

THE COLLEGE OF  
FAMILY PHYSICIANS  
OF CANADA



LE COLLÈGE DES  
MÉDECINS DE FAMILLE  
DU CANADA



# CanMEDS–Family Medicine Indigenous Health Supplement



## CanMEDS-Family Medicine

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### **This document was adapted from**

Shaw E, Oandasan I, Fowler N, eds. *CanMEDS-FM 2017: A competency framework for family physicians across the continuum*. Mississauga, ON: The College of Family Physicians of Canada; 2017.

### **How to cite this document**

Kitty D, Funnell S, eds. *CanMEDS-FM Indigenous Health Supplement*. Mississauga, ON: The College of Family Physicians of Canada; 2020.

Artwork provided courtesy of James Wedzin.

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# Acknowledgements

The College of Family Physicians of Canada thanks the Indigenous Health Committee, as well as the external reviewers and contributors who assisted with the development of this document.

## Indigenous Health Committee

Dr. Darlene Kitty, Co-chair  
Dr. Sarah Funnell, Co-chair  
Dr. Lynden (Lindsay) Crowshoe  
Dr. Ojistoh Horn  
Dr. Veronica McKinney  
Dr. Amanda Sauvé  
Dr. Leah Seaman  
Mr. Simon Brascoupé

## External reviewers

Dr. Mandy Buss  
Dr. Melinda Fowler

## External contributor

Dr. Madeleine Cole (Narrative for Leader Role)

## How to cite individual Roles

### Family Medicine Expert

Seaman L. Family Medicine Expert. In: Kitty D, Funnell S, eds. *CanMEDS-FM Indigenous Health Supplement*. Mississauga, ON: The College of Family Physicians of Canada; 2020.

### Communicator

Crowshoe L. Communicator. In: Kitty D, Funnell S, eds. *CanMEDS-FM Indigenous Health Supplement*. Mississauga, ON: The College of Family Physicians of Canada; 2020.

### Collaborator

Sauvé A. Collaborator. In: Kitty D, Funnell S, eds. *CanMEDS-FM Indigenous Health Supplement*. Mississauga, ON: The College of Family Physicians of Canada; 2020.

### Leader

Funnell S, Cole M. Leader. In: Kitty D, Funnell S, eds. *CanMEDS-FM Indigenous Health Supplement*. Mississauga, ON: The College of Family Physicians of Canada; 2020.

### Health Advocate

Horn O. Health Advocate. In: Kitty D, Funnell S, eds. *CanMEDS-FM Indigenous Health Supplement*. Mississauga, ON: The College of Family Physicians of Canada; 2020.

### Scholar

Kitty D. Scholar. In: Kitty D, Funnell S, eds. *CanMEDS-FM Indigenous Health Supplement*. Mississauga, ON: The College of Family Physicians of Canada; 2020.

### Professional

Crowshoe L. Professional. In: Kitty D, Funnell S, eds. *CanMEDS-FM Indigenous Health Supplement*. Mississauga, ON: The College of Family Physicians of Canada; 2020.



# Introduction

We call upon ourselves and all of our colleagues to practice with Cultural Safety, Humility, and Courage as we engage in compassionate care with Indigenous patients, their families, and their communities within Canada.

## Overview

Indigenous populations experience a high burden of poor health that is disproportionate to other populations in Canada. In response, the College of Family Physicians of Canada (CFPC) advocates for equitable health outcomes for Indigenous populations by understanding the needs and strengths of communities, paying particular attention to this across the continuum of medical education, and advocating on behalf of patients to address the needs of the vulnerable.<sup>1</sup>

This Indigenous supplement to the CanMEDS-FM 2017 competency framework will help family physicians provide high-quality care that aligns with the needs and circumstances of Indigenous peoples living in Canada. This resource outlines critical knowledge and skills needed for effective therapeutic interactions and culturally safe care of Indigenous patients, families, and communities. Each competency reflects the basic format of CanMEDS-FM, focusing on Indigenous-relevant situations and foundational knowledge needed to develop these enabling competencies.

This supplement is a resource for undergraduate, postgraduate, and continuing medical education with potential to assist with program design, curriculum content, learning methods, and learner assessment. The competencies presented here support the foundation for family physicians, medical trainees, and educators to better engage in care that authentically respects Indigenous peoples and their cultural, historical, political, and social contexts. This ultimately leads to culturally safe and improved quality of health care to Indigenous populations.

## Context

Indigenous peoples across Canada face many challenges in their daily lives that impact their health and well-being, as demonstrated by poor health statistics and social problems. However, their cultures, strengths, resilience, and motivation can help improve their overall health. Family physicians are important contacts to the health care system for Indigenous populations. Therefore, the therapeutic relationships must be founded on partnership, respect, and knowledge.

Family physicians are called to work with Indigenous peoples using an approach that is trauma informed and healing centred. Trauma-informed care acknowledges how colonization continues to impact the health and lived experiences of Indigenous peoples, and is an approach that encourages the support and treatment of the whole person instead of focusing on individual symptoms and specific behaviours.<sup>2,3</sup> Healing-centred engagement is a similarly holistic approach. However, it offers an asset-driven approach that seeks to address root causes and involves culture, spirituality, civic action, and collective healing.<sup>3</sup> By using these approaches, family physicians can address the ongoing traumas of colonization while emphasizing the strengths of Indigenous peoples and communities.

Health inequities are disparities between population groups that are broadly systemic, avoidable, and unjust.<sup>4</sup> For Indigenous populations, the overwhelming social burden is defined by pervasive poverty and intergenerational psychosocial adversity perpetuated by society through structural violence and racism. The history and the ongoing legacy of colonization sustain social inequities, which in turn perpetuate health inequities. Pathways to health inequity involve many factors including social resource deprivation and social trauma as well as the nature and quality of health care.<sup>5</sup>

Addressing inequity involves engaging with broad social dynamics, important for application within clinical practice, that ultimately requires multisectoral advocacy. Addressing inequity also compels family physicians to look at their clinical approach—at the nature and quality of health care they provide to ensure they do not perpetuate structural and systemic violence. The following reinforces the critical need to improve the care provided:

“[A] modern industrial health care system can be a determinant of ill health, especially where it is culturally unsafe. At present, Canadian health care for Indigenous people is not culturally safe owing to the ways that health law, health policy and health practice continue to erode Indigenous cultural identities.”<sup>6</sup>

The Truth and Reconciliation Commission of Canada’s (TRC) report and seven health legacy calls to action (18–24) are important resources for family physicians in building clinical approaches for the needs of Indigenous patients.<sup>7,8</sup> As a college of family physicians and as individuals, we all need to take action. The response to the TRC can begin with building knowledge, through reading and reflecting on the narratives and principles described within the report, and carefully understanding what each of the seven health legacy calls to action means with clinical practice. Application of the TRC directives then calls on everyone to nurture a safe and ethical clinical space that respects Indigenous patients, engaging with body, mind, heart, and soul.



## Indigenous Supplement Development

This supplement was rigorously developed using a consensus-based and iterative approach, deeply grounded within Indigenous health research methods. The overall method was discussed, explored, and approved by the Indigenous Health Committee (IHC) prior to starting. The following Committee members led each role development:

- Family Medicine Expert, Dr. Leah Seaman
- Communicator, Dr. Lynden (Lindsay) Crowshoe
- Collaborator, Dr. Amanda Sauvé
- Leader, Dr. Sarah Funnell
- Health Advocate, Dr. Ojistoh Horn
- Scholar, Dr. Darlene Kitty
- Professional, Dr. Lindsay Crowshoe

### Repeated for each role, the process involved the following steps:

<b>Step 1</b>	Pre-discussion review and reflection by each member of the Committee about Indigenous contexts inherent for the specific CanMEDS-FM 2017 role.
<b>Step 2</b>	Initial virtual group discussion with lead author providing context and potential directions.
<b>Step 3</b>	Preparation of initial draft of the role by the lead author, integrating all Committee feedback.
<b>Step 4</b>	Distribution of draft to Committee for review
<b>Step 5</b>	Summative virtual talking circle for feedback that the lead author then used for the final draft revision.
<b>Step 6</b>	Review and feedback about the supplement by non-IHC Indigenous family physicians. The feedback was incorporated in the final version.

In the preparation and development of each role, authors reviewed existing Indigenous competency documents and purposefully facilitated exploration of inherent concepts with the broader Committee. Of note, the virtual discussions were intended to engage the rest of the Committee in discussion and feedback. It employed an Indigenous talking circle protocol ensuring all Committee members had space and opportunity for input. Given that storytelling is a central Indigenous tradition, a narrative was also incorporated in each role to help contextualize the role description.

## Common Themes

Key common themes emerged during the development process, which are reflected in each role. These themes highlight approaches for providing high quality and culturally safe health care to Indigenous patients:

- Working side-by-side with Indigenous patients, families, and communities, incorporating family and community perspectives and values within patient-centred care
- Addressing racism, discrimination, and inappropriate power differentials within the clinical context, starting with addressing physicians' and others' misconceptions and assumptions of Indigenous peoples
- Understanding the legacy effect of colonial history on current health outcomes and health care contexts
- Learning about and practising trauma- and violence-informed care and healing-centred engagement
- Respecting and valuing Indigenous knowledge and traditional ways for health, wellness, and healing
- Sustaining a healthy workforce within Indigenous communities, ensuring physician wellness

# Glossary of Key Terms

Considering the complexity of Indigenous health contexts, an important question for family physicians is how to achieve providing care that is appropriate, high quality, and culturally safe for the specific needs of often diverse Indigenous patients. This supplement provides a critical guide for family medicine clinicians of all levels and each of the following concepts provides a distinct lens for working with Indigenous patients.

For example, a non-deficit lens may help to accept Indigenous information as relevant and important. Using a social determinants of health lens may provide a fuller picture of the health challenges of an Indigenous patient. A decolonizing lens may provide a different perspective on learning about Indigenous cultures, communities, and realities. These provide alternative ways of understanding, and thinking and learning about Indigenous perspectives on historical, social, political, and present-day challenges.

**Aboriginal, First Nations, or Indigenous** – **Aboriginal** is a term used in the **Canadian Constitution**, which describes the Indian, Inuit, and Métis peoples. First Nations is preferred to describe 'Indian' nations or groups, though the term 'Indian' is no longer used. It is preferred to use the name of the First Nation, such as Cree or Ojibwe; there are over 600 First Nations communities in Canada today. There are increasingly more First Nations, Inuit, and Métis people living in urban locales. **Indigenous\*** is a term used by the United Nations, referring to the peoples who identify themselves or their group by:

- Self-identification as Indigenous peoples at the individual level and accepted by the community as their member
- Historical continuity with pre-colonial and/or pre-settler societies
- Strong links to territories and surrounding natural resources
- Distinct social, economic, or political systems
- Distinct language, culture, and beliefs
- Form non-dominant groups of society
- Resolve to maintain and reproduce their ancestral environments and systems as distinctive peoples and communities

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\* United Nations Permanent Forum on Indigenous Issues. *Indigenous People, Indigenous Voices: Fact sheet*. New York, NY: United Nations; 2016. Available from: [http://www.un.org/esa/socdev/unpfii/documents/5session\\_fact-sheet1.pdf](http://www.un.org/esa/socdev/unpfii/documents/5session_fact-sheet1.pdf). Accessed February 19, 2020.

**Anti-racism** – An active and consistent process of change to eliminate individual, institutional, and systemic racism.<sup>9</sup>

**Colonialism** – The processes by which Indigenous peoples were dispossessed of their lands and resources, subjected to external control, and targeted for assimilation and extermination.<sup>10</sup> It is an ongoing phenomenon by settlers or the dominant society that continues to negatively affect Indigenous peoples in Canada politically, economically, and culturally.

**Cultural competency** – The alignment of knowing, behaving, and acting in a way that respects and honours the beliefs of others.<sup>11</sup>

**Cultural humility** – A process of self-reflection to understand personal and systemic biases, and to develop and maintain respectful processes and relationships based on mutual trust. Cultural humility involves humbly acknowledging oneself as a learner when it comes to understanding another's experience.<sup>12</sup>

**Cultural safety** – A concept that may be considered as the rationale and goal in having good therapeutic interactions with Indigenous patients, families, and communities and becoming a Scholar in Indigenous health. According to the First Nations Health Authority, cultural safety is “an outcome based on respectful engagement that recognizes and strives to address power imbalances inherent in the health care system. It results in an environment free of racism and discrimination, where people feel safe when receiving health care.”<sup>12</sup>

**Decolonizing** – To resist and undo the forces of colonialism and re-establish Indigenous nationhood. This approach is rooted in Indigenous values, philosophies, and knowledge systems. Decolonization is a way of doing things differently and challenging the colonial influence by making space for marginalized Indigenous perspectives.<sup>13</sup>

**Deficit modelling** – To highlight poorer health outcomes in one group compared to another. It can perpetuate deficit-based narratives that contribute to stigmatization and stereotyping. In contrast, reframing approaches around strengths and solutions can focus on enabling individuals and communities through familiar traditional and cultural approaches to health and health care.<sup>14</sup>

**Equity** – The ability to provide everyone with the same opportunities while recognizing their unique situation and addressing systemic barriers.<sup>15</sup>

**Ethical space** – The space formed when two societies with different world views are positioned to engage with each other in cross-cultural conversation. Engagement within the ethical space is based on dialogue and interaction that is concerned with exploring new ways of thinking, a cooperative spirit, and an awareness of how the biases of cultural backgrounds have shaped behaviour.<sup>16</sup>

**Healing-centred engagement** – An approach that is holistic and strengths-based, advancing a collective view of healing and repositioning culture as a central feature in well-being. This approach views trauma not as an individual isolated experience but highlights the ways in which trauma and healing are experienced collectively. It expands how to think about responses to trauma and offers a more holistic approach to fostering well-being.<sup>3</sup>

**Inclusiveness** – The responsibility that health professionals have to engage patients and Indigenous communities in care decisions and support the development of patients' capacity to self-advocate.<sup>17</sup>

**Indigenous ethics** – Indigenous ethical principles, fundamental within Indigenous epistemologies, provide broad directions for facilitating social cohesion within a collectivist context. Relationalism, a focus of Indigenous ethics, involves recognizing the importance of respecting and facilitating appropriate relationships within social, physical, and spiritual dimensions. Focusing on non-interference and reciprocity, this concept is embodied within an Indigenous narrative approach that is central in Oral Traditions.<sup>18</sup>

**Knowledge contextualization and exchange** – Positions the speaker and the message they are communicating within broader relational, social, political, and cultural contexts.<sup>19</sup>

**Narrative approach** – A culturally appropriate method for prompting the collection of information through stories. The underlying premise of this method is that individuals make sense of their world most effectively through telling stories. This approach is often used because many Indigenous cultures have an oral-based storytelling tradition, and it is a relational methodology that respects Indigenous epistemology and ways of knowing through co-constructing and co-participating in storytelling.<sup>20</sup>

**Non-Insured Health Benefits (NIHB) Program** – Provides eligible First Nations and Inuit clients with coverage for a range of health benefits that are not covered through other social programs, private insurance plans, or provincial or territorial health insurance. The program covers vision care, dental care, mental health counselling, medical supplies and equipment, prescription and over-the-counter medications, and medical transportation.<sup>21</sup>

**Non-interference** – A non-intrusive modelling approach that promotes autonomy and interpersonal relationships by discouraging coercion of any kind.<sup>18</sup>

**Oral Tradition** – A culture's collection of spoken words that have been handed down for generations including epic poems, prayers, speeches, spiritual teachings, songs, stories, and histories. First Nations and Inuit cultures are rooted in their Oral Traditions, through which they pass on their history, customs, values, and practical skills. Teachings within the Oral Tradition are often indirect and metaphoric, leaving listeners responsible to think about the stories and form their own decisions and plans of action. Sharing an Oral Tradition reinforces interpersonal relationships and social bonds.<sup>22</sup>

**Patient-centred approach** – Patient-centredness is a core value in family medicine. This approach broadens the conventional medical approach to include the patient as an active participant in their care, and to promote the physician-patient partnership. This approach consists of three values: considering patients’ needs, wants, perspectives, and experiences; offering opportunities for patients to provide input and participate in their care; and enhancing partnerships and understanding in the patient-physician relationship.<sup>23</sup>

**Residential schools** – A school system that was in place for over 100 years in Canada to separate Indigenous children from their families in order to minimize and weaken family ties and cultural links, and to indoctrinate children into the legally dominant Euro-Christian Canadian society. Schools were administered largely through religious institutions. The establishment and operation of residential schools was a central element of cultural genocide of Indigenous peoples in Canada. Children in the system were abused physically and sexually, and thousands died. The federal government has estimated that at least 150,000 First Nations, Métis, and Inuit students passed through the system. The last federally supported residential schools closed in the late 1990s.<sup>7</sup>

**Structural competency** – “[T]he trained ability to discern how a host of issues defined clinically as symptoms, attitudes, or diseases (e.g., depression, hypertension, obesity, smoking, medication ‘non-compliance’, trauma, psychosis) also represent the downstream implications of a number of upstream decisions about such matters as health care and food delivery systems, zoning laws, urban and rural infrastructures, medicalization, or even about the very definitions of illness and health.”<sup>24</sup> This concept can direct family physicians in providing care that engages with broad social upstream causes of health outcomes.

**Structural violence** – Structures and social mechanisms that cause harm, deny human rights, constrain human agency, and/or prevent certain individuals and population groups from having the resources necessary to reach their full potential. Structural violence is insidious and silent, which causes it to be invisible to many and accepted as “the way things are.”<sup>25</sup>

**Systemic racism** – The legacy of colonial policies that legitimized the idea that Indigenous peoples were a separate and inferior race. In Canada this is manifested as a society where one social group has disproportionate access to power and resources, leading to inequities and systemic racism against Indigenous peoples. This imbalance of power and resources is maintained through unequal treatment under the law; unfair policies, rules, and regulations; social exclusion and isolation that prevents political, social, and economic participation; and barriers to access and participation in other social systems such as education and health. Interpersonal or relational racism and erroneous assumptions based on negative stereotypes, including in health care settings, fuels systemic racism.<sup>26</sup>

**Trauma-informed care** – This approach recognizes how common trauma is and how it can affect all aspects of people’s lives, including their interactions with service providers. As family physicians, taking a trauma-informed care approach involves creating a safe space for Indigenous patients and acknowledging how colonization continues to impact their lived experiences and social determinants of health. Rather than reliving or reflecting on traumatic experiences, this approach to care emphasizes the strengths developed from surviving trauma and how that resiliency can foster healing. By not taking a trauma-informed care approach, patients may be re-traumatized and feel unsupported or blamed. This may discourage them from seeking health care and related services in the future.<sup>2</sup>

**Trauma and violence informed care** – Expands the concept of trauma-informed care to underscore the connection between trauma and violence. This approach recognizes the connections between violence, trauma, negative health outcomes, and behaviours. The approach increases safety, control, and resilience for people who are seeking services related to experiences of violence and/or who have a history of experiencing violence. It is based on the following policy and practice principles: understand trauma and violence, and their impacts on peoples’ lives and behaviours; create emotionally and physically safe environments; foster opportunities for choice, collaboration, and connection; and provide a strengths-based and capacity building approach to support client coping and resilience.<sup>27</sup>

**Two-eyed seeing** – A theoretical framework that embraces both Indigenous and Western views. The concept was introduced by Mi’kmaw Elders Albert and Murdena Marshall. This framework calls on family doctors to learn to draw on multiple perspectives when informing and building on existing knowledge, such that they learn to see through “both eyes,” with neither “eye” becoming subsumed or dominated by the other.<sup>28</sup>





# Family Medicine Expert

## Definition

Family physicians in Canada are generalists with a high level of knowledge and skills that enable them to provide high quality, responsive, community-based care to Indigenous peoples living in Canada, regardless of where they live. We commit to delivering respectful, comprehensive, and responsive care that is informed by the context of Indigenous patients. All practitioners are called on to commit to knowing and learning about such toxic traumas and history as residential school experiences; murdered and missing Indigenous women and girls (MMIWG); the LGBTQ2+ community; the effects of environmental and industrial events; and current situations that impact individual and community health (e.g., a suicide crisis or a multiple drowning tragedy). Both Indigenous and non-Indigenous peoples are called on to protect the land. Everyone's physical, mental, and spiritual health depends on it.<sup>29</sup>

As Family Medicine Experts we are called on to practice with clinical courage, providing compassionate care, engaging with patients and their communities, acting in all the roles described in this document.<sup>30</sup> Family Medicine Experts will work with Indigenous peoples, whether we practice in urban, rural, or remote settings. First Nations, Inuit, and Métis people live in both homogenous and diverse populations that span all of these settings.

Family Medicine Experts should view their medical career as a journey, embracing lifelong learning, and expanding and focusing their knowledge and skills in response to the needs of Indigenous peoples and their communities. Our practices should be patient-centred, collaborative, respectful of all, and extending across the life cycle.

## Description

The Family Medicine Expert Role subsumes all the other roles identified in this document. Our task and duty involve mastering of the art and science of medicine. We start with the four principles of family medicine, which underpin our values and work in the health care system. We build on the CanMEDS-FM Roles, concepts, and competencies and align them with the needs and contexts of Indigenous peoples of Canada.

For many Indigenous people culture is a strong and powerful factor in fostering resilience—recognition of cultural context contributes to positive health outcomes.<sup>31</sup> As Family Medicine Experts we commit to learning from Indigenous patients, participating in community life, and reflecting deeply on our own values and attitudes on an ongoing basis. Practising with humility is essential. We are each expected to do our part to create an anti-racism environment in the health

care settings where we serve. This involves, but is not limited to, acknowledging and correcting micro-aggressions and overt racism in ourselves and our colleagues. We must also advocate and challenge the systems that we work in to make changes to racist processes and policy.

Family Medicine Experts must serve Indigenous patients and their communities with trauma-informed care and healing-centred engagement, and to be aware of the social determinants of health that impact patient health in order to provide culturally safe care.<sup>2,32</sup> Our service is based on an equitable and collaborative therapeutic relationship.

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**Simon booked an appointment with you to seek your guidance on complex screening test instructions he received in the mail, which are written in English. He has brought the papers with him to the appointment. Because of the trust and respect you have shown him since he moved to the city from his rural Métis settlement, he admits that he never learned to read English. Instead he grew up speaking his native language Michif. Although he speaks English fluently, he is asking for help interpreting the instructions. You review the instructions together and answer his questions to ensure he understands it well. As he leaves the clinic, he asks to make a follow-up appointment with you to discuss other non-urgent health concerns.**

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Recognizing the importance of trust to this Role serving Indigenous patients and their communities is also a core value. Relationality is an important aspect of Indigenous well-being. This requires family physicians to be dedicated and committed to working in Indigenous communities and building mutually respectful relationships with individuals and communities over time.

Family physicians need to recognize and eliminate the power differential between ourselves and our patients. We must demonstrate our humanity while also modelling healthy self-care and respectful interactions.

## Key and enabling competencies

### **1. Practice high-quality generalist medicine within the scope of professional activity and embedded in the context of the Indigenous peoples we serve.**

- 1.1 Practice with humility, in an engaged, relationship-based manner. Strive to lessen power differentials between Indigenous patients and physicians as Family Medicine Experts.
- 1.2 Recognize and incorporate the CanMEDS-FM Intrinsic Roles,<sup>†</sup> including those further developed in this supplement.
- 1.3 Strive to provide care through a challenging and extensive spectrum of health promotion and disease prevention, diagnosis, and treatment. This includes the complexities of life-threatening illness, acute and chronic disease, and palliative care. Within this work, Family Medicine Experts bring to this an awareness of the Indigenous patient's cultural health practices and values, recognizing the diversity that exists amongst Indigenous peoples across Canada. Family physicians demonstrate a willingness to learn from their patients and to include them and their families and communities in health-related planning and are engaged in planning and implementing health services, while using relevant clinical and cultural resources.
- 1.4 Work with clinical courage in the face of multiple and competing demands. Family Medicine Experts commit to current and ongoing self-awareness and self-reflection when engaging with Indigenous patients.
- 1.5 Family physicians are called on to act as bridges between conventional Western medicine ("the system") and Indigenous patients' traditional beliefs and practices, as they see it. If an Indigenous patient chooses traditional practices, family physicians must respect this choice.

### **2. Patient-centred practice for an Indigenous patient may involve, according to their wishes, their family, community, and/or Nation.**

- 2.1 Establish a relationship with Indigenous patients and families, including in emergent situations; this contributes to identifying and setting priorities for assessment and management.
- 2.2 Use a narrative approach, instead of a direct checklist style, when eliciting a history from most Indigenous patients. The roles of Collaborator, Leader, Health Advocate, Scholar, and Professional will all come into play.

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<sup>†</sup> The CanMEDS Roles: Medical Expert, Communicator, Collaborator, Leader, Health Advocate, Scholar, Professional.

- 2.3 Establish goals of care in collaboration but also within the community and cultural context. Bringing a holistic approach to work with Indigenous patients involves the therapeutic use of self, with the practitioner engaging intellectually, physically, emotionally, and spiritually.<sup>31,33</sup>
  - 2.4 Collaborate with the patient, the family, and any other relevant team members when working in Indigenous communities. Family physicians bring to the encounter all of their knowledge, skills, and empathy. They may attend important events such as funerals and community feasts, and sample 'country food.'
  - 2.5 Synthesize history, physical exam, investigations, past and current medical conditions, and social and cultural context, as all of these inform clinical decisions and management.
  - 2.6 Use clinical knowledge, knowledge of relevant Indigenous health and social issues, and experience to engage the patient in making the most appropriate decisions for their care.
- 3. Clinical plans are developed in collaboration with Indigenous patients. Family physicians recognize and flatten the power discrepancy between practitioner and patient. They consider the patient's wishes as informed by their Indigenous context. They present advice in a culturally safe manner. Family physicians commit to transparency and communicating thought processes that have led to conclusions, differentials, and recommended treatments.**
- 3.1 Determine the most appropriate treatments, procedures, or therapies, and if not available in the patient's community, facilitate access at the nearest appropriate health care facility. This links to the Advocacy role. Family physicians think outside the box; for example, assembling a team to transport a terminally ill patient back to a fly-in community, providing expertise, leadership, and support to the health centre staff, the caregivers, and the family.
  - 3.2 Explain the rationale and obtain informed consent in a culturally appropriate, transparent, and informative manner, outlining risks and benefits of treatments. Check respectfully for patient comprehension.
  - 3.3 Make diagnoses and treatment decisions that are free of bias.
  - 3.4 Ensure treatments are carried out in priority in a timely manner.
- 4. Continuity of care, important in all domains of medicine, is particularly important for Indigenous patients, and almost certainly impacts outcomes.<sup>34</sup>**

- 4.1 Understand the ways in which colonization, racism, and trauma affect Indigenous patients. Family physicians need to hear their truths and learn from them to provide comprehensive care.
  - 4.2 Use an evidence-based, holistic, and culturally safe approach, while taking into account the Indigenous patient's context.
- 5. Facilitating continuous quality improvement (QI) subsumes awareness, knowledge, and implementation of current clinical standards and guidelines. Family physicians practise with these in mind, continually evaluating its efficacy in improving the health of Indigenous patients. They practise with safety, cultural humility, and continuous evaluation—evaluation that involves Indigenous patients, their families, and their communities.**
- 6. Family physicians are called to practice respectful, patient-centred, inclusive, and culturally safe care. The practitioner engages with humility and openness toward Indigenous patients and their culture. Family Medicine Experts are willing to learn from patients and demonstrate behaviours that are collaborative, consciously working to diminish power inequities in the therapeutic relationship. They engage in the community; for example, sending their children to school where they work and serve.**
- 6.1 Seek out the patient's ideas about their health and whether they practise or wish to use traditional Indigenous health practices. Such ideas are received openly and without judgement.
  - 6.2 Seek to learn about Indigenous concepts of health and well-being.
  - 6.3 Be trauma-informed and healing-centred, as this is essential to work as family physicians engaging with Indigenous patients. Knowledge of the residential school history, the work of the TRC and the Calls to Action that arose from that work are expected. Helping operationalize the Calls to Action in daily practice is expected. Additionally, familiarity with MMIWG and LGBTQ2+ issues, the MMIWG inquiry, and the ensuing calls to justice are expected. Learning about family situations, community history, and current context is expected.
- 7. Family physicians commit to working with Indigenous individuals and groups in a way that is mindful of the complexities of the ongoing effects of colonization, and awareness of the impact of trauma past and present. They humbly seek information and patients' perspectives. They work to be open to feedback and making adjustments in work and behaviours. Family physicians commit themselves to lifelong learning.**



# Communicator

## Definition

Communication with Indigenous patients entails engaging in the same interview tasks (such as relationship building, information gathering, explanation, and planning) as with non-Indigenous patients. However, effective communication with Indigenous patients also involves responsive adaptation of interview tasks to consider an additional range of cultural (patient and physician) and societal (arising from colonization) contexts.

## Description

Culture defines the norms of communication.<sup>35</sup> If communication can be defined as a process of sharing information using a set of common rules, within the intercultural context, those rules and their meaning may differ.<sup>‡,36</sup> Before exploring Indigenous cultural concepts related to communication, we physicians need to acknowledge and reflect on the influence of our own natal and medical cultures. Of note, a list of all cultural traits that may influence communication is unobtainable due to the large diversity of Indigenous peoples across Canada.<sup>§</sup> Such a list potentially perpetuates generalizations. Instead, distinct ethical themes, defined as rules of conduct that express social and cultural values based in Indigenous community perspective, provide touchstone constructs to be called on during the interview.<sup>37,38</sup>

**Non-interference** is a principal construct applicable to the medical interview.<sup>18</sup> An interaction shaped by this construct guides physicians to ensure that the patient has appropriate space and uninterrupted time to share their perspective at all phases of the interview. Rather than directive commands, this ethic supports an indirect mode of explanation and diagnosis delivery and planning, best shared with a narrative approach.<sup>18</sup> Sharing our own medical experiences and outcomes related to similar clinical situations, and using metaphors relevant to the patient's perspective, are examples that build relationships and empower patient decision making, as opposed to an approach that is overly instructive and directive.

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<sup>‡</sup> General intercultural communication theory and constructs are relevant to communication with Indigenous patients, but an inclusive appraisal is beyond the scope of this description.

<sup>§</sup> Readers are encouraged to explore evidence of Indigenous-specific cultural and social concepts to supplement their knowledge base.

The preceding example, grounded within values inherent to an Indigenous oral tradition, reflects a narrative approach to the interview.<sup>39</sup> Knowledge contextualization and exchange position the speaker and their content within broader relational, social, political, and cultural contexts.<sup>19</sup> An approach that embodies this ethic facilitates and engages with patient perspective, building a shared understanding through reciprocation of narrative.<sup>39</sup> This ethic, central to the task of information gathering, builds a robust picture of the Indigenous patient's world. In terms of relationship building, this ethic directs physicians to reciprocate in sharing social contexts as an important strategy for building rapport.<sup>39</sup>

Societal influence on health care communication with Indigenous patients originates from the ongoing impacts of colonization. Colonization has resulted in ongoing racism against Indigenous peoples.<sup>40</sup> Indigenous patients experience a perpetuation of inequities within health care arising from a colonial legacy that reinforces historical relationships through ongoing racism.<sup>41</sup> The reality of stereotyping and prejudice within health care results in unequal treatment, contributing to poor outcomes.<sup>19</sup>

As family physicians, we need to be conscious of our potential for enforcing health service inequity within the clinical interaction through oppression, prejudice, stereotyping, and perpetuating power imbalance. Physicians must first gain a critical awareness of colonization and its health and health care impacts on Indigenous people. Self-reflection on our own perspectives and potential stereotypes of Indigenous peoples is fundamental. Becoming aware of and addressing an imbalance of power with Indigenous patients is another key aspect. Language is a powerful mediator of oppression, and we are advised to pay close attention to our messages and approaches to ensure that a strength-based approach is used. To support leveling power within the clinical relationship, we are encouraged to adopt verbal and non-verbal approaches rooted in humility.



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For the sake of keeping the clinic flow reasonable, Dr. McIntosh instructed Jenny (a second-year rural family medicine resident) to keep the next appointment short as his next patient, Rose, could be quite a talker. Rose, a 74-year-old Indigenous female, was recently hospitalized for community-acquired pneumonia and was at the clinic for a follow-up. Rose also has a history of diabetes, high cholesterol, and high blood pressure, all in good control as Rose is generally quite active and careful with her nutrition.

During the visit, Rose was quite upset by the frequent interruptions by Jenny when she tried to respond to Jenny's questions. Asked about tobacco use, Rose mentioned that she quit smoking many years ago and began to explain how she uses tobacco in ceremony. Jenny quickly cut her off, saying that is still a high-risk behaviour and Rose should immediately stop. Rose's reaction was to disengage from the conversation, merely nodding as Jenny concluded the appointment with a list of plans.

Since Jenny was new, Rose was just trying to provide appropriate context so Jenny would be better able to understand. Rose felt that being cut off and interrupted when trying to respond was quite jarring and disrespectful. Rose also felt that Jenny's questions and comments about tobacco use were rude and judgemental, and she felt interrogated and chastised. Rose was not interested in engaging in conflict over Jenny's misinterpretation of traditional tobacco use, so she did not attempt to defend or argue her position. Rose felt voiceless during the appointment, similar to her experiences in residential school, and chose to withdraw. Rose was not sure about returning to see Jenny or Dr. McIntosh for future appointments.

**Continued in the Professional Role...**

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## Key and enabling competencies

### **1. Ensure interactions do not perpetuate inequity.**

- 1.1 Develop a critical understanding of the influence of colonization, racism, and oppression within the medical interview.
- 1.2 Reflect on our personal culture(s) and the perspectives of Indigenous peoples in relation to racism and colonialization.
- 1.3 Address power imbalances within the therapeutic relationship.
- 1.4 Refrain from using oppressive and authoritarian language.

### **2. Develop rapport, trust, and ethical therapeutic relationships with patients and their families.**

- 2.1 Use approaches based in reciprocity of context.
- 2.2 Provide appropriate space and time for the patient's narrative.

### **3. Elicit and synthesize accurate and relevant information from, and perspectives of, patients and their families.**

- 3.1 Facilitate a non-judgemental exploration of the patient's broader social and cultural contexts in relation to the patient's health concern.
- 3.2 Build a robust picture of the patient's world.

### **4. Share health information and plans with patients and their families.**

- 4.1 Contextualize knowledge to the reality of the patient's social and cultural realities.
- 4.2 Use an indirect mode of communication to provide information, diagnoses, and recommendations, using narratives and metaphors relevant to the patient.
- 4.3 Build a shared understanding, facilitating capacity for patient decision making.
- 4.4 Explain medical information and treatment plans at the educational level and capacity of the Indigenous patient and family and avoid overly medicalized language.
- 4.5 Provide an opportunity to clarify and answer questions.



# Collaborator

## Definition

Family physicians work collaboratively with patients, families, community members, and other health care providers. From an Indigenous lens, family physicians practice cultural humility when seeking to build and striving to maintain inclusive relationships with Indigenous-led organizations (e.g., Indigenous health and social programs, friendship centres), communities, families, and individuals, to provide culturally-safe, equitable, relationship-centred care.

## Description

Collaboration is essential for safe, high-quality, patient-centred care. The 2018 report *Bringing Reconciliation to Healthcare in Canada: Wise Practices for Healthcare Leaders* calls for transformative system-level and organization-level changes to improve the health of Indigenous peoples in Canada, and emphasizes “that health leaders are guided by and work with local, provincial, and national Indigenous leaders and organizations. Otherwise, they risk reproducing existing colonial structures in the health care system.”<sup>42</sup> To be effective collaborators in Indigenous health, we must understand and incorporate Indigenous perspectives of health to support Indigenous individuals and communities in achieving equitable health outcomes.

For Indigenous health, collaborators recognize the Indigenous principle of inclusiveness. Inclusiveness draws attention to the goal of patient empowerment, and the responsibility that health professionals have to engage patients and Indigenous communities in care decisions to support the development of patients’ capacity to self-advocate.<sup>17</sup> Due to our role in the creation of longitudinal relationships based on trust, we play an integral role and demonstrate skills in facilitating ethical relationships with Indigenous patients, families, and organizations. In building collaborative relationships, we recognize the dominance of Western scientific knowledge, while making space and prioritizing equally valuable ways to understand health, which includes Indigenous perspectives.

The concept of ethical space models partnerships in a cooperative spirit between Indigenous peoples and Western institutions that will create new currents of thought and overrun the archaic ways of interaction.<sup>16</sup> The Indigenous principle of **two-eyed seeing** “holds that there are diverse understandings of the world and that by acknowledging and respecting diversity of perspectives (without perpetuating the dominance of one over another) we can build an understanding of health that lends itself to dealing with some of the most pressing health issues facing Indigenous peoples and communities.”<sup>28</sup> We seek ethical relationships with Indigenous patients, families, organizations, and leaders through promotion of non-competitive spaces for shared decision making and leadership, with the common goal of supporting Indigenous wellness.

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A physician working in an urban family practice clinic recognizes that he has many Indigenous patients who have identified their health benefits as the NIHB Program. He spends time researching the eligibility and covered services of this program and calls the regional office for further information. He downloaded and now regularly references the latest NIHB Drug Benefit List when preparing prescriptions for patients. When caring for a young pregnant patient he learns that prenatal vitamins are a covered over-the-counter medication as long as patients have a prescription from their physician, which he gladly provides. He is familiar with various prenatal and parenting classes in his area. However, he has learned from his patients that they often feel stigmatized and fearful when attending these groups, learning that many have personal or family stories of traumatic childhood experiences of growing up in the foster care system. He visits the local Indigenous friendship centre to meet with a resource coordinator to learn about Indigenous-led culturally-based prenatal and parenting programs in the area that he can suggest to his patients. While there he connects with an Elder/knowledge keeper from the centre and learns about a land-based cultural program that is being offered. He has begun to visit the centre regularly to learn more about traditional Indigenous perspectives of wellness, colonial history, and the ongoing social and racial barriers faced by urban Indigenous peoples. He is grateful for the new knowledge and continues to build relationships with local Indigenous organizations so that he can better serve his Indigenous patients.

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As Indigenous health collaborators, family physicians embody anti-racism.<sup>43</sup> In bringing anti-racism to health care, we reflect on our own positions of privilege and power and seek to change the colonial policies that continue to systematically disadvantage Indigenous people in Canadian health care.

## Key and enabling competencies

- 1. Respect inclusiveness by demonstrating skills in fostering and maintaining collaborative and ethical relationships with Indigenous individuals, organizations, and communities.**
  - 1.1 Foster non-competitive and interdependent relationships with Indigenous health stakeholders for knowledge sharing and capacity building in the provision of Indigenous health care.<sup>17</sup>
  - 1.2 Respect the diversity of roles and perspectives, and recognize the importance of shared decision making in Indigenous health care.<sup>17</sup>
  - 1.3 Prioritize Indigenous perspectives on health care to ensure collaborative outcomes that align with the needs of Indigenous patients and communities in the spirit of Indigenous self-determination.

- 1.4 Demonstrate role flexibility; for example, show a willingness and ability to take on leadership positions as requested, but also serve as a team member under the leadership of Indigenous stakeholders to ensure Indigenous perspectives on health and healing are represented appropriately.<sup>17</sup>
  - 1.5 Describe personal role and the roles of others in Indigenous health care, including not only Western-trained allied health professionals, but also those valued under Indigenous models of health (such as traditional medicine practitioners, Elders, knowledge keepers, families, and communities).
  - 1.6 Appreciate and give equal consideration to diverse Indigenous and non-Indigenous ways of knowing, such that one system of knowledge does not dominate or undermine the contributions of the other.<sup>28</sup>
- 2. Cultivate and maintain culturally safe health care environments by embodying the principles of Indigenous anti-racism in clinical, educational, research, and administrative roles.**
- 2.1 Recognize and reflect on personal positions of privilege and power related to profession, race, gender, and level of education.
  - 2.2 Advocate for equitable Indigenous representation on health care teams, including clinical, educational, research, governance, and leadership committees.
  - 2.3 Advocate for increased representation and retention of Indigenous physicians, nurses, allied health professionals, and community members in all areas of health care, and ensure Indigenous voices are valued.<sup>42</sup>
  - 2.4 Recognize conscious and unconscious stereotypes about Indigenous people, including personal thoughts and actions, as well as those of others, that discriminate against and prevent safe and equal experiences of Indigenous patients, families, colleagues, and organizations in health care settings.
  - 2.5 Seek knowledge and understanding of historical and ongoing experiences of systemic and epistemological racism faced by Indigenous people as a result of colonial policies.<sup>44</sup>
  - 2.6 Engage in discourse and participate in activities with health care colleagues, health care organizations, and governing bodies with the goal of changing behaviours, policies, and resources that prevent equal Indigenous involvement in health care planning and resource allocation.

**3. Recognize the importance of continuity of care, facilitate necessary transitions in care, and participate in shared care, transfer of care, and/or handover of care involving Indigenous and non-Indigenous health care colleagues and organizations to enable safe, culturally appropriate care.**

- 3.1 Communicate effectively (both verbally and in writing) about individual and/or shared responsibilities pertaining to patient care with patients, families, health care professionals, and Indigenous organizations to ensure safe and coordinated patient care.
- 3.2 Have knowledge of and relationships with Indigenous organizations in their area of practice and facilitate appropriate referrals for Indigenous patients.

**4. Understand barriers faced by Indigenous patients accessing health services and supplies, including social determinants of health and jurisdictional factors that inhibit health care access, and act to coordinate referrals that align with Indigenous patients' needs.**

- 4.1 Understand the social determinants impact on access to health services from the perspective of Indigenous patients (e.g., geographic location, language, income, employment, status, race, etc.) and facilitate appropriate referrals to community programs or organizations.
- 4.2 Understand the differences between federally recognized Indigenous people in Canada (Status First Nations, Non-Status First Nations, Métis, and Inuit) and seek information about a patient's identification to ensure coordination of appropriate services for patients (e.g., access to services covered by the NIHB Program for Registered Inuit and Status First Nations people).
- 4.3 Possess the knowledge and skills necessary to obtain timely health services for First Nations children under Jordan's Principle, and Inuit children under the Inuit Child First Initiative.<sup>45,46</sup>



*John White*



# Leader

## Definition

Family physician leaders play an important role in improving the health of Indigenous people and advocating for health equity at all levels of the health care system. We do so through strong leadership skills in patient-centred and community-driven approaches. The Leader Role is not restricted to managing people and organizations—family physicians demonstrate leadership by adhering to high ethical and moral values in our work.<sup>47</sup>

Traditionally, leadership in Indigenous societies demonstrates a different concept of power: leaders put aside their individual needs and represent the voices of the collective. The idea of a “helper” is central to leadership, where the one with the most experience illuminates the path ahead, but the community comes together about what decisions need to be made. In serving Indigenous people, we resist the temptation toward paternalism and seek to put the needs of Indigenous patients, families, and communities ahead of our own.<sup>48</sup> Family physician leaders demonstrate humility and challenge concepts of power and hierarchy when serving Indigenous people.

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**As in all Indigenous cultures, Inuit are not a monolith and there are evolving and different beliefs about leadership. Not so long ago, the leader of a community or family group was the male hunter most capable of providing for the group. However, in keeping with a culture that is less individualistic than non-Indigenous Canadian culture and is better at sharing, it was often acknowledged that there could concurrently be different leaders with different domains of expertise. Gathering, working with skins, sewing skills, and child-rearing were as important to survival as hunting. Respected Elders, women and men, who might no longer be active hunters or gathers, and Angakkuut (shamans or spiritual leaders) would often have leadership roles. Elders are a huge part of the decision making as they hold the most knowledge and have experienced life, which gives them the expertise, and they are well respected. There is no hierarchical framework as seen in a westernized leadership framework.**

To learn more about Inuit societal values, Inuit Qaujimajatuqangit Principles, please see: [https://www.gov.nu.ca/sites/default/files/iq\\_brochure\\_draft\\_1.pdf](https://www.gov.nu.ca/sites/default/files/iq_brochure_draft_1.pdf)

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## Description

All family physicians play leadership roles in promoting the health of Indigenous people at the individual, practice, and community levels. We respect Indigenous world views and work alongside Indigenous communities to advance improvements in Indigenous health. At the individual and community levels family physicians act as helpers, which have traditionally played an important role in Indigenous societies.<sup>49</sup>

### Micro level

As helpers, we act as system navigators while also providing quality and safe health care to Indigenous people, free of racism and discrimination. Leaders in family medicine seek out opportunities to learn about trauma-informed, healing-centred, anti-racist, and culturally safe practices. We demonstrate the importance of doing so through our actions, not just words. We strive to challenge our biases through self-reflection and seek out opportunities for self-improvement. We understand the importance of maintaining our own health and wellness and knowing when to seek help.

### Meso level

Family physician leaders recognize that systemic racism exists in the Canadian health care field and within our own practices. We challenge colleagues who demonstrate culturally unsafe practices. We encourage colleagues and institutions to adopt anti-racist, healing-centred, and trauma-informed practices.

### Macro level

Family physicians who predominantly work with Indigenous patients often find ourselves being called on to take leadership roles within and outside our organizations in efforts to improve Indigenous health. As helpers, we advocate for Indigenous communities and challenge the structures that prevent Indigenous peoples from living healthy active lives.

## Key and enabling competencies

1. **As helpers, family physicians embody a humble leadership style that respects Indigenous world views and perspectives as equal to Western ways in efforts to reduce health inequities experienced by Indigenous people.**
  - 1.1 Apply concepts of leadership that embody humility, respect, transparency, and honesty to improve the health of Indigenous people.
  - 1.2 Listen actively and allocate equal or greater time to Indigenous voices.
  - 1.3 Foster a culture that respects Indigenous world views.

- 1.4 Act as a system navigator to improve access to health care services.
- 1.5 Recognize capacity in others and offer mentoring opportunities.
- 1.6 Collaborate with Indigenous patients and communities to develop ways to improve their health, avoiding paternalistic hierarchy models of decision making.

## **2. Family physician leaders engage in the practice of self-improvement.**

- 2.1 Practice self-reflection to understand own biases.
- 2.2 Recognize the importance of self-care and when to seek care.
- 2.3 Engage in (continuing medical) education activities to further understand critical concepts of trauma-informed care, healing-centred engagement, cultural safety, and anti-racism.
- 2.4 Acknowledge when skills and knowledge are lacking and ask others for help.

## **3. Family physician leaders challenge systemic racism and encourage others to do so.**

- 3.1 Ensure that clinical practices offer quality and culturally safe care to Indigenous people.
- 3.2 Implement processes to improve practices with mechanisms in place to receive feedback from Indigenous patients.
- 3.3 Challenge colleagues who demonstrate culturally unsafe behaviour, including words and behaviours that are racist.

## **4. Family physician leaders go beyond their practices to reduce health inequities experienced by Indigenous people.**

- 4.1 Recognize that systemic changes are needed to improve the health of Indigenous people.
- 4.2 Work with Indigenous people, communities, and organizations to better understand their needs and work toward improving their health.
- 4.3 Enable Indigenous people, communities, and organizations to advocate for themselves.



*The Janavady*

# Health Advocate

## Definition

As successful advocates for Indigenous health, family physicians work in partnership with patients, families, and communities. We contribute our expertise and influence, and respect that of members of the community to improve health through an understanding of cultural values, strengths, needs, and mobilization of unique, complex, and limited resources.

## Description

Family physicians must learn the policies that govern the clinical spaces and the community's unique social determinants of health. Advocacy must include communication and collaboration with the particular community's social and traditional culture.

Doctors, Indian agents, lawyers, businesses, corporations, and researchers often speak "on behalf" of Indigenous communities and people, leaving the Indigenous voice and experience diminished and not reflected in most platforms. A fragile relationship exists between non-Indigenous agencies and the Indigenous people for whom they tend to advocate.

Traditionally, Indigenous people appointed persons to speak on their behalf. This speaker always had a younger mentor beside them who could take their place if and when needed, and the source of the information and ideas was acknowledged. In this way the narrative style, which is a format that makes it easier to remember the context, would be expressed. Advocates must acknowledge their role in narrating the story of health in the Indigenous communities we work in. Advocates explicitly interact with community members in a non-clinical setting where there is no power imbalance.

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**"By contaminating our food chain, including mother's milk, with toxic compounds such as PCBs, dioxins, DDT and many others, corporate society has removed from us our very ability to feed ourselves, our families, and our communities ... Exposure to toxic contaminants in the environment (air, water, soils, local food, fish, wildlife, and mother's milk) has resulted in a rapidly changing epidemiology among many Native peoples."**

**Katsi Cook, Midwife, Akwesasne**

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Advocates use their power, privilege, and platform strategically to support grassroots community initiatives. Culture, language, and land-based programs, and supporting efforts for economic development, are means of fostering resilience and health.

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**In the Haudenosaunee community of Akwesasne, a ceremony to foster resilience among adolescents through land-based ritualization provides opportunities for Indigenous health advocates to support and participate in such grassroots efforts. Called Ohero:kon, or “under the husk,” the rite of passage ceremony brings together families in a land-based curriculum that culminates in a medically supervised spiritual fast. Indigenous health advocates have an important supporting role in this intentional expression of the people’s original ways of relating to land.**

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In 2018 the Lancet reported that climate change is the most important threat to human health.<sup>50</sup> Advocating for the Earth because it cannot speak for herself is part of the Indigenous world view. Emerging Western ideas about mindfulness and balance, understanding that social inclusion is a protective factor for health, and the recent links between health and climate change, are aligned with a wholistic approach. We as physicians have a voice and can be strong advocates for the Earth and Indigenous health in creative, collaborative, respectful, and complementary ways.

## Key and enabling competencies

- 1. Study the Royal Commission on Aboriginal Peoples, the Truth and Reconciliation Commission and its Calls to Action, and the Calls for Justice of the Inquiry into Murdered and Missing Indigenous Women and Girls, which are important to advocacy-themed reports.<sup>7,10,51</sup>**
  - 1.1 Advocate for initiatives that increase the number of Indigenous medical students in the health profession programs.
  - 1.2 Identify current and future culturally safe learning environments for Indigenous medical students and residents. When these safe learning environments are identified, advocate for their support and sustainability.
  - 1.3 Advocate for the acknowledgement of traditional medicine practices and collaborate with Elders and traditional medicine practitioners.
  - 1.4 Advocate for cultural competency training for all health care students and professionals.

## **2. Understand the differences between Indigenous and dominant Western paradigms.**

- 2.1 Acknowledge observational, qualitative, and appreciative inquiry.
- 2.2 Acknowledge Indigenous expertise and experience as valid and important.
- 2.3 Identify collaborative advocacy strategies to optimize resources.
- 2.4 Encourage mentorship, experiential learning, and capacity-building consistent with the particular Indigenous community's cultural norms.
- 2.5 Understand land stewardship as an instructive, central responsibility of Indigenous peoples, in alignment with their cultural traditions and current strategies to mitigate effects of climate change.

## **3. Understand the existing landscape of the particular Indigenous community's health care infrastructure and policy.**

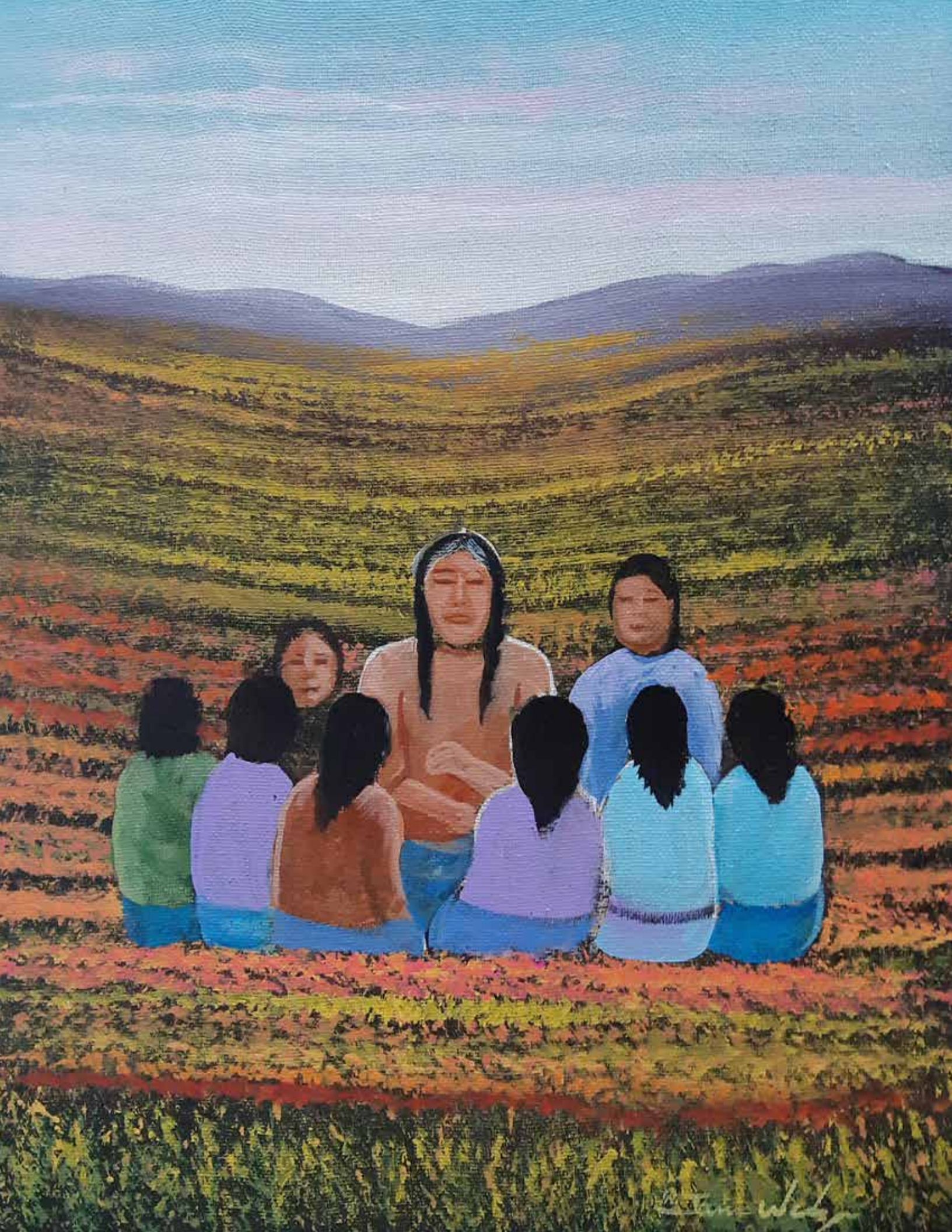
- 3.1 Understand community-specific historical, economic, environmental, social, and political determinants of health.
- 3.2 Understand the complex health resources that are provided by the federal, provincial, and/or territorial governments and administered by First Nations band councils and Inuit health organizations.
- 3.3 Understand Health Canada's NIHB formulary and services.
- 3.4 Understand the impact of legislation affecting Indigenous health (e.g., Canadian Environmental Protection Act of 1999, and various provincial midwifery acts).<sup>52</sup>
- 3.5 Advocate for billing strategies that reflect the reallocation of medical support to under-resourced communities.
- 3.6 Advocate for billing strategies that reflect the longer and complicated clinical encounters with Indigenous clients and their families.
- 3.7 Advocate for billing strategies that acknowledge the narrative approach often used by Indigenous clients.

#### **4. Contribute to the continuing development of an Indigenous public health policy.**

- 4.1 Acknowledge the lack of a comprehensive federal Indigenous public health policy.
- 4.2 Prioritize participatory research (e.g., invite community researchers to co-author and disseminate research) using principles such as those defined in OCAP® (ownership, control, access, and possession).<sup>53</sup>
- 4.3 Highlight strength-based outcomes. Think about the implications of culture-based versus land-based programming language.
- 4.4 Acknowledge data loss resulting from the dissolution of advocacy organizations (e.g., National Aboriginal Health Organization) and advocate for the preservation of Indigenous health data and research.

For additional information see Appendix 1.





# Scholar

## Definition

Family physicians must possess a broad range of evidence-based clinical knowledge and practice skills in caring for patients, including emergency medicine. For Indigenous patients, families, and communities, family physicians must pursue further knowledge in epidemiology, health, and social issues relevant to this population, as well as the historical, political, and social contexts of First Nations, Inuit, or Métis populations. While there is a growing body of evidence-based Indigenous health literature, physicians must also be aware of non-academic sources of knowledge, such as that of Indigenous leaders, traditional healers, cultural resource persons, or knowledge keepers.

## Description

Through medical education and clinical training, family physicians must gain and maintain knowledge and skills in family medicine, particularly in light of changing medical literature, and new information and treatments. With respect to caring for Indigenous populations, this requires additional efforts to learn about their contexts, capacity, and resources with cultural safety and cultural humility. While it is important to read and understand Indigenous health literature and epidemiology, we must also critically evaluate these resources and use ethics and contextual perspectives.

Family physicians and learners will gain a deeper understanding of Indigenous cultures, history (including the residential school experiences), multi-generational trauma, and the social determinants of health that impact the health and social context of their communities. Learning about and using trauma- and violence-informed approaches and healing-centred engagement, we can create an ethical space to positively engage our Indigenous patients and create a trusting and safe therapeutic relationship. Upon self-reflection and as this foundation of knowledge increases, we will enrich our experience caring for Indigenous peoples, eventually achieving culturally safe care.

There are many resources available for family physicians to learn about Indigenous health, particularly regarding First Nations, Inuit, and Métis cultures, history, community contexts, social and political backgrounds, and current issues. In addition to relevant literature sources, there are sources external to health care academia. These include Indigenous community and health organization reports and similar documents, or the historical, cultural, and other contextual knowledge of Indigenous community leaders and resource persons. For example, the 2015 Truth and Reconciliation Report documents the residential school experiences endured by Indigenous survivors and their families as a major factor in the health and well-being that still profoundly affects all communities.<sup>7</sup> This knowledge can be complemented by participation or integration into the Indigenous community meetings and cultural activities, such as gatherings and feasts.

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A family physician working in a rural town decided to work in a weekly clinic in the nearby First Nations community. She started learning about the Cree culture and this community's history, with many older persons having attended residential school that was located about 300 km away. The health clinic has some local health statistics although this is quite limited. She is familiar with some common health issues, such as diabetes, hypertension, and obesity, but she would like to learn more about social issues, so she plans to meet with the social worker. She recognizes that there are some families that are dysfunctional or struggling because of addictions, alcohol use, relationship issues, and other reasons, which may be related to intergenerational trauma and adverse childhood events. In her first few months of work she has learned much but appreciates there is more to learn from her patients, the health care team, and community members. She has also met and chatted with some Cree women at the sharing circle held every week, gaining some insight into families' realities, which helps her in her patient interactions. She has learned that their Cree culture, resilience, traditions, and connection to their lands are highly valued and help them heal.

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The knowledge and the experience gained through this role will foster other competencies, particularly Health Advocate, as family physicians work in any Indigenous communities. We must also participate in lifelong learning and teach medical trainees and other health professionals, perhaps conducting or supporting Indigenous health research and doing administrative work. For example, family physicians who work with First Nations populations must become familiar with the NIHB Program, which requires some knowledge of treaty rights and supplementary health coverage. Most importantly, such a strengthened and enlightened knowledge base will complement the efforts of family physicians and trainees to give culturally safe care and continue the journey to reconciliation.

## Key and enabling competencies

1. **Appreciate cultural humility and in doing so, recognize that knowledge of Indigenous health broadly defined is needed to advance competence and capacity to provide culturally safe care to Indigenous patients, families, and communities.**
2. **Actively pursue and accrue continuing education in Indigenous health through learning and experiential activities.**
  - 2.1 Gain knowledge of evidence-based Indigenous health literature, and learn from Indigenous experts, resource persons, and traditional healers. When learning about health and social conditions and epidemiology that are pertinent to Indigenous populations, family physicians and learners must use both ethical and cultural safety lenses in actively engaging this knowledge.

- 2.2 Use critical appraisal to evaluate and integrate the knowledge gained, justified, and contextualized. Indigenous-relevant knowledge extends into cultural and social domains, beyond academia, which can also be pertinent in certain situations such as birthing and bereavement traditions.
  - 2.3 Understand that the First Nations, Inuit, or Métis concept of health is different than mainstream society and is based on a holistic approach to health and life. When applying this concept to health status, the family physician will learn how to use this knowledge to engage and give better clinical care using a holistic approach. It is important to understand and respect the perspectives of Indigenous peoples, what health means to them, and how illness affects the person, family, and community.
  - 2.4 Recognize Indigenous knowledge as important, valid, valued, and justified just as academic or Western knowledge already is. Family physicians must learn other means of gaining Indigenous-relevant knowledge, such as storytelling, oral history or teachings, active engagement, sharing, and traditional ways of giving information or teaching, such as an Elder teaching youth about being a parent.
- 3. Guide peers, medical students, residents, and health care team members in their learning about Indigenous health and social issues, including doing so together as needed, to eventually attain culturally safe care. Learning and teaching others (humility) are key Indigenous values and ethics that help everyone to do this.**
- 3.1 Contribute to and enable a supportive learning environment that encompasses cultural safety.
  - 3.2 Appreciate deficits in knowledge as opportunities to learn, including collaborating with medical trainees and health care team members.
  - 3.3 Seek relevant sources of Indigenous health information, and social and community issues, including those from Indigenous health professionals, knowledge keepers, and community leaders. By being aware of and accessing different knowledge sources, family physicians can focus on information that will aid learning and practice, and not perpetuate deficit-based thinking or epistemic racism.
  - 3.4 Conduct learning activities for medical trainees and health care team members with an Indigenous lens, such as case discussion(s), clinical teaching rounds, morbidity and mortality meetings that enable knowledge gathering, learning and change in practice or treatment(s), and support cultural perspectives in care.

- 3.5 Recognize that current issues set the context of what is happening in Indigenous communities today, such as the Truth and Reconciliation Calls to Action, trauma- and violence-informed care, Indigenous women's issues, challenges in Indigenous child welfare, and systemic racism.
  - 3.6 Self-reflection by family physicians, trainees, and other health care team members will guide further steps in learning and consolidating this knowledge to culturally safe practice.
- 4. Participate in patient education or teaching that is amendable to the culture, language, community context, and capacity of the Indigenous patient and their family member(s).**
- 4.1 Deliver information that is relevant to their language, clinical context, and education level.
  - 4.2 Offer opportunities to answer questions and clarify information as needed.
  - 4.3 Provide relevant written, electronic, or online resources to help engage the patient and support their understanding.
  - 4.4 Use community resources or opportunities in teaching, such as radio broadcasts or meetings on health topics, as needed.
  - 4.5 Enable appropriate and informed decision making with Indigenous patients and their families regarding clinical condition and treatments.
- 5. Contribute to generating health and other knowledge that will enable capacity of the health care team and Indigenous community to achieve improved health.**
- 5.1 Support, conduct, and/or incorporate Indigenous-relevant research if appropriate.
  - 5.2 Conduct a literature search as needed to seek evidence-based approaches to care that support best practices in Indigenous health, as well as other relevant sources of information at local or regional levels.
  - 5.3 Use recognized principles of research ethics, including OCAP® and the CIHR Tri-Council Guidelines in generating Indigenous-relevant knowledge through research and respecting Indigenous ethics.<sup>53,54</sup>
  - 5.4 Create or support research agreements that are transparent and collaborative.

- 5.5 Create, disseminate, or use Indigenous health and other knowledge such as health indicators, research outcomes, and data to aid in QI activities that ultimately contribute to improved health services and resources in Indigenous communities.
- 5.6 Recognize limitations of research and data collection in Indigenous contexts, and support or facilitate better data collection and research as needed.
- 5.7 Integrate knowledge gained (including non-academic information in cultural, social, historical, and political realms or in broader context) through knowledge translation and exchange, which contributes to the professional development of family physicians, medical trainees, and other health care team members.



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# Professional

## Definition

The Professional Role calls on family physicians to incorporate cultural, social, and ethical dimensions of care with diverse Indigenous patients and populations. Defining competent medical practice with Indigenous patients frames accountabilities to patients, colleagues, the community, and the profession. They direct us to act on cultural, structural, and systemic dynamics that influence health and health care as experienced by Indigenous people.

## Description

Similar to the general CanMEDS-FM description, a societal role is central to working within Indigenous contexts. Family physicians engage with communities and individuals in upstream social, cultural, and political contexts that enable health and wellness. Our work requires understanding how colonization and culture distinctly influence health outcomes. For effective care, family physicians integrate these distinct concepts within a clinical approach. This integration of complex knowledge and skills specific to Indigenous health requires a lifelong learning approach.

Professional relationships centre on disrupting the exclusion of Indigenous people within society and health care that persists due to the legacy of ongoing colonization. We are urged to be fully aware of and address the oppression, power imbalance, and racism that is often re-enacted within health care. When working with others we seek to sustain non-competitive collaborative approaches, valuing interdependence and flattening of hierarchy to counter oppression and power imbalance. We facilitate effective and collaborative team-based care.

Indigenous ethical principles—including inclusiveness (of people and perspectives), centring relationships, and valuing interconnectedness—provide a grounding in professionalism with Indigenous patients. For family physicians, this means respecting the importance of family and community relative to the patient's needs and autonomy as per a collectivist context, in contrast to a western individualist focused mode. We are expected to be knowledgeable and skilled, but not behave as an expert or perpetuate hierarchy via our knowledge or position within the relationship. Honesty and humility offer a means to level inappropriate power differentials between the physician and patient. Building a relationship as a helper to the patient for achieving health and wellness is in line with Indigenous approaches, as opposed to an expert who merely assesses and dispassionately directs care.

Self-reflective inquiry into our own perspectives originating from culture, social position, and profession is core to achieving self-awareness, a foundation of professionalism. Regarding the



systemic health care inequities that Indigenous people experience due to the ongoing legacy of colonization, we need to be aware of the power and privilege held by virtue of our profession and societal position. Through self-reflection and humility, we seek, respect, and hold in relationship, the lines of difference between ourselves and our patients to ensure that we do not presume or impose our perspectives and values, nor perpetuate systemic inequity.

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### **Continued from Communicator Role...**

Reflecting on how she was treated during the last appointment, Rose mentioned the interaction to her daughter Gail.

Gail asked her mother what the most upsetting part was of that visit, thinking that it was the doctor's misinterpretation and judgement about traditional tobacco use.

Rose paused and said, "It was when I realized that the doctor was not interested in seeing me or hearing me in light of the bigger picture. Yes, I am an individual, but I am also deeply connected to family, community, place, and course of time. It is hard to untangle me from the stories that we need to tell to respect those relationships and it feels quite self-centred for me to do so."

"It would be nice if doctors would take the time to understand our ways. It would help doctors to build trusting relationship and better communicate with us," Gail replied.

"Yes," Rose said. "It would also be great if they recognized how all those connections, good and bad, influence us. We have experienced much bad from colonization. We are still trying to heal and recover. I'm tired of being told to 'get over it' and 'pull yourself up by your bootstraps'."

"Yeah Mom, it would be good," Gail said.

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## **Key and enabling competencies**

- 1. Demonstrate a commitment to clinical excellence, focussing on not perpetuating colonization.**
  - 1.1 Integrate cultural and upstream social and political contexts into patient care that enable health and wellness.
  - 1.2 Engage in lifelong learning of how colonization shapes all aspects of health and health care.
  - 1.3 Recognize and address racism, oppression, and imbalance of power within clinical approaches and relationships.

## **2. Demonstrate a commitment to Indigenous ethical concepts within clinical approaches.**

- 2.1 Facilitate effective interdependent team-based care by promoting collaborative approaches that are non-competitive and that flatten hierarchy.
- 2.2 Maintain an inclusive approach that respects, elicits, and explores Indigenous perspectives.
- 2.3 Approach care with patients in a way that values the importance of the connections and relationships of people, knowledge, and experience.
- 2.4 Approach patient care with humility, position as helpers to the patient that facilitate healing and wellness, as opposed to experts that perpetuate hierarchy.

## **3. Demonstrate a commitment to reflective practice.**

- 3.1 Seek and demonstrate understanding of the individual, family, societal, and medical cultural influences of identities in relation to the Indigenous patient.
- 3.2 Identify and examine misguided presumptions about Indigenous people and understand origins and implications on the patient and on the health care interaction and outcome.
- 3.3 Identify differences between self and the patient to ensure presumptions of Indigenous patients and personal perspectives and values are not imposed on the patient.

# Appendix 1: Additional Information for Health Advocate Role

The legislative policies governing all aspects of Indigenous peoples' life in Canada derive from the British North America Act, the Indian Act, and the Indian Lands Act.<sup>55,56,57</sup> In 1974 the report *A new perspective on the health of Canadians: A working document* stated that there are elements of health such as genetics, environment, and lifestyle that are distinct from the medical system, and are referred to as the social determinants of health.<sup>58</sup> In 1986 the Ottawa Charter for Health Promotion recognized these determinants and introduced the concept of public health policy.<sup>59</sup>

Public health policy is the model of understanding, investing in, and coordinating the components of unique healthy environments, and placing these models on the policy agendas of all levels of government. Currently, there is no public health policy supporting Indigenous health and well-being at the provincial and federal levels in Canada. The Truth and Reconciliation Commission's recommendations include supporting research in Indigenous communities that can be used to create a public health policy. Advocacy would require that this research follow the principles of participatory research.

*Building on Values: The Future of Health Care in Canada – Final Report* describes Indigenous health inequity as being caused by the general mismanagement of funding and poorly established systems of providing health care.<sup>60</sup> The solution to addressing the inequities requires that all levels of government, including the community level, must be involved.

The Kelowna Accord of 2005 included five national Aboriginal organizations with community roots that pledged to work together with the federal government on addressing inequities in education, housing, and employment.<sup>61</sup> When the succeeding government did not endorse the Accord, and even though the Health Council of Canada was established to oversee these pledges, eventually it and all related Aboriginal advocacy organizations were disbanded and their mandates absorbed into other organizations.

As a result, there is no coordination of community engagement with local, provincial, territorial, and federal governments and no long-term strategy such as the development of an Aboriginal health policy. Without Indigenous-specific data many clinical decisions are based on anecdotes rather than evidence-based medicine.

## Appendix 2: Resources

Indigenous Relationship and Cultural Safety Courses

**Cancer Care Ontario**

<https://elearning.cancercare.on.ca/course/index.php?categoryid=2>

Finding Your ACE Score

**National Council of Juvenile and Family Courts**

<https://www.ncjfcj.org/wp-content/uploads/2006/10/Finding-Your-Ace-Score.pdf>

Health and Health Care Implications of Systemic Racism on Indigenous Peoples in Canada

**College of Family Physicians of Canada**

[https://portal.cfpc.ca/ResourcesDocs/uploadedFiles/Resources/PDFs/SystemicRacism\\_ENG.pdf](https://portal.cfpc.ca/ResourcesDocs/uploadedFiles/Resources/PDFs/SystemicRacism_ENG.pdf)

What is a SPOR unit?

**Hotì ts'eeda Northwest Territories SPOR Support Unit**

<https://nwtspor.ca/about/what-spor-support-unit>

Non-insured health benefits for First Nations and Inuit

**Government of Canada**

<https://www.sac-isc.gc.ca/eng/1572537161086/1572537234517>

Inuit Qaujimagatuqangit

**Government of Nunavut**

[https://www.gov.nu.ca/sites/default/files/iq\\_brochure\\_draft\\_1.pdf](https://www.gov.nu.ca/sites/default/files/iq_brochure_draft_1.pdf)

The CFPC's Actions on the Recommendations of the

Truth and Reconciliation Commission of Canada

**College of Family Physicians of Canada**

[https://portal.cfpc.ca/ResourcesDocs/uploadedFiles/Health\\_Policy/Truth\\_Reconciliation\\_one-pager\\_FINAL.pdf](https://portal.cfpc.ca/ResourcesDocs/uploadedFiles/Health_Policy/Truth_Reconciliation_one-pager_FINAL.pdf)

The First Nations Principles of OCAP®

**First Nations Information Governance Centre**

<https://fnigc.ca/ocap>

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