First Nations, Inuit, Métis Health
CORE COMPETENCIES

A Curriculum Framework for Undergraduate Medical Education

Updated April 2009

Indigenous Physicians Association of Canada | Association des Médecins Indigènes du Canada

AFMC

The Association of Faculties of Medicine of Canada

L'Association des facultés de médecine du Canada

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This document is available in English and French on the IPAC and AFMC web sites (www.ipac-amic.org; www.afmc.ca/social-aboriginal-health-e.php)

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Introduction

The AFMC Aboriginal Health Task Group (now called IPAC-AFMC Aboriginal Health Task Group), co-chaired then by Dr. Linden Crowshoe and Dr. Marcia Anderson, provided recommendations to the AFMC Council of Deans at their May 2005 meeting.

Their recommendations focused primarily on the issues of education (curricular content and faculty development on Aboriginal health care issues) and human resources (admissions into the MD program and Aboriginal student support). Members of the Task Group represent a range of expertise in Aboriginal health and medical education.

Recommendations presented and unanimously approved at the 2005 Council of Deans meeting include:

"That all medical schools should:

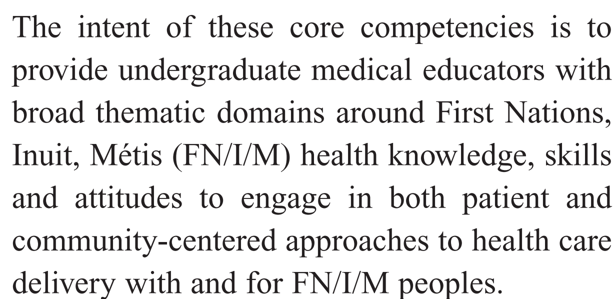
a. *make a commitment to increase content of undergraduate curriculum related to Aboriginal health;*
b. *strive for Aboriginal health curricula that respect principles of cultural competence and particularly emphasize skill-based and attitudinal themes;*
c. *develop, implement and evaluate core and elective curriculum that has both discrete and integrated elements and is apparent within course and clinical teaching;*
d. *recognize that Aboriginal health is a specialist area and requires experts such as Aboriginal faculty, local Aboriginal community members and national Aboriginal resources to develop and teach culturally appropriate Aboriginal curriculum content and context; and*
e. *utilize appropriate teaching methods such as experiential and interactive methods to facilitate cultural competence.*

And that the Association of Faculties of Medicine of Canada support the development of a multi-stakeholder National Aboriginal Health Curriculum Framework to act as a guiding document for Aboriginal health curriculum in each medical school."

One of the underlying principles in the recommendations is for the development of meaningful partnerships between local First Nations, Inuit and Métis communities and each medical school and residency program in order to incorporate local, Indigenous values.

It is under these principles and recommendations that the current Aboriginal Health Task Group's curriculum subcommittee led by Drs. Alan Neville and Barry Lavallee embarked on developing a national set of recommended First Nations, Inuit, Métis health core competencies for the 17 medical schools across Canada using the CanMEDs[1] format.

[1] Frank, JR. (Ed). 2005. The CanMEDS 2005 Physician Competency Framework. Better standards. Better physicians. Better care. Ottawa: The Royal College of Physicians and Surgeons of Canada.



The intent of these core competencies is to provide undergraduate medical educators with broad thematic domains around First Nations, Inuit, Métis (FN/I/M) health knowledge, skills and attitudes to engage in both patient and community-centered approaches to health care delivery with and for FN/I/M peoples.

Enhancing the current curricula regarding FN/I/M health could also have a positive impact on the increasing number of FN/I/M medical students, as culturally safe learning environments will foster collaborative learning environments for all students, medical faculty and practitioners.

We encourage the faculties of medicine to engage with their local First Nations, Inuit and Métis communities, workers and leaders in order to promote respectful working environments with those whose health these core competencies will impact. The IPAC-AFMC Aboriginal Health Task group believes learning is bidirectional in that medical schools will need to increase and utilize their knowledge and understanding of local FN/I/M communities as an ongoing activity to support successful implementation of the competencies into the curriculum.

Acknowledging that the implementation of the core competencies will present challenges for some of the medical schools, the IPAC-AFMC Aboriginal Health Task Group has identified a number of strategies to enable all undergraduate medical programs to deliver this innovative curriculum.

At the outset, "faculty development" workshops will be held in conjunction with national medical education conferences. A FN/I/M Health Curriculum Implementation "Toolkit" will be produced to offer an effective general strategy guide for medical schools to use in partnership with their local FN/I/M communities. This will provide a basis upon which to support the ubiquitous learning environments at each medical school. In addition, a national Working Group will be established to share and support curriculum implementation experience and best practices; and available FN/I/M health learning resources will be gathered to develop an on-line resource repository. We envision this site could also provide a moderated forum to share successes and challenges over the years.

Medical educators and schools with established support programs geared for FN/I/M students are well placed to work collaboratively to advance the core competencies. In order to share that success, those universities with little structural support would be encouraged to work with their local FN/I/M communities to develop targeted FN/I/M student support programs and for curriculum implementation.

The IPAC-AFMC Aboriginal Health Task Group and the curriculum subcommittee view the implementation of this framework as an ongoing learning endeavour. As the process moves forward, the subcommittee will invite feedback from medical school educators, learners and FN/I/M communities.

Feedback or enquiries: info@ipac-amic.org

Terminology

We at Indigenous Physicians Association of Canada use the term Indigenous to refer to “communities, peoples and nations…which, having a historical continuity with pre-invasion and pre-colonial societies that developed on their territories, consider themselves distinct from other sectors of the societies now prevailing on those territories, or part of them. They form, at present, non-dominant sectors of society and are determined to preserve, develop and transmit to future generations their ancestral territories, and their ethnic identity, as a basis of their continued existence as peoples, in accordance with their own cultural patterns, social institutions and legal system.”[2]

In Canada, the Constitution terms Indigenous peoples as Aboriginal and includes First Nations, Métis and Inuit peoples.

2 http://www.un.org/esa/socdev/unpfii/documents/PFII%202004%20WS.1%203%20Definition.doc - The Concept of Indigenous Peoples; United Nations Department of Economic and Social Affairs. Retrieved February 7, 2008

Rationale

Health disparities between First Nations, Inuit and Métis (FN/I/M) peoples and the general Canadian population continue to exist. Canada's history of colonization of FN/I/M peoples with its resulting racism, discrimination and marginalization continues to affect the health and well being of many communities.[3]

As the First Peoples of Canada, these communities are diverse in their languages, beliefs, histories and health practices. And while varied languages, histories and health practices may also be true of cultural groups who have immigrated to Canada, *FN/I/M peoples are not a cultural group to Canada*, but rather distinct constitutionally recognized peoples with Aboriginal and treaty rights.

A brief overview of some of the persistent health disparities between FN/I/M peoples and the overall Canadian population further highlights the urgent need to prioritize the health and well being of these communities in medical school curriculum[4].

- The **life expectancy** of First Nations peoples was estimated at 68.9 years for males and 76.6 years for females, reflecting differences of 7.4 and 5.2, respectively, from the Canadian population's life expectancies.
- Preventable deaths due to **circulatory diseases** (23% of all deaths) and **injury** (22% of all deaths) account for a near staggering 50% of all deaths.
- For First Nations ages 1 to 44, the most common cause of death was **injury and poisoning**. The primary cause of death for children less than 10 years was classified as unintentional (accidents).
- **Suicide** rates for Aboriginal youth range from 5-7 times higher than the national average.[5] Inuit males are at the most risk with rates 20 times higher for **completed suicide** amongst ages 15-24 years old, as compared to the rest of Québec.[6] Suicide is one of the greatest causes of injury related deaths of Aboriginal peoples in Canada.
- **Infectious diseases** continue to drive current disparities with the rates of pertusis (2.2 times higher), rubella (7 times higher), tuberculosis (6 times higher) and shigellosis (2.1 times higher) than the overall Canadian population for the year 2000.

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3 Ministry of Supply and Services (1996). Royal Commission on Aboriginal Peoples. Report on the Royal Commission on Aboriginal Peoples. Ottawa, Ontario

4 http://www.hc-sc.gc.ca/fnih-spni/pubs/gen/stats_profil_e.html - Statistical profile on the health of First Nations in Canada; Health Canada. Retrieved January 10, 2008.

5 http://www.ainc-inac.gc.ca/pr/info/fnsocec/abhl_e.html - Factsheet on Aboriginal Health, Indian and Northern Affairs Canada. Retrieved January 10, 2008.

6 Completed Suicides Among the Inuit of Northern Québec, 1982-1996, A Case Control Study. Canadian Medical Association Journal, Sept 18, 2001; 165 (6).

- The potential **years of life lost from injury** alone was more than all other causes of death and was almost 3.5 times that of the general Canadian population.

Systemic barriers continue to undervalue the importance of working towards collective solutions which will advance the health and well being of FN/I/M peoples. The Kelowna Accord is one example of this. The Accord is a collection of documents, collectively entitled "First Ministers and National Aboriginal Leaders Strengthening Relationships and Closing the Gap" and is the culmination of roundtable discussions among First Nations, Inuit and Métis leaders and the Canadian government.

The intention was to address the health disparities faced by FN/I/M peoples through improved housing, employment and health with significant monetary and resource allocation. Since the development process involved the cooperation and consultation of all stakeholders, the Kelowna Accord was viewed as a step forward by FN/I/M leaders. However, with no clear plan for implementation, the strategies set out in the working paper were never put in place.

What does this have to do with the health care systems and providers?

FN/I/M patients are often faced with physicians who might not recognize, acknowledge and address some of the barriers they face to improving their health.[7] When physicians are trained and supported, they are better able to bridge barriers such as language, social challenges, and institutional racism and to recognize and develop the necessary advocacy skills to work collaboratively with these clients, their communities and other members of interdisciplinary teams in achieving better health outcomes.

At the same time, FN/I/M peoples have shown great resiliency in dealing with these challenges and have a rich body of knowledge and traditions to share. Traditional knowledge and ways of healing continue to be facilitated through healers, midwives and traditional medicine persons who constitute a significant FN/I/M health provider system.

Medical schools are well positioned to work with FN/I/M communities and their existing health systems to advance the goal of improving their health and well being. Many opportunities exist to prepare and support physicians to work with FN/I/M communities to meet these challenges. Acquiring the skills to engage in culturally safe health care to FN/I/M peoples also has broad benefits for other communities and populations served by Canadian physicians.

[7] Ministry of Supply and Services (1996). Royal Commission on Aboriginal Peoples. Report on the Royal Commission on Aboriginal Peoples. Ottawa, Ontario

Successful implementation of the First Nations, Inuit, Métis health core competencies developed by the IPAC-AFMC Aboriginal Health Task Group, its curriculum subcommittee and representatives of First Nations, Inuit and Métis communities will require all medical educators to have a working knowledge and definition of *cultural safety*.

Cultural safety refers to a state whereby a provider embraces the skill of self-reflection as a means to advancing a therapeutic encounter with First Nations, Inuit, Métis peoples and other communities including but not limited to visible minorities, gay, lesbian, transgendered communities, and people living with challenges. Self-reflection in this case is underpinned by an understanding of power differentials. For First Nations, Inuit and Métis communities this power imbalance is unequal and can be seen as a residual element of colonization and act as a barrier to facilitating the health and healing for First Nations, Inuit and Métis citizens of Canada. Providers should be able to understand their own biases and prejudices, and how racism might play a role while providing care to these diverse communities.

A *cultural safety* lens will provide favourable conditions for medical educators and learners to embark on developing meaningful knowledge, skills and attitudes necessary to become effective health care providers to the diverse First Nations, Inuit and Métis communities across Canada.

This is an evolving area associated with many different terms, including cultural awareness, cultural competence, cultural safety and cultural humility. We chose to use cultural safety in this document as it encompasses the additional skill of self-reflection. For health care practitioners and educators, the skill of self-reflection is fundamental to the relationship between the patient and physician. This skill is a continuation of the patient-centered approach engendered in many medical curricula across Canada.

The concept of cultural safety has its origins with the Māori People of Aotearoa (New Zealand).[8]

Cultural safety takes us beyond:

- Cultural awareness, the acknowledgement of difference;
- Cultural sensitivity, the recognition of the importance of respecting difference, and;
- Cultural competence, which focuses on the skills, knowledge, and attitudes of practitioners.[9]

While these three approaches have contributed to our understanding of the need to attend to a patient's culture, there are real limitations and concerns associated with each of them.

Recently, the problems associated with cultural competence have been highlighted and include:

- the reduction of culture to technical skills for which clinicians can be trained to develop expertise;
- a series of "do's and don'ts" that define how to treat a patient of a given cultural

8 Ramsden, I. (1990) Cultural safety. New Zealand Nursing Journal83(December): 18-19

9 http://web2.uvcs.uvic.ca/courses/csafety/mod1/index.htm - Cultural Safety, Module 1 – Peoples' Experience of Colonization. University of Victoria, School of Nursing; Initiatives in Indigenous Nursing. Retrieved on February 14, 2007.

and or ethnic background;

- the idea that cultural communities exist as isolated societies with shared, homogenous cultural meanings; and,
- the fact that cultural factors are not always central to medical care.[10]

Moreover, power relationships, gender, sexuality, spiritual beliefs, and socioeconomic status may remain “invisible” to care providers who simply focus on cultural competence and cultural differences. Cultural safety is predicated on understanding the power differentials inherent in health service delivery and redressing these inequities through educational processes.[11]

Taking a cultural safety approach to dealing with inequities enables physicians and other care providers to improve health care access for patients, aggregates, and populations; acknowledge that we are all bearers of culture; expose the social, political, and historical context of health care; and interrupt unequal power relations.[12]

A central tenet of cultural safety is that it is the patient who defines what “safe service” means to them.[13] This avenue opens up opportunities to learn about the unique histories, current challenges and successes of First Nations, Inuit and Métis (FN/I/M) communities in achieving an equitable level of health and wellness as enjoyed by many non-Aboriginal citizens. Furthermore, physicians are encouraged to ask patients (family members and communities as appropriate) what matters most to them in their experience of illness and its treatment. When health care providers engage with patients in this way, it can present opportunities to become more FN/I/M patient-centred.

It is important to appreciate that FN/I/M patients may exist within their own health systems already, and that physicians must work alongside and/or within these existing systems. These systems can be extensive, and can include family members, community-based services, and interdisciplinary primary health care workers including other physicians, non-governmental organizations and government agencies.

While cultural safety is addressed in light of the First Nations, Inuit and Métis health core competencies presented in this framework, all patients, including those of visible minorities, immigrant and new Canadians, those with disabilities, and those with varied sexuality, etc., will benefit as well.

Embracing cultural safety will strengthen the attitudinal domain of medical education. As a component of communication skills, it should readily be embedded in most learning opportunities shared by medical educators and students alike.

[10] Kleinman, A., & Benson, P. (2006). Anthropology in the clinic: The problem of cultural competency and how to fix it. Plos Medicine 2(10): 1673-1676. See also http://www.plosmedicine.org

[11] Spence, D. (2001). Hermeneutic notions illuminate cross cultural nursing experiences. Journal of Advanced Nursing 35(4): 624-630.

[12] Varcoe, C. (2004). Context/culture. Unpublished segment for Collaborative Nursing Program in BC curriculum guide. Vancouver. Collaborative Nursing Program in British Columbia.

[13] Varcoe, C., & McCormick, J. (2006). Racing around the classroom margins: Race, racism and teaching nursing. In L.E. Young & Paterson, B. (Eds.), Teaching nursing: Developing a student-centred learning environment (p. 437-466). Philadelphia, PA: Lippincott, Williams & Williams.

1. *Medical Expert*

Key Competency

The graduating student will demonstrate compassionate, culturally safe, relationship-centred care for First Nations, Inuit, Métis patients, their families or communities.

Enabling Competencies (Objectives)

Students are able to...

1.1 Describe the connection between historical and current government practices towards First Nations, Inuit, Métis peoples (including, but not limited to colonization, residential schools, treaties and land claims), and the resultant intergenerational health outcomes.

1.2 Describe the various health care services that are delivered to First Nations, Inuit, Métis peoples, and the historical basis for the systems as they pertain to these communities.

1.3 Identify the diversity amongst First Nations, Inuit, and/or Métis communities in your local area in terms of their various perspectives, attitudes, beliefs and behaviours. Describe at least three examples of this cultural diversity.

1.4 Articulate how the medical, social and spiritual determinants of health and well being for First Nations, Inuit, Métis peoples impact their health.[14]

1.5 Identify and describe the range of healing and wellness practices (traditional and non-traditional) present in local First Nations, Inuit and Métis communities.[15]

[14 and 15] Indigenous knowledge is different but equal to Western knowledge. By learning about Indigenous ways of knowing and practices, medical students will have the opportunity to acknowledge and respect this truth.

2. Communicator

Key Competency

The graduating student will demonstrate effective and culturally safe communication with First Nations, Inuit, Métis patients, their families and peers.

Enabling Competencies (Objectives)

Students are able to...

2.1 Describe cultural safety as it pertains to First Nations, Inuit and Métis patients.

2.2 Identify the centrality of communication in the provision of culturally safe care, and engage in culturally safe communication with First Nations, Inuit and Métis patients, families and communities.

2.2 Demonstrate the ability to establish a positive therapeutic relationship with First Nations, Inuit, Métis patients and their families, characterized by understanding, trust, respect, honesty and empathy.[16]

[16] Teachings in this area should include, but not be limited to understanding how the "oral tradition/culture" may impact a First Nations, Inuit, Métis patient's willingness to discuss health issues freely.

3. Collaborator

Key Competency

The graduating student will demonstrate the skills of effective collaboration with both Aboriginal and non-Aboriginal health care professionals, traditional/medicine peoples/healers in the provision of effective health care for First Nations, Inuit, Métis patients/populations.

Enabling Competencies (Objectives)

Students are able to...

3.1 Identify key principles in developing collaborative and ethical relationships.

3.2 Describe types of Aboriginal healers/traditional medicine people and health care professionals working in local First Nations, Inuit and/or Métis communities, and how they are viewed in the community.

3.3 Demonstrate how to appropriately enquire whether a First Nations, Inuit, Métis patient is taking traditional herbs or medicines to treat their ailment and how to integrate that knowledge into their care.[17]

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[17] Integration of knowledge into the patient's care may be at the post graduate level.

4. Manager

Key Competency

The graduating student will be able to describe approaches to optimizing First Nations, Inuit, Métis health through a just allocation of health care resources, balancing effectiveness, efficiency and access, employing evidence based and Indigenous best practices.

Enabling Competencies (Objectives)

Students are able to...

4.1 Discern the concepts of community development, ownership, consultation, empowerment, capacity-building, reciprocity and respect in relation to health care delivery in and by First Nations, Inuit and Métis communities.

4.2 Identify key First Nations, Inuit, Métis community contacts and support structures in the provision of effective health care.

4.3 Describe successful approaches that have been implemented to improve the health of First Nations, Inuit, Métis peoples, either locally, regionally or nationally.

5. *Health Advocate*

Key Competency

The graduating student will be able to identify the determinants of health of Aboriginal populations and use this knowledge to promote the health of individual First Nations, Inuit, Métis patients and their communities.

Enabling Competencies (Objectives)

Students are able to...

5.1 Outline the concept of inequity of access to health care/health information for First Nations, Inuit, Métis peoples and the factors that contribute to it.[18]

5.2 Identify ways of redressing inequity of access to health care/health information with First Nations, Inuit, and Métis patients/populations.[19]

[18 and 19] Teachings should include, but not be limited to understanding the potential power of self-governance and determination, and the real impact of these political forces on improving the health of First Nations, Inuit, and Métis peoples.

6. Scholar

Key Competency

The graduating student will be able to contribute to the development, dissemination, critical assessment of knowledge/practices and dissemination related to the improvement of First Nations, Inuit, Métis health in Canada.

Enabling Competencies (Objectives)

Students are able to...

6.1 Describe appropriate strategies to work with First Nations, Inuit, and Métis populations to identify health issues and needs.[20]

6.2 Engage in effective strategies to share and promote health information with First Nations, Inuit, and Métis patients/populations.[21]

6.3 Describe various ways of respectfully acquiring information (in a transparent manner) about First Nations, Inuit, and Métis populations which involves communities as partners.[22]

6.4 Critically appraise the strengths and limitations of available data used as key indicators of Canadian Aboriginal health.

Demonstrate ways to acknowledge and value Indigenous knowledge.[23]

20, 21 and 22 Teachings should include, but not be limited to the importance of partnership, ownership, consultation and participatory action in developing successful health surveillance, research and dissemination strategies with First Nations, Inuit and Métis communities. There is sensitivity around research issues in some communities based on past experiences with Universities who have come into the community, conducted research and never reported back or shared with the community afterwards.

23 Emphasis is on recognizing non academic/empirical ways of knowing that are of equal value to western scholarship values.

7. *Professional*

Key Competency

The graduating student will demonstrate a commitment to engage in dialogue and relationship building with First Nations, Inuit, and Métis peoples to improve health through increased awareness and insights of First Nations, Inuit, Métis peoples, cultures, and health practices.

Enabling Competencies (Objectives)

Students are able to...

7.1 Identify, acknowledge and analyse one's own considered emotional response to the many histories and contemporary environment of First Nations, Inuit, and Métis peoples and offer opinions respectfully.[24]

7.2 Acknowledge and analyse the limitations of one's own knowledge and perspectives, and incorporate new ways of seeing, valuing and understanding with regard to First Nations, Inuit, Métis health practice.

7.3 Describe examples of ways to respectfully engage with and give back to First Nations, Inuit and Métis communities as a medical learner.[25]

7.4 Demonstrate authentic, supportive and inclusive behaviour in all exchanges with First Nations, Inuit and Métis individuals, health care workers and communities.[26]

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[24] This key competency opens up potential reflective space (personal/professional) to consider the difficult concepts of prejudice, discrimination and racism.

[25] This competency emphasizes the importance of reciprocity and exchange with First Nations, Inuit and Métis communities, which is a foundation piece to relationship building.

[26] The emphasis is on the demonstration of ethical behaviour as defined by First Nations, Inuit and Métis culture.