers reported a higher level of satisfaction with the health care they received. Trusted providers were willing

Author/Year	Methodology/ Methods	Country	Phenomena of interest	Setting/Context/ Culture	Participant characteristics/ Sample size	Description of main results
	observation; analysis through immersion and crystallization; themes.  Thesis				the health care system.	to take the time to discuss the medical care, and were willing to help as needed and participate in community events.
Ludeke et al., 2012 <sup>63</sup>	Qualitative research design; focus groups using semi-structured interviews; thematic analysis.	New Zealand	Framed as cultural competency & primary health care.  Purpose: To identify barriers experienced by Pacific peoples in accessing mainstream General Practice services.	Pacific Peoples in Christchurch and New Zealand. Health care encounters with GPs (doctors) & staff (receptionists).	20 participants from three focus groups were Pacific peoples; included 8 health care workers, and 12 care receivers. 6 of these were (age 25 and over) and 6 were youth participants. (age 17–25).	Findings demonstrate that participants are more likely to access care when the importance of building relationships and spending time with patients is valued.
Maar et al., 2009 <sup>64</sup>	Participatory action research; document review, ethnographic	Canada	Framed by an Aboriginal mental health model, with	Manitoulin Island in Northern Ontario; a large rural island with seven First Nations communities; setting	Participants included 23 Aboriginal clients; 15 providers; and	Participants described high levels of cultural safety at this particular clinic, which included the importance of health

Author/Year	Methodology/ Methods	Country	Phenomena of interest	Setting/Context/ Culture	Participant characteristics/ Sample size	Description of main results
	interviews, and focus groups; thematic analysis.		cultural safety as an outcome.  Purpose: To evaluate a collaborative community-based Aboriginal mental health service model, the Knaw Chi Ge Win service, by exploring strengths and challenges related to this care delivery model.	was the Knaw Chi Ge Win mental health service. Health care encounters with visiting consultants, doctors, & nurses. Some community service providers were Indigenous para-professionals.	16 participants from 3 focus groups with community service providers.	care provider acceptance of clients' beliefs.
Moeke-Maxwell et al., 2020 <sup>65</sup>	Qualitative study drawing on a Kaupapa Māori research framework; semi-structured interviews; Kaupapa Māori thematic analysis.	New Zealand	Study framed by Māori model for palliative care “infused with Māori cultural values.”  Purpose: To explore the perspectives of bereaved family members (Indigenous and non-Indigenous) regarding their	A bicultural context, including Māori and non-Māori people; a variety of settings including hospital, residential care, hospice. Health care encounters with staff including nurses & physicians. Some Indigenous health care providers.	Participants included 58 bereaved family members; 19 Māori whanau (family); and 39 non-Māori families.	Good health care was centered on relationships and respected the person's authority, status, spiritual power across four domains: 1) social/family, 2) emotional/ mental), 3) spiritual and 4) physical health.

Author/Year	Methodology/ Methods	Country	Phenomena of interest	Setting/Context/ Culture	Participant characteristics/ Sample size	Description of main results
			experiences with end of life care.			
Monchalín, 2019 <sup>66</sup>	Qualitative study; part of a larger longitudinal cohort study; conversational interviews; thematic analysis.  Paper-based dissertation with 3 papers.	Canada	Framed as cultural safety with decolonizing aims.  Purpose: To explore Metis women's perspectives and experiences with the health care system.	Urban setting in Toronto, Ontario. Health care encounters with health & social service providers.	Participants were 11 people who self-identified as Metis and female. No other details provided.	Findings demonstrate that participants had positive experiences with health services when providers were non-judgmental and compassionate.
Pearce et al., 2019 <sup>67</sup>	Qualitative sub-study of 2 larger studies; interpretive description; semi-structured interviews; thematic analysis.	Canada	Framed as cultural safety and decolonization.  Purpose: To explore the perspectives of Indigenous people living with Hepatitis C and health care providers treating clients with Hepatitis C with an aim of	Multi-province including British Columbia, Saskatchewan, and Ontario; Hepatitis C care. Health care encounters with health & social service providers including doctors, nurses & addiction specialists.	45 participants who self-identified as Indigenous and had Hepatitis C; age 35–58; 10 Hepatitis C treatment providers were also interviewed.	In the context of Indigenous people living with Hepatitis C, safe relationships with health care providers results from being non-judgmental and respecting patient autonomy.

Author/Year	Methodology/ Methods	Country	Phenomena of interest	Setting/Context/ Culture	Participant characteristics/ Sample size	Description of main results
			decolonizing Hepatitis C care.			
Seear et al., 2020 <sup>68</sup>	Qualitative descriptive approach; interviews (yarns); thematic analysis.	Australia	Framed as cultural safety.  Purpose: To better understand the antenatal health care experiences of Aboriginal women residing in the Kimberly with the aim of improving antenatal care.	The Kimberly region of Western Australia; antenatal care. Health care encounters with midwives but some women spoke about the involvement of Aboriginal health workers.	124 participants who self-identified as Aboriginal women; had accessed antenatal care; median age was 26 years.	Findings revealed that women receiving antenatal care found positive, caring relationships with their health care provider to be important, as was demonstrating cultural awareness.
Slater, 2016 <sup>69</sup>	Case study; in-depth semi-structured interviews; thematic analysis; a Māori-centered ethics of care framework was used for analysis  Dissertation	New Zealand	Framed by cultural safety and a Māori-centred approach.  Purpose: To explore cancer care experiences from the perspectives of those who plan, manage and administer, deliver, and receive such care.	Primary health care settings that include Māori and mainstream health providers for cancer care. Health care encounters with nurses, GPs and specialists. This study also included health service administrators and policy makers.	Four Case studies one for each area of cancer service delivery to explore the experiences of 1) Patients and Whānau; 2) Community, including health care providers; 3) Managers, 4)	Findings revealed the importance of a positive and long-term general practitioner (GP) and patient/whanau (family) relationship in community-based cancer care.

Author/Year	Methodology/ Methods	Country	Phenomena of interest	Setting/Context/ Culture	Participant characteristics/ Sample size	Description of main results
					Health Policy makers.  Age of Māori participants ranged from mid-30s to mid-70s. All care receivers (except one) had experienced cancer in the last 5 years.	
Strobel et al., 2020 <sup>70</sup>	Indigenous research methodology and phenomenology guided the collection and analysis of data, semi-structured interviews, thematic analysis.	Australia	Framed as cultural awareness and cultural competency for culturally inclusive and appropriate care.  Purpose: To explore caregiver perspectives of their children's journey through the specialist paediatric services.	Tertiary children's hospital in Western Australia. The AACC program employed both Indigenous and non-Indigenous health care providers. AACC program staff provided additional assistance to help keep families engaged in the health care process, and ensure a smoother transition from	Interviews with the families of 18 kids (ages 0-16) who identified as Aboriginal and had one recent hospital admission.	Aboriginal children and their caregivers using this program had positive culturally safe experiences, which included providing the best care possible, and being culturally responsive, and caring.

Author/Year	Methodology/ Methods	Country	Phenomena of interest	Setting/Context/ Culture	Participant characteristics/ Sample size	Description of main results
				emergency to the wards, and wards to home and then outpatient clinics. Health care encounters were with medical, nursing and other hospital staff.		
Tipa, 2021 <sup>71</sup>	A kaupapa Māori methodology, constructivist grounded theory research design; constructivist interviews; theory generation.  Thesis	Aotearoa New Zealand	Framed as culturally safe, responsive and competent care.  Purpose: To offer a theory for health care providers working with Māori peoples.	Aotearoa well child services for children under 5 years old. Health care encounters with Well Child/Tamariki Ora [WCTO] health care providers, including nurses.	Eighteen whanau (family) (35 participants) with children under five.	Findings identified culturally responsive ways of working with whanau (family) as: being included; feeling connected (which represents the relationship); and the sharing of power in the health care relationship.
Wiebe and Young, 2011 <sup>72</sup>	Exploratory qualitative approach; open-ended interviews;	Canada	Framed as cultural safety and culturally congruent care. This purpose of this study was to explore the perceptions of the parent/client relating	Level 3 NICU hospital in Edmonton, Alberta. Health care encounters with NICU staff (including doctors and nurses).	21 participants (13 parents, 7 mothers and 1 father) from culturally diverse families including 6	Research findings demonstrate the importance of caring and trust in the health care relationship for parents in the NICU.

Author/Year	Methodology/ Methods	Country	Phenomena of interest	Setting/Context/ Culture	Participant characteristics/ Sample size	Description of main results
	thematic analysis.		to culturally congruent care within a Neonatal Intensive Care Unit (NICU).		families identified as Indigenous.	
Williams et al., 2003 <sup>73</sup>	Qualitative research design using a Kaupapa Māori research framework; in-depth semi-structured interviews; document and thematic analysis.	New Zealand	Culturally safe care is one of the findings. The purpose of this study was to explore Māori men's perceptions and experiences with health care, specifically relating to their prostate health issues.	Wellington Region Community; urban setting; prostate care. Health care encounters with doctors & nurses.	20 participants who self-identified as Māori men; age range 40-70 years; all from an urban area.	Research findings show that positive health care experiences for men with prostate issues included the importance of good relationships, and enhanced comfort with Māori health care providers.
Wilson, 2008 <sup>74</sup>	Grounded theory Māori-centered; interviews; field notes: inductive Glaserian grounded theory analysis. This research report is a KT companion	New Zealand	Culturally responsive and appropriate care. Purpose: to explore Māori women's understanding of health, and their interactions with mainstream health services guided by the question, What is happening for Māori	Māori women (Indigenous to Aotearoa New Zealand). Māori women were also actively involved in advising the development of the research question and the process of meeting and working with	38 Māori women, aged 24-61 years. The Māori women participating in the study came from mixed backgrounds. They lived in a variety of	Findings suggest that an individualized approach to health is preferred by participants rather than a universal approach. As there is much diversity within Indigenous cultures, these findings highlight the positive aspects of an

Author/Year	Methodology/ Methods	Country	Phenomena of interest	Setting/Context/ Culture	Participant characteristics/ Sample size	Description of main results
	paper from her 2004 dissertation.		women, their health, and their interactions with 'mainstream' health services?	participants, which was based on Māori values and practices, such as sharing food and establishing mutual connections with places and people. Health care encounters with a variety of health providers (including doctors and nurses) within "mainstream" health services.	relationships and the majority had children, with many living in homes with more than one family or generation.	individualized approach to care.
Wright et al., 2020 <sup>75</sup>	Interpretive description and two-eyed seeing (Indigenous) framework; part of a larger study; interviews and discussion groups, thematic analysis.	Canada	Framed as cultural safety. The purpose was to better understand the experiences of Indigenous mothers when accessing the health care system for their infants.	Hamilton, Ontario; Indigenous families in the neonatal intensive care unit (NICU). Health care encounters with NICU staff including hospital nurses and community health nurses.	5 participants who self-identified as First Nations women; were mothers whose infants were in the NICU; all over 26 years of age.	Findings identified that building relationships with health care providers is important to Indigenous families in the NICU.

## Appendix IV: List of Study Findings with Illustrations

<p>Adcock A, Cram F, Edmonds L, Lawton B. He Tamariki Kokoti Tau: Families of Indigenous infants talk about their experiences of preterm birth and neonatal intensive care. <i>Int J Environ Res Public Health</i> 2021;18(18):9835.<sup>46</sup></p>	
<p>Finding 1</p>	<p>“When health practitioners were loving and empathetic, caring for parents and whanau (family) as well as their infant/s, whanau felt comfortable and confident to participate in hospital routines.”<sup>46(p.13)</sup> (U)</p>
<p>Illustration</p>	<p>"Father: there's definitely some good ones there. Mother: they'd like to joke around with you and make sure you were alright. Father: they made mom quite happy. Mother: they don't want to pressure us at all. Father: You know, the way they treat us, it's just like human beings."<sup>46(p.14)</sup></p>
<p>Adcock A, Cram F, Edmonds L, Lawton B. He Tamariki Kokoti Tau: Whānau of preterm Māori infants (pāpi) reflect on their journeys from birth to first birthday. <i>J R Soc N Z</i>. 2022;52(S1):57–74.<sup>47</sup></p>	
<p>Finding 1</p>	<p>“Health practitioner champions, like this doctor, became an important part of the lives of whānau, and were remembered for their support long after whānau returned home.”<sup>47(p.567)</sup> (U)</p>
<p>Illustration</p>	<p>"Mother: As soon as they told me baby was sick I did all this, ‘Is this ‘cause I had that, I did this?’ I threw everything at them. ‘Could it be because of this?’... It was doctor [name] that was like, ‘No, look, stop Mum, you gotta stop blaming yourself ‘cause this is not anyone’s fault. You could have had the most perfect pregnancy and then last-minute, boom, your baby’s born with this, so it’s no-one’s fault. You just have to get through this hard step and hopefully with the strength of your family you can get her through this.’ And so that’s why I had to try and retrain my thoughts.”<sup>47(p.567)</sup></p>

Baker C, Daigle MC. Cross-cultural hospital care as experienced by Mi'kmaq clients...including commentary by Biro A and Joe JR with author response. West J Nurs Res. 2000;22(1):8–28.<sup>48</sup>

Finding 1	“On one hand, participants felt that caregivers created understanding by acknowledging and accepting certain cultural differences; on the other, they felt that understanding was created when caregivers ignored social differences by treating them the same as everyone else.” 48(p.20) (U)
Illustration	"To me the hospital care I got was the same as everyone else there. I received no special treatment because I was Indian. As far as I could see we were all treated equally and that is the way it should be." 48(p.20)
Finding 2	“Participants acknowledged and appreciated caregivers who had conveyed a tolerance of family visiting, the native custom that seemed to be particularly problematic for staff but important to participants.” 48(p.20) (U)
Illustration	"I felt they understood that I needed my family around even though there were so many of them. When they visited, they used to all come at once --children, grandchildren, uncles, aunts. But they [the nurses] were very good about this." 48(p.20)
Finding 3	“Participants described caregivers who created understanding as kind.” 48(p.19) (U)
Illustration	"She was so kind to me --she seemed to understand what I was feeling. She was always there for me." 48(p.20)
Finding 4	“Although every respondent had experienced one “bad apple” among the caregivers, they all singled out an individual staff member who made them feel understood.” 48(p.19) (U)

Illustration	"Well, you know, there was one person there that had a heart... she took her time to talk to me... she showed me compassion." 48(p.19)
Brown AE, Fereday JA, Middleton PF, Pincombe JI. Aboriginal and Torres Strait Islander women's experiences accessing standard hospital care for birth in South Australia - A phenomenological study. <i>Women Birth</i> . 2016;29(4):350–8. <sup>49</sup>	
Finding 1	"When the women felt supported they had more positive experiences of their births." <sup>49(p.354)</sup> (U)
Illustration	"When I went into labour and I was screaming and some people, the nurses [midwives] who weren't meant to be checking on me, they'd come in and check on me and stayed with me and they were really good." <sup>49(p.354)</sup>
Finding 2	"When women felt included in what was happening, they reported positive experiences." <sup>49(p.353)</sup> (U)
Illustration	Ella explained: "they were open, they were just open and just talking about what is going on and ... maybe when you are talking about the patient to let the patient in ... which I found was good with the [hospital name] they were open and discussed about, talked about what was going on." <sup>49(p.353)</sup>
Finding 3	"Many of the women were not asked by their midwives about their cultural needs around birth. Shelley was asked and she described how this made her feel respected as a person." <sup>49(p.355)</sup> (U)
Illustration	"The first person that has ever asked about respecting the wishes of my Aboriginal [culture] and I was, I was shocked about it and I was, I was amazed and that was a good feeling. . . Well, I liked it, I was like wow ...I felt so good and it's good to know that somebody is respecting you in that way and if, especially if you're like a native

	woman, for you know, but it's just understanding." <sup>49(p.355)</sup>
Browne A, Fiske J. First Nations women's encounters with mainstream health care services. <i>West J Nurs Res.</i> 2001;23(2):126–47. <sup>50</sup>	
Finding 1	“Validation of self-identity and cultural pride signalled a willingness to listen to the patient and to understand her health within the social and cultural dimensions that she defined as most important to her.” <sup>50(p.141)</sup> (U)
Illustration	"He recognized that I was proud of my culture. He talked about my culture and the positives about the Aboriginal people, the land. He was proud that—he was happy I was going to school, I was doing well. I talked about my goals and things like this to him. ... And he encouraged me. And that's what I liked, eh?" <sup>50(p.141)</sup>
Finding 2	“Affirming encounters frequently arose out of long-term, positive relationships with family doctors or community health nurses. Participants recognized the value of having a stable provider whom they trusted.” <sup>50(p.141)</sup> (U)
Illustration	“I was getting bumped around and seeing whatever doctor was available at the clinic. Until I finally got hold of a doctor that I thought we could work something out with, and I asked him to be my doctor. And that's who I just see now, all of the time. And he was kind of shocked that anybody would ask. I guess they just have to take whoever they're given. But I wanted a better relationship.” <sup>50(p.142)</sup>
Finding 3	“Being able to speak openly and to participate in health care decisions through sharing knowledge and power were seen as extremely important.” <sup>50(p.139)</sup> (U)

Illustration	"There was no time limit, and she helped me to become more in control of my own health, which was the big thing. So I didn't feel uncomfortable asking questions or [saying] okay, well no, I don't want to do that, can you try something different? ... I wasn't just a piece of meat." <sup>50(p.139)</sup>
Finding 4	"Participants shared stories of health providers who demonstrated an outstanding ability to convey a caring attitude." <sup>50(p.139)</sup> (U)
Illustration	"When my husband died, my doctor phoned me to tell me to come in to talk with him and see if I was okay and [talk about] things that happened. ... And he explained it to me really softly; things like this happen. He was really caring. And that was the best thing that ever happened to me was him phoning me on his own to tell me that." <sup>50(p.140)</sup>
Burns L, Whitty-Rogers J, MacDonald C. Understanding Mi'kmaq Women's Experiences Accessing Prenatal Care in Rural Nova Scotia. <i>ANS Adv Nurs Sci.</i> 2019;42(2):139–55. <sup>51</sup>	
Finding 1	Respect for cultural beliefs and traditions. "Josie explained how her cultural beliefs and traditions were respected..." <sup>51(p.151)</sup> (U)
Illustration	"I found at the hospital here they're very open and embrace our differences. There was no limit to how many people in the room when I was in labour. Which, I know, you know, they don't allow for everyone but it's important for us. Just very respectful" <sup>51(p.151)</sup>
Butler TL, Lee N, Anderson K, Brotherton JML, Cunningham J, Condon JR, et al. Under-screened Aboriginal and Torres Strait Islander women's perspectives on cervical screening. <i>PloS One.</i> 2022;17(8):e0271658. <sup>52</sup>	
Finding 1	"Sensitive HCP communication and empathetic, trauma-informed care was central to one woman's recent positive experiences of screening after a 24-year

	interval following experience of sexual violence.” <sup>52(p.10)</sup> (U)
Illustration	"[The nurse] was just so in tune. She actually explained to me, “Okay, so when the apparatus hits that part of your cervix, it’s going to send all sorts of messages to the brain. It’s not going to know what to do with it.” I was, “Is that what’s happening.” [. . .] She gave me some breathing techniques, she actually told me where [the speculum] was positioned. [. . .] and I took my partner with me, and she didn’t care. I’m like, “My partner is coming in.” “Yes, that’s fine.” <sup>52(p.11)</sup>
Finding 2	“Trusting relationships were very important to women, and many had searched hard to find a HCP they could trust.” <sup>52(p.8)</sup> (U)
Illustration	“I guess for a very long time to be honest, I doctor shopped if they started raising the subject with me, it was, oh, time to find a new doctor. Because I didn’t want to have to tell them all the time that this [childhood sexual violence] is why I don’t have them done. So I just would jump from doctor to doctor then when I [. . .] started seeing the doctor regularly and [. . .] built that trust, I was then able to tell her, and she had a really good understanding, so I stopped doctor shopping.” <sup>52(p.8)</sup>
Churchill ME. Defining and evaluating cultural safety at Seventh Generation Midwives Toronto: Exploring urban Indigenous women’s perspectives on culturally safe maternity care. [internet]. 2015 [cited on 2022 November 1]. <sup>53</sup>	
Finding 1	“For the women who did not know what to ask for, IK &P [Indigenous Knowledge & Practice] was only included in their care when the midwives offered it to them, or directed them towards the appropriate resources.” <sup>53(p.119)</sup> (U)
Illustration	"It wouldn’t have been something that we would have asked. Whereas my midwife

	just took it upon herself to say, “hey do you wanna smudge?” and we’re like “yeah, that’s great, like we didn’t even know that was an option” because of, you know, you’re in a hospital.” <sup>53(p.119)</sup>
Finding 2	“Some of the women told stories about how their midwives advocated for them in mainstream health care context (e.g. in hospital, with doctors) when their autonomy was threatened or taken away.” <sup>53(p.105)</sup> (U)
Illustration	"She was able to be my advocate when I was unable to like... I guess I wasn't expressing myself like... in a way that the doctor was understanding. So she was able to like be in my corner and be like “no, she doesn't actually have to do this. Like she's not... there's nothing indicating that she needs to be in this position.” So because of that, she kind of gave me... the strength to continue to be my own advocate even when she wasn't in the room.” <sup>53(p.106)</sup>
Finding 3	“Many of the women voiced their desire to have a deep, personal, kin-based, and/or reciprocal relationship with their midwife.” <sup>53(p.111)</sup> (U)
Illustration	"So when you met with them (the midwives), it's just, they're more... I guess they're looking at you as more than as a number, or like a health card number, or whatever... with the midwives, I found the biggest difference was they were talking to me as a person.” <sup>53(p.111)</sup>
Finding 4	“When the women were told what was happening and what they should expect in ways that were easy to understand, they regained their sense of control, their confidence, and their ability to manage uncertainties.” <sup>53(p.113)</sup> (U)
Illustration	"She [primary midwife] explained to me what was going to happen... it was good to

	have her in [the operating room], explaining in normal terms what was happening to my body." <sup>53(p.114)</sup>
Finding 5	"In emotionally or mentally stressful situations, the women looked to their midwives for guidance. There were many stories that emphasized the importance of the midwives being present in the stressful situations to calm the women down and make them feel comfortable." <sup>53(p.113)</sup> (U)
Illustration	"I was at a place where I didn't want to be giving birth, cuz she was coming early. I was, you know, emotional about it. I was in the hospital and really didn't want to be in the hospital, and...she was just there emotionally for me, that she just provided such great emotional support." <sup>53(p.113)</sup>
Finding 6	"All of the women wanted their midwives to respect them as individuals and honour their diversity." <sup>53(p.106)</sup> (U)
Illustration	"I told her I didn't want to breastfeed, and she respected that instead of constantly, "you gotta breast feed, you gotta breast feed." <sup>53(p.106)</sup>
Finding 7	"When the midwives supported the women in their choices and did not make assumptions, the women felt comfortable and respected." <sup>53(p.105)</sup> (U)
Illustration	"She was so easy to relate to, so easy to talk to, and she didn't make me feel bad about any of my past and I've done some... I'm an ex-drug addict, prostitute slash, you know? [Laughs]... But she... that never phased her." <sup>53(p.105)</sup>
Finding 8	"For some women, having a midwife that approached the entire care experience with a positive attitude and outlook was highly important." <sup>53(p.106)</sup> (U)

Illustration	"With my midwife, she was always positive, and that's one thing that I always look for when talking to her because I know she'd always have a positive feedback or just – she was really positive and sincere, right? She didn't always have a negative attitude." 53(p.106)
Finding 9	"When the women felt that they had enough time to establish trusting relationships with their midwives and obtain knowledge without being made to feel guilty or rushed, they felt more comfortable and safe in their care." <sup>53(p.107)</sup> (U)
Illustration	"Like they actually took the time to... get to know you and your family situation and your concerns and the appointments are... there's lots of time for questions that I had." 53(p.107)
Cook C, Clark T, Brunton M. Optimising cultural safety and comfort during gynaecological examinations: Accounts of Indigenous Māori women. <i>Nurs Prax N Z</i> . 2014;30(3):19–34. <sup>54</sup>	
Finding 1	"Additional time was also needed early in the relationships in order for women to feel safe to divulge. A young woman described the power of a nurse's sharing." <sup>54(p.24)</sup> (U)
Illustration	"She [nurse] talks about her life as well... and then we'll be talking to her about our kids and we can relate mother-wise... she can just talk about anything." <sup>54(p.24)</sup>
Finding 2	"Connections between women and clinicians who had consistently provided care were spoken about by women as part of an extended kinship." <sup>54(p.24)</sup> (U)
Illustration	"I recommend this clinic to everyone and because... they make you feel comfortable and you grow a close relationship with the staff...[nurse] and [nurse], they're both mothers and you feel comfortable because you're a mother and they make you feel

	comfortable with your body and you feel like you can open up to them about anything. We've been coming here since we were sexually active so we have a close bond with them, we can talk to them on the street and feel comfortable seeing them and they're always lovely and nice and want to know how we are. So we keep coming back." <sup>54(p.24)</sup>
Finding 3	"Clinicians who prioritized communication made substantial differences to women's experiences." <sup>54(p.24)</sup> (U)
Illustration	"She also invited me – whether I wanted a full sexual history and then a full sexual check and so I thought why not, part of the experience and the only reason I said yes to that was because she had established that relationship and we had some sort of rapport going." <sup>54(p.25)</sup>
Finding 4	"In practice cultural safety means demonstrating trustworthiness, compassion and hospitality." <sup>54(p.23)</sup> (U)
Illustration	"The trust for them, mainly the reason was that I felt welcome and safe.... also, since I'm a younger person, they [nurses] also took consideration of that and they didn't treat me like a little kid.... they just seemed really friendly and really warm and they were joyful...and when they talked to me it felt like they put all the attention on me, not anything else.... I had their attention when I needed it and if anything would go wrong they would be there for me and that they would look after me and be there to help me for any reason" <sup>54(p.23)</sup>

Fretts JM. A phenomenological analysis of the White therapist and American Indian client dyad: Common factors, cultural competence, cultural humility, and microaggressions. ProQuest Dissertations Publishing. 2016.<sup>55</sup>

Finding 1	“Participants also appreciated having their experiences acknowledged.” <sup>55(p.56)</sup> (U)
Illustration	“She was very genuine. She challenged me. She acknowledged what I’d been through, what I had accomplished up to this point, my addiction, and where I came from.” <sup>55(p.56)</sup>
Finding 2	“Several participants also reported feeling understood by White therapists and were able to verbalize that they felt were important components to feeling understood... openness and validation.” <sup>55(p.55)</sup> (U)
Illustration	“I had another therapist for a DUI. She was a White, older female, who was new to the reservation. I told her a lot of things when I would visit with her and it wasn’t too hard to share with her. She was very understanding and accepting of what I was going through, which made me feel glad that I had somebody to vent to.” <sup>55(p.55)</sup>
Finding 3	“Several participants verbalized that they would have liked to incorporate traditional American Indian practices into their therapy.” <sup>55(p.53)</sup> (U)
Illustration	"He was White. The good thing for me was that he ran a sweat lodge, he knew people from my reservation. They [tribal spiritual leaders] showed him how to run a sweat lodge. He knew a lot about my tribe. He knew more about my own tribe’s ceremonies than I did. I really liked that. The sweat lodge was every week and that was part of the treatment. I guess my overall experience with that was great. It was really, really great. It was life changing, honestly." <sup>55(p.53-54)</sup>

Gott M, Wiles J, Mason K, Moeke-Maxwell T. Creating safe spaces: A qualitative study to explore enablers and barriers to culturally safe end-of-life care. *Palliat Med*. 2023;37(4):520–9.<sup>56</sup>

Finding 1	“A pair of sisters talked about the care preferences their mother had for their father. This included a preference for Māori nurses, especially those with a whakapapa (genealogical) connection to their whānau.” <sup>56(p.5-6)</sup> (U)
Illustration	"Sister 1: If there was a nurse coming in, there was a preference that it was a Māori nurse." <sup>56(p.6)</sup>
Finding 2	“Non-indigenous allies could provide support to create safe spaces and resources.” <sup>56(p.6)</sup> (U)
Illustration	"A few years ago my brother. . . passed on. One of the things that I remember quite distinctly was the fact that. . . his specialist came and mihi'd (greeted, acknowledged) the family. Beautiful. And he let all the whānau know where he was at, what was happening. . . I think he had a love for Māori culture. And he knew how everyone was feeling, all the family was feeling. But to have him come in ... and I will never forget those last words, 'I'm here to make his passing as seamless as possible'. And so that, that's really wonderful. . . Ah, he was Pākehā. . . Not too many specialists will actually come do a personal home visit." <sup>56(p.6)</sup>

Hohl S, Molina Y, Koepf L, Lopez K, Vinson E, Linden H, et al. Satisfaction with cancer care among American Indian and Alaska Natives in Oregon and Washington State: a qualitative study of survivor and caregiver perspectives. *Support Care Cancer* 2016;24(6):2437–44.<sup>57</sup>

Finding 1	“Similar to other minority groups with communalistic values, involving family members emerged as an important factor in
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	how care providers increased satisfaction and helped ease the burden.” <sup>57(p.2441)</sup> (U)
Illustration	“The doctors here in town were just wonderful, and they all said, If any of your family has questions, just give them our number and what hours we’re in. My daughter always had more questions than I did, because you get where you can’t think. You know what you wanted to ask. By the time you get there you done forgot it.” <sup>57(p.2441)</sup>
Finding 2	“The survivors and caregivers further widely reported that care providers’ empathic communication practices contributed to satisfaction.” <sup>57(p.2440)</sup> (U)
Illustration	“A lung cancer survivor relayed his experience, reporting, “The nurses up there and radiation and the whole crew there were very friendly and, you know, talk to you all the time, you know, and it made you feel like somebody cared.” <sup>57(p.2441)</sup>
Finding 3	“Regardless of their initial level of understanding of cancer care, the survivors and caregivers who were satisfied with care said their care providers mitigated this multi-level burden by offering informational support and building health literacy.” <sup>57(p.2440)</sup> (U)
Illustration	“The doctors really made a big difference. They worked to break it down into terms that we could understand, and it was really reassuring as far as how the outcome would be, and it just felt he really cared about his patients. It just made us feel better, and he was very confident in how he talked to us, and it just felt really good that he was on our side.” <sup>57(p.2440)</sup>
Finding 4	“Providers’ ability to listen and invite questions, thereby involving respondents as decision-makers in their own treatment,

	emerged as a key element for satisfaction.” 57(p.2440) (U)
Illustration	"My doctor, he was really good and he showed me three different plans I could follow and gave us great statistics for each plan. And even though we took the more lengthy route, there was a better chance of survival rate than the other routes."57(p.2440)
Finding 5	“Provider awareness and comfort with AI/AN (American Indian and Alaska Natives) cultural healing traditions was an important influence on satisfaction.”57(p.2441) (U)
Illustration	“I told them I needed my eagle feather hanging from my IV thing, and he asked me what it was for and I says, ‘Well, the eagle feather is my protection. It’s my power, my healing.’ So he understood that.” 57(p.2441)
Hole RD, Evans M, Berg LD, Bottorff JL, Dingwall C, Alexis C, et al. Visibility and voice: Aboriginal people experience culturally safe and unsafe health care. <i>Qual Health Res</i> 2015;25(12):1662–74. <sup>58</sup>	
Finding 1	“Being visible and being acknowledged as Aboriginal in the health care relationship promoted a sense of cultural safety.”58(p.1666) (U)
Illustration	"If I stayed later than the regulation time nobody ever said anything and I didn't stay longer than maybe half an hour or so. I was up at the hospital when a friend was dying and there was mega Native people there and nobody complained. We were in the hallway and in the room, and nobody complained. In fact the nurses' station was just right there and they told us where we could go to get a cup of coffee, if we wanted to get a coffee or something to drink, whatever. They were really good. I was really impressed."58(p.1666)

Finding 2	“Some individuals framed their positive health care experiences in ways that reflected the importance of being treated like others, rather than as someone who was different.” <sup>58(p.1666)</sup> (U)
Illustration	"But you know, they knew I was Aboriginal and they didn't treat me any different than anybody else on the ward." <sup>58(p.1666)</sup>
Finding 3	“Participants’ positive interactions focused on being "treated well" and "respected" by staff who were particularly attentive and responsive.” <sup>58(p.1666)</sup> (U)
Illustration	"They respected him. they were, any little thing that he had happening to him, they were on it right away when he was in the hospital.” <sup>58(p.1666)</sup>
Finding 4	“The importance of respect for families and their ceremonies.” <sup>58(p.1666)</sup> (U)
Illustration	"When my mom passed on I thought it was just great that staff members had let us do smudging in the room she was in [and] that we didn't have to go some place else. And they respected what we wanted to do." <sup>58(p.1666)</sup>
Jensen-Ross C. Cervical screening among Southern Alberta First Nations women living off-reserve. 2006. Lethbridge, Alberta: University of Lethbridge, School of Health Sciences. <sup>59</sup>	
Finding 1	“One participant shared her admiration of the collaborative, seamless approach experienced by her grandmother.” <sup>59(p.113)</sup> (U)
Illustration	"The community was very small, so the doctor was almost like a part of the family.... He thinks of my grandma like his grandma. When he looks after her, it's like looking after his own family ... so the care was very, very good.... He made sure that when they sent her out [of the hospital]

	everything was explained to her and [he] gave her a call at home." <sup>59(p.113)</sup>
Finding 2	"The need for simple, non-medical, easily understood language and pictorial representations was reinforced." <sup>59(p.111)</sup> (U)
Illustration	"It's really good because [my doctor will] even do a drawing.... [For example, when discussing contraceptives, my doctor explained] 'The blood vessel is like this, so if you had a clot... it makes a thickening in the blood vessel.' She really explains it to you so that you don't walk out of there still wondering, you know." <sup>59(p.112)</sup>
Finding 3	"Another young woman spoke of participating as an active and respected member of the health care team during the hospitalization of a young relative." <sup>59(p.110)</sup> (U)
Illustration	"I got to stay with her in the hospital for the two weeks that she was there and they treated me with [respect].... They [had] a portable phone that people could call. I stayed there for two weeks ... they gave me all the information so I was able to pass that information.... They even brought a mat, but I slept with her in her bed." <sup>59(p.110)</sup>

Laczko D. Focus on First Peoples, first thousand days: Cultural safety from the perspectives of select Aboriginal women in Regina Saskatchewan. [Internet]. 2016 [cited on 2022 November 1].<sup>60</sup>

Finding 1	"HCPs (health care providers) at the community health centre provided advocacy for participants in their interactions with these other agencies and this was important to the participants and to their relationships with HCPs." <sup>60(p.31)</sup> (U)
Illustration	"She said that if child protections, because I've been coming to the programs and they see that I'm doing good, she's like a support for me like when, because there will,

	because of my previous history dealing with child protections, they will come and talk to me after baby is born and that's what she said, she'll like help me, to make sure I understand, that I'm not just signing random papers, that I know what's going on and like if there's no reason for them to take baby then she'll make sure she'll speak up for me, and like help me." <sup>60(p.31)</sup>
Finding 2	"Several participants discussed how it was important to them to get to know a health care provider and to develop a personal relationship with them." <sup>60(p.30)</sup> (U)
Illustration	"It felt like really warm and welcoming and I noticed that each and every time I came back like the staff remembered my name and were like 'oh how is baby' and you know 'how's the boys' and like 'how's things going' and just slowly just developed a relationship I guess." <sup>60(p.30)</sup>
Finding 3	"Reassurance was provided in the form of a supportive presence from a caring person. It was reassuring to know that they had somewhere to go and someone to trust if they had any problems especially with their new babies." <sup>60(p.31)</sup> (U)
Illustration	"It's really good. She's totally, she seemed like really understanding about everything. Because when my first appointment with her, you know that whole process, and they were like, I don't know, no judgment or nothing like that. I didn't feel uncomfortable at all." <sup>60(p.31)</sup>
Finding 4	"The participants described feeling well cared for when they were able to have all their questions answered. It was important that staff asked the women if they had any questions or concerns and then were willing to respond." <sup>60(p.30)</sup> (U)

Illustration	"He's a really good doctor. Like he'll check baby, check baby's heartbeat, tell me what's going on. He asks me how I feel, he , if I ask him, he does the check up more better, like he checks more thoroughly, and he does the things that he says he's going to. Yeah and he asks me if I have any concerns. He'll go over it with me." <sup>60(p.30)</sup>
Lipsett N. Mindful bridging: A pathway to culturally competent care delivery. 2007. ProQuest Dissertations Publishing. <sup>61</sup>	
Finding 1	Issues of trust were addressed by demonstrating care for the Indigenous community. "A non-Native doctor is trusted for having demonstrated care, partly by learning the names of many children in the community." <sup>61(p.200)</sup> (U)
Illustration	"And this family doctor ... knows everybody in town, probably because 2,000 [of his] patients are children. And he has to know them all by name. [...] So, it's pretty interesting." <sup>61(p.200)</sup>
Finding 2	"Communicating cross-culturally is more than a dialogue between individuals... It is an attempt to convey particular meaning, meaning that finds validity in a particular cultural context." <sup>61(p.237)</sup> (U)
Illustration	"Often when things work well in regards to non-native people being involved with native ... whatever it might be, is that they take a back role position. They're not out there in the front and they have an attitude of humility about it and ... respect. So, you know, they may not be out in the foreground ... they try to encourage native people to be out in the foreground and to support them." <sup>61(p.239)</sup>
Finding 3	Bridging between cultures through accommodating Indigenous beliefs and healing practices. <sup>61</sup> (U)

Illustration	<p>"And it's more than the native way of doing things. It comes back to the circle. You know it's not like ... God has decided re-doing things, this hierarchy; that you're the expert, not the counselor or doctor or whatever it is. You know, that person is not the expert... [The doctor's] premise is that people heal themselves; the body heals itself and people heal themselves.... You're just there to create the conditions for it and to ...introduce people to different things. Whether it's acupuncture or herbs or therapy or yoga, or some sort of spirituality.... They would be healing themselves which fits in very well, I think, with what I know in regards to... the native practice."<sup>61</sup>(p.210)</p>
Finding 4	<p>"Listening differently can be a difficult challenge because much listening tends to be an unconscious, passive activity... In these instances, practitioners tend to unconsciously succumb to the particular and conditioned listening skills appropriate to the context."<sup>61</sup>(p.251) (U)</p>
Illustration	<p>"I think that they have to learn how to listen.... They're always so busy. They want things, like, oh this is this, and they never really listen to you. That maybe they should stop and listen ... maybe to open their minds up so that they can hear the words and see the words."<sup>61</sup>(p.252)</p>
<p>Lottis K. Engaging the liminal: Indigenous perceptions within the healthcare system. 2011. ProQuest Dissertations Publishing.<sup>62</sup></p>	
Finding 1	<p>Trusted providers were willing to take the time needed to discuss a medical situation. "This sense of being respected and heard by providers who were willing to take the time and review tests, to actually sit and discuss a medical situation and offer counselling arose repeatedly."<sup>62</sup>(p.99) (U)</p>

Illustration	<p>“He took the time to like sit down and, "Let's go over this" and then he'd take the information ... like go into his office ... and he'd take all kinds of information, put it in his thing, check Internet if he had to, pull out books, and I could feel important sitting in his office. Then he'd say, ‘OK, let's go do a check-up.’ We could be in his office for an hour — like until we were done. Then he'd say ‘OK, I think we're done here.’ ... instead of just getting up and saying ‘See you.’”<sup>62(p.99)</sup></p>
Finding 2	<p>Trusted Providers were willing to help as needed and regularly participated in community events. “Multiple accounts shared the implicit trust with which those living on-reserve spoke of one particular outpost RN, who had many years of experience serving remote communities.”<sup>62(p.101)</sup> (U)</p>
Illustration	<p>"She was described as always attentive to the needs of the people, and was respected in return for her skill as an RN. Examples given included her willingness to drive her boat across the bay to the village for emergencies, explain to patients or family members when there was confusion regarding a diagnosis or treatment plan, advocate for some with the physicians, and perhaps most importantly show respect by regularly participating in community events such as potlatches and other celebrations.”<sup>62(p.101)</sup></p>
<p>Ludeke M, Puni R, Cook L, Pasene M, Abel G, Sopoaga F. Access to general practice for Pacific peoples: a place for cultural competency. <i>J Prim Health Care</i> 2012;4(2):123–30.<sup>63</sup></p>	
Finding 1	<p>“Building relationships with Pacific patients was important in overcoming language barriers.”<sup>63(p.125)</sup>(U)</p>
Illustration	<p>"At the beginning of [my mother's] relationship with her GP, you know, they</p>

	had, there's a language barrier... as the years, went by, like my mum would go to the doctor's and they know straight away what she was there for... so, yeah, I think the doctor's helped to break down the barrier." <sup>63(p.125)</sup>
Finding 2	"Spending time with the patient was viewed as an indicator of quality of care, and important in developing rapport." <sup>63(p.126)</sup> (U)
Illustration	"The doctor that they gave me yesterday, he was really good... we talked about other things that had nothing to do with anything, but we just we connected really well and he was really good." <sup>63(p.126)</sup>

Maar MA, Erskine B, McGregor L, Larose TL, Sutherland ME, Graham D, et al. Innovations on a shoestring: a study of a collaborative community-based Aboriginal mental health service model in rural Canada. *Int J Ment Health*. 2009;3:27.<sup>64</sup>

Finding 1	"Of great important to many [participants] was provider acceptance of clients' beliefs, religions, backgrounds, and history, and a focus on building on the strengths of Aboriginal people." <sup>64(p.9)</sup> (U)
Illustration	"Living on the reserve is a different way of life...a different way of thinking. Maybe some needs are different. A lot of people I talked to in the past who were counsellors that hadn't worked for Mnaamodzawin or Noojmowin. - they didn't understand certain things that seems like it's a part of your life when you're on the reserve. It's a different way of thinking. A different way the whole community deals with things. These two [Knew Chi Ge Win] counsellors understand that; it's not even an issue." <sup>64(p.9)</sup>

Moeke-Maxwell T, Collier A, Wiles J, Williams L, Black S, Gott M. Bereaved families' perspectives of end-of-life care: Towards a bicultural whare Tapa Whā older person's palliative care model. *J Cross Cult Gerontol*. 2020;35(2):177–93.<sup>65</sup>

Finding 1	"Health care delivery that had a strong focus on supporting the emotional well-being of
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	the older person was considered important.” <sup>65(p.184)</sup> (U)
Illustration	"It was just people taking a bit of time; I know they're nursing or they've got to do caring, but, for me, that made the difference for her because she knew that they weren't going to fly in and fly out" <sup>65(p.184)</sup>
Finding 2	“Families appreciated being involved in health care planning initiatives.” <sup>65(p.183)</sup> (U)
Illustration	"[Name of health professional] had a health plan which he had developed from a template for [Mum] and it was very clear the steps that had to be gone through... he actually produced something which was followed... a layperson could follow as well, such as myself not [knowledgeable] in that particular area.” <sup>65(p.183)</sup>
Finding 3	“Good physical care also included the physical health care environment and infrastructure as medical places were transformed into cultural and spiritual spaces that helped families carry out their care practices and death customs.” <sup>65(p.187)</sup> (U)
Illustration	"Yes, we had mattresses on the floor... and the sisters, the mokos [great/grandchildren], they had the guitar and they were singing. That’s why I loved those people up there and she was at the end. Because, I said to one of them [staff]... I said, “Is that alright?” She said, “Look, up in this wing they’re deaf anyhow, it’s all right.” I went, “Oh, kia ora” [thank you]. Our kids were running up and down - they [residents] couldn’t hear. It was lovely having the mattresses in [there]” <sup>65(p.187-188)</sup>
Finding 4	“Health care delivery that had a strong cultural and spiritual health care focus

	appeared to support older people and their families.” <sup>65(p.185)</sup> (U)
Illustration	"She arranged this room and came to see [Ani] a lot and arranged for this lady...to come in with her children, grown up of course, and to be with [Ani] quite a lot and when [Ani] was very low. They sang karakia [prayers, incantations, chants], waiata [songs]... and said prayers. [Ani] seemed to be thinking a lot in terms of Māori traditions and culture, and so when this family came in and people were with her that was good for her... I know she got a lot out of it, and that was good and I was very pleased for that reason.” <sup>65(p.186)</sup>
Monchalin R. Digging up the medicines: Urban Metis women’s identity and experiences with health and social services in Toronto, Ontario. 2019. ProQuest Dissertations Publishing. <sup>66</sup>	
Finding 1	“The women shared how service providers at SGMT (clinic) were non-judgmental and compassionate.” <sup>66(p.103)</sup> (U)
Illustration	“They’re so women centered, they’re so client centered and non-judgmental and supportive ... even when I told them... I smoke cigarettes and I’m having a really, really hard time even cutting down. I didn’t feel an ounce of judgement ... where I know that if I had an OB, some of them would say, you can’t be my patient because of something like that, right?” <sup>66(p.103)</sup>
Pearce ME, Jongbloed K, Demerais L, MacDonald H, Christian WM, Sharma R, et al. “Another thing to live for”: Supporting HCV treatment and cure among Indigenous people impacted by substance use in Canadian cities. <i>Int J Drug Policy</i> 2019;74:52–61. <sup>67</sup>	
Finding 1	“Safe attitudes were demonstrated by doctors who respected patient autonomy and held non-judgmental, strengths-based perspectives on substance use.” <sup>67(p.56)</sup> (U)
Illustration	"The doctor, she's amazing. I'd like to have her as my doctor till the day I die. She's so

	understanding and she'll speak to me in ways that I understand. She's so supportive, no matter what the decision is that I do. She'll support it, support you. 'I may not like some of your decisions, but I'll always be there for you'." <sup>67(p.57)</sup>
Seear KH, Spry EP, Carlin E, Atkinson DN, Marley JV. Aboriginal women's experiences of strengths and challenges of antenatal care in the Kimberley: A qualitative study. <i>Women Birth</i> . 2021;34:570-577. <sup>68</sup>	
Finding 1	"Some women spoke of their non-Aboriginal care provider demonstrating cultural awareness, which contributed to women feeling comfortable." <sup>68(p.572)</sup> (U)
Illustration	"She has worked up here and understands the Aboriginal people and their culture." <sup>68(p.572)</sup>
Finding 2	"The importance of positive relationships... was prominent in the participant's stories. Women appreciated antenatal care providers who were friendly, "nice to talk to", caring, and allowed sufficient time during appointments." <sup>68(p.572)</sup> (U)
Illustration	"The Dr [Name] was great. She gave me time and made me feel comfortable." <sup>68(p.572)</sup>
Slater TM. The role and potential of community based cancer care for Maori in Aotearoa/New Zealand: A thesis. [internet]. 2016 [cited 2023 Apr 1]. <sup>69</sup>	
Finding 1	Importance of a positive and long-term GP and patient/whānau relationship. "One patient described an extensive medical history and swift referral from her GP when she had cancer symptoms." <sup>69(p.154)</sup> (U)
Illustration	"Same GP, yeah. She has got two files that thick. And she was the one that um, when I first was diagnosed she sent me to a specialist. So there was no shilly shallying." <sup>69(p.154)</sup>

Strobel N, Moylan C, Durey A, Edmond K, McAuley K, McAullay D. Understanding an Aboriginal and Torres Strait Islander child's journey through paediatric care in Western Australia. *Aust N Z J Public Health*. 2020;44(2):95–101.<sup>70</sup>

Finding 1	“Participants also expressed that AACC staff had done all they could, were culturally appropriate and sensitive, liaised with their Aboriginal health teams, ensured participants were kept informed and provided the best possible care by being responsive and caring.” <sup>70(p.100)</sup> (U)
Illustration	“Only because of the history I’ve got with the doctor and the girls; they know my girl off by heart so and they are so, cause the Aboriginal health team are so, they know how to work with Aboriginal kids and my child knows them and they go all out, they don’t just do your crappy little appointment. They go all out so that’s what I like.” <sup>70(p.100)</sup>

Tipa Z. Mahi Ngatahi: Culturally responsive ways of working with whānau accessing well child/tamariki ora services. [internet]. 2021 [cited 2023 Apr 10].<sup>71</sup>

Finding 1	“Being included refers to the ways whānau see themselves within a service and are involved in the decision-making processes.” <sup>71(p.119)</sup> (U)
Illustration	"I felt like she could understand my views, asked me what I wanted and gave me steps, and like my concerns, were heard and not like oh ok we’ll just leave that, she was like ‘ok, we’ll just do this and this, how does that sound?’ gave me directions and into the right direction and I really liked her.” <sup>71(p.120)</sup>
Finding 2	“Feeling connected... represents the relationships required for culturally responsive ways of working with whānau.” <sup>71(p.117)</sup> (U)
Illustration	"When they took the time out to actually have those conversations about me and what I think. That just tells me that they are

	interested in getting to know who I am as a parent.” <sup>71(p.118)</sup>
Finding 3	“Feeling safe consists of... service humility, understanding power sharing and creating opportunities for feedback and change.” <sup>71(p.122)</sup> (U)
Illustration	“I think if you want to glean as much information in terms of baby’s progress and development and what whānau are doing then you need to have a really good relationship with the wahine that you’re working with so they can speak freely and they’re not restricted ... not hiding stuff.” <sup>71(p.123)</sup>
Wiebe A, Young B. Parent perspectives from a neonatal intensive care unit: A missing piece of the culturally congruent care puzzle. <i>J Transcult Nurs.</i> 2011;22(1):77–82. <sup>72</sup>	
Finding 1	“The strongest theme that emerged from the interviews with parents was the importance of feeling that NICU staff and physicians genuinely cared about their infant.” <sup>72(p.79)</sup> (U)
Illustration	"We had one doctor and she was so wonderful. After they would do their assessment of the baby, she would turn to me and explain everything in plain English, and we really appreciated it. She would even come during the day if we had an issue or something, she would come see us immediately.” <sup>72(p.80)</sup>
Williams PN, Gray MA, Ka’ai TM, Moorfield JC, McPherson KM, Weinstein P, et al. Maori men’s perceptions and experiences of health seeking for prostate health problems in New Zealand. <i>Pac Health Dialog.</i> 2003;10(2):71–8. <sup>73</sup>	
Finding 1	“Developing a good personal rapport and understanding was also seen as important. Displaying an interest in the whanau (family) and personal life was described as a way of establishing rapport.” <sup>73(p.76)</sup> (U)

Illustration	"He's quite good, and he's very open. He just doesn't talk about the medical thing. He talks about the family." <sup>73(p.76)</sup>
Finding 2	"Participants suggested that they and their family felt more comfortable when dealt with by Māori health professionals because of the cultural understandings they share." <sup>73(p.76)</sup> (U)
Illustration	"I felt more comfortable with her than the Pakeha one. It happens all the time. If you are in hospital and a Māori nurse comes up, you feel more at home because you express your feelings." <sup>73(p.76)</sup>
Wilson D. The significance of a culturally appropriate health service for Indigenous Māori women. <i>Contemp Nurse</i> . 2008;28(1–2):173–88. <sup>74</sup>	
Finding 1	"The diverse experiences and influences Māori are exposed to highlights the need for nurses to reject adopting a universal approach." <sup>74(p.181)</sup> "Some Māori women noted how a change toward universal approaches missed their culturally related needs." <sup>74(p.182)</sup> (U)
Illustration	"Nurses used to do 'things', but they do not do these now. The 'things', such as old values and practices, contribute to spiritual well- being." <sup>74(p.182)</sup>
Wright AL, Ballantyne M, Wahoush O. Caring for Indigenous families in the neonatal intensive care unit. <i>Nursing Inq</i> . 2020;27(2):e12338. <sup>75</sup>	
Finding 1	"Building relationships with their infants' nurses in the NICU was repeatedly emphasized by mothers as important to their feeling safe and cared for... One mother shared how effective communication skills and a non-judgmental attitude facilitated building a relationship with her family." <sup>75(p.4)</sup> (U)
Illustration	"He's great—he explains things. He's informative and very helpful. It's not like you're in and you're out. It's most like you're

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	in—let's try to spend this time to talk about the kids, let's talk about you. Is there anything I can do, is there anything that you have questions about?" He doesn't look at me like a young mom." <sup>75(p.4)</sup>
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## **Chapter Four: Understanding of Cultural Safety through Systematic Review and Relational Inquiry**

### **Introduction**

Indigenous health and health care inequities are central concerns for nurse practitioners (NPs). The enduring impact on Indigenous peoples of intergenerational trauma that resulted from harmful colonial policies, including Residential Schools, the Sixties Scoop, and Indian Hospitals, is profound (Truth and Reconciliation Commission of Canada, 2015). As a result of colonial violence, policies, and practices, Indigenous peoples score lower on numerous indicators of health (Allan & Smylie, 2015; Kim, 2019; Public Health Agency of Canada, 2018). Indigenous peoples have lower life expectancy (up to 12 years lower) than non-Indigenous people, higher rates of infant mortality, accidental injury mortality, and suicide mortality than non-Indigenous people, and a higher prevalence of chronic conditions such as arthritis, asthma, diabetes, disability, obesity, and tuberculosis when compared to non-Indigenous people (Public Health Agency of Canada, 2018). These differences in health status are known as health inequities, defined as “systematic, socially produced (and therefore modifiable) and unfair” (Whitehead & Dahlgren, 2006, p. 2).

Health inequities for Indigenous peoples are further compounded by culturally unsafe care (Goodman et al., 2017; Hamed et al., 2022; Turpel-Lafond, 2020). In 2008, Brian Sinclair, an Indigenous man, waited 34 hours in a hospital waiting room to be seen for a urinary tract infection but died while waiting to receive care (Brian Sinclair Working Group, 2017). In 2015, Keegan Combes, a 29-year-old Indigenous man who lived with disabilities, suffered from accidental poisoning (First Nations Health Authority, 2022). Health care providers made certain assumptions about the reasons that he presented to the hospital that day (First Nations Health

Authority, 2022) and unfortunately, neglected to diagnose methanol poisoning, despite confirmation from a urinalysis, which led to his death (First Nations Health Authority, 2022). In 2020, Joyce Echaquan, a 37-year-old Indigenous woman and mother who sought health care for ongoing medical issues, was able to video record the demeaning and culturally unsafe care she experienced and posted it on social media just before she died in the hospital (Kamel, 2021).

In addition to the numerous high-profile media cases in Canada demonstrating the widespread existence of culturally unsafe care, there are many Indigenous peoples whose stories have not been as widely heard (Truth and Reconciliation Commission of Canada, 2015; Turpel-Lafond, 2020). Health care professionals need to recognize and acknowledge that culturally unsafe health care experiences kill Indigenous peoples, a fact that demonstrates the resounding need to adopt a culturally safe approach to health care.

Cultural safety is a promising approach to address culturally unsafe care experienced by Indigenous peoples. In an effort to assist NPs in implementing culturally safe care in practice, this paper presents a mnemonic tool. This mnemonic was designed to furnish a way for NPs to consider culturally safe care and strengthen their capacity to provide that care in different health care situations. This mnemonic was informed by knowledge learned from a systematic review and interviews with Indigenous peoples to hear their experiences with culturally safe health care.

## **Background**

Many studies have been conducted to describe the concept of cultural safety, although its practical application has received little attention (Anderson et al., 2003; Brascoupe & Waters, 2009; Brooks-Cleator et al., 2018; Browne et al., 2009; Gerlach, 2012). There is also an extensive body of literature describing Indigenous peoples' culturally unsafe experiences and racism (Allan & Smylie, 2015; Browne et al., 2016; Goodman et al., 2017; Tang & Browne,

2008; Truth and Reconciliation Commission of Canada, 2015; Turpel-Lafond, 2020); however, literature describing Indigenous peoples' culturally safe experiences is sparse (Gerlach et al., 2018; Hadjipavlou et al., 2018).

### ***Cultural Safety***

Cultural safety was developed by Māori nurse leaders concerned with the poor health of Māori peoples of New Zealand, which was a consequence of colonialism and racism (Browne et al., 2009; Gerlach, 2012; Robinson et al., 1996; Wepa, 2015). One of the earlier definitions of cultural safety was “the effective nursing of a person/family from another culture by a nurse who has undertaken a process of reflection on (their) own cultural identity and recognizes the impact of the nurses' culture on (their) own nursing practice” (as cited in Papps & Ramsden, 1996, p. 491). Unlike other approaches to culture in nursing practice, cultural safety is underpinned by critical theoretical perspectives (Anderson et al., 2003; Browne et al., 2009; Curtis et al., 2019; Papps & Ramsden, 1996; Ramsden, 2000; Richardson et al., 2017; Richardson et al., 2009; Smye et al., 2010), which draw attention to power structures and oppression (Browne, 2000). Most notably, cultural safety is linked to the goals of social justice (Browne et al., 2009; Curtis et al., 2019; Smye et al., 2010) and health equity (Pauly et al., 2015).

Cultural safety is based on several assumptions. First, the client decides whether a health care interaction is culturally safe (Papps & Ramsden, 1996). This approach effectively shifts power in the health care relationship toward the client and away from the health care provider (Blanchet Garneau et al., 2018; Papps & Ramsden, 1996; Robinson et al., 1996). Second, cultural safety directs health care providers to examine their own culture and biases and how these will impact the care they provide (Anderson et al., 2003; Gerlach, 2012; Papps & Ramsden, 1996). Third, it highlights influences such as social, historical, economic, and political

factors that construct health care and the interactions that occur within (Browne et al., 2009; Doane & Varcoe, 2021; Gerlach, 2012; Papps & Ramsden, 1996).

### **A Clinical Example**

I observed the following experience during a research internship when I was administering a survey to clients in an emergency department. I was explaining the survey to Curtis (pseudonym), a person sitting in a wheelchair who self-identified as Indigenous, when a physician approached and started asking him why he used so much narcotic pain medication. Curtis began to explain that he had not taken any pain medication since last year when his gallbladder was removed, but before he had a chance to finish, the physician walked away. Turning to me Curtis stated, “It happens all the time. Indigenous people are treated this way all the time.” A moment later, a nurse walked over to Curtis and, without introducing herself, said, “I am going to dress that wound on your leg.” In response, Curtis asked if he could have a chair to prop up his leg up. “I am quite capable of doing the dressing with your leg on the floor.” In response, Curtis began to explain that it was not that he thought she was incapable, but rather that it was more comfortable for him because his leg was so painful. Before he could finish his first sentence, the nurse turned and walked away. I sat watching this interchange feeling aghast at the way he was being treated and wanting to say something. Yet I was not a nurse working in the emergency department; I was a guest as a research assistant. My concern over potentially jeopardizing the research study by complaining about the care led me to be silent. Even as I sat quietly beside Curtis, his head was hanging down. When he looked up and met my eyes, I finally spoke. “I saw that,” I said. “Thank you,” he replied.

Acknowledging Curtis’ experience was the only way I knew how to care for him. I could see that this was happening to him. I wanted him to know that he was not invisible; the behaviors

of the health care professionals were not invisible either. I wanted him to know that I saw what he had experienced and that he deserved better care than this. The reality was that on this day, an Indigenous person sought help at the hospital and was poorly treated. It was unacceptable. We were startled then when another client peeked from behind the curtain and kindly offered his chair to Curtis to put his leg up. I felt that the client in the bed next to us could sense the disrespectful way Curtis was being treated and was trying to intervene. But, when the nurse returned with the dressing supplies, she told us to stop moving the furniture around. Then, she crouched on the floor, put down some waterproof pads, and, without warning, began to pour saline on Curtis' wound. He threw his head back and winced in pain. Realizing that this was no longer the time to conduct a survey, I said I would be back after the dressing change.

I waited to give the nurse time to finish the dressing change before returning to Curtis' bed, but when I got there, his bed was empty. I checked the board and his name was no longer on it. I asked the unit clerk where he went and was told that he had left against medical advice. I felt a sense of urgency to see if Curtis was alright or if there was anything I could do to help facilitate his care that day. I walked to the main part of the emergency department looking for him. I went out of the side doors and searched for him. I walked around the block of the hospital to see if I could catch a glimpse of him somewhere, but just like that, he was gone.

### **Locating Myself**

I was born and raised on the traditional, ancestral, and unceded territory of the Stó:lō Nation in Chilliwack, British Columbia, Canada. I experienced many unearned privileges at the expense of others by growing up in a White, middle-class family. As a child and even as a young adult, I was not taught about the history of colonization in Canada and the devastating harms that Indigenous peoples were faced with as a result. I had no insight into my unearned privilege and

made no connection between the Indigenous peoples I knew and the harmful stereotypes I held. Because of my own ignorance and unconscious bias, I failed to recognize how damaging stereotypes harmed Indigenous peoples through culturally unsafe care. It was not until I was an adult in graduate education that I began to learn about the history of colonization, and I came to understand that my nursing practice was ingrained in the dominant biomedical, Westernized, and liberalist health care system in Canada (Browne, 2001; Doane & Varcoe, 2021; Pauly et al., 2009; Reutter & Kushner, 2010). These experiences gave life to the focus of my doctoral research.

### **The Research**

Seeing firsthand the deleterious impact of culturally unsafe care with Indigenous peoples, and realizing the unconscious bias that NPs (like myself) might carry and/or be unaware of, led me to undertake research to address this concern. Two critical theoretical perspectives, postcolonial feminism and critical social justice, informed this research. Together, these critical perspectives focus on: power structures; domination and oppression; emancipation and social change; and critiquing health and health care inequities (Anderson, 2000; Anderson et al., 2009; Browne, 2000; Kirkham & Browne, 2006; McGibbon & Lukeman, 2019; McGibbon et al., 2014).

Relational inquiry also informed this research project. Doane and Varcoe (2021) contend that relational inquiry is a form of culturally safe nursing practice. As a culturally safe health care process, it involves three levels of inquiry. Intrapersonal inquiry focuses on what is happening *within* people (Doane & Varcoe, 2021): considering the inner values, beliefs, practices and concerns of both people receiving health care and those providing health care. Interpersonal inquiry, on the other hand, examines what is happening *between* and *among* people

for the purpose of ensuring positive health care encounters through authentic, meaningful, responsive, power-with relationships (Doane & Varcoe, 2021). Finally, contextual inquiry considers the systemic elements that might be shaping people and health care encounters, and in turn how systemic elements might be shaped by people, including socio-historical elements (Doane & Varcoe, 2021). Together, these three levels of inquiry draw attention to what is required for culturally safe and responsive health care.

Informed by these perspectives, the overarching purpose of this research project was to gain insight into Indigenous peoples' experiences with culturally safe health care. To achieve this research purpose, two methods were used: a qualitative systematic review and a descriptive qualitative study. The qualitative systematic literature review followed the Joanna Briggs Institute (JBI) meta-aggregative approach (Aromataris & Munn, 2020) to provide a comprehensive synthesis of existing knowledge about culturally safe health care from the perspective of Indigenous peoples (Harding et al., 2021). The research question guiding the systematic review was, "What are Indigenous peoples' experiences with culturally safe health care encounters?" The findings from the systematic review were used to inform a smaller qualitative study that aimed to learn directly from Indigenous peoples about their experiences with cultural safety. The research question guiding the descriptive qualitative study was, "How is cultural safety enacted in health care as described by Indigenous peoples?" The results of the systematic review and qualitative interviews were used to develop guiding principles as a way for NPs to consider cultural safety in their practice and to create the mnemonic discussed in this paper.

## Methods

In order to hear culturally safe (as opposed to culturally unsafe) stories from Indigenous participants in the qualitative interviews, I partnered with an Indigenous-led primary care clinic that combines conventional primary care services with Indigenous ways of knowing, healing practices, and Elders to provide health care to clients. Partnering with this particular clinic increased the likelihood that clients would have had positive experiences and would be able to share those experiences with me. Indigenous Elders were consulted throughout the research process. Ethics approval was obtained from the University Ethics Review Committee and the clinic's own research and ethics process (see Appendices D and E). Further, the study adhered to the *Tri-Council Policy (TCP) Statement: Ethical Conduct for Research Involving Humans* (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, Social Sciences and Humanities Research Council of Canada, 2018), which emphasizes the importance of meaningful engagement of Indigenous peoples in research.

To be eligible for inclusion in the study, participants needed to self-identify as Indigenous, be over the age of 19, be able to communicate in English, have had a recent health care encounter, and provide informed consent. Participants were excluded if they recognized the student researcher (JH) as someone who had provided health care to them or if they were licensed, trained health care providers, as this study sought the perspectives of Indigenous peoples receiving care.

The recruitment strategy included third-party recruiters to help identify individuals who had positive experiences with health care and would be willing to share them (see Appendix A). With the guidance of Indigenous Elders at the participating clinic, third-party recruiters (Indigenous Elders, research coordinators, physicians, nurses, social workers, etc.) identified

several potential participants. They used their personal contacts and knowledge of the Indigenous community to help recruit participants. Interested participants could contact the student researcher (JH) in person at the clinic or through a work email address. Potential participants were provided with information about the study and asked to complete a pre-screening eligibility questionnaire. Participants who met the eligibility requirements were then asked to sign a written consent form (see Appendix C). Participants received a \$50 honorarium in cash to recognize their time and expertise.

Data collection took place in 2022. Five participants were interviewed using an informal and unstructured interview process, like a conversation. The interviews took place in a private room at the participating clinic, and the participants were offered drinks and snacks. Each interview lasted less than 60 minutes. Some participants wanted their names to be attached to their stories, and some preferred to use a pseudonym and remain confidential.

In addition to orienting my attention to the three levels, relational inquiry guided how I approached my interviews in the study. For example, I utilized relational inquiry tools to guide the interview, such as “following the lead of people” (Doane & Varcoe, 2021, p. 346). In other words, I enlisted the hermeneutic phenomenology (HP) lens, as described by Doane and Varcoe (2021), to ensure the direction of the interview was determined by what was meaningful and significant to the participant. Also, I was actively listening to both verbal and non-verbal cues from the participant, as well as being attentive to what they were not saying (Doane & Varcoe, 2021). I achieved this by listening for the participants’ unique experiences and what was particularly meaningful to them, as well as for the influence of societal norms, dominant narratives, and how social structures were constraining the participants’ capacity (Doane & Varcoe, 2021). An interview guide, which included some follow-up questions, was used (see

Appendix B). Each interview began by asking participants to recount any positive experiences with health care that they had encountered.

Prior to beginning each interview, participants were made aware of the possibility of potential harm, such as re-traumatization, which could arise from reliving difficult memories while sharing their experiences (Munhall, 2012; Polit & Beck, 2021). Indigenous-specific supports and resources were provided in a handout to the participants in case they felt distressed after the interview. The participants were made aware that they could stop the interview at any time if they felt uncomfortable or upset. The cash honorarium was theirs to keep, even if they decided to stop the interview. Following the interview, I checked in with each participant to see if the interview had left them feeling upset in any way and none of the participants reported feeling distressed.

### **Data analysis**

The qualitative study involved audio recording and transcribing the participant interviews with the assistance of a trained transcriptionist. Data analysis was conducted in three steps: 1) systematic review (details of that analysis were submitted for publication elsewhere); 2) thematic analysis of the qualitative interviews; and 3) a reflexive, interpretive process (drawing on relational inquiry) aimed at scrutinizing the data to formulate guiding principles for NPs to promote cultural safety in their practice. I drew on relational inquiry strategies (Doane & Varcoe, 2021) to critique my own interpretive process, draw my attention to the three levels of inquiry, and create the guiding principles for the mnemonic. It involved questioning how my position as a human, an NP, and a researcher influenced the research study and the knowledge that was constructed. Further, relational inquiry was used as a way to think about the data, with the main focus on what could be learned from each person's experience. This analysis was done with the

overarching pragmatic purpose of influencing nurses' and NPs' practice toward a more culturally safe approach.

### **Developing the Mnemonic**

The mnemonic was informed by the knowledge gleaned from through the three steps identified above. From the systematic review, three overarching themes (Synthesized Findings) related to engaging with cultural safety from the perspectives of Indigenous peoples were identified. The themes were: 1) building and maintaining relationships that respect and acknowledge Indigenous peoples, families, communities, and cultures; 2) embodying caring, non-judgmental, and supportive ways of being; and 3) walking beside Indigenous clients, families and communities on their path to health and health equity. This journey involves promoting shared care and collaborative decision-making, sharing power, and speaking up when the person's autonomy is jeopardized or when additional services are required, and including Indigenous providers, knowledge, and wellness practices. Indigenous cultural and spiritual spaces in the health care system are also required.

The participants' experiences from the qualitative interviews were closely aligned with the findings of the systematic review. After completing the data analysis of the qualitative interviews, I began to see that the systematic review identified *what* constituted cultural safety, and the qualitative interviews provided examples of *how* cultural safety was brought to life in health care settings. Through the data analysis process, it became apparent that the findings offered what could potentially serve as guiding principles for NPs.

As the goal of this research was to translate this knowledge into a pragmatic, usable form to support culturally safe practice at the point of care, I turned my attention to translating these principles into a mnemonic. As nursing educators, we often use mnemonics to help support NP

students in learning new skills and preparing for the objective structured clinical examination (OSCE). Therefore, it made sense to put what we learned from Indigenous peoples about cultural safety (which was informed by the systematic review and the interview findings) into the form of a mnemonic. I conceptualized these guiding principles into the following mnemonic:

***Promoting Cultural SAFETY: A Mnemonic for Practice***

**S** - Share power: shift from the health care provider to the client.

**A** - Acknowledge the unique personal experiences of the client and their Indigenous cultural identity.

**F** - Facilitate access to traditional Indigenous wellness knowledge and practices and Elders if wanted by the client in their care.

**E** - Educate yourself about the consequences of colonialism on Indigenous peoples' health (social, historical, political, and economic).

**T** - Trusting relationships are built and maintained with clients, and embody caring, non-judgmental, and supportive ways of being. Developing trust is the responsibility of the NP.

**Y** - You. It starts with you: the importance of critical self-reflection for the NP (adapted from the British Columbia College of Nurses and Midwives, 2022).

**Discussion**

This section presents a summary of the guiding principles (informed by the systematic review and qualitative interviews) that informed the development of this mnemonic. Quotes from Indigenous care receivers from both the systematic review and qualitative interviews were used to illustrate the guiding principles. This mnemonic is designed to assist NPs in considering important factors when working with Indigenous clients who are accessing health care. One

caveat to mention with this mnemonic is that it is not meant to be a prescriptive list of ‘how to do’ cultural safety, because what is experienced by one person as culturally safe may not be the same for someone else (Gerlach, 2012). Relational inquiry points out that it all depends on the multiple unique factors of each health care situation (Doane & Varcoe, 2021); therefore, this mnemonic has been proposed as a tool for NPs to inquire into the aspects of cultural safety that have been recognized as significant by Indigenous peoples in the context of health care.

**S - Share power: shift from the health care provider to the client.**

Cultural safety is based on the assumption that the client, not the health care provider, defines what is culturally safe care (Papps & Ramsden, 1996). Grounded in this assumption, one working principle of culturally safe care is that power is shifted from the health care provider (in this case an NP) to the client (Blanchet Garneau et al., 2018; Robinson et al., 1996). This involves paying close attention to the unequal power dynamics between health care providers and clients in health care interactions (Papps & Ramsden, 1996). One way to shift power toward the client is through shared decision-making, by providing them with information, and supporting them in their health care choices (Browne & Fiske, 2001), as illustrated by these participants:

Argus, interview participant: *They tried helping me by sending me to a treatment centre, but I don't want to go, so they talked to the treatment centre, you know, [so I can go] whenever I'm ready to go to treatment.*

Systematic review: *“There was no time limit, and she helped me to become more in control of my own health, which was the big thing. So I didn't feel uncomfortable asking questions or [saying] okay, well no, I don't want to do that, can you try something different? ... I wasn't just a piece of meat”* (Browne & Fiske, 2001, p.139).

## **A - Acknowledge the unique personal experiences of the client and their Indigenous cultural identity.**

In the systematic review, our review team found that many Indigenous people wanted to be recognized and respected for both their cultural identity and individual life experiences (Browne & Fiske, 2001; Browne et al., 2016; Burns et al., 2019; Churchill, 2015; Fretts, 2016; Hohl et al., 2016; Hole et al., 2015; Lipsett, 2007; Maar et al., 2009). As such, it is important for NPs to value both cultural identity and personal knowledge in order to avoid making assumptions about Indigenous peoples (Doane & Varcoe, 2021). By relying on assumptions and stereotypes, health care providers might erroneously believe that they know everything there is to know about a client, thus limiting the capacity to provide culturally safe care (Doane & Varcoe, 2021). By recognizing and honoring the unique needs and perspectives of Indigenous individuals along with their cultural identity (if they so choose), health care providers can contribute to positive care experiences, as shown in the following excerpts:

Systematic review: *“She was very genuine. She challenged me. She acknowledged what I’d been through, what I had accomplished up to this point, my addiction, and where I came from”* (Fretts, 2016, p. 56).

Systematic review: *“being visible and being acknowledged as Aboriginal in the health care relationships promoted a sense of cultural safety”* (Hole, 2015, p.1666).

Systematic review: *“respecting and honoring diversity of identity, of experience”* (Churchill, 2015, p. 106).

Systematic review: *“I told them I needed my eagle feather hanging from my IV thing, and he asked me what it was for and I says, ‘Well, the eagle feather is my protection. It’s my power, my healing.’ So he understood that”* (Hohl, 2016, p. 2441).

**F: Facilitate access to traditional Indigenous wellness knowledge and practices and Elders if wanted by the client in their care.**

Many Indigenous peoples place significant emphasis on the importance of holistic health, which encompasses physical, mental and emotional, family and social, and spiritual well-being (Moeke-Maxwell et al., 2020). Incorporating traditional Indigenous wellness and healing practices into health care spaces can create a more welcoming and supportive environment for Indigenous peoples (Moeke-Maxwell et al., 2020) and helps to foster a sense of community and connection. The systematic review and qualitative interviews illustrated that many Indigenous peoples wanted their health care experience to include traditional, cultural, and spiritual practices (Fretts, 2016; Moeke-Maxwell et al., 2020). It is important as NPs to inquire with clients who self-identify as Indigenous if there are ways that we can support their cultural and spiritual wishes in the health care setting. This interview participant illustrates how her health care experience was positive when she had access to Indigenous Elders and a clinic that blended primary care services with Indigenous ways of health and healing:

Janet, interview participant: *I’ve got two favorite Elders ... By the time I get through with them, that’s when I feel like a whole different person. I came in with all these things like some stressed out about my sister, stressed out about my brother, I was stressed out about everything, and by the time I get through with them, the Elders, I’m not the same person that walked in that door. It feels like oh, wow.*

Janet, interview participant: *I've never been to [a health care setting] like this. This is fabulous. It is everything. It is a dream come true compared to just going to a doctor's office, blah, blah, here's your meds, I'll see you next week sort of thing. It is nothing like that.*

To honor diversity, there is an immense need to incorporate various approaches to health care delivery. As such, it is important for NPs to inquire about and to facilitate access to Indigenous-specific services that can be done in several ways: through traditional Indigenous medicine, wellness knowledge, and healing practices; establishing Indigenous-led clinics; increasing Indigenous health care providers; integrating Elders into conventional health care systems; and making cultural and spiritual practices available to clients who want them, such as drumming circles or smudging. The clinic where I conducted the interviews deserves huge recognition for providing culturally safe care in all of the above ways with their clients.

**E - Educate yourself about the consequences of colonialism on Indigenous peoples' health (social, historical, political, economic).**

To effectively support Indigenous communities, it is essential for NPs to educate themselves about the history of colonization and the social, political, economic, and historical factors that continue to impact Indigenous peoples' health (Browne et al., 2009; Doane & Varcoe, 2021), including systemic racism (Truth and Reconciliation Commission of Canada, 2015). This is crucial in order to understand the root causes of the health inequities endured by Indigenous communities. The effects of colonization, such as forced assimilation, loss of culture, and extensive intergenerational trauma, have led to devastating health inequities (Truth and Reconciliation Commission of Canada, 2015). By learning about these contextual factors, NPs can develop an understanding of the unique circumstances that have been inflicted on Indigenous

peoples and work to provide tailored and responsive nursing care that is culturally safe (Doane & Varcoe, 2021).

**T: Trusting relationships are built and maintained with clients and embody caring, non-judgmental, and supportive ways of being.**

In both the systematic review and the qualitative interviews, many Indigenous peoples described wanting positive, long-term relationships with their health care providers (Brooks-Cleator et al., 2018; Browne & Fiske, 2001; Churchill, 2015; Cook et al., 2014; De Zilva et al., 2022; Jennings et al., 2018; Poitras et al., 2022; Seear et al., 2021; Slater et al., 2016; Tipa, 2021; Williams et al., 2003; Wright et al., 2020), which some described as “an extended kin-ship” (Cook, 2014, p. 24) or “kin-based” (Churchill, 2015, p. 111), meaning family-like. One of the interview participants expressed this as follows:

*Janet: That's what I like about the ladies [referring to staff at the clinic] here. We're friends, and not only a nurse and patient. Anybody can do nurse and patient, nurse and patient, but they take it a few steps further and make darn sure you feel real happy. I know in my times I've felt like people are just acting and they're just like robots. They've got only one mission in mind and that's all they're going to do, that's it. But here, I don't feel it at all. Yeah, they make me feel like family. I like that part ... They make me feel important and like I've never thought of nurses feeling like they love me, but they all do. I love that part.*

According to the systematic review, many Indigenous clients had positive experiences with health care when they felt genuinely cared for by their providers (Browne & Fiske, 2001; Hohl et al., 2016; Wiebe & Young, 2011). This sentiment was echoed by the following interviewee:

Nelson: *They [health care providers] make you feel cared for. When you come from this neighborhood, for people to genuinely care about each other, you don't see too much of that down here. I mean really ... Yeah, and you can usually tell when it's real ... Oh yeah, you can see it in somebody's eyes.*

In the systematic review, Indigenous peoples described health care providers who were non-judgmental and open-minded as those who contributed to culturally safe health care encounters (Churchill, 2015; Fretts, 2016; Jennings et al., 2018; Monchalin, 2019; Pearce et al., 2019). This was also affirmed by this interview participant:

Susan: *They're understanding, they're open minded, which is really important, you know, because we are a different kind of people, you know, and we experience a lot more than most people out in the general population do. It's hard for us being able to talk about anything like that of any sort, whether it's that or anything because of mistrust of them we've had in society and how we're looked at ...*

*I'm welcomed with open arms, open heart, open mind. There was nothing that I could say or do that would you have to go away. None of that. It has always been okay, let's see what we can do about that. She [the health care provider] helped me deal with that. She said we can put in a plan to make sure that you're okay ... For me, I mean, because anything that I deal with is, it's always special because of the fact that they make me feel special, you know, and I don't always feel that because I don't feel that, so. [gets emotional]. Any time that I come here, anything I share with them, I've felt like I'm okay and not such an oddity.*

**Y - You. It starts with you: the importance of critical self-reflection for the NP (adapted from British Columbia College of Nurses and Midwives, 2022).**

Another important element of cultural safety is “that people are all bearers of culture” (Bourque Bearskin, 2011, p. 553), meaning that NPs need to critically reflect upon their own culture and biases to illuminate how they influence practice (Anderson et al., 2003). Self-reflective practice is also highlighted as important in the *Indigenous Cultural Safety, Cultural Humility, and Anti-Racism* standard set forth by the British Columbia College of Nurses and Midwives (2022), which I drew on for this particular letter of the mnemonic. Reflecting on my own culture, biases, and assumptions and the negative impacts my lack of awareness had for Indigenous peoples whom I cared for as a nurse has been life-changing. I strongly encourage all NPs to engage in a daily and lifelong critical self-reflection and question their attitudes, beliefs and judgments that may limit the care provided to Indigenous peoples. Each person’s journey of learning and unlearning will be unique, and we may stumble and fall as we work towards integrating cultural safety into our practices (I do). Nevertheless, it is essential that we persevere, learn from our mistakes, and embrace the hard lessons as a necessary part of engaging with cultural safety.

**Limitations**

This research project has several limitations. As a non-Indigenous researcher, this project would have been strengthened by partnering with Indigenous researchers and team members from the beginning to the end of the research process. Although this did not come to fruition, I was able to consult with and receive ongoing guidance from Indigenous Elders at the participating clinic regarding this project. Also, as a non-Indigenous researcher engaging in research with Indigenous peoples, careful and critical self-reflection of my own positionality and

the ingrained colonial reference points that influenced my perspective was required; however, the limitations of my perspective were still present throughout the research process (Doane & Varcoe, 2021; Krusz et al., 2020). Another potential limitation was that I did not have a previous working relationship with the staff at the clinic; however, I was able to lean into the positive, long-term relationships that one of my committee members had previously established. Nonetheless, a lack of relationship with me personally may have led to hesitation surrounding my intentions and limited how comfortable participants felt sharing with me. I used an unstructured, conversational style of interview to help increase participants' comfort level. Additionally, my lack of experience conducting qualitative interviews as a novice researcher could have affected the quality of the data I collected. Further, although a small sample size might be considered a limitation, this was an intentionally small sample of five people receiving care at an Indigenous-led organization that posits cultural safety as a core value. Also, this project did not include the perspectives of health care providers, which could have provided valuable insights into enacting cultural safety in nursing practice.

Further, one of the key limitations of the research was my sole focus on the interpersonal level of health care encounters in our systematic review. As De Zilva et al. (2022) noted, "The scope of cultural safety extends beyond the patient-provider interface (communication, relationships, and Indigenous health staff) and encompasses the entire healthcare system" (p. 81). At the time of this research project conceptualization, I intended to concentrate on the interpersonal domain as the site of inquiry. This decision was influenced by past research documenting negative interactions that deter Indigenous peoples from seeking health care, as well as my own experience as an NP witnessing stigma and discrimination in health care. My interest was to explore the interpersonal interactions between health care providers and

Indigenous clients that led to positive health care experiences. Early on in my doctoral work, I planned to use relational inquiry with my research, but the fact that I ended up designing a research question for the systematic review that focused on the interpersonal level reflects my limited understanding and application of relational inquiry at the time. That, and my nursing reference point, tends to direct my attention to the interpersonal level, rather than intrapersonal or contextual levels. However, as a result of the systematic review, I realized firsthand the importance of looking beyond the interpersonal level of health care encounters to encompass the intrapersonal, interpersonal, and contextual aspects of engaging with cultural safety.

## **Conclusion**

The goal of this research project was to learn from Indigenous peoples about their experiences with culturally safe health care, with the aim of supporting culturally safe practice for NPs. Despite the immense harms associated with colonial violence, Indigenous peoples show remarkable resilience and strength in their resistance to ongoing colonial harms. As bell hooks (1992) reminds us, we cannot forget our past on the road to recovery. While keeping the colonial history in view, we can also focus on more socially just, equity-oriented ways to deliver health care and promote Indigenous peoples' health. By learning from Indigenous peoples' stories, NPs can work towards creating a more culturally safe and respectful environment for all clients, which in turn can lead to healthier and more rewarding work for NPs.

As I think back to that day when I witnessed the culturally unsafe care Curtis experienced, I know that I should have done better. I was a silent bystander of a harmful, unsafe interaction and allowed culturally unsafe care to occur. I could have done something; anything would have been better than the nothing I did. Not only was I aware of the harm happening before my eyes, but I also perpetuated it by virtue of not stopping it. That is on me. This

experience propels me forward to do better. I am finding my voice in conversations about anti-racist work and cultural safety. I am standing up when I hear racist remarks and challenging stereotypical assumptions, and I am raising awareness about the ongoing colonial violence against Indigenous peoples that disproportionately affects their health and well-being. My commitment to Curtis and to all Indigenous peoples is this: when I witness culturally unsafe health care, I will stand up, I will say something, I will do better.

## **Declaration**

As the author of this paper, I identify as a White nurse practitioner, educator, and researcher. I am committed to working to address Indigenous-specific racism, Indigenous health and health care inequities, and their harms.

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## **Chapter Five: The Afterword**

Typically, the afterword of a dissertation is where you discuss the practical implications of your research. In consultation with my supervisory committee, we determined that the third manuscript of this dissertation (Chapter 4) effectively communicates the significance of this work. As such, the purpose of this chapter is to discuss the methodological tensions that arose over the course of this research. This final chapter also discusses the implications of this work for nurses and nurse practitioners (NPs).

The overarching purpose of this dissertation was to gain insight into Indigenous peoples' experiences with culturally safe health care. The specific objectives of this research were: 1) to conduct a qualitative systematic review of Indigenous peoples' experiences with culturally safe health care encounters, 2) to learn from Indigenous people who shared their stories about culturally safe health care experiences, and 3) to disseminate the findings among nurses and NPs as a means of promoting cultural safety in their nursing practice. The focus of this dissertation came about because I witnessed an Indigenous person receiving culturally unsafe health care. During that experience (described in Chapter 4), I realized that I did not know how to act and did not have the courage to act. Doing something, even an imperfect intervention, would have been better than doing nothing. Cultural safety became a way for me to address the discrimination I was seeing and the ineptness I was feeling. In order to translate the knowledge from my doctoral work into something usable for nurses and NPs, I developed a mnemonic as a tool for inquiring about features of cultural safety that were identified as important by Indigenous peoples.

### **Experiences from Engaging in this Research**

One of the greatest strengths of this research is that it was done by asking Indigenous peoples about their experiences with culturally safe health care. While a great deal of literature

has been written about cultural safety from the perspective of health care providers, this research intentionally sought the experiences of Indigenous peoples receiving care. A fundamental principle of cultural safety is that it must be defined as culturally appropriate by the person receiving care, rather than by the health care provider delivering the care (Papps & Ramsden, 1996). Thus, the fact that this study used a strengths-based approach to learn from Indigenous peoples about culturally safe care is a major strength of this research.

Though the strengths-based approach is a much-needed contrast to a fair amount of the existing cultural safety literature, a critique of my doctoral work could be in relation to using multiple methodologies. As Butcher (2017) points out, some may view the utilization of multiple methodologies within the same research project (a systematic review and qualitative interviews) as epistemologically incompatible. However, following a pragmatist orientation to knowledge, knowledge gleaned from varied epistemological traditions can be seen to strengthen the potential impact in terms of making a useful difference (Doane & Varcoe, 2021). It is how that knowledge can be useful in making us increasingly more sensitive, informed, and responsive regarding peoples' needs and experiences that is important (Doane & Varcoe, 2021; Rorty, 1999). Therefore, although the methodologies employed in this dissertation may seem to clash as far as philosophical and epistemological underpinnings go, they align in that they contribute useful knowledge for the nursing discipline.

Before my doctoral studies, when I would start the process of writing an academic paper, I searched one or two databases and selected articles that supported what I wanted to say. However, early on in my PhD, I realized the limitations of this approach. I began to think about literature that did not support my topic and articles that I was missing by searching only one database. This realization led me to explore research synthesis methods, which are ways of

“combining, aggregating, integrating, and synthesizing primary research findings” (Schick-Makaroff et al., 2016, p. 174). I learned how to amalgamate evidence in an unbiased and rigorous manner, rather than simply cherry-picking particular articles.

One particular synthesis methodology, the JBI systematic review process, is well known for its unbiased and rigorous approach to combining available evidence and providing recommendations to guide health care practitioners and policymakers (Aromataris & Munn, 2020). The JBI methodology was initially helpful to me as a novice researcher with a postpositivist background. The structured and concrete approach outlined in the JBI methodology was beneficial for someone inexperienced in research. For example, a team of reviewers is required to complete a JBI systematic review (Aromataris & Munn, 2020), and I was able to work closely with one of my committee members, Dr. Karen MacKinnon, who was experienced in the JBI approach. Her guidance was instrumental in helping me navigate the systematic review process. As a solid starting point, the systematic review methodological approach provided me with a general understanding of the existing knowledge pertaining to culturally safe health care experiences from Indigenous peoples’ perspectives.

Although the systematic review allowed me to gain some insight into the existing cultural safety literature, I began to see that my understanding of cultural safety gleaned from the knowledge I synthesized was limited for several reasons. One of the first tensions I bumped up against early on in conducting the systematic review was how to define or operationalize cultural safety. To extract relevant findings for the systematic review, we needed to operationalize a definition of cultural safety. Through a thorough review of the literature, we learned that common words used to describe cultural safety included *safe*, *positive*, and *affirming*. We chose to use these words for the purposes of extracting findings related to cultural safety for the

systematic review. Later, I realized that my previous understanding of cultural safety was narrow and decontextualized, particularly in relation to critical theoretical perspectives, which emphasize the role of power dynamics and social, historical, and political processes in creating and perpetuating health inequities (Anderson et al., 2003; Browne, 2000; Browne et al., 2009; Kirkham & Browne, 2006). As a result of relational inquiry and its reminder to pay attention to the three levels of nursing practice, my current understanding of cultural safety has now shifted and reflects the importance of critical self-reflection for nurses and NPs, as well as the necessity to consider contextual factors in creating culturally safe health care experiences (Doane & Varcoe, 2021).

Another tension that became apparent to the review team when we started the extraction phase of the systematic review was that cultural safety seemed more easily spoken about in the literature in a negative sense. For example, what is culturally unsafe care, or what does racism, stigma, and discrimination look like in health care? It seemed more difficult to find cultural safety that was highlighted in a positive sense. Perhaps this was because it overlaps with many other concepts, such as person-centred care, or family-centred care, or respectful care. Thus, it was challenging to tease out examples of culturally safe care (positive examples) when they were so enmeshed in the literature with examples of culturally unsafe care (negative examples).

A tension specific to using the JBI methodology to synthesize the cultural safety literature was related to the joining of a Western analytical approach (such as meta-aggregation) with Indigenous ways of knowing. For example, Wilson (2004) discussed the idea of weaving and threading Indigenous voices and perspectives throughout one's work, and yet the confines of our systematic review expected us to sort and categorize these voices and perspectives. It quickly became challenging to deconstruct participants' experiences in this way. This is about when I

started to bump up against the limitations of my past self's postpositivist orientation. The deconstructive process seemed at odds with the principles of Indigenous philosophy, which emphasize connection and unity rather than separation and division (Denzin et al., 2008). In hindsight, there are methodologies that incorporate both Indigenous and Western research methodologies that may have been better aligned for this research project. A well-known example is the Indigenous research approach, Two-Eyed Seeing, which originated from Mi'kmaq Elder Albert Marshall and combines the strengths of both Indigenous and Western perspectives in the methodology (Forbes et al., 2020). In hindsight, it is possible that the meta-aggregation methodology was not the most suitable approach for this particular project, given the inherent methodological tensions and challenges that arose during the process of sorting and categorizing the qualitative evidence.

An additional tension I encountered was the result of my limited and/or biased understanding of cultural safety at that time. Earlier on in my exploration of cultural safety, I narrowly thought that culturally safe health care interactions solely occurred at the interpersonal level (between a health care provider and a client). This led me to overlook the importance of the intrapersonal and contextual levels in providing culturally safe care (De Zilva et al., 2022; Doane & Varcoe, 2021), which became evident the more deeply I engaged with the cultural safety literature. In addition to what is happening between the health care provider and the client, I learned how important it is for NPs to critique their own assumptions, biases, and culture (intrapersonal), and to consider the (contextual) factors shaping health care interactions, such as the colonial history of Canada and the impact of the social determinants of health in contributing to ill health (Doane & Varcoe, 2021). As articulated by Doane and Varcoe (2021), "A relational orientation goes beyond the interpersonal level (what happens between and among individuals)

and includes an examination of the intrapersonal, interpersonal, and contextual dimensions” (p. 2). As a result of my doctoral learning, I now understand that cultural safety is grounded in a relational orientation.

Based on my early understanding of the interpersonal level as the site for culturally safe health care interactions, the design of my systematic review question reflected my narrow and limited understanding. As I was only interested in what happened between the health care provider and Indigenous person receiving care, the systematic review question was, “What are Indigenous peoples’ experiences with culturally safe health care encounters?” (Harding et al., 2021, p. 2436). I went on to define a health care encounter as “any interaction between a person receiving care and a health care provider, occurring in a health care environment” (Harding et al., 2021, p. 2436), while excluding studies that lacked specific details regarding the experiences of a *particular* encounter (Harding et al., 2021). Therefore, in structuring the question in this way, I put limits on what I could include from the cultural safety literature in my systematic review. As an example, when participants spoke about how they appreciated being offered something to eat or a safe space to connect with community members, I did not include that in the review because it did not pertain to the particular encounter between the person receiving care and the health care provider. Similarly, some participants from the literature reviewed spoke about a positive impact on their care when health care providers had an understanding of the impacts of colonial violence on Indigenous peoples’ health. Yet, I did not include this in the systematic review either because it was not about the particular interaction between the client and health care provider. In retrospect, I was only gathering a one-dimensional view of cultural safety: the view from the interpersonal level.

Following the systematic review, I conducted a qualitative study using relational inquiry tools to bring in the other two levels (intrapersonal and contextual) that I had initially not understood in my learning about cultural safety as being so salient. Relational inquiry was a particularly useful framework to consider how all three levels of inquiry play out in every health care encounter, and how they influence NP practice and culturally safe practice (Doane & Varcoe, 2021). Relational inquiry *and* cultural safety are about caring for the whole person while considering and attending to all three levels simultaneously. Relational inquiry gave me a way to re-examine all of the data (the systematic review and qualitative interviews) through the three levels of attention that can bring about culturally safe care, while considering what was meaningful for the individual and keeping a focus on critical theoretical perspectives (Doane & Varcoe, 2021). Therefore, relational inquiry was necessary to incorporate contextual factors and intrapersonal aspects of culturally safe health care that I was missing in my research.

Even though the findings of my systematic review did not encompass the three levels of relational inquiry (and I would now say culturally safe practice), the qualitative interviews helped to provide a more in-depth and extended understanding of cultural safety. I began to grasp how crucial relational inquiry was for orienting myself, as a researcher, to pay attention to all three levels. Paying attention to the three levels offered by relational inquiry helped guide me towards what critical questions to ask, both of myself and of the participant data, and to analyze the data more deeply (Doane & Varcoe, 2021). In the end, the qualitative interviews built upon and expanded the findings of the systematic review by introducing the intrapersonal and contextual pieces that were needed for a relational understanding of cultural safety.

Another challenge that I encountered during my experience conducting the JBI systematic review was in terms of synthesizing the stories and examples shared by Indigenous

peoples about their culturally safe health care encounters and gearing the findings towards publishing in a journal that had historically quantitative roots. Specifically, the evidence we reviewed for the systematic review was quotes, illustrations, stories, and examples told by Indigenous people about their culturally safe health care encounters. To synthesize this knowledge, we were expected to reduce these experiences to categories that were not in line with the very heart of cultural safety that we were trying to illustrate. Oftentimes, a person's story or experience did not fit neatly into a single theme. As an example, there were often overlapping features in any given finding (caring, kind, open-minded, non-judgmental) that we needed to sort and organize into single or double-barrelled themes. In our attempt to do so, we risked losing the full meaning of participants' experiences. By using this reductionist categorization style synthesis methodology, we were losing the complexity and uniqueness of cultural safety that we were trying to illuminate in the first place. It ended up not being sufficient to truly convey the meaning of cultural safety. It was as if we were obscuring the complexity of what Indigenous peoples were saying about cultural safety as a relational and multidimensional process for caring.

Despite some challenges and methodological tensions, we managed to complete the systematic review after several years of hard work. I then submitted the manuscript of the completed systematic review to a journal that primarily focused on systematic reviews. The manuscript underwent two rounds of revisions, and after the third submission, it was ultimately rejected. Although my inexperience as a novice researcher and with the publication process contributed to the rejection, I learned many valuable insights from the reviewer's feedback regarding my understanding of cultural safety, and also about the importance of aligning the research methodology with the phenomenon being researched. Specifically, the standard publishing process for the systematic review, which focuses on distinguishing cultural safety as a

*concept*, was not conducive to distinguishing it as a multidimensional relational process.

Interestingly, however, the reviewer's comments helped me better understand the significance of the three levels of relational inquiry and why they were crucial to culturally safe NP practice. For instance, an integral aspect of cultural safety is the process by which health care providers critically examine their own culture, biases, and assumptions and how these factors can limit the nursing care they provide (intrapersonal inquiry) (Doane & Varcoe, 2021). Thus, I realized that reflecting on and declaring that our review lacked Indigenous consultation was crucial for engaging in culturally safe research. However, the reviewers suggested reducing this limitation to one sentence, simply stating the lack of Indigenous representation in this review. Certainly, future research endeavors that explore culturally safe health care that I am involved in will be in partnership with Indigenous research team members from beginning to end. This was one of the many significant moments of learning for me during my doctoral work.

### **Implications for Nursing**

In this section, I will discuss how the findings from the systematic review and qualitative interviews have significant implications for nursing and NP practice, education, and research with the goal of improving Indigenous peoples' health care experiences. What is discussed in this chapter is in addition to the recommendations that came out of the qualitative systematic literature review (see Chapter 3 for details). Much of the existing cultural safety literature focuses on culturally unsafe experiences, with a high proportion studied from the health care provider's perspective rather than the client's perspective. As a result, this dissertation research provides valuable insights that have been recognized as important by Indigenous peoples and that are highly relevant for health care providers across various roles and contexts, with a particular emphasis on nursing and NP practice. This research extends our understanding of

cultural safety by exploring Indigenous peoples' experiences with culturally safe health care and demonstrates how a relational inquiry approach to nursing practice is well aligned with cultural safety. Together, cultural safety and relational inquiry can offer a guide to nurses and NPs on how to enact cultural safety in their practice. This research provides new knowledge that moves cultural safety beyond “what” culturally safe care is into the “how” of enacting cultural safety in nursing practice. In other words, this research helps evolve the concept of cultural safety into a relational process that can be operationalized in practice.

### *Practice*

The knowledge and stories shared by Indigenous peoples have greatly influenced my understanding of the recommendations I would like to offer for nursing and NP practice. The first point relates to the idea that culture is always fluid and changing, not merely a static set of beliefs or practices (Anderson et al., 2003; Doane & Varcoe, 2021). Similarly, cultural safety is not a static one-dimensional thing or concept that can be simply known or applied prescriptively (Doane & Varcoe, 2021). Rather, cultural safety varies among individuals, groups, settings, and circumstances. Experiences of cultural safety may change based on a person's identity and context because what constitutes culturally safe practice for one person may not be the same for another person (Gerlach, 2012). Since the experience of feeling culturally safe depends on so many factors, there is no one recipe or one right way to enact cultural safety. As such, it is imperative to consider the unique experiences and perspectives of each individual in health care encounters, and the need for health care providers to be self-reflective and aware of their own biases and assumptions (Doane & Varcoe, 2021).

The second point is that in addition to seeing cultural safety as an experience rather than a concept, it is also a relational process. This builds on the work of Doane & Varcoe (2021), who

contend that “culture is a relational process” (p. 233). The meanings of culture are socially constructed (Crotty, 1998) and influenced by anything and everything, including political, economic, historical, and social influences (Browne & Varcoe, 2006). Also, culture is “complex, critical and multidimensional” (Stephenson, 2001, p. 4). Earlier on in my learning, I was trying to identify the tangible and concrete elements of the *concept* of cultural safety. But if we think about culture (and cultural safety) instead as relational process (Doane & Varcoe, 2021) which is multidimensional (Stephenson, 2001), this extends how we currently understand cultural safety. Cultural safety, therefore, is a multidimensional relational process that is experienced between people and is influenced by various factors at multiple levels of inquiry. This is because what makes up cultural safety all depends (Doane & Varcoe, 2021). It depends on anything and everything, including attending to the three levels of inquiry (intrapersonal, interpersonal, contextual), which can help in showing what may be of significance to a particular person in a specific situation in order to provide culturally safe care.

Informed by the knowledge gleaned from the systematic review and interviews with Indigenous individuals to hear their experiences, the recommendations for practice are outlined in the mnemonic I developed and provided in Chapter 4 to assist NPs in implementing culturally safe practice at the point of care. This mnemonic is intended to provide a way for NPs to think about culturally safe care and enhance their ability to provide that care in specific health care situations. As an inquiry tool, the mnemonic can be used to cue their clinical thinking and decision-making process by directly focusing the NP’s attention to enable careful consideration of the elements shaping the person and situation. In so doing, the mnemonic is intended to support more informed and responsive choices at the action level. The dissemination of this

mnemonic will primarily occur through publications, speaking at relevant conferences, and through my role as an NP educator.

It is worthwhile repeating here in the practice section that the strongest finding that was apparent from both the systematic review and the qualitative interviews was the importance that many Indigenous people placed on having positive, trusting, and authentic relationships with their health care provider (see Chapters 3 and 4). It is vital for nurses and NPs to recognize that “relating in itself has the ability to promote well-being or potentiate harm” (Doane & Varcoe, 2021, p. 99). Building and maintaining positive relationships is the responsibility of the health care provider. Despite the notion that nurses and NPs are too busy for genuine connection with clients, “meaningful, health-promoting nursing action can occur in any amount of time” (Doane & Varcoe, 2021, p. 100). It can be as simple as a smile, introducing oneself, inquiring about what is important to them and how you can help, asking how their family is, or offering a cup of coffee. One of the participants from the qualitative interviews (Chapter 4) said it best:

Nelson: *Yeah, and you can usually tell when it's real ... Oh yeah, you can see it in somebody's eyes.*

### ***Education***

This research offers implications for the education of nurses and NPs to support the provision of culturally safe care and the reduction of health inequities. As previously noted by McGibbon et al. (2014), “Working toward decolonizing nursing includes a commitment to exposing colonizing ideologies, values and structures embedded in nursing curricula, teaching methodologies and professional development” (p. 186). Central to this work is the implementation of the Truth and Reconciliation Report *Calls to Action*, particularly Calls to Action 23 and 24 (Truth and Reconciliation Commission of Canada, 2015). Call to Action 24

mandates that nursing schools require students to take a course learning about Indigenous health inequities, such as the history of colonization in Canada, including Residential Schools, the Sixties Scoop, and Indian hospitals (Truth and Reconciliation Commission of Canada, 2015). By gaining a deeper understanding of the profound harms inflicted upon Indigenous peoples as a result of colonial harms, including the loss of traditional lands, cultural practices, and many Indigenous languages (United Nations, 2015), nurses and NPs can better understand the root causes of the lower health outcomes experienced by Indigenous peoples. Understanding this history helps us see how ongoing health inequities are a direct result of colonial violence, practices, and policies. This moves us beyond an individualist discourse as a way to blame people for health inequities (Browne & Tarlier, 2008; Horrill et al., 2021). I also believe that learning about the truth behind Indigenous health inequities (colonial violence) helps us “to begin to grasp the nature of present-day relationships between Indigenous and non-Indigenous peoples” (Krusz et al., 2020, p. 205) and create empathy in health care providers who may have been previously under the spell of colonial narratives. Call to Action 24 further calls upon nursing schools to incorporate Indigenous knowledge and practices into courses (Truth and Reconciliation Commission of Canada, 2015), so that they are not solely focused on the biomedically dominant way of delivering health care.

Moreover, Call to Action 24 emphasizes the need for training in anti-racism. Racism is a social determinant of health (Berry et al., 2021) and a contributing factor to health and health care inequities; therefore, embedding anti-discriminatory approaches into nursing education can help fight racism and subsequent health inequities (Blanchet Garneau et al., 2018). Similarly, although not quite as strong as the call for education in anti-racism, Call to Action 23 stresses the need for cultural competency training for all health care providers (Truth and Reconciliation

Commission of Canada, 2015). This refers to licensed and practicing nurses and NPs in various health care settings. By adhering to the above Calls to Action, nurses and NPs can better understand the health care needs of Indigenous communities and work towards providing equity-oriented health care through the provision of culturally safe care (Ford-Gilboe et al., 2018).

To promote Indigenous peoples' health and cultural safety, several well-known reports can guide nursing and NP educators, including *The United Nations Declaration on the Rights of Indigenous Peoples* (2007), the *Truth and Reconciliation Commission of Canada Report* (2015), and the *In Plain Sight* report (Turpel-Lafond, 2020). As mentioned previously, these reports highlight the detrimental health effects of Indigenous-specific racism and provide recommendations for a path toward reconciliation. Additionally, the mnemonic derived from the systematic review and qualitative interviews in this dissertation is another useful tool for nursing and NP students and educators to inquire about culturally safe practice.

Another tool that can be used by nursing and NP educators is the British Columbia (BC) College of Nurses and Midwives' *Indigenous Cultural Safety, Cultural Humility, and Anti-Racism Practice Standard* (2022). Cultural safety requires us to take a hard look at ourselves as nurses, NPs, educators, and researchers and to critically examine our culture, privilege, and biases, and how these factors can contribute to experiences of culturally unsafe health care for Indigenous peoples. This practice standard is useful tool that can be used to aid in this process of reflexivity. It is also applicable to nurses and NPs living outside BC, as it provides practice expectations that are relevant to any geographic location.

In circling back to the above-mentioned Calls to Action, scholars have suggested that an epistemological approach alone is insufficient to disrupt deeply entrenched beliefs (Anderson et al., 2009; Doane & Varcoe, 2008). In other words, it is not enough to 'know' it; simply providing

nurses and NPs with cultural safety knowledge may not work. Drawing on the earlier work of Doane and Varcoe (2008), it is important to note that there needs to be an ontological motivation in addition to an epistemological motivation. Another way of putting it is that to just learn about cultural safety or acquire some cultural safety knowledge, although part of it, is not alone sufficient for providing culturally safe care. You have to want to engage in culturally safe care because you can appreciate the immense value in it. You want to embody it as a human, and center it in how you show up as a nurse or NP. Nurses and NPs must work at this each and every day.

In thinking about my own experiences as an NP educator, I realized that I had previously thought about the educational courses that students completed as inflexible containers of specific biomedical subject matter. Until one of my committee members told me that no matter what course she was officially teaching, she was always teaching the same thing (Varcoe, personal communication, February 1, 2020), meaning that social justice, health equity, and cultural safety teachings can and should be included, no matter what the course. This led me to think about integrating cultural safety education throughout an entire nursing program and across all of its courses, rather than just belonging to a single class. Although I primarily teach biomedical courses as an NP educator, I have learned to ask questions of the students such as, “What if their previous experience with a health care provider was culturally unsafe?” or, “What if they were a Residential School survivor?” or, “What is the link between colonial trauma and the etiology of diabetes?” This newfound (to me) approach provides frequent opportunities to engage in hard discussions about the origins and realities of Indigenous health inequities and how we can promote the health of Indigenous peoples just by the way we show up and relate in practice.

## ***Research***

My doctoral work has provided me with such valuable insights into how I might approach research that explores cultural safety in the future. It is imperative that future research happens in genuine partnerships with Indigenous peoples (Morisano et al., 2024). This starts with building trusting relationships with Indigenous peoples and communities prior to and throughout the research process. Moreover, it is important to ensure that the research team includes Indigenous members, including researchers, Elders, knowledge keepers, and/or community members (Morisano et al., 2024), which would highlight the best ways to ask about and incorporate Indigenous understandings of health and well-being into the research.

Most importantly, non-Indigenous researchers doing this work must also be acutely aware of their social positionality and the harmful impact that we may have on the research relationship, as Indigenous communities have often been harmed by research (Cochran et al., 2008; Goodman et al., 2018; Harfield et al., 2020; Krusz et al., 2020). Ongoing critical self-reflection is required and action regarding these reflections is needed to ensure that the research itself is culturally safe (Krusz et al., 2020). When I started this research project, I think I was envisioning a way to help ‘other’ nurses and NPs in taking up cultural safety in their practice, but I neglected to see myself as one of those health care providers who needed to analyze themselves. It was only through years of reading, thinking, and writing that I now believe that if the outcome of my doctoral work has been to embark on the lifelong process of attempting to decolonize myself, then the last seven years have been worth it.

The challenges I faced in using my chosen synthesis methodology in the study of cultural safety have highlighted potential ways in which I could explore cultural safety in the future. I have become familiar with the JBI meta-aggregative approach and learned of its advantages

through my doctoral work, so I may still consider doing another systematic review in the future. However, I would design the research question to explore cultural safety from the three levels of relational inquiry (intrapersonal, interpersonal, contextual) (Doane & Varcoe, 2021). Concerns regarding cultural safety occur at all levels of the health care system (De Zilva et al., 2022). The insights that could be gathered from a relational and multidimensional approach to cultural safety research could be important for nurses and NPs.

Nonetheless, I will also consider other methodologies that might better align with the gathering of Indigenous peoples' experiences with cultural safety. For example, Indigenous methodologies may be more appropriate than Westernized ones, as they are grounded in Indigenous philosophies and perspectives (Denzin et al., 2008). Using qualitative interviews or talking circles would likely be more suitable than quantitative surveys for learning about Indigenous peoples' experiences (Barlo et al., 2020). Community-based participatory research could also be a worthwhile approach, working closely with Indigenous communities in meaningful collaborations to identify their needs and priorities (Simonds & Christopher, 2013).

Also, there continues to be a lack of research from the perspectives of Indigenous peoples receiving care, and further research should prioritize centring the experiences of Indigenous peoples. Early on in my doctoral work, I could not appreciate the significance of the health care provider's perspective in research exploring cultural safety because culturally safe care must be defined by the client (Papps & Ramsden, 1996), and thus is the perspective we need to seek in order to learn about culturally safe care. My thinking has shifted somewhat, in that I think research from both the perspective of the client and the health care provider would be valuable. As an example, I have learned that it is essential in future research to pay attention to how health care providers' understanding of colonization and racism contributes to culturally safe

encounters. As such, this is why it becomes important to ask nurses and NPs about their cultural safety learning journey and their experiences in working to promote Indigenous peoples' health. Similarly, questions pertaining to the barriers experienced by nurses and NPs in providing culturally safe care are also important to address (Horrill et al., 2021). Lastly, studies could also be conducted to learn about cultural safety within particular health care settings, such as Indigenous-led health care models and clinics, with the goal of evaluating the impact of such settings with Indigenous peoples' positive health care experiences and favorable health outcomes (Allen et al., 2020; Tu et al., 2019).

## **Conclusion**

The overarching purpose of this dissertation was to gain insight into Indigenous peoples' experiences with culturally safe health care. Using relational inquiry as a guide to think about what the participants have shared has shed some light on 'how' cultural safety is enacted in practice and move us beyond just 'what' cultural safety is. Overall, I aimed to shift health care experiences from the widely known negative interactions that Indigenous peoples often endure towards positive interactions that focus on strengths, capacity, and increase opportunities for health and well-being. Ultimately, I anticipate that the findings from this research will help nurses and NPs reflect on their current practices, and both reimagine and enact care in a better, more culturally safe way that promotes Indigenous peoples' health and reduces health inequities. It is hoped that the S-A-F-E-T-Y mnemonic gives direction by providing a tool that can be brought to NP practice to promote cultural safety and Indigenous peoples' health. As this dissertation comes to a close, my wish is that this research will contribute to positive, culturally safe health care encounters when Indigenous people like Curtis present for health care—that they will feel seen, valued, and heard by health care providers.

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## Appendix A: Third-party Recruitment Brochure



# Indigenous Peoples' Positive Experiences with Culturally Safe Health Care

## RESEARCH VOLUNTEERS NEEDED

- Purpose of study?** The purpose of the research is to learn from Indigenous people about what good health care looks like from their view.
- Who can participate?** If you self-identify as Indigenous, 19-years and older, and had a recent health care experience (within the last two years).
- What is involved?** If you would like to take part in this study, you will be asked to have a 30–60 minute conversation to share your experiences for the purpose of informing nurses and enabling them to provide culturally safe health care. The conversation will be audio-recorded for research purposes. Prior to starting the conversation, you will be asked to fill out a short demographic survey. The conversation will take place in one of the rooms here at Kilala Lelum. There may be an option to have the interview at an alternative location, such as a café or park of your choosing.

**If you would like to participate, please contact Jillian Harding (UVIC PhD Student) at [jillian.harding@ubc.ca](mailto:jillian.harding@ubc.ca)**

If you have any questions, concerns, or desire for further information about this study, you may contact the research study's Principal Investigator, Dr. Esther Sangster-Gormley, School of Nursing, University of Victoria at [egorm@uvic.ca](mailto:egorm@uvic.ca)

In appreciation for the time spent participating in the research, you will receive \$50 cash.

## Appendix B: Interview Guide



# Indigenous Peoples' Experiences with and Perceptions of Culturally Safe Health Care

### Interview Guide

*Preamble* – I am doing this study to try and learn from Indigenous people what culturally safe care looks like, with the goal of improving health care experiences for Indigenous people.

*Unstructured, conversational style questions to help facilitate the interview -*

- Can you think about a positive health care experience; tell me about that.
  - Probe: What did the health care provider do specifically that made it a positive experience?
- Times where you felt the health care experience was safe, positive, and/or affirming and what specifically made it feel that way?
- Tell me about your favorite interaction with a health care provider?
- How have these experiences with health care providers affected you.
- What could health care providers do that would most improve your health care experiences and/or your health.

*Follow-up Questions -*

From “*How to nurse: Relational inquiry with individuals and families in changing health and health care contexts*”, by Gweneth Doane and Colleen Varcoe, 2015, (p. 360).

- What was that like for you?
- Tell me more about that.
- How did that make you feel when that happened?
- What was important for you when that was happening?
- What was of concern for you?
- What was difficult for you in that experience?
- What was missing for you in that experience?
- What did not happen that you would have wished to happen?
- What would you liked to have seen happen in that experience?
- How is care that you have received at this clinic different from care that you have received at other places?

## Appendix C: Participant Consent Form



University  
of Victoria

# Participant Consent Form

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## Indigenous Peoples' Experiences with and Perceptions of Culturally Safe Health Care

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You are being invited to participate in a research study that is being conducted by Jillian Harding, a graduate student in the School of Nursing at the University of Victoria. As a graduate student, this research is part of the requirements for the degree Doctorate of Philosophy (PhD) in Nursing. It is being done under the supervision of Dr. Esther Sangster-Gormley, Principal Investigator. Dr. Sangster-Gormley is an Assistant Professor in the School of Nursing at the University of Victoria and you may contact her if you have further questions by email: [egorm@uvic.ca](mailto:egorm@uvic.ca)

This research is being funded by University of British Columbia, School of Nursing, Internal Research Grant, Logan Lindlay Fund.

### **Purpose and Objectives**

The purpose of this study is to learn from Indigenous Peoples about what positive culturally safe health care looks like. The objective is to provide suggestions for nurses about how to promote cultural safety in their practice.

### **Importance of this Research**

The goal of the study is to help improve care for all Indigenous Peoples. This research might influence nurses to practice in more culturally safe ways. This could improve the health and well-being of Indigenous Peoples.

## **Participants Selection**

You are being asked to participate in this study so that nurses can learn from Indigenous Peoples' about what good health care looks like. To participate, you must be 19 years of age or older, self-identify as Indigenous, and have received health care within the last two years.

## **What is involved**

Your participation will include sharing your positive health care experiences with the student researcher during an in-person interview lasting approximately 30-60 minutes at Kilala Lelum. There may be an option to have the interview at an alternative location, such as a café or park of your choosing. The interview will be recorded and the student researcher may also take written notes. The student researcher will transcribe the recorded interview later.

## **Inconvenience**

Participation in this study may cause some inconvenience to you, including the time that it takes to complete the interview (30-60 minutes).

## **Risks**

There are some potential risks to you by participating in this research and they include:

### *Emotional Distress*

Talking about your health and the health care you receive may be upsetting. In talking about positive health care experiences, you may reflect on negative health care experiences which could trigger emotional discomfort and result in psychological distress. We will provide all participants with contact information to culturally appropriate counselling services and community supports.

### *Fatigue/Stress*

The interview process may be stressful and/or tiring for some people. Participation is completely voluntary, and you can stop the interview and withdraw from the study at any time. The honorarium will be yours to keep, whether or not you complete the interview.

### *COVID 19*

We are aware that there are health risks associated with possible exposure to COVID-19 during this research. We have read and adopt the University of Victoria Communicable Diseases plan and the guidance from Kilala Lelum on COVID-19 . The student researcher will wear a mask and use hand

sanitizer. These will be available in the clinic to help mitigate transmission of COVID-19. You will be advised if you have or may have come into contact with someone who has tested positive for COVID-19 during the interview. Contact information for participants will be stored in a separate file from research data at Kilala Lelum clinic, should follow up be needed.

### **Benefits**

This study will give you a chance to share your thoughts and experiences about positive health care experiences you may have had. You may find that telling your story is helpful. What you share may help health care providers and policy makers to improve the quality of care for Indigenous Peoples.

### **Compensation**

You will receive a gift of \$50 from the student researcher to show our appreciation.

### **Voluntary Participation**

Your participation in this research is completely voluntary. You may withdraw at any time without any consequences or any explanation. If you withdraw from the interview, your data will not be used unless you give permission. The \$50 gift will be yours to keep whether you complete the interview or not.

### **Researcher's Relationship with Participants**

The student researcher may have a relationship to potential participants as a nurse practitioner. To help prevent this relationship from influencing your decision to participate, the following steps to prevent pressure have been taken: 1) the nurse practitioner will not work in the role as a nurse practitioner during data collection of this study 2) people who recognize the student researcher as a nurse practitioner who provided health care to them will be excluded from participating in the study.

### **Anonymity**

A pseudonym or false name will be attached to the information you provide for this study, unless you would like to have your real name used. Even after our best attempts to protect your identity you may still be identifiable by people who know you well due to the small number of participants.

### **Confidentiality**

Your confidentiality and the confidentiality of the data will be protected. Information collected is strictly confidential. All information will be stored securely in a locked cabinet and password-protected computer in the student researcher's office at University of British Columbia.

## Dissemination of Results

Consultation with Elders at Kilala Lelum will provide guidance on the best ways to share the study results to participants and Indigenous communities. This information you provide will be used for the student researcher's PhD dissertation, articles in professional academic and practice-based journals, practice-oriented tools that may be published on the Equip Health Care website (<https://equiphealthcare.ca/>), and public talks.

## Disposal of Data

The data from this study will be stored for 5 years and then destroyed (shredded hard copies or deleted electronic copies from hard drives).

## Contacts

Individuals that may be contacted regarding this study include:

Student Researcher: Jillian Harding [jillian.harding@ubc.ca](mailto:jillian.harding@ubc.ca)

Supervisor and Principal Investigator: Dr. Esther Sangster-Gormley [egorm@uvic.ca](mailto:egorm@uvic.ca)

In addition, you may verify the ethical approval of this study, or raise any concerns you might have, by contacting the Human Research Ethics Office at the University of Victoria (250-472-4545 or [ethics@uvic.ca](mailto:ethics@uvic.ca)).

Your signature below indicates that you understand the above conditions of participation in this study, that you have had the opportunity to have your questions answered by the researchers, and that you consent to participate in this research project.

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*Name of Participant*

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*Signature*

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*Date*

I consent to be identified by name / credited in the results of the study: \_\_\_\_\_ (Participant to provide initials)

I consent to have my responses attributed to me by name in the results: \_\_\_\_\_ (Participant to provide initials)

**Future Use of Data**

I consent to the use of my data in future research: \_\_\_\_\_ (Participant to provide initials)

I **do not** consent to the use of my data in future research: \_\_\_\_\_ (Participant to provide initials)

***A copy of this consent will be left with you, and a copy will be taken by the researcher.***



## Conditions of approval

This Certificate of Approval is valid for the above term provided there is no change in the protocol.

### **Amendments**

To make changes to the approved research procedure in your study, please submit "Amendments" or "Annual renewal with amendments" form. You must receive research ethics approval before proceeding with your amended protocol.

### **Renewals**

Your ethics approval must be current for the period during which you are recruiting participants or collecting data. To renew your protocol, please submit a "Request for Renewal" form before the expiry date on your certificate. You will be sent an emailed reminder prompting you to renew your protocol about six weeks before your expiry date.

### **Project Closures**

When you have completed all data collection activities and will have no further contact with participants, please notify the Human Research Ethics Board by submitting a "Notice of Project Completion" form.

## Certification

## Appendix E: Kilala Lelum Ethical Approval Letter for Study

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### **Kilala Lelum** **Urban Indigenous** **Health And Healing** **Cooperative**



December 21, 2021.

(Updated: February 15<sup>th</sup>, 2022)

Hi Jillian,

Thank you kindly for your patience and interest in working with us. Our committee has assessed that your project is well aligned with KL's greater mandate and guiding principles. Your proposal provides contrast to the trends of how aspects of culturally relevant care have been framed in the past, and we believe it gives voices directly to those that our health care system needs to hear from. We are happy to partner you in this project.

We would like to acknowledge your willingness to pursue this work in a good way and identifying that space and time are at a premium. Our committee's main concern was logistical: how do you expect to run these interviews and where? And how are you going to ensure non-coercive, fair recruitment? By non-coercive, we are referring to members who may not feel completely in control of their healing journey feeling pressured to participate if they were approached by a care provider for example. We acknowledge that these are questions you may not necessarily have answers for right away.

As a starting point, we are able to help you connect with an Elder for input around incorporating Indigenous voices in meaningful ways, if this is agreeable to you. Once ready, you are cleared to conduct in-person interviews at Kilala Lelum with the possibility of off-site accommodation if needed.

At Kilala Lelum, we offer a unique Model of Care that is guided by our values of equity and wellness, respect, kindness, Indigenous culture, love, and elder leadership. We strongly believe that anything worth doing is worth doing in a good way. I am happy to answer any questions you may have, and we look forward to working with you.

Kindest regards,

On behalf of the Kilala Lelum Research Committee.