Canadian Journal of Indigenous Studies ISSN:2819-6104
Vol 2, Issue 1 (2026) 125-142 https://doi.org/10.36939/cjis/vol2no1/art59

INDIGENOUS PEDAGOGIES FOR TRANSFORMATIVE CHANGE: DELIVERING INDIGENOUS CULTURAL SAFETY EDUCATION TO MEDICAL STUDENTS

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Abstract. Relying on western pedagogies to promote culturally safer care undermines its principles and intent. More research is needed on the use of Indigenous pedagogies to engage settlers in cultural safety education. This paper reports findings from the Beading Cultural Safety project, which delivered cultural safety education rooted in Indigenous pedagogies to second- and third-year medical students in Northern Ontario. The one-day training session found that the use of storytelling, sharing circles, and gifting Indigenous beadwork challenged participant beliefs, fostered reflexivity and relationality, and enabled participants to explore new roles.

Keywords. Cultural safety education, Indigenous pedagogies, Medical education, Storytelling as pedagogy, Reflective practice

1. Positionality

Boozhoo! I am an Anishinaabe-kwe from Opwaaganisiniing (Red Rock Indian Band) located in Northern Ontario. I continue to reside close to home and have relationships with Indigenous Peoples in the area: family members, friends, teachers, colleagues, and fellow community members. I am invested in creating culturally safer health care environments for my family and my community, having witnessed and experienced the ways in which settler colonialism and institutional and personal bias result in subpar care and dire health outcomes for Indigenous peoples.

2. Introduction

Indigenous knowledge systems are holistic, comprised of intergenerational knowledge, empirical knowledge, and revealed or spiritual knowledge (Castellano, 2000). They are distinct from Eurocentric knowledge systems, employing theories, philosophies, histories, ceremonies, and stories rooted in pedagogies of

Date: Received: October 15, 2025
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observations, experiential learning, modelling, meditation, prayer, and ceremonies (Battiste, 2002, p. 18). These pedagogies are relational and often a collective effort involving members of the family and wider community (Ariss & Stevens, 2022). Knowledge transmission can occur outside of human-to-human interaction, through the land, song, artwork, symbols, and ceremonies (Battiste, 2002). Due to relationships between humans, to the land, to animals, to ancestors, and to future generations, learners engage in reciprocity and relational accountability whereby with collective support and guidance, individuals learn how they affect the rest of creation and how to serve the community in a good way (Ariss & Stevens, 2022; Bone, 2023; Richardson et al., 2017). Pedagogical approaches can be both direct and indirect, allowing learners to observe, participate, listen, reflect, relate, and develop their own understanding with minimal intervention or instruction (Ariss & Stevens, 2022; Battiste, 2002).

The Royal Commission on Aboriginal Peoples (1996) and the Truth and Reconciliation Commission (TRC; 2015) both speak to the importance of situating education within Indigenous cultural contexts, worldviews, and practices (Ariss & Stevens, 2022). While the use of Indigenous pedagogies is gaining traction in western institutions due to the efforts of Indigenous Peoples, their uptake remains marginalized (Ariss & Stevens, 2022). For example, the calls to action from the TRC (2015), including the one that urges medical and nursing students to take an Indigenous health course containing skills-based training in intercultural competency, conflict resolution, human rights, and anti-racism (no. 24) have been a driver of cultural safety education among established health service providers and trainees (Barnabe et al., 2021; de Leeuw et al., 2021; Hardy et al., 2023). Still, there has been little research focused on the use of Indigenous pedagogies in cultural safety training (e.g., Brascoupé & Waters, 2009; de Leeuw et al., 2021; Jamieson et al., 2017; Mills et al., 2022). Instead, there has been an overemphasis on the cultural components of Indigenous content, with less attention paid to critical content and Indigenous pedagogies (Berg et al., 2019; Ray, 2024).

Relying on western pedagogies to educate settlers for the purpose of identifying, understanding, and addressing colonial histories, attitudes, and behaviours undermines the principles and intent of cultural safety education. Razack and colleagues (2025) assert that cultural safety learners must examine their epistemological assumptions about dominant knowledge systems and develop epistemic humility and respect for Indigenous ways of knowing so that they can balance the pedagogical norms of their profession and examine structural inequalities. Cannon (2012) argues that the need for pedagogies that trouble and disrupt "normalcy" is just as relevant as the content itself (p. 23).

The exclusive use of western pedagogies hinders learners from developing the necessary consciousness to engage with the logics of colonialism and power domination. When western pedagogies are privileged, it reinforces the myth that European thought is superior (Battiste, 2002). When institutions continue to focus their gaze on Indigenous Peoples through western ways of knowing, colonial logics are further enshrined; those in settler society are positioned as

the ones who can know, and Indigenous Peoples are positioned as those who can be known. As Cannon (2012) notes, focusing on the other does not help one know, understand, and challenge one's own investments in colonialism. The use of Indigenous pedagogies to educate settlers and interrogate their complicities and pedagogies challenges colonialist knowledge hierarchies (Ariss & Stevens, 2022) and can bring about new and balanced vantage points to education (Battiste, 2002).

This paper summarizes and reports findings from the Beading Cultural Safety (BCS) project, which delivered cultural safety education rooted in Indigenous pedagogies to second- and third-year medical students in Northern Ontario. The one-day training session used the Indigenous pedagogies of storytelling and sharing circles and gifting Indigenous beadwork afterward to foster ongoing learning and reflection. The present study explores how medical students self-reported their experience with the use of Indigenous pedagogies and how those pedagogies worked on and with white and racialized settlers to reflect, relate, and enact cultural safety education. This study is among the few that have explored pedagogical approaches to effecting transformative change from the perspectives of students (Bullen & Roberts, 2019).

3. Cultural Safety Education and Transformative Learning

Cannon (2012) lays out the challenge of culturally safe education by asking readers to consider how to engage structurally privileged learners to think about settler colonialism when it requires them to contemplate and transform their own investment in and relationship with colonialism. This is no easy feat. Cultural safety education requires learners to continuously and critically reflect on how their worldviews, biases, and practices impact clients' experiences and health outcomes (Kerrigan et al., 2024; Micheal et al., 2021; Mills et al., 2022; Razack et al., 2025). Learners are implicated in this process whereby pedagogies used in cultural safety education must have the capacity to support settler learners in interrogating the construction of the other and how they are invested in that construction (Cannon, 2012). This can be complex, requiring pedagogies that engage learners intellectually, relationally, and emotionally (Kurtz et al., 2018; Mills et al., 2022) to promote humility, reflexivity (Wong et al., 2021), and relationality with not only settlers but also Indigenous Peoples and their lands (Cannon, 2012).

Most scholarship to date has relied on western pedagogies to address the challenges of cultural safety education. Among the popular pedagogical approaches for health education is transformative learning (Van Schalkwyk et al., 1999). For example, an Australian study suggests that transformative learning theory has the potential to effect powerful shifts in student attitudes and behaviours toward Indigenous Peoples and their preparedness to work in Indigenous health contexts (Bullen & Roberts, 2019). Transformative learning theory proposes that as learners receive new information, they evaluate their past ideas and understandings, shifting their worldview through critical reflection that occurs through several

stages: (1) the learner encounters an issue or something that contradicts a previously held belief; (2) the learner self-reflects before transitioning to a critical assessment of their prior held belief; (3) the learner plans a new course of action, learning new skills to implement the plan and exploring their new roles in relation to this new information; and (4) the learner builds self-efficacy in these new roles and relationships (Western Governors University, 2020). Transformative learning is described as reflexive and emancipatory through its attention to redefining the learner's perspective of self, lifelong learning, and learning for community development (Barker, 2020). Although transformative learning theory does have much to offer to the field of cultural safety education, it is but one approach (Cannon, 2012), and space must be made for Indigenous pedagogies.

4. Indigenous Pedagogies for Transformative Change

Indigenous pedagogies have many similarities to transformative learning; they also foster relationality and critical reflection, holistic knowing, relational accountability, lifelong learning, and humility (Ray & Vaillancourt, 2024). Indigenous Peoples also have their own theoretical learning models that resemble transformative learning theory. For example, the "Gifts of the Four Directions" outlines a cyclical four stage process that begins with awareness (seeing it), moves to time (relating to it), then to reason (figuring it out), and finally wisdom (do it) (Bell, 2014). This point is not made to conflate or contain Indigenous pedagogies within western theories of knowing. It must be acknowledged that Indigenous pedagogical approaches are far older than transformative learning theory. Instead, the point is made to demonstrate the marginalization of Indigenous pedagogies by western institutions and the transformative potential of Indigenous pedagogies. If Indigenous pedagogies share much with transformative learning, it can be assumed that they can offer at least some of the same benefits, but they continue to be underused in cultural safety education.

What is available in the literature suggests that Indigenous pedagogies can be transformative, shifting medical students' knowledge, attitudes, and preparedness (Brascoupé & Waters, 2009; de Leeuw et al., 2021; Jamieson et al., 2017; Mills et al., 2022). For example, Brascoupé and Waters (2009) found that stories about lived experiences and the perspectives of Indigenous Peoples induced cultural disorientation in students, leading them to question personal and societal attitudes, critically self-reflect on values and beliefs, and transform their thinking on power imbalances in health care. Meanwhile, a cultural immersion program for undergraduate medical students reported the program enhanced medical students' social accountability and responsibility competencies (de Leeuw et al., 2021, p. 93). Evidence from a class that incorporated smudging, exercises, Elders, and Indigenous-led presentations and storytelling, talking circles, and reflection-based assignments showed that the class evoked emotional responses and relationality from students (Ariss & Stevens, 2022). The authors concluded that the use of Indigenous pedagogies that recognized relationships and spirituality supported critical thinking and deepened students' understandings of Indigenous perspectives (Ariss & Stevens, 2022).

Moreover, although the use of Indigenous pedagogies in the context of cultural safety education is emerging, Indigenous pedagogies are not new, and they have been used by Indigenous Peoples for generations upon generations to transmit values, principles, and knowledge that are not merely relevant but necessary to creating culturally safer health care providers and care environments. For example, beading involves an Indigenous ethics of reciprocity and relationality, with design aesthetics that represent community expressions of land and culture (Mills & Woods, 2023; Ray, 2015).

One BCS project is part of the Engaging for Change project, which seeks to support health care institutions at two sites in Ontario to foster culturally safer environments: Northern Ontario and Southwest Ontario. Cultural safety recognizes how colonization and power structures negatively impact Indigenous people's health care experiences and requires health service providers to reflect on their power, privilege, and bias so that they can be open-minded and responsive to socio-cultural differences and disrupt culturally unsafe practices (Kurtz et al., 2018; Micheal et al., 2021). The Northern Ontario site formed a working group to develop and implement cultural safety education. The working group consisted of Indigenous health administrators from three of the main health care institutions in the area: one Indigenous-led and two non-Indigenous led. Training developed by the Indigenous health team at one of the non-Indigenous health care institutions had developed a three-hour in-person cultural safety training for use within their own organization. The working group adapted the training to deliver a one-day voluntary training to second- and third-year medical students enrolled in the local medical school. The training was delivered online using Zoom because although the students attended the same medical school, they were located across the province.

The BCS education session was offered twice to two separate cohorts of blended second- and third-year medical students. The delivery of the training was Indigenous-led. It was facilitated primarily by two Indigenous health administrators from the working group. In one offering an Elder was also present to support the facilitators but due to unforeseen circumstances was not present at both. The training began with a traditional opening that was followed by a presentation on key terms and concepts related to cultural safety, including racism, white supremacy, and micro-aggressions. The facilitator incorporated storytelling throughout the presentation, sharing examples of the key terms and concepts in practice. This was followed by the second facilitator sharing stories and scenarios about Indigenous Peoples' experiences in a hospital setting. These stories were open-ended, with the facilitator asking the students to engage in "story work" (Archibald, 2008) to reflect on the story and identify its meaning, including whether there was anything problematic about the story and, if so, what could be done differently. The training closed with a sharing circle. The purpose of a sharing circle and how it operates was explained to the participants, and all participants had an opportunity to check in and share their reflections about the day.

The day ended with a virtual gifting of beadwork to each participant. It was explained to participants that they would be mailed a custom piece of beadwork designed and beaded by their peer at medical school (a research assistant), with input from Elders on the beadwork design. Medical students who participated in the cultural safety training received one of three beadwork designs that merged the medicine wheel with one of three anatomically correct organs: the heart, the lungs, or the brain (see Figure 1).

FIGURE 1. Example of beadwork given to study participants

The custom-designed beadwork could be attached to participants' scrubs or lanyards for day-to-day wear. The beadwork that participants received in the mail was accompanied by a letter explaining why they were being gifted the beadwork, the meaning of the beadwork, including a teaching about the "spirit bead," and an invitation to wear the beadwork daily during their placements. The letter also explained that many Indigenous Peoples do not have access to their cultural items due to settler colonialism and that, it was a luxury and a privilege for a settler to be gifted this item. Settler colonial policies and practices

resulted in Indigenous beadwork being stolen (Prete 2019), negatively impacting not only intergenerational knowledge but also socio-economic status, making it difficult to access supplies or buy beadwork.

5. Methodology

An Indigenous participatory action research approach was used that privileged Indigenous control over research and Indigenous worldviews while cycling through the plan, act, observe, and reflect cycle (Ray, 2021). In the planning stage, an Indigenous health education working group was formed to oversee the adaptation and delivery of the training and to develop the research tools to evaluate its impact. The working group was comprised of three Indigenous health care administrators who represented the partner organizations involved in the project. They worked with a settler-Métis medical student (research assistant) and a First Nation researcher (author); input was also sought from Elders through one of the partner organization's Elder advisory group. During the act phase, two members of the working group took on an expanded role by implementing the training. Alongside Elders and other members of their organizations, they conducted the cultural safety training, and the medical student-research assistant chaired the training sessions. The First Nations researcher attended the training sessions and carried out data collection. A community report was prepared to help the working group members and partner organizations in reflecting on the findings.

5.1. **Recruitment and Participants.** Eligible participants were (1) enrolled in their second or third year at the local medical school, (2) about to begin a mandatory placement for medical school in the fall or winter semester, and (3) had completed the one-day cultural safety training in the fall semester. Eligible medical students were recruited via purposive sampling through their email addresses. Prior to participating in the cultural safety training, they were informed that a sharing circle would be part of the one-day training and would be asked if their contribution to the sharing circle could be included as part of the research. They were also informed that they would be asked to complete an anonymous survey at the end of the one-day training and participate in a follow-up interview or focus group near or at the end of their upcoming mandatory placement. All participants provided informed consent prior to participation (Lakehead University Research Ethics Board File No: 1469415); upon completing the cultural safety training, they were asked to consent to including their sharing circle contribution in the research, sent the link to participate in the survey, and reminded that they would receive a request to participate in a follow-up interview or focus group at or near the completion of their mandatory medical school placement.

All medical students who took part in the cultural safety training participated in at least one form of data collection, all eligible participants agreed for their sharing circle contributions to be included in the research, and all participants agreed to take part in the survey; however, only 20 of 25 (80%) of eligible participants completed the survey, and 7 of 25 (28%) eligible participants took part in a follow-up interview or focus group. Most participants were non-Indigenous with

only four participants identified as Indigenous. For the purposes of the present study, which focuses on settler experiences, these four individuals' contributions to the study were excluded. Participants received a $25 gift certificate for taking part in an interview or focus group; one participant declined the gift certificate.

5.2. **Data Collection.** Data collection consisted of two sharing circles occurring at the end of each cultural safety education session, an online survey, three follow-up semi-structured interviews and one follow-up semi-structured focus group (n = 4). Both interviews and focus groups were used for pragmatic and data completeness reasons. Medical students had limited availability and often had the same or similar schedules. The option for a focus group created more opportunities for medical students to participate in the study. In addition, the combination of semi-structured interviews and focus groups provided the flexibility to explore anticipated and newly emergent themes (Lambert & Loiselle, 2008).

One sharing circle was approximately 45 minutes long; the other was 125 minutes, and survey participants took approximately 15–20 minutes to complete it. Follow-up interviews ranged from 35 minutes to 70 minutes; the focus group lasted 63 minutes. The follow-up data collection occurred six months ±16 days after completion of the cultural safety training. The sharing circle at the end of each one-day cultural safety training was emergent, and the follow-up interviews and focus group used an interview guide that was co-created with the Indigenous working group. The survey questions were also co-created with the Indigenous working group.

The purpose of the sharing circle was to create an open space for medical students to reflect on and share their learnings and experience in the session, while the survey included questions to assess the outcomes of the training content and questions to understand the relevance of the training. The follow-up interviews and focus group concentrated on understanding the impact of the gifted beadwork on participants while also providing a final opportunity to obtain insights and feedback on the training content and delivery. The present study includes data associated with the relevance and impact of the pedagogical components of the training but does not focus on training content or training content outcomes. The interviews and focus group were recorded on video for the purpose of transcription. A research assistant transcribed the recordings verbatim.

5.3. **Analysis.** All data were anonymized and analyzed using the NVivo 15 software package. The author familiarized themselves with the data and engaged in open coding. Next the author searched for, refined, and defined themes. Data sufficiency was used as a measure of data trustworthiness. It relies on data quality as a measure of rigor (Hennink & Kaiser, 2022; LaDonna et al., 2021), which stems from analytical sufficiency and the richness of the data generated (LaDonna et al., 2021). Data sufficiency is more closely aligned with Indigenous concepts of relationality, situatedness, humility, reflexivity, and life-long learning than data saturation. Data richness was fostered by multiple sources of data, including conversational, topic-focused, and adaptable approaches where there is a rapport

with the participants. The duration of interviews, the focus group, and sharing circles provides an indication of data richness (LaDonna et al., 2021).

6. Results

Medical students' accounts of their experiences in the cultural safety education and wearing the beadwork at their placement uncovered four main themes: (1) challenging beliefs (2) reflexivity (3) relationality, and (4) exploring new roles.

6.1. **Challenging Beliefs.** Participants shared that the use of storytelling challenged beliefs they had about health care and worked to decentre their own beliefs and perspectives. In the survey, one participant described how the use of storytelling challenged them to acknowledge and think from a different standpoint: "Patient case examples were great at thinking from their perspectives and the prompting questions helped a lot" (anonymous).

Participants 17 from the sharing circle indicated that the use of stories challenged their beliefs about the prevalence of racism in the health care system:

> For me having a bit more of the theory aspect in the morning of a presentation, and then an opportunity to have some case studies or not even case studies but real situations that happened that kind of put things in perspective, and reminded me that these ... that racism in health care is still happening on a daily basis. It's so easy to fall into the mindset that it's a historical concept, and you think that we're so much better than that now, but I think hearing those stories is so valuable to constantly remind ourselves that, there's a lot of work to be done. (P17)

6.2. **Reflexivity.** For some medical students, storytelling and the sharing circle prompted them to reflect on how their own standpoint impacts their thoughts, actions, and notions of normality. Participant 16 reflected on how the normality of whiteness is connected to feeling valued and comfortable and suggested that fostering a welcoming care environment could be a strategy to counter white settler normality:

> One thing that I thought was really interesting that we talked about more was the concept of white supremacy and I haven't... I always thought of it as a notion ... that it's the concept that white people are better than others, but I never really thought of it in the context that white is considered the norm [making air quotes], and everything else is a deviation from the norm. I think it links to [the facilitator's] discussion about validation and feeling valued. I think that growing up as a white person, I've always felt valued because everywhere I go (movies, dolls, growing up), everything was white. ... Makes my living in my circumstances much more comfortable and less stressful. So that's something I think I just need to think about, and then that can relate to being a clinician; that is why I've been trying to open up the floor and

> make sure that people feel comfortable, regardless of whether or not they're white as well, and making sure that I am establishing that comfort.

In addition, many of the medical students who participated in the follow-up interviews and focus groups shared that the gifted beadwork ensured that there was ongoing reflexivity beyond the training and during their practicum. For example, participant 23 noted the following:

> [The beadwork is] not an accessory; there's meaning behind it. And like it, there's a sense of responsibility of when people ask about it or having a meaningful... prompting a meaningful discussion and encouraging myself and others to reflect through having the beadwork. So, I guess there is that sense of responsibility [that] came through or was reflected upon.

6.3. **Relationality.** The gifted beadwork supported medical students to orient themselves in relation to Indigenous Peoples and their worldviews and to foster relationships with them. For participant 25, wearing the beadwork was an ongoing reminder that a distinct people with a rich culture must be acknowledged and respected: "I understand the meaning behind it [the beadwork], and when we're wearing it, we need to be respectful and appreciate the culture that we're wearing."

Several participants also mentioned that the beadwork was a conversation starter or a way to begin a relationship with an Indigenous person:

> He was from one of the communities in that area whose services or who uses [town] services and it was a nice way to break the ice, and then we had a conversation about what was in the training... He's like, oh, that's really, really neat. Did you learn anything? And I was like, yeah, yeah, I know I did. I did learn stuff and ... we touched on a lot of the historical aspects in Canada. Colonization, like Sixties Scoop, residential schools: lots of different things. And then we talked about kind of microaggressions and cases in the news.... And he very much enjoyed the pin, so it was just a great way to kind of make a connection with the patient that I might not have otherwise. We never would have talked about that; I don't know how else it would have come up. (P24)

Notably, some medical students were gifted a piece of beadwork that had personal meaning; they believed that this occurred because of a coincidence or because the beader-research assistant knew their circumstances and that this was intentional. However, the beader confirmed that they did not purposefully gift certain pieces of beadwork. From the researcher's perspective, this was spirit at work and provided a way for these participants to foster personal and deep associations with the beadwork and its meaning and purpose:

> I got the brain, so I don't know if it was coincidence or not, but my dad has a brain injury. So, I thought that maybe [the beader] might have done that. (P7)

> So I got a set of lungs and [the beader] had done a couple auctions for Grassy Narrows [First Nation] last year, and I set alarms on my phone for a set of lungs and I was like trying to outbid people and just was never able to get them, and that's what I got. So, I thought that was super thoughtful of [her] because she knew that that's a piece that I had in the past and that was the one she gifted me.... So, I definitely think that there was a lot of thought behind it. One of my other friends had a similar experience too, so that just made it that much more special. (P22)

6.4. **Exploring New Roles.** The storytelling and the gifted beadwork were avenues for participants to explore new roles and responsibilities related to providing culturally safer care and were also identified as a mechanism to support trying out these new roles:

> And I think that piece that [the facilitator] mentioned in the story about making sure the patient feels valued, saying, "Thank you for coming to see me, and I appreciate that you took the time to come" could really make a difference, especially when people, especially Indigenous populations or other marginalized populations might feel like they're just used to getting subpar treatment in the first place. We can't allow ourselves to fall into that trap of judging and passing judgment because ultimately the care that we provide is going to change their lives, and that is a very large responsibility that we have all signed up for already by being here. (P6)

Participants shared that they saw a role for themselves as advocates or radical allies, but they identified the power imbalance between themselves as medical students and their superiors as a barrier. More specifically, the beadwork was identified as a way to broach the subject: "Part of it will be my own comfort as it comes up in clinical settings in communicating. I will be notifying my preceptors of my training and why I will be wearing the beading" (Anonymous). For participant 3, the stories shared by a facilitator also helped them identify roles for them amid unequal power relations:

> I think we also get a really golden opportunity where we're less crucial to the patient care at this point, so we can kind of take a step back and notice more and have more mental energy and more time to think about how we can address these issues as they come up case by case, So, thank you [facilitator] for all those cases that were really detailed and that really showed me that a role for me during my placement is to try to be a witness to these things and to also work on talking and confronting people about issues as I see them come up. So that's something that I'm definitely going

to carry with me this year and hopefully continuing during my career.

7. Discussion

The insights and experiences shared by white and racialized settlers via sharing circles, open-ended survey responses, and follow-up interviews and a focus group demonstrate how Indigenous pedagogies can engage learners in ways that incite transformation. Participants spoke to how they critically reflected on their own beliefs and bias, their potential impact on patient experiences and health outcomes, and how this was ongoing through wearing the beadwork (Kerrigan et al., 2024; Micheal et al., 2021; Mills et al., 2022; Razack et al., 2025). They also discussed the ways in which using Indigenous pedagogies fostered holistic connections, coming to see themselves in relation to Indigenous Peoples and engage in spaces of acknowledging, sharing, and learning with Indigenous Peoples (Cannon, 2012; Kurtz et al., 2018; Mills et al., 2022). These findings corroborate earlier research about the use of Indigenous pedagogies for cultural safety education. For example, like Rice and colleagues (2020), the present study found that opportunities for settlers to listen and learn from Indigenous perspectives equipped them to revise their relationalities with Indigenous Peoples. The findings also align with the broader literature base that describes the impact of transformative learning.

The themes of challenging beliefs, reflexivity, relationality, and exploring new roles coincide with the iterative processes of understanding, reflecting, relating, and acting within the Gifts of the Four Directions and transformative learning theory. Participants' descriptions of challenging beliefs allowed them to develop a new awareness about the realities that Indigenous Peoples experience in the health care system, and their engagement with stories led to reflection on how their standpoints can impact their beliefs and actions, fostering their own relationships to the learning. Through wearing the beadwork, they began to see things more deeply, bringing intention to practice culturally safer care in their day-to-day interactions during their placements. They also began to envision how they can enact wisdom through sustained practices, which also included the identification of barriers to doing so in their new roles.

Although medical students' experiences demonstrate affinities between transformative and Indigenous pedagogies, one key differentiator may be the presence of spirit. Some participants described instances where they connected to the beadwork on a deeper level because of its personal meaning, which they presumed to be intentional on the beader's part or a mere coincidence. This was not the case on the part of the beader and may instead be spirit at work. The word in Anishnaabemowin for bead is *manidoominens*, which can be loosely translated to "little spirit," and its spiritual affinity can also be tied to the role of beads in relationship-building (Ray, 2015). In their findings, Ariss and Stevens (2022) concluded that Indigenous pedagogies have the capacity to recognize relationships and spirituality which is advantageous to advancing cultural safety learning. By

receiving beadwork that was imbued with spirit, medical students developed a deeper or more personal meaning, further cementing their relationship to the beadwork and what it symbolizes.

8. Conclusion

The Beading Cultural Safety project engaged Indigenous pedagogies to deliver cultural safety education to second- and third-year medical students in Northern Ontario. Through a one-day cultural safety education session that employed storytelling, sharing circles, and gifting Indigenous beadwork, medical students described how their beliefs regarding the health care system were challenged and how they engaged in reflexivity, explored new roles as advocates and allies, and deepened their investments in providing culturally safer care for Indigenous patients through personal connections and new relationships that may have been guided by spirit.

These findings are consistent with what Indigenous Peoples know to be true about their knowledge systems. Although the use of Indigenous pedagogies in cultural safety education is only emerging, Indigenous pedagogies have been used by Indigenous Peoples for generations upon generations to transmit values, principles, and knowledge that are both relevant and necessary to creating culturally safer health care providers and care environments.

Indigenous pedagogies foster transformative learning (Poitras Pratt & Bodnaresko, 2023). They embrace "both the circumstances people find themselves in and their beliefs about those circumstances in that way that is unfamiliar to Eurocentric knowledge systems" (Battiste, 2002, p. 19). They centre relationships and seek to disrupt white settler power and privilege (Rice et al., 2020), promoting responsibility and reflexivity (Cormier, 2016; Kennedy et al., 2020; Ray & Vaillancourt, 2024).

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