

Community as Teacher Model: Health Profession Students Learn Cultural Safety from an Aboriginal Community

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Communication between health care professionals and Aboriginal patients is complicated by cultural differences and the enduring effects of colonization. Health care providers need better training to meet the needs of Aboriginal patients and communities. We describe the development and outcomes of a community-driven service-learning program in which health professional students learn with, from, and about the community through brief immersion in summer camps put on by an Aboriginal agency to teach their own youth about their culture. Outcomes were assessed by semi-structured interviews with students and community members. Health profession students learn about important cultural differences, become more aware of their own values, beliefs and stereotypes, and consider ways to overcome communication barriers that interfere with developing trust with Aboriginal patients. These outcomes are retained long-term and influence relationships with patients in practice as well as career paths. Students are seen by the community as good role models. The opportunity to educate university students enhances the community's sense of pride in their culture.

Introductory lessons for health professional students about Aboriginal peoples emphasize their poor health status and persistent health disparities, a picture of ill health reinforced during clinical training. Although we need to attend to the disproportionate burden of ill health experienced by Aboriginal peoples, we must also help health profession students understand the contexts in which these disparities exist and better prepare them to work with Aboriginal patients and communities. Lack of understanding of how historical and socio-cultural contexts of Aboriginal people influence health care encounters can lead to poor communication and misunderstandings that jeopardize patient safety (Elliott & de Leeuw, 2009). A study of family medicine residents identified inadequate knowledge of Aboriginal culture, lack of understanding of traditional medicine, feeling like an outsider, and difficulties they experience with medical management of their patients' problems as barriers, whereas having community-based experience was associated with a likeliness to work with Aboriginal people (Larson, Herx, Williamson, & Crowshoe, 2011). Most health profession programs have few opportunities for interactions with the Aboriginal community outside clinical or academic settings.

Cultural safety is an approach to cross-cultural education that has gained attention from health profession educators. It originated as an educational

model and pedagogy in New Zealand nursing education designed to redress health disparities as a response to the distrust experienced by Maori people in health care settings (Ramsden, 2002). The Indigenous Physicians Association of Canada-Association of Faculties of Medicine of Canada [IPAC-AFMC] Aboriginal Health Task Group subsequently endorsed cultural safety as a means to implement Aboriginal (First Nations, Inuit, Métis) core competencies for undergraduate medical education (IPAC-AFMC, 2009). A central tenet of cultural safety is that health professionals need to be mindful of cultural differences that make each patient unique (Wepa, 2005). Each encounter with a patient is a unique bicultural (one person to one person) relationship that requires professionals to understand how their own social conditioning (both personal and professional) affects them and their practice (Papps, 2005). Cultural safety's focus on professionals acquiring awareness of their own culture (values, beliefs, biases, and prejudices) makes it distinct from widely held ideas about cultural competence training in which the primary objective is to obtain knowledge about cultural practices of various ethnic groups. Cultural safety asserts that health professionals need to examine their cultural selves through self-reflection that includes analysis of power inequalities between professional and patient (Papps & Ramsden, 1996). To offset the power imbalance that favors the

health professional, cultural safety contends that responsibility to establish trust lies with the care provider and it is the patient who determines whether the encounter was culturally safe.

The process to achieve cultural safety has been described as a step-wise progression from cultural awareness to cultural sensitivity and ultimately to cultural safety (Ramsden, 2002). Cultural awareness is a beginning step toward understanding that cultural differences exist and are influenced by the social, economic, and political contexts in which people live. Cultural sensitivity is a stage of legitimizing difference through self-exploration. Cultural safety is an educational outcome that enables safe service to be defined by the patient. An example of how a patient might define culturally safe care is given in a study of communication difficulties between Aboriginal patients and their doctors (Towle, Godolphin, & Alexander, 2006a) that identified the importance of the relationship between Aboriginal peoples' history, the time given in the medical interview, and the extent to which a physician is trusted. The negative legacy of history (e.g., residential school experience) was a barrier to communication (and trust) that could be attenuated by the physician taking time to know the patient as an individual and member of their community. When asked what doctors should do to improve communication, the Aboriginal informants said they needed to "understand the history of Aboriginal people of Canada and its effect on individuals and communities," "get to know the patient as an individual and as a member of their community," and "allow the person to tell their story without interruption."

Kelly & Brown (2002) investigated the process of acculturation for non-native physicians working in First Nations communities and concluded it occurs over a 2-5 year time frame. Such a prolonged time in the community is impractical in most training programs as a means to enhance cultural understanding. Shorter periods of cultural immersion (1-6 weeks) have been used in health profession education with favourable cultural safety outcomes in Maori communities in New Zealand (Dowell, Crampton & Parkin, 2001), an Indian Reservation in the United States (Kavanagh, 1998), and a Mayan village in Belize (Ekelman, Bello-Haas, Bazyk, & Bazyk, 2003). However, these programs were part of credit-based elective or required coursework that immersed students in the community for 1-6 weeks. Given the limitations on students' time and lack of space in the curriculum, we investigated whether similar benefits could be achieved with a shorter, extracurricular immersion program. We hypothesized that students might learn to develop culturally-appropriate relationships with Aboriginal patients from an experience in which the Aboriginal community acted as

their teacher. Consultations with key informants from the community (mental health team leader, traditional healer, agency director, Elder, program director) led to a plan to permit students to spend time in an Aboriginal community. Although an unconventional approach to service-learning, the idea of reversing the flow of expertise by creating opportunities to learn in the community without necessarily providing service has recently been confirmed by Steinman (2011). We describe the development of this community-led educational intervention and its outcomes as they relate to cultural safety. The study was guided by three questions: What did students learn? What was the learning process? What were the benefits to the community? Approval was granted by the University Research Ethics Board and a letter indicating support for the project was obtained from the First Nations-serving community agency.

Methods

Developing the Intervention

A request for help to develop educational programs for health profession students was emailed to contacts in Aboriginal communities within reasonable travel distance of the university. This led to meetings with a program supervisor for an Aboriginal child and family services agency of the Stó:lō Nation (First Nations people inhabiting the Fraser Valley of British Columbia), who agreed to host health profession students at summer camps for Aboriginal youth organized by her agency. Working in partnership with this agency, we developed a unique educational model in which students learn alongside the Aboriginal youth at the camps and experience the community as teacher.

The summer camps, led by Elders, youth workers, and cultural leaders (community members with cultural knowledge and skills), are opportunities to experience the lifestyles of the Stó:lō people, including aspects of the medicine wheel (spiritual, mental, physical, and emotional) while learning about oneself and the larger First Nations community (Xyolhemeylh Health and Family Services, 2009). Camps are typically held on the Chehalis Indian Reserve, in a Longhouse or outdoors. Four different camps are offered: family, youth, and two puberty camps. The purpose of the family camp is to share traditional teachings about family and parenting skills with Aboriginal families. The youth camp is a co-ed camp for 12-14 year olds that provides cultural teachings through traditional activities, sports, and games. The puberty camps are a coming of age celebration held separately for boys aged 12-19 and girls aged 10-16 to teach self-discipline, traditional responsibilities, and customs. Some of the youth participants are in foster

care with non-Aboriginal families where exposure to their cultural roots is limited. Each camp is three or four days in length with 20-30 participants.

Health profession students attend the camps in groups of two to six. Their role is to learn through drumming, singing, canoeing, Longhouse ceremonies, talking with Elders, and interacting with the youth. In exchange for their camp experience, students have, at the request of the community, provided different kinds of service. For example, students were initially asked to help with organizational aspects such as set-up and meal preparation, and provide basic first aid. Over time students also were asked to facilitate discussion groups on health-related topics chosen by camp leaders and camp participants such as nutrition, body image, hygiene and sexual health, and a modified version of a high school outreach program to teach adolescents how to develop independent and active relationships with health care providers (Towle, Godolphin, & Van Staalduin, 2006b). The type of service students are called on to provide is determined by the community and based on each student participant's knowledge and skills. Virtually no background training about the community, its customs, or culturally appropriate behaviour is provided prior to the camps. Although students bring with them a range of previous experiences with Aboriginal people, the intent is to place them in the role of an outsider or foreigner in the community. This facilitates a shift in power and control of the teaching to the community.

Participants and Recruitment

Students are recruited through university email listservs. Camps were advertised as a learning opportunity for medical and midwifery students in the first two years of the partnership and subsequently to students in other health profession programs. Criteria are that they must be a registered student in good standing in a healthcare-related discipline. Between 2006 and 2009, 54 students participated (25 medicine, 7 nursing, 4 occupational therapy, 3 social work, 3 pharmacy, 3 pre-medicine, 2 midwifery, 2 dietetics, 2 dentistry, 2 land & food systems, 1 psychology).

Data Collection

Semi-structured interviews were conducted using interview guides developed by the research team and recorded with participants' consent. Community members and students were interviewed separately to allow disapproving comments about the students or camp experience. Students were interviewed by a member of the research team (Kline) or research assistant; most community interviews were conducted by a research assistant at arm's length from the research team.

Ten group interviews and 9 individual interviews for a total of 19 were done with 45 students and 3 group and 2 individual interviews for a total of 5 were done with 16 community members. Student interviews were 13-105 minutes (avg. 50). Community interviews were 17-107 minutes (avg. 52). Forty-five students (83%) were available for interview within 2 months of the camps (see Table 1). Thirty-nine students (69%) were at least half way through their academic program. Twelve were interviewed again 6-24 months after their camp experience to assess the long-term impact of the experience. Community interviews were usually coordinated by the camp organizers to coincide with scheduled debriefing sessions for staff at the end of each summer and included camp leaders and coordinators, youth workers, cultural leaders, and an Elder (see Table 1). The selection of these individuals was determined by the camp organizers and by the available contract staff. We did individual interviews with two community members outside of the community-coordinated group interviews, but time and distance precluded interviewing all community members involved in the camps. All community interviews took place at a location chosen by the participants—often the agency's office or local coffee shop. The purpose was to gather information about how they viewed the students and the partnership with the university.

Interview guides were framed by open-ended trigger questions to invite participants to talk freely about what was important to them. Participants' responses led to deeper exploration of their experiences. Questions asked of the students focused on what the students learned from and contributed to the camps. Examples were: "Tell me about your experience at the camp." "What did you learn?" "What surprised you?" and "What might you take away from the experience for your future role as a health professional?" We also probed for students' previous experience with Aboriginal people. The questions were re-phrased in the long-term follow-up, e.g., "Tell me about a moment that has most stayed with you" and "How have you carried forward what you learned at the camp into what you're doing now?" Community members were asked about their views on the students' participation, for example: "How did the students' presence affect the camps?" "In what ways did the students contribute to the camps?" and "What do you think the students learned?" We probed for negative aspects of the students' participation in the camps and did not receive any negative feedback.

Data Analysis

All interviews were transcribed verbatim. An interpretive thematic analysis was completed by the first

Table 1
Study Participants

Students or Community Informants and their Programs or Role	Number of Initial Interviews		Number of Follow-up Interviews (6-24 Months Later)	
	Female	Male	Female	Male
<i>Student academic program</i>				
Medicine	16	5	6	2
Nursing	5		1	
Occupational Therapy	3	1		1
Pharmacy	1	2		1
Pre-medicine	2	1		
Dietetics	2		1	
Dentistry	1	1		
Land & Food Systems	1	1		
Social Work	1			
Midwifery	1			
Psychology		1		
Total students interviewed	33	12	8	4
<i>Community member role</i>				
Cultural leader	4	4		
Camp leader	0	2		
Youth worker	1	2		
Camp coordinator	2	0		
Elder	1	0		
Total community members interviewed	8	8		

author (Kline), with assistance from the third author (Chhina) and two research assistants, using procedures for qualitatively-derived data (Auerback & Silverstein, 2003; Flick, 2002). A coding framework was developed from multiple readings of the transcripts to identify recurring ideas. Major themes were checked with several study participants (3 students, 3 community members) and presented to the management team responsible for overseeing the community agency's programs, including the camps. Member checking confirmed the data fit with the range of experiences they encountered. An auditable decision trail was maintained throughout the study and discussed with other experienced Aboriginal health researchers and educators.

We developed 26 codes in 5 categories: (a) Cultural Learning, (b) Learning about Self, (c) Communication, (d) Student Gifts to Community, and (e) Learning Process. Atlas.ti (Murh, 1997), was used to organize and manage coding. Long-term follow-up interviews were coded in the same way and rater discrepancies were discussed and jointly resolved. Codes were organized into the cultural safety process—a step-wise progression from cultural awareness (understanding that cultural differences exist) to cultural sensitivity (legitimizing difference through self-exploration) and cultural safety (safe service as defined by the patient) (Ramsden, 2002) to gauge the depth of the students' learning and effectiveness of the intervention. Codes from the 'Cultural Learning' category, such as understanding cultural differences about family and community, were

grouped under cultural awareness. Codes from the 'Learning about Self' category, such as challenging stereotypes, were placed within 'Cultural Sensitivity' as they fit with the notion of legitimizing difference through self-reflective processes.

For cultural safety, we used codes from the 'Communication' and 'Student Gifts to Community' categories as proxy measures of students' capacity to practice cultural safety because they were not yet in clinical practice with 'real' patients. The 'Communication' category included codes with references to distrust of health professionals and how to build trust, the importance of listening and giving time when communicating. We took these as evidence for cultural safety because history-time-trust were themes identified by Aboriginal informants (Towle et al., 2006a). We triangulated the 'Communication' codes with codes from the 'Student Gifts' category which were about how students behaved at the camps that demonstrated a capacity to practice cultural safety, namely their desire to learn. Figure 1 illustrates the relationship between the codes, categories, and the cultural safety process.

The 'Learning Process' category was separated from the cultural safety analysis because it was not about what students learned but about how they learned from the community, e.g., where and how the teachable moments occurred. Findings are organized by these two domains: learning outcomes and learning process.

Results: Learning Outcomes

We present students’ learning outcomes using the three steps of the cultural safety process (Ramsden, 2002) in which students move from cultural awareness to sensitivity and ultimately to safety. Fillers such as “um”, “like”, and “you know” have been removed from quotations.

Cultural Awareness

One of the most pronounced areas of student learning, which is consistent with the first step of the cultural safety process—developing cultural awareness—was identified by 45 students (100%; 216 quotations). The most frequently coded cultural differences students learned about, identified by 30 students (67%; 68 quotations), were broader concepts of family and community:

... that term family, the understanding that I had of it was very different because my family is the nuclear family ... Here everybody was calling each other aunty, uncle, this is my sister, this is my cousin, and at first we thought, ‘Oh everyone’s really related, tightly related by blood’ but actually it was either by marriage, by friendship. They were all connected into a family ... [Student A, 2nd year medicine]

Twenty-six students (58%; 52 quotations) learned about the important role that connection of community and family through traditional culture has for well-being: “... we talked about forms of First

Nations medicine, what’s good medicine in terms of community and family and song and dance and tradition and the culture and the teachings from the Elders, all that was good, good medicine.” [Student B, 4th year medicine]

Twenty-five students (56%; 41 quotations) learned about having and showing respect (for Elders, one another, themselves, and nature) and 28 students (62%; 30 quotations) learned about a different notion of time:

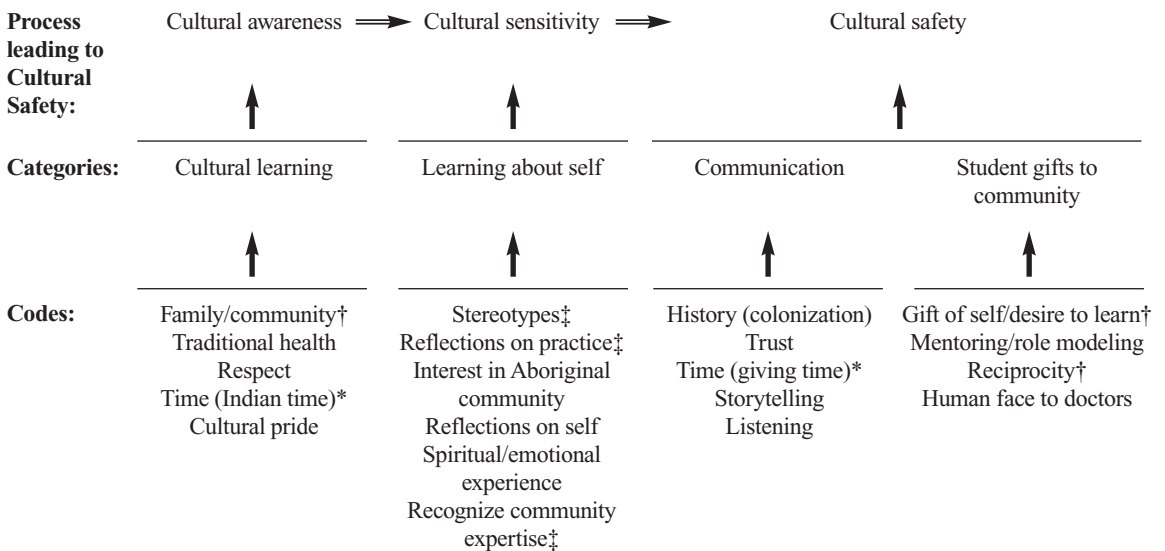
...I think it’s a big cultural thing to see how things sort of progress and how time’s not really important during the camp. There was no, “you have to be here at this time;” “we have to eat at that time;” if we got talking to somebody who had stuff to say, we stayed there until they were finished saying it and then we went on to the next thing. [Student C, 2nd year occupational therapy]

Cultural Sensitivity

Forty-four students (98%; 140 quotations) gave numerous examples of being prompted to examine their own values, beliefs, and behaviours, i.e., legitimize cultural differences through a process of self-exploration (Ramsden, 2002). Reflections most often fell into one of three themes: challenging stereotypes, professional practice, and interest in working with or learning more about Aboriginal people.

Challenging stereotypes. The most frequently coded reflections were about stereotypes. Twenty-three students (51%; 36 quotations) noted positive

Figure 1
Relationship between the Process Leading to Cultural Safety and the Learning Outcomes Codes and Categories



Notes: Codes are listed in descending order of frequency within each category, based on initial student interviews. * = These are different codes. † = Most frequently used codes in the community interviews. ‡ = Most frequently used codes in the long-term follow up student interviews.

images of the community in sharp contrast with the health disparities they had been taught or seen in health care settings and the media. This helped them to examine negative stereotypes.

I think one of the major stereotypes that I had was the loss of family or having parents that weren't responsible. That was one of the things that was always at the back of my mind and coming here we saw some really great people, people who were great parents, great role models ... [Student A, 2nd year medicine]

Consistent with developing cultural sensitivity, 15 students (33%; 22 quotations) demonstrated awareness of their own cultural norms:

...and the whole concept of family kind of expanded my view on how you could find help within the community. It's not just your parents that can help you or your grandparents. It's the whole community that comes together and you have the big house, the smoke house and you have these big healing sessions where everybody's involved in your care and I think that was very eye-opening cause I don't see that in my culture ... [Student A, 2nd year, medicine]

Professional practice. Twenty-four students (53%; 31 quotations) reflected on how cultural differences and their attitudes may affect their professional practice—a critical component of developing cultural sensitivity.

... there was a lady that came and talked about family interactions and at the end as we were wrapping up she said to ask your children, "What is it that you need?" So I guess that just made me reflect that in the hospital I do try to do my best when caring for patients. I do their vitals, analyze their O2 stats, their meds, their heart beat, etc. But sometimes, and I ask always, "Is there anything else you need?" ... but I don't really, now that I reflect, I don't think I have given them the time to say what they really need or want from us health care professionals ... [Student D, 2nd year nursing]

Interest in the Aboriginal community. Seventeen students (38%; 30 quotations) shared this student's revelation:

I think it sparked an interest to work with the Aboriginal community. I mean before it was an idea that I really wanted to pursue because I was just interested, but to have experienced first-hand the community and the culture, it really made me want to help and I'm keen and genuinely I really want to come back in some way informed. That was something I learned I want to do in the future. [Student A, 2nd year medicine]

Cultural Safety

Evidence that the camps are an education in cultural safety emerged in the descriptions of 18 students' (40%; 26 quotations) learning about history, 14 students' (31%; 17 quotations) learning about time, and 12 students' (27%; 19 quotations) learning about trust, as well as the community's descriptions of the way students behaved and in the long-term follow-up interviews.

History, time, and trust. Aboriginal people suggest that doctors need to understand the history of Aboriginal people and its effect on individuals and communities (Towle et al., 2006a). Students learned about the impact of colonization from Elders who shared their personal histories with residential schools that removed Aboriginal children from their families in an effort to assimilate them into White society. Through listening to Elders' stories, students came to understand how these experiences interfere with their ability to establish trusting relationships in health care settings.

...especially the Elders in the group that were in residential schools, they have a lot of issues with health care providers and a lot of trust issues. ... And so, I kind of learned a lot about the background and about why there's some distrust with medical professionals in general. [Student E, 4th year medicine]

Trust is associated with "the doctor getting to know the patient as an individual and as a member of their community" (Towle et al. 2006a, p.344). The camp experience brought this association to students' attention.

...there were a few who didn't really talk to us and perhaps seemed a little bit uncomfortable with us and it was nice to see that slowly improve over the days as we got to know them and I think as they got used to us as well and it made me very aware that you can't just automatically assume that you're going to have someone's trust or have someone's respect right from the beginning and that those relationships have to be fostered.... [Student F, 2nd year medicine]

Students described ways they might build trust by allowing the patient to "tell their full story" (Towle et al., 2006a, p.344).

I felt there was a really big emphasis on telling stories and sharing and while it's always emphasized when dealing with patients ... I think it's even more so for Aboriginal people to let them tell their, let them communicate their full story so that you understand fully where they're coming from ... [Student G, 2nd year dentistry]

The Community's Perspective

In the community's view, students demonstrated an aptitude for cultural safety through their culturally-appropriate behaviour. The reciprocity, identified by 10 community members (63%; 22 quotations), was particularly important. The students' enthusiasm to "help where they could," "get their hands dirty" and participate fully in camp life in exchange for their learning was consistent with the community's ways of teaching and learning.

... they just pitched in and helped with the drum making and they learned but they helped the instructor cause they sat in there and did the singing and drumming. And, when we did the bannock making they were right in there to help out and helped to set up the food and being a part of all of the whole process. [Elder]

More importantly, the students' desire to learn from the community showed a respect for cultural teachings that is an important skill for culturally-safe practice. Fourteen community members (88%; 22 quotations) talked about the students' eagerness to learn from them, and appreciated that, in some cases, this required taking initiative to seek out Elders and spend significant periods of time with them.

... they would sit there for maybe hours sometimes and just sitting there and talking with our Elders and learning ... like a sponge, they just soaked it all in ... that's what we're there for was to show them like thank you for showing us that you care enough to come here. [Camp Leader]

The youth also noted that the students had a positive impact on camps. During closing ceremonies of one of the camps, youth were asked how they liked having the students at the camp. Comments such as, "The students were nice, they understand you" and "The students were helpful, you could ask them anything" were common and suggest the students earned some degree of trust in the eyes of the young campers. At the closing ceremonies of all camps, youth are encouraged to honour someone who they connected with at the camps with a ceremonial blanket and other items. We estimate that the majority (perhaps 90%) of the students were recipients of these gifts.

There was also evidence that the students are well on their way to being able to deliver culturally-safe care. A cultural leader at one of the camps expressed this.

... they're so outgoing and easygoing and they don't seem like they carry themselves like, "Oh I'm higher than you, I'm better than you." They don't seem like they judge. I don't know what it is for doctors. I don't know if they have this thing

where they have to look like this certain person or they're not allowed to be friends with their patients. I don't know what their standards are but with them [the students] they could be your doctor and your friend, they would make you feel really comfortable. I would feel comfortable with going to them. [Cultural Leader]

Long-Term Impact

Students. In the follow-up interviews conducted 6-24 months after the camp experience, seven health profession students (58%) remembered learning about cultural differences related to family and community (19 quotations) and hearing from Elders about residential school experiences (11 quotations). However, even more frequently, 11 students (92%; 42 quotations) remembered positive attributes, strengths, and expertise of the community. Students recalled the resilience and talents they saw in the youth, the good role modeling of the camp leaders, the expertise of the Elders and cultural leaders, and the community's good work to heal the past and move forward through reclaiming their culture. They noted how these assets gave them a more positive outlook on the Aboriginal community than they had acquired through their formal academic curriculum.

...at med school you learn a lot about the hardships and the health inequalities and the struggles that a lot of communities have with things like suicide and addiction and diabetes and high blood pressure ... but you don't learn a lot about the strengths and that's where I think the camp was really valuable cause I got a chance to experience the strengths of the community and chat with the Elders and see how the knowledge and the teaching is being still orally handed down from one generation to another in the camp setting and how positive and how supportive the environment was out there ... [Resident A (Student B), Family Medicine]

Ten students (83%; 38 quotations) continued to find themselves challenged by the disconnect between the Aboriginal community they came to know during the camps and the understandings they had formed from health statistics, media, and treating patients. The disconnect encouraged students to reflect upon their preconceived notions about the Aboriginal community.

... we'd like to think we don't have prejudice and we don't look at people of other groups and have these preformed notions, but I think what the camp made me face front-on is that even though I think I didn't have prejudice there are kind of these automatic thoughts that you have when you think 'Aboriginal person' and I think that camp helped me kind of just find out what those initial

thoughts were ... [Student H, 3rd year medicine]

The self-awareness demonstrated by this student is a critical part of developing cultural sensitivity within the cultural safety process.

Eleven students (92%; 28 quotations) also remained keenly aware of the importance of building trust. They reported trying to do this in three main ways: telling patients about their experience in the community, giving time, and listening. They noted that telling patients about their camp experience was a quick, yet powerful, way to build trust.

...having had that experience I think it just opens doors for a conversation of 'Oh yeah I went...' when you're taking their blood pressure or whatever you're doing to mention something about that you made a First Nations drum or what beautiful music that was or something where you can just share that you were interested in them as a person ... builds that relationship with them. [Student I, 4th year medicine]

It was also a way to tell the patient not to worry about being judged.

I've told patients about the experience that I had and I think that helps them be a bit more comfortable with me sometimes because they get the impression, 'Oh this is somebody who is not antagonistic towards us, they're somebody who's excited about learning about my past.' [Resident B, Family Medicine]

Five students (42%) remembered the importance of listening (8 quotations) and giving time (16 quotations). This was admittedly more challenging to do in practice but the pay-off was significant.

...the biggest thing is that whole time issue. So not feeling rushed when you're with a patient, to sit down with them and not necessarily ask them about why they've come to see you right away but ask them about their life. How are they doing, where are they living, are they from this area, where is their family, to understand who they are in the context of their life before diving into the medical aspect. I think, cause once you can build that rapport then it's a lot easier. I found that often times if I try to do it the regular way, I just go in and ask them, 'So what have you come in to see me for?' it often doesn't work cause I'm missing the bigger picture, bigger issues. [Resident C, Family Medicine]

Eleven students (92%; 45 quotations) reported that they now had a better understanding of the barriers faced by Aboriginal people. One told how this helped in an encounter with an angry patient.

... she sort of went on a rampage about how doctors never listen to her. She was really upset with

me. She was swearing. She'd never even met me before. She was just saying that the medical system is terrible, no-one can help her, no-one's really listening to her. And my first reaction was frustration, obviously. I just wanted her to get out of the office. It's totally inappropriate. But then what came to mind was that whole idea of this cultural barrier that this lady had already encountered, so many, probably, judgments with regard to her own health care that she hasn't been able to get adequate health care and I think for me that's probably directly related to the camp cause that's what made me realize that there are a lot of Aboriginal people who have had encounters with health care that have been unhealthy ... so I had a chance to really just sit down with her and asked her what were her issues, what were her experiences with the health care system, and as a result you know she ended up coming back to me a couple of times and she was really upset when I left because she wanted me to be her family doctor. [Resident C, Family Medicine]

This student's reaction to give time (sit down with her) diffused the situation and resulted in the patient coming back. The patient wanting this student to be her family doctor suggests the student had success in creating a culturally-safe environment for the patient.

Results: Learning Process

The ways in which students developed cultural awareness, sensitivity, and safety came from spending time in the community and getting to know community members. In the initial interviews, 23 students' (51%; 49 quotations) learning was rooted in their interactions with the youth and 16 students' (36%; 24 quotations) learning in conversations with elders. In speaking about a mentorship interaction she had with a youth, a midwifery student said this:

I think it kind of started right in that moment when she was asking questions about drugs or STDs or I'd say, 'oh I do feel useful, I actually feel like I can contribute to her life and help her, empower her to make her own decisions,' and I would like definitely to continue that with her, but also in my life I think, or as a midwife I can see sort of playing that role more with, I guess it sounds strange to say about Aboriginal people, but I think I do feel like you have a knowingness, when you've spent time with this family it's part of you and so when you meet somebody, a different family, you kind of transmit that somehow I feel. [Student J, 1st year midwifery]

Twenty students (44%; 37 quotations) distinguished the experiential learning environment of the camps as an important factor in their learning that could not be replicated in the classroom or clinic. For example,

...in school you learn about certain issues but you never ever learn about anything positive. You learn about the diabetes and problems with alcohol and drugs and I may learn about residential schools a little bit, but you learn nothing about the culture in the sense of community and how amazing everyone is with each other within that community. I think we're really used to seeing in society, First Nations people as being kind of the odd ones out, you never ever see a whole community of them. They're the ones that stand out, usually in negative ways, in broader society and they're stereotyped in negative ways and it was incredible to be there where we were the odd ones out. And to imagine what that feels like to say a girl who's growing up as a First Nations woman, what that must be like ... it really makes you feel that. [Student K, 2nd year nursing]

Similarly, a medical student said this:

For me I've always seen people from the Aboriginal community either in the hospital or clinical setting, so they're kind of entering your setting and they're not comfortable in it. So it was really nice to be able to become the visitor and visit them in their setting and see how the culture is, again that strong sense of community really spoke out to me... [Student L, 2nd year medicine]

Although there were no overall negative comments about the camps, 16 students (36%; 19 quotations) described initial feelings of discomfort that faded as they began to make sense of cultural differences. For example,

You're not in the hospital and you're not in a doctor's office, you're in a Long House so you're not on your turf, you're on their turf and that was really important and there's actually a really, you feel different, like you walk in out of this hot sunny day into a cool Long House and actually there were fires because it was so cold inside the Long House because it was so dark and that was just, wow, and we would, one of the days we basically spent the whole day inside this Long House and people were talking and actually, one of the, I think the biggest thing I learned was the way that they teach, the way that they tell, they use storytelling to teach ... and that was actually really frustrating for me for the first couple days. I was like, 'oh my gosh, I know there's a point to this, just get to it.' {Laughing} But then I realized there's a lot to be said for having this, like it's an amazing skill to be able to have a story that just meanders all over the place before getting to sort of the point, but really the point is actually all that stuff that they touched upon ... it was just really a different kind of pace of doing things and it helped me understand why sometimes if you're having a clinical interaction maybe it happens in a different way... [Resident D, Community Medicine]

We also asked students what they wanted to learn more about but didn't at the camp. Ten students (22%; 10 Quotations) identified the community's history, 8 (18%; 8 quotations) identified traditional medicine/healing, and 3 (7%; 3 quotations) identified health care delivery on reservations.

In the follow-up interviews, 10 students (83%; 22 quotations) referenced the connections they made with the youth and 8 students (68%; 15 quotations) referenced the conversations they remembered with elders. However, the juxtaposition of the experiential learning environment of the community with their formal curricula was far more salient, with all 12 students (100%; 53 quotations) mentioning this. The experiential nature of the learning process left a lasting impression because of how different it was from other ways they learn about Aboriginal health. Living in the community, just for a few days, gave them a glimpse of the individuals and contexts behind the problems that enhanced their understanding.

... when you're learning about any population you're prone to make generalizations about the population. Because my learning prior to that experience had primarily been through these generalized concepts or statistics, it was easier to, when I met an Aboriginal patient, not necessarily assume, but sort of leave it to likelihood that certain things would be higher and maybe anticipate those things, and to the point of making generalizations where the experience changed my perception in that I knew more so that I couldn't do that, that each person's story was unique ... [Resident B, Family Medicine]

Community Benefits

From our experience working with the community to develop and implement these learning opportunities for students, we have witnessed a transformation in community members' thinking about their role and recognition of their own capacity to teach health profession students. In the making of an informational video about the project, one community partner reflected on her impressions from the first meeting about the project and the opportunities it led her to see in her community for correcting misperceptions.

...when we met with [the project leaders from the University] it became really clear what they were looking for and I think what they were really looking for was building knowledge for their students who wanted to become doctors and when I thought of that concept I thought you know, that's probably not a bad idea because I think that the First Nations people have so much to give in terms of cultural knowledge and experience and letting people know who we are because there is this misnomer out there about

who we are and what we are. And this was a time for us to showcase that, and to allow us to show other people, especially professionals, who we are. [Former Program Supervisor]

Another said this about the partnership:

One of the neat concepts [of the partnership with the university] was the concept of the community as teacher which I think is unbelievably beneficial. It's actually served to help us in our work to secure funding for some of our programs because this concept of community as teacher helps us push forward to making sure we are community-driven as an agency. ... I also think it works well for our camps for really empowering our kids to know their own culture. It's one thing to go to camp and to live your own culture, it's another thing to be explaining it to folks that have no idea why they're doing it. So I think it really helps the kids that we have coming to camp to realize their own knowledge when it comes to their culture and where they're at and how they've come to terms with living in that dual world of Aboriginal culture and modern society. [Camp Coordinator]

Our community partners further reported that they have observed a benefit to their camp participants deriving from the opportunity to educate university students. For example,

Another way that our camp participants have benefitted is in the area of self-esteem. While helping to educate the UBC students in various aspects of Aboriginal culture and community, the camp participants gain self-awareness not only of how much knowledge they actually have, but also a sense of pride in their culture and community. [Camp Coordinator]

A sense of pride in being able to teach students was also conveyed by a cultural leader in a community interview.

It was kind of cool for me to see such interest in our culture. ...she [a nursing student] asked me about the drum...and about different songs that we sing and it was really cool for me cause that's my specialty in culture is singing and the songs and the drum, so I was just kind of really excited about that... [Cultural Leader]

Discussion and Conclusions

Our findings suggest that cultural safety can be learned from brief immersion with the Aboriginal community as the teacher. Students' descriptions of what they learned demonstrate enhanced cultural awareness and sensitivity. Students' ability to conceptualize how they might overcome communication

barriers in practice to build trust, as well as the community's description of the students' behaviour at the camps, show that the former developed a capacity to practice culturally-safe care. Long-term follow-up suggested students came to appreciate the expertise that exists within the community, which enhanced their understanding of Aboriginal health and helped them practice cultural safety. Self-awareness, generated by positive images from immersion in the community, prevailed in the long-term more than awareness of cultural differences, which was prevalent in initial interviews. Self-awareness was brought about by the questioning of stereotypes and assumptions and was carried into practice.

That students learned about cultural differences in the values attached to time, family, and community is not surprising. What is surprising is the depth to which students engaged in critical self-reflections, also referred to as cultural humility (Tervalon & Murray-Garcia, 1998), that resulted in increased awareness of their own attitudes and sensitivity to other worldviews. Although these outcomes have been demonstrated in other immersion programs, the immersion times were longer (1-6 weeks vs. 3-4 days living in the community) and part of credit-based elective (Ekelman et al., 2003; Kavanagh, 1998) and curricular (Dowell et al., 2001) coursework. We found the same educational benefits with brief, extra-curricular, immersion.

The experiential nature of the camps is a marked departure from formal academic curricula. Most Aboriginal health curriculum in Canadian medical programs is delivered through lectures or problem-based cases (Spencer, Young, Williams, Yan, & Horsfall, 2005). In the community as teacher model, the service provided by students is determined by the community and is secondary to their role as learners. Although the services that students have been called on to provide have become more health-related as the community has recognized the expertise of students that fits well with the needs and goals of the camps, the learning environment is relatively free of responsibilities for providing service (other than facilitating health discussions at the request of the coordinators/attendees), delivering patient care (other than offering basic first aid when needed), or acquiring other competencies and without the pressures of reporting to a preceptor. Through their participation, the students became part of the community and in so doing learned about Aboriginal culture. Students reported feeling surprised at how open and inclusive the community was toward them. This inclusivity likely contributed to the respectful way students saw their community teachers and valued their teachings.

The community as teacher model addresses some of the shortcomings of formal academic cultural

competence training which has been criticized for being abstract, theoretical, and simplifying the complexities of culture to narrowly-defined knowledge, skills, and attitudes that reinforce stereotypes by encouraging students to see “others” as deviant (Beagan, 2003; Kumas-Tan, Beagan, Loppie, MacLeod, & Frank, 2007; Tervalon & Murray-Garcia, 1998). Such approaches tend to focus on deficiencies that overshadow community strengths and expertise, and undermine cultural safety. We found that the experiential nature of the community as teacher called into question stereotypes conveyed by formal curricula.

The program is also an example of successful service-learning where the focus of students is not to take action for the community partner. Similar to Steinman’s (2011) experience in collaborations with the Makah and Ohlone peoples, our community partners placed greater value on the students just “being” there over taking action. They saw the program as an opportunity for cross-cultural sharing—university students learning about Aboriginal culture and camp participants learning about the possibilities of post-secondary education and developing better relationships with health care professionals. Partnership with a large post-secondary institution validates the work of the Aboriginal child and family services agency in the community and the opportunity to educate university students enhances the camp participants’ sense of pride in their culture and community.

To this end, the model begins to address the unequal distribution of power inherent in service-learning for which the pedagogy has been criticized (Bortolin, 2011; Mitchell, 2008). The community as teacher approach led us to co-create, with a community partner, a shared learning experience about the expertise that the community can bring to the university, not only the expertise the university brings to the community. It is one approach to developing “deeper” community-university relationships where “reciprocity, community voice in service-learning design and co-defined outcomes” (Steinman, 2011, p. 8) are possible. On the continuum of community engagement proposed by the Centres for Disease Control and Prevention (CDC, 2011, p. 8), our model moves well beyond outreach and service toward an increased level of community engagement characterized by a bidirectional relationship with shared leadership and mutual trust that recognizes the unique community strengths and expertise.

Our model allows students to see the community as an authority on its members’ unique strengths, needs, and challenges. It engages students in self-exploration and adds a degree of authenticity often lacking in academic cultural competency training. The authenticity of the community as teacher may

explain how such significant learning could occur during a brief 3-4 day immersion. The community provided the learning content and context that gave students insights into their historical, socioeconomic, and geographic lived realities, just as argued by Gregg and Saha (2006) for effective cross-cultural education.

Although the program had positive learning outcomes and was a welcomed connection with the university, it also had limitations. It is difficult to reach a large number of students and make it part of formal academic curricula because increasing the number of students would jeopardize the immersive nature of the experience and burden the community. That there were no negative student learning outcomes or negative community reports suggests that the voluntary nature of the intervention may attract students who are inherently self-reflective and/or learn effectively from cultural immersion, and/or who have an interest in learning about other cultures or Aboriginal cultures in particular. Similar learning outcomes may not be achieved with all learners. Students who are comfortable with other cultural groups may be most likely to participate and those less culturally competent may be least likely to participate. Although we do not know the students’ level of comfort with cultural diversity prior to the camps, when probed, even the most experienced students characterized their past interactions with Aboriginal peoples as limited. We would argue that the program attracts students who would benefit most (those considering career paths in which they may work with Aboriginal patients) as indicated by 17 (38%) of the students interviewed.

Not all students benefited equally from the program. Although all student interviewees noted learning within the ‘Cultural Learning’ category (cultural awareness), one student did not describe any reflections that met the criteria for the ‘Learning about Self’ code category (cultural sensitivity) and three students did not report learning coded within the ‘Communication’ code category (cultural safety). However, follow-up interviews suggest that students continue to process their learning when they encounter new experiences as evidenced by the way they contextualized the positive attributes they witnessed in the community as assets.

The research also had limitations. In reflecting on the research process, the community could have been more involved in the research design. While our community partners selected who took part in the community interviews, reviewed an early draft of the manuscript, and confirmed the presentation and interpretation of the findings, they were not involved in the study design or analysis. Had time and distance permitted, a participatory research design could have

been used to fully involve the community in the research process.

Nonetheless, the outcomes of the research have been shared with the community. We produced a poster of quotations from the student interviews which hangs in the agency's office and, at the request of our community partners, the results of the research were presented to regional managers at an annual gathering in which they were seeking continued support for their programs. Our community partners report that they have begun to use cultural safety to guide their own practice.

Although the community as teacher model shows promise in teaching students important skills and attitudes, it remains to be seen if it is generalizable to other Aboriginal communities or patient groups. A key ingredient, as demonstrated in this study, is to remove students from their familiar settings so they can interact with the community on the latter's turf and terms. Students' immersion in the community as learners (not service providers) helped the community assume the role of teacher and created a favourable learning environment for cultural safety. The ways in which students contributed were guided by the community and remained within the scope of regular camp activities. Participating alongside community members in existing community activities allowed students to set aside their professional identities and provided opportunities to examine their own values, beliefs, and biases. Placing students in roles other than learners could undermine community expertise and interfere with learning. The model also presents an opportunity for interprofessional learning, noted by 22 (49%; 30 quotations) students in the interviews, as students came from a range of health and human service programs at different stages in their education (pre-med to residency). This also suggests the model may be effective irrespective of professional orientation and level in professional school.

We conclude that brief immersion with the community as active teacher is an effective model for teaching cultural safety in the Aboriginal community. By spending time in the community as learners, students not only become aware of cultural differences but gain self-awareness and sensitivity to other world-views that enables them to practice cultural safety. Such community-university partnerships enable communities to contribute to shaping their future health care providers to better meet their needs.

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¹ Throughout the paper "students" is used to describe University of British Columbia students enrolled in any health profession program (e.g. medicine, nursing, occupational therapy, pharmacy, dentistry, social work, midwifery, etc.).

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