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Cultural Safety in Clinical Research: A Conceptual Overview and Call to Action

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Abstract

Black Americans are two to three times more likely to develop ADRD than their white counterparts, yet Black Americans make up only 2.4% of ADRD clinical trial participants. Here we provide an overview of the current state of initiatives to maximize racial and ethnic inclusivity in clinical research, particularly among ethnoracialized groups, and introduce the Indigenous-rooted concept of cultural safety through an integrative review and outline of its applicability to the research context. Cultural safety ensures that cultural identities, values, and experiences of minoritized persons are respected, understood, and integrated in their health care journey, empowering them to define and evaluate their own experiences. Implementing cultural safety challenges individuals to confront and critically examine their own perspectives on the dominant culture's traditions and values, as well as their implicit racism, biases, privileges, and inherent power structures. We extend prior conceptual work on cultural safety by proposing two subdimensions: environmental and internal. These must be synergistically integrated to heal fractured relationships between communities of color and researchers. By championing cultural safety, we can create a workforce of self-aware researchers who embody cultural safety's true essence as defined by the communities they serve. Community-engaged research serves as an ideal platform for cultural safety to be meaningfully implemented and sustained. This approach can uplift previously silenced voices in research, build long-term relationships, and generate empirical data that substantiates its positive effects. Importantly, applying environmental and internal cultural safety can empower participants in ADRD research where it is critically needed.

Keywords: Community engagement, Health equity, Inclusive research practices

> **Translational Significance:** Ethnoracialized individuals are under-included in Alzheimer's disease and related dementia (ADRD) clinical trials. Cultural safety is an intentional practice that grows diversity in participant populations while honoring the cultural traditions and needs of the patient (Ramsden, 2002), and this practice is needed in clinical research. Participant experiences collectively shape the landscapes of research recruitment, retention, and social relationships between ethnoracialized participants and clinical research institutions. Diversity in clinical research is critical to generate generalizable data that support the care and treatment of age-related illnesses in people from all backgrounds.

The importance of involving persons who have been under-included in health research has been recognized for decades (National Institutes of Health, 1993), yet minimal advancements have occurred. In particular, individuals identifying as a member of an ethnoracialized group, including Black, Indigenous, Persons of Color (BIPOC) have been under-included in several areas of clinical research. Lack of inclusion is rooted in the interrelated phenomena of historical traumas, racism, discrimination, and colonization. Unless addressed, failing to conduct inclusive research will have continued implications for the evaluation, dissemination, and implementation of treatments. Although the issue of insufficient inclusion of racially and ethnically diverse samples affects many areas of clinical research, its implications in the context of Alzheimer's disease and related dementias (ADRD) are particularly strik-

ing. For example, although Black Americans are two to three times more likely to develop ADRD than their non-Hispanic white counterparts, Black Americans make up only 2.4% of ADRD clinical trial participants (Vyas et al., 2018). This discrepancy raises concerns not only regarding the efficacy and safety profiles of new treatments in diverse populations but also regarding how these treatments will be accepted as community members learn that the data leading to their approval was based on samples overrepresenting non-Hispanic whites. Such patent inequities have led to increasing demands for urgent action (Abdel-Rahman et al., 2021).

Although Black Americans and persons from other ethnoracialized groups are perpetually under-included in clinical research, studies have shown that persons from such communities have a notable willingness and interest in getting

involved (Hunsaker et al., 2011), if the goals of the research are aligned with participant values. There is mounting recognition of the need for approaches that actively address power imbalances and ensure that cultural identities, values, and experiences of minoritized persons are respected, understood, and integrated in their health care journey. For those facing progressive, life-altering conditions like ADRD this journey may include interactions with clinical research. The National Institutes of Health (NIH) budget proposal for the 2025 fiscal year has been published and reflects the need for an estimated $318 million in additional support for new research, with the overall resources needed totaling $4.07 billion (National Institutes of Health, 2025). However, the funding proposal stops short of offering concrete plans to increase diversity in clinical trials. This is problematic because data from diverse samples is critical to developing generalizable pharmacologic and other treatments across conditions, including ADRD, that work for all people across the full spectrum of life experiences—including the experience of being minoritized. Although investigators bear responsibility for inclusive research plans, funding agencies could better enforce mandates like the 1993 NIH Revitalization Act, which codified requirements for adequate minority, female, and childbearing-age representation in NIH-funded clinical trials. Without a dedicated plan to broaden inclusivity in clinical research, there is a risk of perpetuating an unjust cycle that leaves persons from under-included communities without health solutions. Using ADRD as an example, the purpose of this paper is to provide an overview of the current state of initiatives to maximize racial and ethnic inclusivity in clinical research and to introduce the Indigenous-rooted concept, cultural safety, through an integrative review and outline of its applicability to the research context.

Background

Academic research institutions have been implicated in playing a major, system-level role in the historic under-inclusion of persons from minoritized communities in clinical studies (Wilkens et al., 2023). Some authors argue that this exclusion is not a mere oversight but a systemic problem with far-reaching consequences. One facet of this complicity is that research institutions often dismiss disparities research as anecdotal rather than empirical, viewing the quantification of issues like racism, and trauma as too complex to fully characterize (Gilmore-Bykovskyi et al., 2021). Moreover, disease models for conditions like ADRD have prioritized a reductionistic biological perspective (Rivera Mindt et al., 2010). Subsequently, methods to measure complex sociocultural factors contributing to ADRD are understudied. Additionally, institutions have often placed the burden of successful participation largely on the participants themselves, rather than examining how the research design and infrastructure may create barriers. Research institutions often primarily serve non-Hispanic white, highly educated participants who can more easily overcome barriers like accessibility, financial, and logistical challenges (Esiaka et al., 2024). In contrast, persons from under-included populations disproportionately face hurdles in overcoming those very barriers. Several authors have pointed out that when under-included participants struggle to meet study requirements, the onus is placed on them for "not moving the science forward" rather than on the research institution's failure to address systemic obstacles (Gilmore-Bykovskyi et al., 2021). This blame-shifting approach perpetuates a vicious cycle: by faulting under-included groups for their own exclusion, research institutions evade responsibility and maintain the very barriers that they often insist are not present. To effectively integrate cultural safety into academic research, we must identify current diversity-enhancing practices within ADRD research that have been successful. These successes are the foundation for initiating cultural safety.

Community-Engaged Research

Community Engaged Research (CER) is a collaborative approach to research that emphasizes partnership, cooperation, and negotiation among various contributors—this includes researchers, patients, health systems, community members, and those affected by the disease(s) being studied. (CDC, 2011; Wilkins et al., 2023) As a field, CER has paved the way in reducing barriers to inclusive participation in ADRD research studies. Most importantly, this movement has shown the need to, and value of, bringing research outside of the academic ivory tower. Numerous CER studies have shown that by investing in and partnering with community leaders who share the vision of inclusive research, research teams can successfully establish rapport and build trust (Green-Harris et al., 2019). There is increasing recognition that rather than immediately requesting research participation, researchers must first learn to listen and give back to the community (Green-Harris et al., 2019). In the ADRD research space, several notable approaches have been demonstrated to work. For example, the Asset-Based Community Development (ABCD) strategy has facilitated enhanced access to care delivery, increased AD awareness among Black communities, and bolstered their representation in AD research studies (Green-Harris et al., 2019). The research team applying an ABCD framework, hired a diverse study team reflective of the community and promoted culturally-tailored programing. They conducted grassroots networking resulting in an established community advisory board that encouraged educational initiatives. The authors exemplified cultural awareness and sensitivity through networking, establishing a community advisory board, and incorporating cultural value systems. This culturally tailored approach, facilitated by a diverse study team reflective of the community, resulted in a remarkable 400% increase in Black research participation, underscoring the significance of building trust and rapport through cultural humility.

Similarly, a National Institute on Aging-funded workshop on African American ADRD research recruitment culminated in consensus that the AD community needs to be aware of "cultural trauma due to both historical events and contemporary experiences; racial identity and cultural norms; and the importance of cultural competency and representation for those doing recruitment and research" (Denny et al., 2020, p. 1738). Evidence suggests that the challenges of ensuring inclusive samples persist even after recruitment. Notably, in one recent report Black Americans had a 60% higher attrition rate compared to non-Hispanic white participants in clinical trials (Denny et al., 2020). To address these challenges, the Network, Give First, Advocate for Research, Give Back, Evaluate (NGAGE) model developed by the AD Center at Rush University demonstrated a similar commitment to cultural awareness by empowering the Black community to take a leading role through community ambassadors and research champions. By recognizing and amplifying the unique perspectives and narratives of this community, the model exhibits

cultural sensitivity. Moreover, its efforts to reduce participant burden through home-based research visits and dedicated support staff showcase cultural humility and a genuine understanding of the community's needs.

Although these studies exemplify the value of cultivating cultural awareness, sensitivity, and humility (see Table 1), a potential limitation and remaining challenge lies in the inherent power imbalances that may persist, even when community partners are given a seat at the academic research table. Efforts to promote equity are vital and necessary aspirations in clinical research but will not necessarily be sufficient to redress historical traumas or create a culturally safe space for all persons engaging in research.

A crucial piece that is often missing from, or unnamed within, CER is cultural safety. Cultural safety involves actively addressing power imbalances and upholding the cultural heritage, personal beliefs, and lived experiences of minoritized individuals by actively acknowledging and incorporating them into every aspect of patient care. CER raises important themes on trust, community involvement, and reciprocity. The CER movement can be credited with laying the groundwork in helping create equal partners in research. Although these elements are also key to cultural safety, the CER model has not yet articulated or fully embodied the concept of cultural safety. CER focuses on the notion of equality more than on the assurance of safety, with objectives such as facilitating culturally tailored community programs, and inviting community members to join decision-making bodies. As outlined later, practicing cultural safety requires achieving objectives such as creating physically safe community spaces and working to dismantle power imbalances between researchers and participants. Although elements of cultural safety are implied in CER models, cultural safety itself is not an overt component of the CER model. As CER is increasingly integrated into academic research, CER serves as a strategic platform for introducing and growing cultural safety.

In the sections that follow, we present cultural safety as it was originally defined by an Indigenous community, the Māori people. Additionally, we propose two novel subtypes of cultural safety, environmental and internal, that we argue provides a template for implementing full cultural safety into academic research.

Cultural Safety Defined

Cultural safety is a term coined by a Dr. Irihapeti Ramsden, a Māori nurse educator, who drew inspiration from a first-year Māori nursing student in New Zealand who said "you people talk about legal safety, ethical safety, safety in clinical practice and a safe knowledge base, but what about cultural safety" (Ramsden, 2002, p. 13). This criticism was in response to the student's experience of witnessing and learning of Indigenous people being silenced, oppressed, and discriminated against in health care and in the nursing workforce. Ramsden's work holds that, at its core, cultural safety demands introspection, compelling those who pursue it toward confronting cultural dominance, racism, and all forms of discrimination (McInerney, 2019). McInerney (2019) goes on to explain that achieving cultural safety requires a renegotiation of power to create partnership. In Ramsden's view, cultural safety cannot be achieved without acquiring historical literacy and acknowledging the unearned privilege and benefits that, in New Zealand, have flowed from genocide and the processes of racialization and inferiorization (McInerney, 2019). In the clinical context, she asserts that cultural safety is "about the nurse rather than the patient" (Ramsden, 2002, p.18). Ramsden describes cultural safety as a vehicle that allows the care recipient to determine whether a health care resource or service is safe to engage with a minoritized person. The subjective term, safety, has been intentionally selected to ensure that the power to call something safe rests with the consumer/patient (Ramsden, 2002).

In applying this concept today, it is essential to recognize that exercising true cultural safety is a more profound act than the familiar terms of cultural awareness, sensitivity, and competency denote (Table 1). Although these terms suggest an understanding of cultural differences, they do not explicitly address the entrenched power structures and historical inequities that permeate interactions between clinicians (or researchers) and patients (or study participants; (Curtis et al., 2019). These terms focus predominantly on the clinicians' or researchers' attributes and in doing so, they fall short in two critical areas. First, they fail to consider the environmental factors that shape the participant's experience, treating culture as a disembodied concept rather than a lived reality. Second, they maintain a unidirectional focus, solely relying on the clinician (or researcher) and neglecting the patient or participant. Cultural safety completes the circle by transferring power to the participant. Unlike the aforementioned concepts, which are researcher-centric or clinician-centric, cultural safety has the unique potential to be measured from the participant's perspective.

Crucially, any discussion of cultural safety must acknowledge its Indigenous origins as the foundational pillar upon

Table 1. The Terms Cultural Awareness, Sensitivity, Humility, and Competence are Valid and Can Be Used Alongside Cultural Safety.

Similar terms	Definitions	Difference from cultural safety
Cultural awareness	Deep self-examination of one's own background and lived experience	• Alternative terms overlook environmental factors • These terms are researcher-centric, neglecting participant viewpoints • Terminology lacks quantifiability and participant-oriented metrics
Cultural sensitivity	Allows us to examine ourselves while recognizing how cultures can be both distinct from and connected to each other	
Cultural humility	Involves looking inward and learning about ourselves to create genuine connections built on respect	
Cultural competence	The ability to engage appropriately and meaningfully with individuals from diverse cultural backgrounds	

which all future applications are built. Cultural safety was born from experiences of the colonized and is rooted in historical, social, and political influences (Anderson et al., 2003). Therefore, researchers employing cultural safety models must exercise restraint in how they use and define cultural safety. Through any redefinition or change, updates to the notion of cultural safety must stay true to the original principles described by the Māori people. "Remember that cultural safety grew out of an Indigenous/colonized experience. Non-Indigenous professionals who have not had the experience of being colonized and who enjoy the privileges of the dominant society need to ensure that they don't colonize cultural safety" (Dowd et al., 2010, p.194).

The Clinical Practice Origins of Cultural Safety

Cultural safety has become an increasingly crucial aspect of health care delivery, particularly in the field of midwifery (Capper et al., 2023; Fleming et al., 2020; Phiri et al., 2010). In New Zealand, this concept is not merely theoretical but is robustly integrated into accreditation standards and nursing curricula, underscoring the imperative of providing culturally appropriate care to Indigenous communities (Fleming et al., 2019; Power et al., 2022). The clinical application of cultural safety principles in midwifery acknowledges the significance of family, spirit, culture, and respect. Practicing cultural safety involves creating an environment where individuals feel valued, understood, and supported throughout their health care experience. Culturally safe practices are multifaceted encompassing the recognition and respect for traditional beliefs, the active involvement of family members in decision-making processes, and the necessity of fostering an atmosphere of openness and inclusivity. Over the past two decades, the principle of cultural safety has gained traction beyond midwifery and become integral to the care of Indigenous persons across a range of clinical settings in New Zealand (Arnold-Ujvari et al., 2024; Dell et al., 2016; McGough et al., 2018; Muise, 2019), Australia (Milligan et al., 2021), and in Canada (Browne et al., 2009; Guerra & Kurtz, 2017; Gurm & Cheema, 2013; Smye & Browne, 2002; Tremblay et al., 2020), and has recently been introduced as applicable to dementia care (Chakanyuka et al., 2022). Across these contexts, by wholeheartedly embracing cultural safety, health care professionals provide care that extends beyond physical well-being and addresses the holistic needs of individuals and communities (Wilson et al., 2022). This approach powerfully acknowledges the deep, often overlooked impact that cultural beliefs, practices, and values exert on those not positioned within the dominant culture.

Implications of Cultural Safety

Cultural safety arose to address concerns about nursing care, stemming from the perpetual power imbalances and inequities facing Indigenous peoples and postcolonial societies. Extending the work of cultural safety to other countries, including the United States, and to the realm of clinical research is fitting as this work embodies the spirit of the Black and Brown individual asking to be respected and heard during their health care or research participation visit. Although a handful of commentators have mentioned incorporating cultural safety into research settings (Canadian Institutes of Health Research, 2023; Maar et al., 2019; Sarmiento et al., 20182024), particularly with Indigenous persons, the concept remains novel and relatively unexamined in the ADRD

research context. When successful, cultural safety creates a sanctuary where the patient or participant can be their true self without being told to act or speak differently. Crucially, cultural safety seeks not only to acknowledge but to fundamentally alter the person implementing it by revealing their own inherent biases, internalized racism, and privileges. Comfort in the dominant culture is challenged, and power imbalances are dismantled. Operating from the inside out, cultural safety demands the health care provider/researcher undergo personal transformation to cultivate an environment conducive to its principles. In essence, this effort shifts the onus from the patient or study participant to the researcher. Ultimately, cultural safety empowers persons from minoritized communities to define and evaluate their own experiences. Cultural safety is not an obligation imposed on the intended individual, but a duty placed upon the person executing it.

In applying cultural safety to the context of clinical research on ADRD, we present the construct as expressed across two proposed subdimensions. First, environmentally, which encompasses the physical spaces used for research. This includes an accessible space that contains culturally appropriate art, music, and food, as well as a diverse staff that is reflective of a community of interest. Second, internally, which tasks the researcher to look inwardly and deconstruct biases and power stances.

Environmental and Internal Cultural Safety

If the integration of cultural safety into mainstream research practices were prioritized, it could represent a powerful tool to shift the narrative and address gaps in trust between persons from under-included populations and those in academia. Although elements of cultural safety can be integrated into any clinical research setting, a fully transformative approach would involve bold action and investment. One example may involve uprooting the location of research sites by establishing community data collection sites—that is, physical locations embedded within community settings that serve as hubs for researchers and local resident interaction. Importantly, these sites can be cocreated in trusted spaces like community centers, churches, or even barbershops—places that evoke an organic sense of belonging and security. Unlike temporary research initiatives or pop-up clinics that risk eroding rapport, trust, and connections between researchers and the community, community data collection sites can be designed to serve as long-lasting resources, embedded within the fabric of the community they serve. In alignment with the themes of cultural safety, such sites must be constructed with intentionality and integrity, making environmental cultural safety not just aspirational, but foundational. This approach ensures that the physical space and overall environment are thoughtfully designed to be welcoming, accessible, and reflective of the cultural identities of the participants involved.

The earlier-described approach differs from prior laudable efforts to bring elements of research into existing environments like homes or community settings (Holden et al., 2015), and conversely, from efforts seeking to ease the process of getting participants into research. Under this approach, environmental cultural safety would be achieved by deliberately cocreating an atmosphere that resonates with the local community. For example, in a primarily Black neighborhood, this could involve decorating the site with artwork from local Black artists, and serving food from local Black-owned and

operated businesses. Research staff should include research specialists, community liaisons, and clinicians who are culturally aware and members of the community that is being engaged. As shared racial identity is not the sole criterion, lived experiences and authentic connections to the community's cultural contexts will facilitate meaningful engagement with participants.

In the context of a stigmatizing condition like ADRD (Garand et al., 2009; Rosin et al., 2020), there is particular value in creating culturally safe spaces for engaging in research. ADRD research encounters have the potential to be fear-inducing by virtue of both the nature of research procedures, like cognitive testing, and their potential to uncover or confirm the presence of a life-altering diagnosis. These downsides to ADRD research participation can be amplified in settings that lack cultural safety. The physical environment of a research site has the untapped potential to assuage participant fears and concerns when culturally safe elements dominate the participant's sensory experience during a research visit. By embedding environmental cultural safety into the core of community data collection sites, they hold the potential to become more than just physical locations—they can transform into spaces that celebrate diversity, promote inclusion, and uplift voices that have been historically disempowered. However, the creation of such welcoming spaces is only one facet of cultivating cultural safety.

Internal cultural safety is cultivated through a deliberate ongoing process of education, self-reflection, and skill-building among research staff. This multifaceted approach involves providing comprehensive and holistic training and experiential opportunities that foster a deep understanding of cultural safety and its critical importance for application in research contexts. When employed in health science education settings, such preparation has been shown to positively affect students' knowledge, attitudes, and behaviors in serving persons from Indigenous populations (Hardy et al., 2023; Kurtz et al., 2018). In the research setting such education should seek to heighten an awareness of the unique vulnerabilities and potential for harm these communities may face when participating in research, while at the same time, equipping staff with the critical skills to recognize and challenge harmful myths, stereotypes, and discriminatory behaviors. In health workforce training, strategies such as storytelling and visual teaching, as well as codesign of training in collaboration with community members, have shown particular promise (Hosking et al., 2023). Crucially, researchers must develop a nuanced grasp of power dynamics and master strategies to consciously dismantle imbalances, promoting equity throughout the research process. Internal cultural safety is not a one-time endeavor but an ongoing journey of learning, unlearning, and growth.

Environmental and internal cultural safety must be synergistically integrated to fully thrive; each is incomplete without an equal commitment to both (Figure 1). Embodying this synergy of environmental and internal cultural safety demonstrates the core values necessary to heal the fractured relationships between communities of color and researchers. Cultural safety is the concept that enables us to approach ADRD research questions with sensitivity and respect for the cultural contexts and lived experiences of persons from minoritized communities. By championing cultural safety, we can create a workforce of self-aware researchers who embody cultural safety's true essence as defined by the communities they serve. This paradigm shift fundamentally transforms

Figure 1. Visual representation of cultural safety. Environmental and internal cultural safety work together synergistically to create full cultural safety in a research setting. The individual components listed within the circle are nonexhaustive, as different research settings and institutions may need additional components to foster cultural safety.

how we conduct research. Engaging with researchers who genuinely value and understand their positional power in academia, while actively acknowledging cultural differences, carries immense potential. Such interactions can forge deeply impactful connections between researchers and communities. Participants from ethnoracialized groups are no longer regarded as "exotic" with data that problematically differs from the white "normal." Instead of feeling like subjects to be experimented upon, facing further traumatic experiences, they engage in open dialogue and honest conversation, where walls are broken, and opinions are respected.

Recognizing the paramount importance of providing both environmental and internal cultural safety for all participants allows us to develop robust, evidence-based models that elevate these practices to standard research protocols. By modeling and studying cultural safety, we generate empirical data that substantiates its positive effects, transcending current anecdotal evidence. Cultural safety can empower previously silenced voices in research and build long-term relationships. Implementing environmental and internal cultural safety aims to respect, understand, and empower all participants, especially in ADRD clinical trials where it is critically needed. We need to remain mindful that research institutions can implement all of the elements known to support internal cultural safety such as recognizing our biases and dismantling power balances, and also the elements that support environmental cultural safety like appropriate physical locations and employing diverse staff. However, regardless of a research institution's efforts or intentions, cultural safety is ultimately evaluated by the participant. If they do not feel safe, respected, or seen, then we as researchers do not do our job to provide a culturally safe research experience. In summary, the concept of culturally safe research is dynamic and continually evolving. Its application requires an iterative model or process

of continual evaluation to ensure its success as a dynamic relational phenomenon. Not everyone is the same; safety is defined in many ways and only a participant can define their experience. It is the duty and responsibility of the researcher to provide an environment and create an experience where a participant can openly and safely make that judgement.

Even well-intentioned community-engaged efforts may inadvertently perpetuate harm or alienation without the critical framework of cultural safety. This is crucial, as true cultural safety cannot exist when power imbalances persist unchecked. Cultural safety rejects the illusion of equality when systemic inequities persist. It demands an uncompromising transfer of power from structures that have long suppressed under-included voices in research. This requires humility, open dialogue, and a genuine willingness to challenge and reshape current research status quos. Scientific expertise does not equate to power over communities. Researchers must separate knowledge from authority. CER and cultural safety are not mutually exclusive; rather, they complement each other and must coexist for truly meaningful and impactful research with communities that have been previously left behind.

CER models lay the foundation for collaboration and cultural safety ensures that this collaboration is built upon a bedrock of trust, respect, and equity. It is a commitment to ceding control, amplifying marginalized voices, and dismantling the very power structures that have historically suppressed and subjugated these communities within research endeavors. By embracing both CER and cultural safety approaches, researchers can forge authentic partnerships that yield transformative insights and catalyze lasting, positive change across all communities.

Solidifying Cultural Safety as a Pillar of Clinical Research

As we look ahead, it is imperative that researchers, institutions, and collaborators are strongly urged to prioritize and implement cultural safety within their studies. By doing so, we can create a more welcoming and accessible research environment, empowering the voices long marginalized and forging enduring relationships with communities currently under-included in research. To truly move forward, we must develop rigorous measurement tools to objectively assess cultural safety, as there are currently no validated instruments to evaluate this concept in research settings. These tools should encompass a comprehensive set of indicators that capture the multidimensional aspects of cultural safety, such as power dynamics, representation, inclusivity, and the prioritization of marginalized perspectives. Additionally, we must provide comprehensive training for researchers to implement cultural safety principles effectively, equipping them with the knowledge, skills, and self-awareness necessary to navigate this complex domain. The positive impacts of deep-rooted cultural safety principles have the potential to catalyze transformative change, fostering novel ideas and future advancements in how we engage individuals in impactful research. This conceptual revolution holds the promise of generating robust empirical evidence, perhaps initially through surveys, interviews, and focus groups. As cultural safety is further integrated into research, more rigorous and validated measures can be developed and the impact of achieving cultural safety can be demonstrated. Such empirical work may underscore cultural safety's importance in producing high-quality, representative data that authentically reflects the experiences and perspectives of these communities. This can lead to the creation of models generalizable to other marginalized groups (LGBTQIA+, physically disabled, neurodivergent) whose communities have endured historically poor relationships with researchers. Developing true cultural safety is an ongoing journey, a temporal condition with no finite end, and we need to make space for it to grow and thrive. Resources needed to make this possible should be meticulously factored into research budgets, encompassing costs for cultural safety training, community engagement, diverse staff recruitment, and the creation of culturally appropriate research environments.

In summary, the integration of cultural safety into clinical research not only holds the potential to strengthen the quality of research, it also creates opportunities to build meaningful and authentic relationships with local communities. Through the intentional practices of environmental and internal cultural safety, researchers can empower participants, build trust, and ultimately improve racial and ethnic representation in research so that downstream findings and treatments are generalizable to all people. Cultural safety can be implemented in diverse ways, tailored to specific communities' barriers and needs, and across many academic and clinical fields. We encourage further research in this area to accelerate its practical implementation and widespread adoption.

Conflict of Interest

None.

Data Availability

This article does not report data and therefore the preregistration and data availability requirements are not applicable.

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