

# **Joint Commitment to Action on Indigenous Health**

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**As approved by the AFMC Board of Directors**

**Prepared by  
Writing Working Group on behalf of  
the Indigenous Health Network**

Dr. Marcia Anderson

Dr. Lynden Crowshoe

Ms. Linda Diffey

Dr. Mike Green

Dr. Darlene Kitty

Dr. Barry Lavallee

Dr. Kent Monkman

Dr. Lisa Richardson

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### BACKGROUND

Indigenous medical workforce development, broadly conceptualized as training more Indigenous physicians as well as training physicians to provide equitable health care to Indigenous peoples, has been occurring on our homelands for centuries, through the initiative of Indigenous peoples. In the early 1800s John Bunn was sent to the University of Edinburgh to study, returning to practice as a surgeon first in Moose Factory in 1819, then several Hudson Bay Company posts and the company ship, before settling in the Red River Settlement in 1824.<sup>i</sup> It is noted that Dr. Bunn, the first Metis surgeon, had “grave misgivings” about sending physicians without full qualifications into the wilderness of Rupert’s Land. Nearly 200 years later, recognizing that medical education is still not preparing physicians who are fully qualified to respond to the needs of Indigenous people, the TRC specifically called on us to train more First Nations, Metis and Inuit physicians and to ensure we are training physicians who can provide high quality, anti-racist, culturally safe care to Indigenous people.<sup>ii</sup>

Medical schools in Canada have trained physicians like Percy E. Moore who participated in experimentation without consent in residential schools and First Nations communities.<sup>iii</sup> We have also trained physicians like Dr. Peter Henderson Bryce who wrote about the conditions of residential schools as a national crime.<sup>iv</sup> It is now our collective responsibility to ensure we are graduating physicians who are more like the latter: medical experts who understand the determinants of Indigenous peoples’ health and are courageous advocates for change.

A foundation for this work was laid in the mid-2000s when Indigenous health was identified by the AFMC as a priority under the social accountability initiative. An Aboriginal Health Task Group (AHTG) was formed in partnership with the Indigenous Physicians Association of Canada (IPAC), initially chaired by Dr. Lynden Crowshoe and Dr. Marcia Anderson. The AHTG made several recommendations to the Board of AFMC at the 2005 Canadian Conference on Medical Education in Saskatoon. These recommendations included:

- The development of structural supports for Indigenous medical education at each medical school;

Truth and Reconciliation Commission of Canada: Calls to Action

23. We call upon all levels of government to:
- i. Increase the number of Aboriginal professionals working in the health care field.
  - ii. Ensure the retention of Aboriginal health-care providers in Aboriginal communities.
  - iii. Provide cultural competency training for all health-care professionals.
24. We call upon medical and nursing schools in Canada to require all students to take a course dealing with Aboriginal health issues, including the history and legacy of residential schools, the United Nations Declaration on the Rights of Indigenous Peoples, Treaties and Aboriginal rights, and Indigenous teachings and practices. This will require skills-based training in intercultural competency, conflict resolution, human rights, and anti-racism.

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- The development of standards for First Nations, Metis and Inuit health curriculum content; and,
- The development of tools that would support medical schools in increasing the number of First Nations, Metis and Inuit medical students.

Over the next several years IPAC and AFMC continued to work together with funding from the Federal Government's Aboriginal Health Human Resource Initiative to develop a series of documents and toolkits to support the medical schools. These documents included:

- First Nations, Inuit, Metis Health Core Competencies Framework for UGME;
- First Nations, Inuit & Metis Health Curriculum Implementation Toolkit;
- First Nations, Inuit & Metis Health Critical Reflection Tool;
- Best Practices to Recruit Mature Aboriginal Students to Medicine; and,
- Pre-Admissions Support Toolkit for First Nations, Inuit, Metis Students into Medicine.<sup>v</sup>

For a variety of reasons including the lack of an accreditation standard that mandated implementation of the recommendations of the AHTG by each medical school, there has been variable utilization of these supportive documents to achieve Indigenous medical education goals. Structural supports for Indigenous medical education range from none to established and funded Indigenous Health Institutes with multiple Indigenous physicians and health experts leading the work. Likewise, admissions supports range from no supports to facilitated admissions policies and processes that attempt to mitigate the structural disadvantage and bias faced by Indigenous applicants. There is a range of mandatory curriculum from minimal hours to 4 year longitudinal courses. Even in medical schools with the most advanced implementation of Indigenous medical education initiatives, Indigenous learners are still experiencing racial micro-aggressions and racism in the classroom and clinical learning environments. This variability in approaches to Indigenous medical education is not creating a physician workforce that is equally qualified to contribute to closing the gaps in Indigenous health, as we are called to do by the TRC.

As we move forward, we must challenge the thinking that guided our past approaches to Indigenous health. First and foremost, we need to stop thinking of Indigenous health as an optional topic, left to the discretion and good will of the leadership of each school. We have an obligation to respond to the Calls to Action of the TRC, to honour and respect Indigenous peoples' right to the highest attainable standard of health and self-determination. We must be training a medical workforce in Canada that can contribute meaningfully to closing the gaps in Indigenous health, through all of the CanMEDS roles and in each arena of physician work. In order to do this we have to be focused on achieving meaningful outcomes. The following sections with accompanying action statements and indicators will provide the framework for action individually and collectively at Canada's seventeen medical schools. This will complement and support the work being done by other national organizations such as the

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Royal College of Physicians and Surgeons of Canada and the College of Family Physicians of Canada.

### **METHODS**

Following CCME 2017 where a public commitment to Indigenous Health was made by the AFMC, an Indigenous Health Network was developed. Following usual AFMC protocols, letters of invitation were sent to the 17 Deans, asking them to nominate a network member. In addition, invitations were sent to key partner organizations including the Indigenous Physicians Association of Canada, Canadian Federation of Medical Students, and the Resident Doctors of Canada. An initial face-to-face meeting of the Indigenous Health Network was held in the Fall of 2017, allowing Network members a chance to participate in the visioning and brainstorming for this paper. It was decided by the Network that the format would be a Joint Commitment to Action, with specific action statements as well as measurable indicators of progress included. It was noted that the indicators of progress should be negotiated between each school and their community partners to ensure that they are also aligned with community priorities and goals.

Following the Network meeting, the Chair of the Network (Dr. Marcia Anderson) convened a Working Group of leading Indigenous medical educators to participate in the drafting of the Joint Commitment to Action on behalf of the Network. Members of the Working Group included:

- Dr. Lynden Crowshoe
- Ms. Linda Diffey (PhD Candidate)
- Dr. Barry Lavallee
- Dr. Lisa Richardson
- Dr. Mike Green
- Dr. Darlene Kitty
- Dr. Kent Monkman

Each member of the Working Group, according to their availability, participated in multiple teleconferences, led the drafting of a section of the paper, helped plan the agenda for the April 27<sup>th</sup>, 2018 face-to-face meeting, and helped facilitate the face-to-face meeting.

In addition to the Indigenous Health Network, the Canadian Association for Medical Education Special Interest Group on Indigenous Health and the National Indigenous Health Sciences Circle were invited to attend the April 27<sup>th</sup> meeting, recognizing their important knowledge, contributions and partnership in this work.

Prior to the meeting, background materials including brief documents explaining the key theme areas and potential action statements were circulated. A modified Nominal Group Technique<sup>vi</sup> process was then used to facilitate small group discussions and collect meaningful input from participants. During this process, participants were able to choose three small groups to participate in sequentially from the following themes:

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- Social Accountability and Community Engagement
- Infrastructure and Organizational Culture
- Admissions
- Curriculum
- PGME

During discussions, participants were given an opportunity to share any idea they thought could contribute to meaningful actions relevant to that theme. At the end of each round of discussion, participants ranked the top ideas from that discussion.

Following three rounds of small group discussions, a master list of the prioritized statements was generated based on the rankings. As a large group, approximately 25 statements were then reviewed. One final ranking was done, with each participant choosing their five most important actions and assigning them a value of 1-5 corresponding with the level of importance. This was done on index cards.

The index cards were then analyzed and grouped into action statements and rank ordered based on the total number of points received. This list is presented as Table 1. Only the top 10 statements are included in the table; the statements that received the fewest votes were not retained.

The Working Group then reviewed the Action Statements, making some changes for clarity as well as suggesting ordering and clarifying content to be included in the accompanying text.

The remainder of this paper is the **Key Themes and prioritized Action Statements** that resulted from this work. Also included are potential indicators for each theme area. It is recommended that medical schools use the potential indicators as a starting point for discussing meaningful indicators with their internal Indigenous leadership as well as the Indigenous communities they serve. In a few years, consideration may be given to developing a set of core national indicators for regular reporting by the medical schools.

### **INDIGENOUS COMMUNITY RELATIONSHIPS**

The first principle of reconciliation according to the TRC is that the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) is the framework for reconciliation.<sup>vii</sup> UNDRIP has several key themes that are relevant to guide how medical schools build and maintain relationships with the Indigenous communities that they serve. UNDRIP asserts the collective right of Indigenous people to be self-determining, to have leadership and decision-making authority over matters that impact them and their rights.<sup>viii</sup> Further, Indigenous people have an equal right to the highest attainable standard of health, to be involved in determining and developing health programs that impact them, and to be free from racism. As medical schools work across the pillars of education, research, and clinical service that are relevant to and

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concern these rights, it is imperative that they build relationships with the Indigenous communities they serve in ways that create space for and support Indigenous self-determination.

This imperative is aligned both with the TRC Calls to Action as listed above and also the social accountability mandate of medical schools. The WHO defined the social accountability of medical schools as “the obligation to direct their education, research and service activities towards addressing the priority health concerns of the community, region, and/ or nation they have a mandate to serve. The priority health concerns are to be identified jointly by governments, health care organizations, health professional and the public.”<sup>ix</sup> In his CCME address in 2017, Dr. Brian Postl Dean of the Max Rady College of Medicine at the University of Manitoba stated:

*“The first accountability of medical schools under their social accountability mandates is to address the persistent gaps in health that Indigenous people experience.”*

Indigenous Peoples in Canada include First Nations, Métis and Inuit. Each have their own way of organizing themselves politically and socially. Communities are present in urban, rural and remote areas and medical schools may serve a wide diversity of communities. It is imperative that the Senior Leadership, faculty and students of medical schools are aware of the communities they serve, including nationhood, languages spoken, and already established mechanisms for engagement or relationship building.

### Action Statements

1. Medical schools focus on the development of meaningful relationships with the Indigenous communities that they serve using rights-based approaches to the co-creation of the terms of the relationship. This includes the development of accountability mechanisms. Indigenous communities are recognized as expert resources for the medical school and are provided with the opportunity and resources needed to participate in all aspects of the admissions process, teaching, hosting learners, research and scholarship, and faculty development.
2. Medical schools respond to their social accountability mandate with respect to Indigenous communities by jointly developing specific Indigenous health goals and reporting regularly on progress within the medical school and to the Indigenous communities they serve.

Potential Indicators

- Each medical school has completed a narrative report/ description of the Indigenous communities that they serve.
- Number of meetings and events held with Indigenous communities.
- Number of signed partnership agreements with Indigenous communities the medical school serves.
- Annual report based on Indigenous community feedback on progress towards shared goals and quality of relationship using existing tool (for example, Ladder of Citizenship Participation<sup>x</sup>) or a newly developed tool.

**THE LEARNING ENVIRONMENT**

As highlighted in the box above, the TRC’s Calls to Action provide direction to medical schools for training a physician workforce with key competencies in providing effective and equitable care to Indigenous populations. Unfortunately, many medical schools do not currently have the foundation or resources base to accomplish these calls. This can be reflected in under-resourced Indigenous health education initiatives that are not strategically positioned to support broad educational impacts across all learner domains. In addition, schools may lack Indigenous people and perspectives throughout the medical school, including learners, administrative staff, faculty and leadership. As a result, many medical schools are challenged in building and sustaining effective Indigenous health educational initiatives that achieve the medical education aligned calls to action.

An institution’s ethos,<sup>1</sup> or some might say organizational culture, drives (and is driven by) educational policies, priorities and values. A disparity of Indigenous health educational resources, indicating a lack of investment, hints at the institution’s values and attitudes with regards to Indigenous people and the priority placed on Indigenous health. Anti-Indigenous sentiment within the medical school reflects unchecked institutional, epistemic and personally mediated acts of racism towards Indigenous people and perspective. The institution’s ethos thus determines the nature of a formal Indigenous health curriculum (or lack of) and a powerful ‘hidden’ curriculum.<sup>2</sup> An environment defined by the above contexts is culturally unsafe for Indigenous people and perpetuates

<p>Institutional Racism: the differential access to the goods, opportunities and services of society by race.</p> <p>Epistemic Racism: the presumed superiority of one knowledge system over another, and/or the use of the believed superior knowledge system to prove the inferiority of the racialized other.</p> <p>Personally Mediated Racism: discriminatory behavior or actions against a racialized other.</p>
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<sup>1</sup> Ethos: the distinguishing character, sentiment, moral nature, or guiding beliefs of a person, group, or institution. *Merriam Webster Dictionary*.

<sup>2</sup> Hidden Curriculum: The unwritten, unofficial and intended or unintended lessons, values and perspectives that students learn in school. *The Glossary of Education Reform*.

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the processes of colonization that persists within Canadian society. The lack of cultural safety will inhibit progress towards Indigenous medical education goals, and consequently limit the ability of medical schools to contribute to closing the gaps in Indigenous Peoples' health.

The medical school's environment, encompassing physical, social and psychological domains, influences what is taught and learned.<sup>xi</sup> Anti-Indigenous racism within any of the environmental domains undermines the intentions of a formal curriculum in Indigenous health. Examples include stereotypes of Indigenous people which maintain a deficit model of Indigenous people within case study materials; peer mediated racism towards Indigenous students and faculty; staff and students minimizing the importance of Indigenous perspectives and content; structural violence towards Indigenous people within the clinical training environment; and lack of investment into Indigenous health education evaluative processes and tools.

Addressing anti-Indigenous sentiment within the medical school means strategic actions within each of the environmental domains with particular attention to shifting the institutions core values and educational policy in ways that are transparent and visible to all who work and learn there. This includes the creation of supportive infrastructure, structured representation on committees with influence and decision-making authority, and the allocation of significant and sufficient resources. Supportive infrastructure includes a formalized office or structure that supports Indigenous health activities and is led by Indigenous physicians and health experts. This Indigenous medical workforce will take time to develop, ideally with leadership development and mentorship support as Indigenous academics grow into influential roles in Indigenous health and other senior roles in curriculum, admissions, and student affairs.

The following are actions intended to foster an environment based in respect and equity towards Indigenous people through dismantling institutional barriers and bias directed towards Indigenous peoples and knowledge systems.

### Action Statements

3. Medical schools invest in the development of a critical mass of Indigenous Faculty and Staff with the appropriate supportive infrastructure to lead all aspects of Indigenous medical education including admissions, student recruitment and retention, curriculum development and implementation, and with structured presence on key decision-making committees within the medical school.
4. Medical schools dedicate sufficient resources to enable full implementation of its Indigenous health goals. The resource needs should be defined with the Indigenous communities, faculty, staff and students and should support action in all three domains of research, education and service.
5. Medical schools have robust policies and processes for identifying and addressing anti-Indigenous racism/ sentiment experienced by Indigenous learners, staff and faculty in



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classroom and clinical environments. This includes institutional measures of the effectiveness of the policy that are regularly reported on.

6. Medical schools commit to developing a safe work and learning environment for Indigenous learners, faculty and staff by supporting leadership and faculty change through focused and strategic professional development activities based in anti-racism, cultural safety and decolonization. This will include a specific focus on clinical preceptors across all clinical learning sites.

### Potential Indicators

- Medical schools have developed an Indigenous workforce development plan.
- Medical schools report annually on numbers of Indigenous Faculty and staff using a distinctions-based approach<sup>3</sup> and including representation on decision-making committees and in senior leadership positions.
- Medical schools have developed an Anti-Racism policy and accompanying process for reporting that includes transparent feedback loops. This includes partnership with relevant authorities to respond to complaints in the clinical learning environment.
- Medical schools report annually on the number of complaints related to Anti-Indigenous Racism, and the number and type of different type of resolutions to complaints (e.g. disciplinary letters, mediation, professional development, removal from teaching duties, dismissal).
- Medical schools report annually on the number and type of professional development activities in anti-racism, cultural safety and decolonization.
- Medical schools set a target and report annually on progress towards reaching it for the percentage of faculty and staff who participate in professional development activities including distribution across departments and clinical teaching sites.
- Medical schools have refined learner evaluations, annual performance reviews or other similar tools to include assessment of cultural safety and anti-racism.

## **ADMISSIONS**

The TRC Calls to Action directed at medical schools contain specific direction to train more Indigenous physicians. In the absence of quality data that contains specific information from each medical school about the number of First Nations, Métis and Inuit students who are applying, being interviewed, and ultimately admitted to medical school it is difficult to know for sure where we are compared to 10-20 years ago. There is a general trend or impression of the admission of more Indigenous students, particularly at schools in the Western half of the

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<sup>3</sup> Distinctions-based approach: reporting by First Nations, Métis and Inuit status separately.

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country. That being said, there are ongoing concerns about the lack of First Nations and Inuit medical students across the country, from urban, rural or remote communities.

Previous IPAC-AFMC work on admissions has described some of the barriers that Indigenous learners face that present structural disadvantage in the medical school admissions process. These barriers include being more likely to live in low income circumstances, being more likely to be the first in their family to attend university or medical school, and the use of evaluative tools in the admissions process that studies have shown are racially biased including the GPA, MCAT, MMI and CASPer.

Previous attempts to mitigate the structural disadvantage that Indigenous people face that makes the playing field unlevel for them when trying to enter medical education have often resulted in stereotyping of Indigenous learners. Not infrequently Indigenous students hear messages that they are not equally qualified to be in medicine or that the admissions processes unfairly advantages them.<sup>xii</sup> As such, along with strategies to mitigate the structural disadvantage that has resulted in insufficient representation of Indigenous learners, medical schools must use deliberate messaging that ensure an understanding of Indigenous learners as equally qualified, and that the mitigation of disadvantage cannot be equated with advantage.

Given the heavy reliance of admissions processes on tools with racial bias, it is important that medical schools consider broader strategies that will help identify the qualifications of Indigenous students that are not adequately assessed with current mechanisms. This could include holistic file reviews that allow assessors to situate GPA within the person's social context; identification of strengths and strategies the individual has shown in navigating systems in order to be eligible to apply; contributions and connections to Indigenous communities; and, support networks available to the learner. These strategies should be accompanied by robust data collection with appropriate data stewardship agreements to allow for building evidence-based admissions procedures for Indigenous people. Similar principles should be applied across the educational journey of the learner, particularly as they transition into residency. Little is currently known about Indigenous learner career trajectories with respect to the percentages of students who match to which specialties or the impact of the unmatched spots on Indigenous learners.

The TRC also calls on medical schools to train physicians who can provide high quality, culturally safe care to Indigenous peoples. Currently, schools have a variety of prerequisite courses or tests like the MCAT that assess a minimum baseline knowledge of sciences, critical analysis and reasoning. No tool, however, ensures a baseline knowledge of content critical to Indigenous health learning, including the history and legacy of residential schools and other colonial policies. TRC Call to Action 18 calls on us to understand Indigenous health as a result of previous government policy. It is beyond the scope of the medical school to teach all of the colonial history and therefore it is reasonable to expect that all students enter medical school with some baseline knowledge. Once in medical school, curriculum can then focus on the health impacts of colonization, anti-racism, and culturally safe practice.

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### Action Statements

7. Medical schools will work towards admitting a school specific minimum number of First Nations, Métis and Inuit students each year by employing distinctions based approaches and practicing holistic file reviews. Robust data collection with appropriate data stewardship agreements will allow for review of progress towards goals at the individual school, provincial and national level.
8. Medical schools will add assessment of knowledge of Indigenous studies, cultural safety, anti-racism or related discipline in the consideration of admission for all candidates through pre-requisite courses, creation of new tools, or modification of existing tools, such as MMI stations that are developed and assessed by Indigenous people.

### Potential Indicators

- Medical schools have worked with Indigenous community partners to determine what the minimum number of First Nations, Métis and Inuit students admitted will be each year.
- Medical schools have developed and implemented a process in collaboration with Indigenous community partners to practice holistic files reviews for Indigenous applicants.
- Medical schools appropriately provide the opportunity for applicants to self-identify as First Nations, Métis or Inuit during the admissions process.
- Medical schools report annually on the number of First Nations, Métis and Inuit students who apply, are interviewed, and are admitted to medical schools.
- Medical schools debrief each admissions cycle with their Indigenous community partners with a focus on strengths and lessons learned, and report these annually.
- Medical schools have added and maintain a prerequisite for consideration of admission for all candidates in Indigenous studies, cultural safety, anti-racism, or related discipline.

## **CURRICULUM**

Call to Action 24 details what the TRC Commissioners believe future physicians should learn about Indigenous health in medical school. It includes the history and legacy of residential schools, Treaties and Indigenous rights, the *United Nations Declaration on the Rights of Indigenous Peoples* (UNDRIP), and Indigenous teachings and practices. Further, the commissioners specify that students will require skills-based training in intercultural competency, conflict resolution, human rights, and anti-racism. In order to meet this call, Canadian medical schools are faced with a number of challenges, from developing curricula that address both national and regional Indigenous health issues, to mobilizing resources and overcoming barriers to implement this curricular change.

Ly and Crowshoe suggest that teaching about racism and stereotyping in medical education would benefit from interdisciplinary collaboration and a flexible approach that draws from

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various pedagogical frameworks in order to meet the specific needs and challenges of the particular setting in which these issues are taught.<sup>xiii</sup> Ideally, a curricular framework should include pedagogic strategies for addressing racism at multiple levels:

1. Interpersonal: challenging stereotypes and personal biases;
2. Systemic: locating racism as a structural problem within society and interrogating power and privilege;
3. Epistemic: challenging the dominance of Eurocentric worldviews and creating space for Indigenous knowledge.

The principles of cultural competency have served as the blueprint for teaching about racial and ethnic difference in health education.<sup>xiv</sup> Although this approach initially focused on learning about health beliefs that may be at odds with the Western biomedical model, it evolved to include issues of unconscious bias, stereotyping, and the development of clinical skills that better address the complexities of cross-cultural interactions.<sup>xv</sup> Nevertheless, cultural competency has been heavily critiqued for perpetuating an essentialized view of culture, failing to adequately examine structural level factors, and avoiding more challenging topics such as racism.<sup>xvi</sup>

Within health education, and particularly nursing, there is a growing body of literature that examines postcolonialism as a teaching framework. Postcolonialism (also known as anti-colonialism) is concerned with the processes and practices that stem from the legacy of colonialism, including ongoing and new forms of colonialism, or neocolonialism.<sup>xvii</sup> It offers a critical perspective for examining the imbalances in power that are the result of the colonial past and neocolonial present.<sup>xviii</sup> Cultural safety is a concept that was first proposed by Maori nurses in New Zealand as a means of translating postcolonialism into nursing education and practice by providing a lens through which to critically examine clinical interactions.<sup>xix</sup> Because postcolonialism exposes and critiques the unjust social processes and structures that drive the health inequities experienced by Indigenous peoples, this framework can help health care providers to recognize how institutions, policies, and practices can perpetuate colonial oppression.<sup>xx</sup> In keeping with postcolonialism's goal of structural change, cultural safety also seeks to effect change in the health care system and supports students to engage in these efforts.

The anti-racist pedagogical framework emerged during the early 1980s in the field of education and has only recently been gaining attention within the literature from health-related fields. Leading Canadian anti-racism scholar George Sefa Dei defines anti-racism education as "an action-oriented strategy for institutional, systemic change to address racism and the interlocking systems of social oppression."<sup>xxi</sup> Issues of race and social difference are explicitly identified as issues of power and equity in this framework, not as cultural or ethnic matters. Like postcolonialism, the anti-racist framework can be used to expose and challenge the structural mechanisms of race-based social oppression, and offers a wide range of tools for examining White privilege and power. However, it is important to take note of the limitations for applying this framework to the context of anti-Indigenous racism.<sup>xxii</sup> Anti-racism tends to

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essentialize racism by not differentiating how it is experienced among racialized groups. Failure to position colonization as foundational in Canadian anti-racism has meant that Indigenous people cannot see themselves and their experiences fully within this theoretical framework.<sup>xxiii</sup> However, anti-racism can be decolonized by integrating an understanding of Canada as a colonialist state, including critical examinations of non-European settlers' role in the continuing colonial project, and through the taking up of Indigenous sovereignty issues, including the reclamation of land.<sup>xxiv</sup>

It is evident that all three frameworks offer useful tools for teaching about Indigenous health, and also that no single framework represents a perfect fit for the specific context of Canadian medical education. While cultural competency has evolved to include a more critical perspective, its tendency to focus on the interpersonal level and use of a cultural frame limit its utility in teaching about settler colonialism. Both anti-racism and postcolonialism provide the tools to examine how racism operates and to situate this within the socio-historical context found in Canada. Drawing from both of these frameworks would provide medical schools with a strong foundation to answer the TRC calls to action.

The IPAC-AFMC undergraduate curricular framework reflects the state of Indigenous health pedagogy and the institutional readiness for including this type of curricular content at the time of its development. As such, the framework maintains an orientation toward the principles of cultural competency, and explicit use of the term 'racism' is limited to the Rationale section and not found within the Core Competencies themselves. Similarly, colonization is addressed minimally and mostly within the Rationale section, with a single appearance in the Core Competency section. Although cultural safety is presented as a central guiding principle, the definition and discussion about the concept tends to focus on the patient-provider dynamic and not at the systemic level. Concepts that form the core of anti-racist/anti-colonial pedagogy, such as privilege, systemic power dynamics, Whiteness, settler, and oppression, are not present in the framework.

To date, implementation of the IPAC-AFMC framework has been variable, and incidents of anti-Indigenous racism in multiple forms persists, even at the most advanced schools. Data is not available for the current state of Indigenous health curricula in Canada's medical schools and the barriers that have been encountered that may have limited their ability to implement the undergraduate curricular framework. As schools move towards meeting the TRC calls to action, it may be useful to consider what is known from the academic literature about the process of adopting anti-racist approaches to teaching. A summary of findings from a recent systematic review identifying factors that either facilitate or inhibit the delivery of anti-racist pedagogy within health education is included at the end of this document (see Table 2).

With appropriate resourcing, national level collaborative work could update the IPAC-AFMC curriculum framework, implementing an anti-racist/ anti-colonial framework and expanding the scope of the objectives. Additional tools such as guidelines for course evaluation and student assessment, and building appropriate supports for faculty and students given the known challenges of implementing anti-racist education would be beneficial.

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### Action Statement

9. Medical schools commit to the development and implementation of a longitudinal Indigenous health curriculum with anti-racism/ anti-colonialism as the core pedagogical approaches.

### Potential Indicators

- Medical schools report annually on the number of hours for various teaching modalities including lectures, case based learning, small group sessions, clinical sessions by year of learning.
- Medical schools report on the development and implementation of various student assessment tools including written, oral, standardized patient and OSCE type exams.
- Medical schools report annually on student performance on assessments of Indigenous health learning.
- Medical schools report annually on the number of curriculum developers, facilitators, Indigenous and non-Indigenous, participating in the Indigenous health longitudinal course.
- Medical schools report annually on the experience of facilitators teaching the Indigenous health longitudinal course using an established or newly developed survey tool.

## **POST-GRADUATE MEDICAL EDUCATION**

Undergraduate training is only the first stage in of medical training. Any advances in curriculum, admissions for Indigenous students and the development of culturally safe learning and clinical environments will need to be reinforced and complemented by parallel advances in postgraduate medical education. While accreditation standards in this area rest with the professional colleges (RCPSC and CFPC), AFMC member medical schools play important roles as the primary agents designing and delivering the educational programs required to achieve these standards. Both colleges have independently recognized the importance of Indigenous Health and have established internal working groups to advance the issues related to healthcare delivery for Indigenous people as well as educational aspects of Indigenous Health in postgraduate training. RCPSC Resolution No. 2017/11-21 endorses the need for Indigenous health to be recognized as a mandatory component of postgraduate medical training. Similarly the CFPC has supported enhancements and changes to its “Red Book” accreditation standards and expected competencies for graduates that specifically address Indigenous health issues.

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During the recent updates to accreditation standards conducted through the Canadian Residency Accreditation Committee (CanRAC) there was recognition that the experience of Indigenous residents (for example, experiences of racism in the learning environment) also required enhanced central program standards.

The importance of including postgraduate training in any response to the TRC calls to Action has been recognized at multiple individual institutions that have either initiated or completed their own local responses.

As described previously, most prior work in the area of Indigenous student admissions for medical education have focused on the pathways leading to initial admission to undergraduate medical training. As increasing numbers of Indigenous students move through the system it will also be important to extend this view to include residency training programs and fellowships. Role models and Indigenous faculty are required in every area of medicine, so it is important that this be addressed in all programs.

PGME curriculum is largely the responsibility of the colleges (to set expectations for graduate outcomes and competencies) and local PG programs (to deliver on these). This work should build on the IPAC-RCSPC frameworks that have already been developed and the work of the CFPC IHWG to update and adapt these to the CanMEDS-FM framework. The role of the AFMC and its member schools will be to support efforts by the colleges and programs and to work together to ensure that a coherent curriculum spanning UGME and PGME is in place. As the AFMC member schools host the PGME programs and engage faculty involved in delivering these programs they can also directly contribute to ensuring that appropriate faculty and support staff resources are allocated to advance and deliver Indigenous health curriculum.

Postgraduate medical education most frequently occurs in clinical settings including teaching hospitals, community hospitals, non-hospital healthcare facilities and community-based physicians' offices. While many conditions in these environments are not under the direct control or responsibility of AFMC member institutions, they do retain responsibility for ensuring that these training environments provide an appropriate learning experience that is safe for learners, faculty and patients. In the context of discussions on Indigenous health this means that the core principles surrounding safety include addressing cultural safety and racism. Indigenous learners have been clear in reporting that they are not infrequently faced with these issues personally and have not often been adequately supported. In addition to this negative impact on Indigenous learners, these environments often serve to undo undergraduate learning through the operation of the hidden curriculum.

It is important to note that the above Action Statements (1-9) are relevant to PGME and should be applied not only to the UGME programs but also interpreted and applied in the PGME programs within medical schools.

### Action Statement

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10. Medical schools commit to the development of Postgraduate Medical Education curriculum and associated tools in Indigenous health with a core focus on cultural safety, anti-colonialism and anti-racism. This curriculum will build on the undergraduate curriculum in Indigenous health and prepare physicians for anti-racist, culturally safe independent practice.

### Potential Indicators

- Medical schools have assessed current Indigenous health education at the PGME level.
- Medical schools have developed and instituted core elements of a common PGME curriculum as well as program-specific curriculum.
- Medical schools report annually on the number of hours of Indigenous health teaching at the PGME level, including number of programs and learners participating.
- Medical schools implement assessment and evaluation of resident learning in Indigenous health, including assessment on rotation ITERS.
- Medical schools report annually on performance of residents on Indigenous health assessments such as on ITERs, comprehensive clinical exams, or other assessments that may be developed.

## CONCLUSION

This report, which includes substantive input from the leading Indigenous medical educators across the country provides a roadmap for concrete institutional change that will best enable the medical schools to respond to the TRC Calls to Action and fulfill their social accountability mandates with respect to Indigenous health. It is clear that there is ongoing need for well-resourced, collaborative work at the national level to support the medical schools as they implement these actions. These actions will provide a strong foundation that will empower the medical schools to do their part in closing the unfair and unjust health gaps that Indigenous peoples experience.

We hope that each medical school will make a full commitment to the implementation of these actions.

1. Medical schools focus on the development of meaningful relationships with the Indigenous communities that they serve using rights-based approaches to the co-creation of the terms of the relationship. This includes the development of accountability mechanisms. Indigenous communities are recognized as expert resources for the medical school and are provided with the opportunity and resources needed to participate in all aspects of the admissions process, teaching, hosting learners, research and scholarship, and faculty development.



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2. Medical schools respond to their social accountability mandate with respect to Indigenous communities by jointly developing specific Indigenous health goals and reporting regularly on progress within the medical school and to the Indigenous communities they serve.
3. Medical schools invest in the development of a critical mass of Indigenous Faculty and Staff with the appropriate supportive infrastructure to lead all aspects of Indigenous medical education including admissions, student recruitment and retention, curriculum development and implementation, and with structured presence on key decision-making committees within the medical school.
4. Medical schools dedicate sufficient resources to enable full implementation of its Indigenous health goals. The resource needs should be defined with the Indigenous communities, faculty, staff and students and should support action in all three domains of research, education and service.
5. Medical schools have robust policies and processes for identifying and addressing anti-Indigenous racism/ sentiment experienced by Indigenous learners, staff and faculty in classroom and clinical environments. This includes institutional measures of the effectiveness of the policy that are regularly reported on.
6. Medical schools commit to developing a safe work and learning environment for Indigenous learners, faculty and staff by supporting leadership and faculty change through focused and strategic professional development activities based in anti-racism, cultural safety and decolonization. This will include a specific focus on clinical preceptors across all clinical learning sites.
7. Medical schools will work towards admitting a school specific minimum number of First Nations, Métis and Inuit students each year by employing distinctions based approaches and practicing holistic file reviews. Robust data collection with appropriate data stewardship agreements will allow for review of progress towards goals at the individual school, provincial and national level.
8. Medical schools will add assessment of knowledge of Indigenous studies, cultural safety, anti-racism or related discipline in the consideration of admission for all candidates through pre-requisite courses, creation of new tools, or modification of existing tools, such as MMI stations that are developed and assessed by Indigenous people.
9. Medical schools commit to the development and implementation of a longitudinal Indigenous health curriculum with anti-racism/ anti-colonialism as the core pedagogical approaches.
10. Medical schools commit to the development of Postgraduate Medical Education curriculum and associated tools in Indigenous health with a core focus on cultural

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safety, anti-colonialism and anti-racism. This curriculum will build on the undergraduate curriculum in Indigenous health and prepare physicians for anti-racist, culturally safe independent practice.

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Table 1: Rank Ordered Action Statements Based on Voting

Statement	Total Votes
1. Medical schools respond to their social accountability with respect to Indigenous communities by jointly developing specific Indigenous health goals and reporting regularly on progress within the medical school and also to the Indigenous communities they serve.	72
2. Medical schools dedicate sufficient resources to enable full implementation of Indigenous health goals. This includes, for example, appropriate resourcing of Knowledge Keepers, meaningful community partnerships, library and librarian services, and physical space.	48
3. Medical schools commit to the development and implementation of a longitudinal Indigenous health course with anti-racism as the core pedagogical approach.	37
4. Medical schools invest in the development of a critical mass of Indigenous Faculty and Staff with the appropriate supportive infrastructure to lead all aspects of Indigenous medical education including admissions, student recruitment and retention, curriculum development and implementation, and with structured presence on key decision-making committees within the medical school.	36
5. Medical schools commit to developing a safe work and learning environment for Indigenous learners, faculty and staff by supporting leadership and faculty change through focused and strategic professional development activities based in anti-racism, cultural safety and decolonization. This will include a specific focus on clinical preceptors across all clinical learning sites.	35
6. Medical schools focus on the development of meaningful relationships with the Indigenous communities that they serve using rights-based approaches to the co-creation of the terms of the relationship. Indigenous communities are recognized as expert resources for the medical school and are provided with the opportunity and resources needed to participate in all aspects of the admissions process, teaching, hosting learners, research and scholarship, and faculty development.	32
7. Medical schools have robust policies and processes for identifying and addressing anti-Indigenous racism/ sentiment experienced by Indigenous learners, staff and faculty in classroom and clinical environments. This includes institutional measures of the effectiveness of the policy that are regularly reported on.	29
8. Medical schools commit to the development of Postgraduate Medical Education curriculum and associated tools in Indigenous health with a core focus on cultural safety and anti-racism. This builds on the undergraduate curriculum in Indigenous health and prepares physicians for anti-racist, culturally safe independent practice.	23
9. Medical schools will work towards admitting a minimum number of First Nations, Métis and Inuit students each year by employing distinctions based approaches and practicing holistic file reviews. Robust data collection with appropriate data stewardship agreements will allow for review of progress towards goals at the individual school, provincial and national level.	23
10. Medical schools will add a prerequisite for consideration of admission for all candidates in Indigenous studies, cultural safety, anti-racism or related discipline.	13

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**Note:** These are only the top 10 statements. Fifteen other statements received insufficient prioritization to be included.

Table 2: Factors that support or limit anti-racist pedagogy in health education.<sup>xxv</sup>

<b>Sphere/level</b>	<b>Facilitating Factors</b>	<b>Limiting Factors</b>
<b>Instructors</b>	<ul style="list-style-type: none"> <li>Engaging in self-reflective practices</li> <li>Viewing skill development as a long-term journey</li> <li>Teaching partnerships across social groups</li> <li>Forming communities of practice</li> <li>Skill at responding to defensiveness and conflict</li> </ul>	<ul style="list-style-type: none"> <li>Lack of anti-racism knowledge/training</li> <li>Emotionally intense work for instructors from racially oppressed groups</li> <li>Built-in failure by hiring unqualified instructors</li> <li>Heavy academic workloads, resulting in lack of energy to engage in anti-racism</li> </ul>
<b>Classroom/students</b>	<ul style="list-style-type: none"> <li>Self-reflective writing helps students process emotions</li> <li>Engagement was enhanced when students                             <ul style="list-style-type: none"> <li>Had prior anti-racism training</li> <li>Could see relevance to application in professional settings</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Privilege is difficult for students to confront, and tend to react with resistance/hostility</li> <li>Students tend to self-segregate to feel safe, causing others to feel alienated</li> <li>Students may feel pressured to agree with other members of their racialized group</li> <li>Younger students or those who have been culturally isolated tend to experience more challenges to learning about racism</li> </ul>
<b>Within the educational institution</b>	<ul style="list-style-type: none"> <li>Introducing anti-racism at a time of curricular change</li> <li>Institutional climate is supportive and ready for change</li> <li>The institution has mandated anti-racism courses/policies</li> <li>University has strategic plans re: anti-racism</li> <li>Opportunities exist for mentorship in anti-racist teaching</li> </ul>	<ul style="list-style-type: none"> <li>Dominance of Whiteness and the biomedical perspective</li> <li>Resistance from management and colleagues</li> <li>Pressure to focus on 'positive' topics</li> <li>Questioning legitimacy of anti-racism content</li> <li>Lack of diversity among faculty</li> <li>Other faculty conveying negative attitudes to students re: anti-racism teaching/content</li> <li>Lack of shared understanding concerning how to teach about race</li> </ul>
<b>Outside the institution</b>	<ul style="list-style-type: none"> <li>Listening/engaging with community stakeholders</li> <li>Professional regulatory standards about addressing racism</li> <li>Shift in socio-political climate to address health inequities</li> <li>Close collaboration with off-campus</li> </ul>	<ul style="list-style-type: none"> <li>Racial tensions in society contribute to conflict in classroom</li> <li>Administrators fear backlash from external interest groups</li> <li>Field placement agencies may not support anti-racist teaching</li> </ul>

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	learning sites/staff	
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