Co-creating Simulated Cultural Communication Scenarios with Indigenous Animators: An Evaluation of Innovative Clinical Cultural Safety Curriculum

Journal of Medical Education and Curricular Development
Volume 7: 1–9

DOI: 10.1177/2382120520980488

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ABSTRACT

BACKGROUND: Building on partnerships with Indigenous communities and with the support of the Northern Ontario School of Medicine, faculty created groundbreaking, authentic cultural immersion curriculum designed to foster culturally safe interpersonal skills and cultural understanding. However, structural barriers to the teaching of clinical communication skills for culturally safe care to Indigenous patients persisted. To address this challenge, faculty collaborated with Indigenous animators on the co-creation of a new teaching modality of Simulated Cultural Communication Scenarios. We evaluated student learning experience, the faculty teaching experience, the attainment of teaching goals, benefits, and areas for improvement for this approach.

METHODS: We piloted 9 Simulated Cultural Communication Scenarios with 64 medical students and 17 tutors. We collected quantitative and qualitative data regarding their experiences and perceptions of the new curriculum. The quantitative data was statistically summarized, and the qualitative data was coded and thematically analyzed.

RESULTS: The emergent themes indicate that co-created Simulated Cultural Communication Scenarios support the acquisition of culturally safe clinical skills because the modality fosters authentic, safe, context rich, and anti-oppressive patient dialogue with Indigenous animators. Recommendations for optimizing the sessions included ensuring tutors have a deep understanding of the significance of cultural safety in patient care. As the pedagogy is different from the familiar standardized clinical skills sessions, tutors and students benefit from education on the pedagogical approach.

CONCLUSION: Simulated Cultural Communication Scenarios, co-created with cultural insiders and academic educators, represent an authentic education approach to teaching culturally safe clinical encounters. The findings contribute to our understanding of translating social accountability into the clinical setting.

KEYWORDS: Cultural safety, Indigenous health, patient co-creation, patient simulation, social accountability

RECEIVED: October 6, 2020. ACCEPTED: November 23, 2020.

TYPE: Original Research

FUNDING: The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: The authors received funding from the Northern Ontario School of Medicine for publication of this article.

DECLARATION OF CONFLICTING INTERESTS: The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

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Introduction

Background

The Northern Ontario School of Medicine (NOSM) was created in 2004 with a social accountability mandate, including a strong focus on addressing the health needs of Indigenous communities.[1] The World Health Organization (WHO) defines social accountability as the obligation of medical schools to direct education, research and service activities toward addressing the priority health concerns of the community.[2] The school has begun to demonstrate progress and positive impacts in responding to NOSM's socio-cultural-geographic context.[3,4] NOSM's Indigenous Affairs staff have been instrumental in supporting the development of community-based learning experiences through community engagement and partnerships and with First Nations and Métis peoples from communities across Northern Ontario. Building on community partnerships, NOSM faculty created unique and groundbreaking, authentic cultural immersion curriculum designed to foster culturally safe interpersonal skills and cultural understanding.[5,6] Community-based learning includes a month-long placement for all first-year students in Indigenous communities where a major portion of the curriculum is designed by the community. This approach has successfully imparted experiential knowledge of Indigenous health care issues, but teaching cultural safety practices in *clinical simulations* remained an educational challenge.

Cultural safety builds on the concept of cultural competence by focusing on the "power differentials within society, the requirement for health professionals to reflect on interpersonal power differences (their own and that of the patient), and how the transfer of power within multiple contexts can facilitate appropriate care for Indigenous people and arguably for all patients."[7]

Unlike medical competencies, which can be demonstrated by learners directly, cultural safety of a provider can, by definition, only be evaluated by patients.[8] In addition, it is difficult to capture the intangible skills that facilitate culturally safe care such as the provider's level of empathy, respect, and relationship building skills toward Indigenous patients, and to apply standardized learner assessment.[9] Finally, in order to allow health care practitioners and students to safely gain practical experience without risking damage to the therapeutic relationship, the common approach to teaching learners examination and communication skills is through the use of simulated clinical scenarios that resemble real life scenarios.[10,11] However, we argue that structural barriers inherent in standardized teaching modalities in academic medicine pose significant obstacles for the inclusion of authentic Indigenous clinical scenarios. These barriers must be disrupted to avoid the risk of further marginalization of Indigenous patient experiences.

Deconstructing structural barriers for Indigenous SPs

During the pre-clerkship years of medical education, trained standardized patients (SPs) are routinely employed to portray patient scenarios.[12] This gives learners the opportunity "to interview and examine a live patient in a simulated, safe, controlled setting, free of the distractions present in real clinical settings" without risking harm to an actual patient.[13] The standardization of the scenarios allows learners to be assessed on very specific aspects of their history taking, communication, and physical examination skills using detailed objective structured clinical examination (OSCE) rubrics.[13,14]

In line with its social accountability mandate, one focus of NOSM's curriculum is the development of skills related to culturally safe care. Therefore, standardized Indigenous patient case blueprints were developed for clinical skills sessions, and efforts were made to recruit Indigenous standardized patients to represent these cases. Unfortunately, this approach was fraught with unintended negative outcomes.

The first significant challenge to the delivery of standardized Indigenous patient scenarios that we observed over several years was that Indigenous SPs often did not relate to the patient cases. At times the case was in conflict with the SPs' own Indigenous lived experiences and in response they often did not "stick to" the blueprint. Instead, SPs tended to add information they perceived as more authentic to the standardized case. The SPs also often resisted the instructions given in their training about when to reveal and when to hold back information from learners during the interviews. Finally, many Indigenous SPs "came out of their role" and provided feedback to the students from their personal experience as opposed to the perspective of the case scenario patient, which also ran counter to the structured clinical skills (SCS) model. SPs seemed to express discomfort with a cultural incongruence, which was perhaps also the reason why the school's simulation unit had difficulty recruiting and retaining Indigenous SPs.

As a result, consistent teaching of SCS with Indigenous SPs became impossible from a pedagogical and a logistical perspective within the standard SP model. Unfortunately, there were no exit interviews to provide the Indigenous SPs perspective, on why some felt the need to resist the case blueprints, or why recruitment and retention of Indigenous SPs was much lower than for other SPs. However, our informal fact finding revealed the following: (1) Indigenous staff members were not involved in the recruitment and training of Indigenous SPs; (2) simulation staff had not received cultural safety training; (3) the NOSM Indigenous Affairs unit was not approached for cultural support; and (4) Indigenous animators with whom we collaborated in this study, reviewed the blueprints, and felt uncomfortable with some of the portrayals of Indigenous patients. We concluded that the recruitment, training, implementation process, and case blueprints lacked cultural safety for Indigenous SPs, and this was a cause for the lack of success of standardized clinical teaching.

Co-creation of SCS scenarios

The SP experience underscores the need to collaborate on the creation of clinical skills curriculum related to Indigenous health and cultural safety with Indigenous people with diverse lived experiences. Similarly, Jacobs and van Jaarsveldt[15] recommend the co-creation of scenarios for SCS sessions as being important for realistic character building and authentic portrayals of patients. Indeed, Hardee and Kasper[16] referred to standardized patients who co-create the scenarios as "Care Actors" to reflect the flexibility and improvisation needed in this role and note that Care Actors are "integral contributors" to the learning process for medical students and residents. Stanley et al[17] noted that the collaborative process used to develop scenarios for patient simulation exercises provided the opportunity for a group of clinicians, patient facilitators, and standardized patients to explore and develop different perspectives rather than a scripted scenario developed only from a clinicians' perspective. Research shows that co-creating scenarios lends itself to realistic clinical encounters with actors who are able to improvise and respond to the learner's questions with authentic information and the flexibility to meet students at their current level of skill with culturally safe care.

Co-creation of simulated cultural communication scenarios

Our academic team, consisting of clinical and research faculty, and an Instructional Designer, became intrigued by the notion of creating less scripted and more authentic scenarios related to culturally safe care and we began to explore the engagement of Indigenous actors. We hypothesized that in order to develop a more authentic teaching modality to culturally safe care we would need to include actors with Indigenous lived experience and knowledge. The academic

Table 1. Guiding questions for animator feedback.

STUDENT FEEDBACK TOPIC	ADDITIONAL PROBES
What did the interviewer do well?	How did they make you feel respected?
Did the interviewer do or say anything that made your character uncomfortable?	If yes, identify what happened and what could have happened to bring the interview to a stronger conclusion. Please remember to be sensory based in your feedback—be specific about what was said or what was done and how that could be interpreted in ways the student hadn't thought of.
Did the questions illicit topics your character wanted to explore?	Was there anything your character would have liked to explore, but didn't?
From a cross cultural perspective, was there anything that could have been done differently to allow your character to feel more at ease, as though the interviewer "got" your character?	Is there a way that the student made your character feel at ease to discuss their choices in traditional and Western medicine?

team members decided to build on a long standing research relationship with a professional Indigenous theatre group, the Debajehmujig Storytellers[18-21] which enabled the respectful co-creation of simulated Indigenous patient cases.

The Indigenous patient actors refer to themselves as animators, defined as *"one who provides or imparts life, interest, spirit, or vitality."* The Debajehmujig animators developed 9 patient cases based on their personal lived experiences as Indigenous people living in Indigenous communities who carry a deep understanding of the fabric of life in their community. Medical conditions for each patient character were created in collaboration with clinical faculty (MR) during face-to-face meetings. Next, the animators diversified the characters by studying other community member's experiences, with their permission, to add rich details to the portrayal of their case. Animators paid particular attention to developing the strengths, cultural perspectives and lived experiences of their characters. The amount of written notes describing each character beyond the brief descriptions of the case scenario were left to the animators' discretion. The final complement of *Simulated Cultural Communication Scenarios* included a wide spectrum of community members such as a tribal police officer, a traditional knowledge keeper, a mental health worker, a single parent, and a person struggling with a history of racist experiences with health care providers. Finally, the team worked together to develop the animators ability to provide strengths-based feedback expressing the subjective level of cultural safety they experienced based on empathy and respect that were conveyed by the student (see Table 1).

In this paper, we report on the cultural safety education outcomes and opportunities for improvements related to our piloted Simulated Cultural Communication Scenarios based on evaluation research with students and tutors.

Methods

Overview of simulated cultural communication scenarios

Tutors and students received an orientation to this session by the physician who worked with animators to develop the cases and a cultural knowledge keeper. During the interaction, students were to complete a patient history while exploring the social context of the patient. Students were instructed to focus on communication strategies that build rapport and to explore culture and its importance in health as experienced by each animator.

Students were divided into groups of 3 and each was instructed to complete 1 Simulated Cultural Communication Scenario. At the start of each interview, the observing tutor and students went to the observation area. The interviewing student then knocked on the interview room door, entered, and began their interview. Each scenario was presented by an Indigenous animator as a Simulated Cultural Communication Scenario.

In terms of timing, a total of 15 minutes were allocated for each interview. After the interview, the tutor and observing students rejoined the interviewing student and animator for a 20-minute feedback session. The interviewing student began by describing how he or she felt coming out of the interview and outlined areas that went well and those that require improvement. Next, the animator was invited to comment. Their feedback included the cultural safety feedback outlined in Table 1. Finally the tutor provided their observations.

From the medical perspective, groups had 1 patient case in each area: Diabetes Follow-Up; Frostbite Follow-up; Blood pressure check (see Table 2 for details). However, students were instructed of the importance of fully eliciting the patient's perspective and carefully understanding the cultural, community and personal context in which the specific health problem occurred. The scenarios were designed to provide an opportunity for students to learn about some of the cultural considerations that should be taken into account when interviewing an Indigenous patient.

Participants

All medical students were in the final weeks of their first year and completed the scenarios during their regular clinical skills sessions. Tutors were selected for their previous experience in

Table 2. Simulated cultural communication scenarios.

CASE DESCRIPTION	JOB IN THE SCENARIO	PATIENT'S CONTEXT
Clinical presentation: diabetes follow-up (well managed)		
Patient was diagnosed three years ago and is now off all medications for the past six months because of their healthy lifestyle choices	Director of the First Nations health center; Patient name: Angel; Animator: Tabitha	As the health director, Angel is very organized and business-like. She is uncomfortable with male providers.
Patient has been living with stable diabetes for ten years	Peer educator in the community (smoking cessation counselor); Patient name: Aaron; Animator: Bruce	Aaron has an open and effusive style of communication and is more than willing to share thoughts and successes with providers
Patient has had stable, diet-controlled, diabetes for five years	Lands Department Manager; Patient name: Jim; Animator: Ashley	In the past year Jim's sugars have been climbing in tandem with increased family stressors
Clinical presentation: frost bite follow-up		
This patient's ears were frostbitten and was advised to return for follow-up	Tribal Police officer; Patient name: Tahney; Animator: Sheila	Frostbite developed while searching for a missing patient from the nursing home. While successful, the search itself was stressful and arduous.
The patient was on a weekend snowshoe and ice-fishing trip with a youth group and developed frostbite to his left hand. Just wants a medical note to return to work.	Community youth worker; Patient name: Allen; Animator: Matt	Allen is skeptical about the need to see a provider and is hesitant to talk or open up due to past negative experiences with medical community
This patient's fingers on both hands were frostbitten while walking home late from a party when they couldn't get a safe ride home, or a taxi	Traditional Knowledge Keeper; Patient name: Alex; Animator: Sunny	Alex shares the challenges of rural winter living. If asked, he is also open about his role as a traditional knowledge keeper.
Clinical presentation: blood pressure check-up		
This patient is dealing with a lot of stress because of the rising opioid addictions they are seeing and the rise in overdoses. His colleagues suggested he should get his blood pressure checked.	Addictions worker; Patient name: Wesley; Animator: Daniel	Wesley is in recovery from an addiction himself and is open to sharing how his use of traditional medicines keeps him grounded
This patient's mom suggested the BP check as she knows he hasn't been accessing preventive care and she worries	Personal Support Worker; Patient name: Randy; Animator: Sheldon	Randy is working full time, a single parent and supporting his sick mom physically and emotionally. Due to her end-stage COPD she is living in his home.
This patient has come to the center to get their blood pressure checked. They are overdue for a follow-up, and their blood pressure was a little high last year.	Band Councilor; Patient Name: James; Animator: Steve	James has been doing a lot of travel for work and is keenly aware of the responsibilities of ensuring adequate housing for his community

facilitating SCS. The animators were selected by the organization based on a number of factors such as years of experience, the ability to support more junior animators and personal attributes such as resiliency. Demographic details are provided in Table 3.

Data collection

We created an evaluation survey for students and tutors, and administered and collected the data as part of the evaluation process for structured clinical skills sessions. The questions were designed to gain the students perspective regarding their progression toward becoming a physician prepared to provide safe care to Indigenous patients. Five questions were measured on a Likert scale (Tables 3 and 4) and 4 open-ended questions with ample space for narrative responses. The open-ended questions included the following: Was this session useful for student learning? Was there anything in particular that you found challenging about this session? Do you have any suggestions for improving this session for future students? Was this session comparable to traditional SCS sessions?

Students and tutors received an electronic link to evaluate the sessions anonymously. Participation rates were 39/64 (61%) for students, and 7/17 (41%) for tutors. These rates are higher than regular NOSM participation rates for program evaluation.

Table 3. Participant demographics.

DEMOGRAPHIC GROUP	DEMOGRAPHIC CHARACTERISTICS	NUMBER OF PARTICIPANTS
Facilitators	Female	14
	Male	4
	Indigenous	2
	Long-term faculty	5 to 6
	NOSM graduates	10
Animators	Female	2
	Male	7
	Indigenous	9
	Age 25 or under	2
	Age 26 or older	7
Students	Female	42
	Male	22
	Indigenous	8
	Francophone	12
	Age 25 or under	39
	Age 26 or older	25

Data analysis

Quantitative data was statistically summarized using Microsoft Excel. The narrative data was analyzed using a reflexive approach to the thematic analysis organized around the central concept of cultural safety learning opportunities during Simulated Cultural Communication Scenarios. A collaborative research team composed of faculty researchers, tutors, academic staff, and a medical student from the same cohort were involved in the coding. The student researcher was recruited after all data collection was completed and provided access to member checking with students. Each researcher analyzed the data separately. The analysis was finalized during several group meetings where consensus was reached on the themes and illustrative quotes.

The study was approved by the Laurentian University Ethics board (Ref No: 15450).

Results

Quantitative student ratings

The student evaluations of the Simulated Clinical Communication Scenarios indicate that significant clinical learning about culture took place (see Table 4). Approximately 80% (n = 30) of students strongly agreed or agreed that they felt better able to judge when they have established good (or not) patient rapport. Additionally, 77% (n = 30) strongly agreed or agreed that they felt better prepared to appropriately respond to the clinical presentation of an Indigenous patient. Three quarters of students, or 75% (n = 28) felt they are better able to develop a perspective of the patient's problem beyond the presenting problem. Likewise, 75% of students (n = 28) strongly agreed or agreed that they learned more about how to appropriately respond to a patient's emotions. Finally, close to 84% (n = 31) of students have expressed that they gained a better understanding and are more sensitive to the impact of culture on patient perspectives on health, illness, and treatment.

Quantitative Tutor Ratings

All faculty members (n = 7) who responded to the survey believed that students gained insight on developing perspective of a patient's problem beyond the presenting problem. Additionally, all of the respondents (n = 7) believed that students gained judgement regarding establishing patient rapport. Eighty-five percent of faculty members (n = 6) felt that students gained knowledge and skills to appropriately respond to the clinical presentation of an Indigenous patient. Likewise, 85% (n = 6) of respondents believed that students learned more about how to respond appropriately to a patient's emotions. Lastly, all faculty members (n = 7) felt that students gained a better understanding and sensitivity to the impact of culture on a patient's perspective on health, illness, and treatment. See Table 5 for details.

Thematic Analysis of Tutor and Student Narratives

The themes that emerged in the analysis of student and tutor narratives of the clinical scenarios and their perception of benefits included: ***Practicing Conversations about Patients' Socio-cultural Contexts; Safe Immersion in a Culturally Authentic Clinical Communication;*** *and* ***Differentiating between Indigenous Animators and Standardized Patients***. In order to optimize learning benefits, students and tutors agreed that ***Enhancing Student and Tutor Preparation*** *and* ***Allocating Sufficient Time*** for the session were required.

Practicing Conversations About Patients' Socio-cultural Contexts

Most students and tutors believed that the sessions allowed them to explore a spectrum of social and cultural factors that physicians need to know about their patients.

> *Absolutely. It was a useful experience to dive into more detail on a social and cultural history with the patient and make that the focus of the interview to understand more about how it affects them and their potential treatment.*

Most students felt the experience allowed them to reflect on and assess their own growing level of awareness of socio-cultural factors that impact on patient care. Students felt that it is essential to practice their dialogue with the help of Indigenous animators in order for them to develop cultural informed communication skills.

Table 4. Student evaluation of simulated cultural communication scenarios.

STUDENT LIKERT SCALE QUESTIONS	STRONGLY AGREE N (%)	AGREE N (%)	NEITHER DISAGREE NOR AGREE N (%)	DISAGREE N (%)	STRONGLY DISAGREE N (%)	TOTAL N (%)
You feel better able to judge when you have established good rapport (or not) with a patient	8 (21.1)	22 (57.9)	7 (18.4)	1 (2.6)	0 (0.0)	38 (100.0)
You feel better prepared to respond appropriately to the clinical presentation of an Indigenous patient	10 (25.6)	20 (51.3)	5 (12.8)	4 (10.3)	0. (0.0)	39 (100.0)
You feel better able to develop a perspective of the patient's problem that goes beyond the presenting problem (eg, access to health care, resources such as food and social support, medical directives that conflict with culture)	11 (29.7)	17 (45.9)	5 (13.5)	4 (10.8)	0 (0.0)	37 (100.0)
You learned more about how to respond appropriately to a patient's emotions as they are expressed	8 (21.6)	20 (54.1)	7 (18.9)	1 (2.7)	1 (2.7)	37 (100.0)
You gained a better understanding and sensitivity to the impact of culture on a patient's perspective on health, illness and treatment	11 (29.7)	20 (54.1)	3 (8.1)	3 (8.1)	0 (0.0)	37 (100.0)

Table 5. Faculty evaluation: cultural considerations in patient communication I.

FACULTY LIKERT SCALE QUESTIONS	STRONGLY AGREE N (%)	AGREE N (%)	NEITHER DISAGREE NOR AGREE N (%)	DISAGREE N (%)	STRONGLY DISAGREE N (%)	TOTAL N (%)
Students gained insight on how to develop a perspective of the patient's problem that goes beyond the presenting problem (eg, access to health care, resources such as food and social support, medical directives that conflict with culture)	4 (57.1)	3 (42.9)	0 (0.0)	0 (0.0)	0 (0.0)	7 (100.0)
Students gained judgement regarding when they have established good rapport (or not) with a patient	5 (71.4)	2 (28.6)	0 (0.0)	0 (0.0)	0 (0.0)	7 (100.0)
Students gained knowledge and skills to respond appropriately to the clinical presentation of an Indigenous patient	5 (71.4)	1 (14.3)	1 (14.3)	0 (0.0)	0 (0.0)	7 (100.0)
Students learned more about how to respond appropriately to a patient's emotions as they are expressed	3 (42.9)	3 (42.9)	0 (0.0)	0 (0.0)	1 (14.3)	7 (100.0)
Students gained a better understanding and sensitivity to the impact of culture on a patient's perspective on health, illness and treatment	6 (85.7)	1 (14.3)	0 (0.0)	0 (0.0)	0 (0.0)	7 (100.0)

I do believe that this was a very useful way to integrate the medical and cultural aspects of the medical interview. As well, it allowed us to begin to investigate how the social/belief systems can impact health, healing mechanisms and perspectives of wellbeing. I do believe it will help me in the future when I am presented with an Indigenous patient and how to allow the topics of religion and belief systems into the interview.

Tutors also commented on the benefits of practicing communication with a focus on the context of social realities.

The rich detail of the animator's cultural history (i.e. details regarding band council, food sources, travel time to the grocery store) [was useful for student learning] (tutor)

Indigenous students commented on the usefulness of the practice scenarios, expressing that they allowed them to apply their lived experience of Indigenous culture with their emerging understanding of the practice of medicine.

As an Indigenous person, I found this session strengthened my understandings and personal experiences of health care on-reserve and traditional medicine. I didn't really learn anything new, but this session was useful to practice and develop the skills I already had.

Safe Immersion in Culturally Authentic Clinical Communication

Besides learning authentically about the Indigenous patients' context, many students commented on the authenticity of the communication styles and how the story telling component of the conversation prepared them for their future practice with patients.

Yes, scenarios were realistic and much more conversational, perhaps more real than encountered in a more structured session. Appreciated the opportunity to practice interviewing with patients who answer with more of a story and give a lot of context to their situation.

Students commented that the simulation allowed them to practice openness and respect in a safe clinical encounter.

I think this was a fun and interactive session to prepare us to be open-minded and respectful while talking with Indigenous patients. The patients portrayed realistic situations and varying characters, so it was fun to watch each interaction.

Students and tutors particularly noted the educational benefit of practicing engaging with Indigenous people in culturally safe manner in simulations to prepare for their month-long community placement in an Indigenous community in Northern Ontario.[4,5]

I think it prepares [students] better for the following 4 weeks they will spend on a reserve, and because of [the Simulated Cultural Communication Scenarios], they will benefit more of that experience. (tutor)

This session was extremely useful to my learning/understanding of cultural considerations during medical interviewing – especially for students about to embark on their [Indigenous community] placements. It was indefinitely more useful than any pre-readings we could have gotten. Please keep this in the curriculum for next year! (student)

Differentiating Between Indigenous Animators and Standardized Patients

Many students and tutors commented on the fact that Indigenous animators were more convincing in their patient roles than the typical standardized patients they had encountered in the past year of medical school. Furthermore, many students and tutors commented that the Simulated Clinical Communication Scenarios were the best simulated educational sessions in which they had ever participated.

The animators did an amazing job and I felt as though it was different than traditional SCS sessions as it felt like I was speaking to someone who truly believed what they were saying - because they were speaking of their Traditional beliefs! I felt as though it was less structured, which I could assume may be more characteristic of what medical interviews will be like in real practice.

It was clear the [animators] put lots of thought into their characters. . . and for that it was valuable.

Most students found the opportunity to interview an Indigenous patient with authentic lived experience and to receive their feedback on the interview to be excellent preparation for their future work with Indigenous patients. Some commented that this skill would be transferable to patients from other cultures.

I think this was different from other SCS sessions because we were able to get at the raw experience of the patient. It didn't feel as artificial as some of the other SCS sessions do.

Many students felt the communication scenarios were challenging, but many thrived as they worked at the limits of their skills.

This session was extremely useful for my learning. I believe it is the most valuable SCS experience I have had to date. It was very realistic and definitely challenged my interview skills. I believe that this experience will help me during my upcoming placement.

Some students felt that they would prefer if Indigenous patients would be integrated throughout their pre-clerkship curriculum and questioned why this had not happened. However, it is important to note that a small minority of students reported feelings of stress associated with their first exposure to less standardized interactions. One student even felt overwhelmed by the cultural and social depth of the scenario within the allotted timeframe.

There was no obvious subjective or objective benefit from this session [for me]. Subjectively it makes me doubt my skills.

As the student's tutor was also unsure how to make the encounter more culturally safe a learning opportunity was missed. This speaks to the complexity of teaching cultural safety skills in the

clinical setting and the need to clearly articulate the focus on establishing good communication, dialogue and rapport instead of a standardized outcome.

Enhancing Student and Tutor Preparation

Many student and tutor groups were very comfortable with the scenarios.

> *I thought the entire experience was very positive. I wouldn't change a thing!*

However some found the new format challenging and additional preparation could elevate some of the perceived challenges. For example, some found the switch to a conversational interview difficult after having spent a year learning to conduct illness- focused interviews with SPs using a prepared interview skills checklist on the body system currently under study.

> *I found it challenging to conduct a medical interview on topics that we have not yet had any education around. I think it would have been more beneficial to have more vague complaints or complaints that pertain more so to the individual's mental health or spirituality (instead of diabetes, perhaps just very stressed, feeling low etc.)*

Some expressed that the scenarios did require them to explore complex cultural issues such as the use of traditional Indigenous medicine with a patient for the first time, which required them to deal with their own discomfort related to spirituality in the clinical setting.

> *The more challenging aspect of this session was to know how to approach the topic of Traditional way of life and belief systems. In particular, how to commence this conversation and what further questions to add. As well, to identify when this conversation is appropriate and to what extent to inquire about this component of their social health.*

Some students were worried about offending the animator over cultural questions and eliciting specific information from the animators, but many took on this challenge believing that the scenarios were a more realistic reflection of an actual encounter.

> *At first, I found it challenging to ask questions about cultural considerations as I wanted to be sure I wasn't offending but I found patients were quite open to explaining their topics. I also found it slightly challenging to take a history when patients do not directly answer questions necessarily but instead give more of a story – I found the challenge helpful and informative and very much enjoyed the history taking.*

Allocating Sufficient Time

Faculty and students agreed that for future cohorts of students, rolling out the cultural communication in this new way would benefit from additional time to be allocated to animators, students and tutors becoming familiar with each other.

> *It would have been helpful to have some time to meet with the students prior to the first case to get to know them. It would have been helpful also to have a little more time which each animator for feedback.*

This additional time to get to know each other is also congruent with Indigenous perspectives of relational teaching. Additional time to review instructions in person would also be beneficial. In addition, tutors requested a training session without students present, so they could discuss questions regarding cultural safety and the new teaching approach amongst faculty.

Discussion

This quote by one of the learners summarizes the overall experience at NOSM with co-creating Simulated Cultural Communication Scenarios

> *Learning something new and being put in a situation out of your comfort zone is always challenging – however, this is necessary for growth and developing new skills and perspectives.*

Students and tutors received written instructions detailing the differences between these scenarios and previous SP scenarios, yet there was confusion in some groups which may have been a result of challenging this comfort zone. However overall, almost all students and tutors appreciated the intrinsic value of the learning sessions, "found the session very useful to [their] learning", valued "listening to Indigenous patient stories, thoughts, feelings, beliefs, and practices" and "highly recommended [the sessions] for future years." These findings corroborate research in medical education that involves actual patients with chronic illness to allow students a better understanding of patients' stories.[22]

But there were also a small minority of students and tutors who thought that the session was only an "interesting experience rather than a learning session" and felt that they "could probably be removed in the future to accommodate more time for SCS practice."

So despite the social accountability mandate, some students and tutors appear to value cultural safety less than one might expect at NOSM. It is important to select tutors that are advocates for social accountability and cultural safety and have received training on implicit bias and systemic racism and have lived experience with Indigenous patients and Indigenous health issues. Tutors should be knowledgeable and comfortable to facilitate a dialogue about racism in health care in their small group. Furthermore, tutors should be provided with a training session with the Indigenous animators to allow tutors to ask questions about Indigenous culture and health without students present. While the tutors are important, it is also important to continue to fine-tune medical school admission requirements to ensure that students who are admitted have an aptitude for culturally safe care and are committed to serving patients from diverse populations.

Animators and tutors require time to come to a common understanding of important issues for cultural safety with each scenario. Animators had undergone training in clinical case presentation and giving constructive feedback in order to provide critical feedback to tutors and students. Despite that, in

some situations the dynamics of the group affected the comfort of the animator to offer that feedback. Further exploration is needed regarding cultural safety terminology, implicit bias, and power and privilege in order to optimize the feedback sessions.

Some students also request that the session be explained to them at the beginning of their learning block to help them feel better prepared and less anxious about the different format. This will include an affirmation that students will not be able to cover all possible medical information in the allotted 15 minutes and that the emphasis is on understanding of the broader patient experience. To further help subsequent cohorts of students and tutors make the conceptual switch from SP to animator scenarios, we have decided to frame the session as a "new patient interview" and to give it the new title of Simulated Cultural Communication Scenarios.

Finally, another pedagogical benefit of the non-standardized format of the sessions was that students were able to practice history taking in a way that supports development of a therapeutic relationship, trust and rapport while critical thinking and analyzing information provided by the patient.[23]

Limitations of this study include that this is only the first cohort of medical students and tutors who have provided feedback on the scenarios and we are lacking animator feedback due to the fact that surveying the animators was not seen as culturally appropriate. Our findings showed that some groups and tutors deviated in their approach from the instructions. Future research should evaluate student and tutor feedback following the implementation of our recommendations for students and tutor training and increasing time allocation. Developing a culturally safe evaluation of the animators' experience using Indigenous research methods will also be an important component of future research.

Conclusion

Overall, the Simulated Cultural Communication Scenarios create an effective and safe space for education of health care providers and medical learners and offer promise for clinical cultural safety education. Community engagement has been the key to the success of NOSM's socially accountable distributed medical education,[24] and this innovative teaching approach expands this approach into clinical skills education.

Acknowledgements

We thank Lisa Boesch for her valuable support with preparations of this manuscript.

Author Contributions

MM, MR and NB conceived the study. All authors contributed to the analysis of the data. MM wrote the first draft of the manuscript. All authors contributed to revisions of the final version.

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