Report on Indigenous Health Dialogue of Truth and Reconciliation within the Cumming School of Medicine

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Preamble

The Indigenous Health Dialogue began in summer 2016 with a group of committed individuals – faculty, trainees, and leadership – in the Cumming School of Medicine keen to explore and advocate for our institution's accountability to the Truth and Reconciliation Commission.

The process was formalized in November 2016 with a pipe ceremony carried out by Dr. Reg Crowshoe, with special guest commissioner Dr. Wilton Littlechild of the Truth and Reconciliation Commission of Canada. That event was attended by faculty leaders Dr. Jon Meddings, Dr. Glenda McQueen, Dr. Lara Cooke, Dr. Charles Leduc; faculty members Dr. Lynden Crowshoe and Dr. Cheryl Barnabe; and trainees Dr. Rita Henderson, Dr. Adalberto Loyola Sanchez, and Ms. Keri Williams.

At the ceremony, Dr. Reg Crowshoe gifted a ceremonial object, the tamper used for the pipe ceremony, to the Cumming School of Medicine as a physical representation of ongoing commitment and partnership.

A list of attendees in the ceremony included:[1]

Cheryl Barnabe	Associate Professor and Chair, Group for Research with Indigenous People (GRIP)
Lara Cooke	Associate Dean of Continuing Medical Education and Professional Development
Barb Cowley	Indigenous Health Dialogue Program Coordinator
Lindsay Crowshoe	Associate Professor and Director, Aboriginal Health Program, Undergraduate Medical Education
Janet de Groot	Associate Dean, Equity and Professionalism
Sue-Ann Facchini	Coordinator, Aboriginal Health Program, Undergraduate Medical Education
Jennifer Hatfield	Associate Dean, Strategic Partnerships and Community Engagement
Rita Henderson	Postdoctoral Fellow, Department of Family Medicine
Charles Leduc	Department Head, Department of Family Medicine
Wilton Littlechild	Commissioner of the Truth and Reconciliation Commission of Canada, Grand Chief of Treaty 6 Nations
Adalberto Loyola Sanchez	Postdoctoral Fellow
Jon Meddings	Dean, Cumming School of Medicine
Keri Williams	Doctoral Candidate

[1]The roles listed for each attendee reflect lead appointments at the time.

Table of Contents

List of Tables

List of Figures

List of Abbreviations

AAMC	Association of American Medical Colleges
ACES	Advisory Committee on Educational Strategy
AFMC	The Association of Faculties of Medicine of Canada
AHP	Aboriginal Health Program
AHS	Alberta Health Services
AHSI	Aboriginal Health Sciences Initiative
ARP	Alternative Remuneration Plan
AIM-HI	Alberta Indigenous Mentorship in Health Innovation
CCME	Canadian Conference on Medical Education
CEIH	Centre for Excellence in Indigenous Health
CFPC	College of Family Physicians Canada
CMA	Canadian Medical Association
CSM	Cumming School of Medicine
FLAG	Faculty Leadership Advisory Group
FNIH	First Nations and Inuit Health
FNMI	First Nations, Métis, and Inuit
GPA	Grade Point Average
GRIP	Group for Research with Indigenous Peoples
IH	Indigenous Health
IHD	Indigenous Health Dialogue
IHE	Indigenous Health Education
IHIG	Indigenous Health Interest Group
IHP	Indigenous Health Program
IHTF	Indigenous Health Task Force
IMN-Ontario	Indigenous Mentorship Network of Ontario
IPAC	Indigenous Physicians Association of Canada
IRSI	Indigenous Research Support Initiative
MCAT	Medical College Admissions Test
MCC	Medical Council of Canada
MD	Doctor of Medicine
MOOC	Massive Open Online Course
NOSM	Northern Ontario School of Medicine
OHMES	Office of Health and Medical Education Scholarship
PGME	Post Graduate Medical Education
RCPS	Royal College of Physicians and Surgeons of Canada
SHINE	Students for Health Innovation and Education
SPaCE	Strategic Partnerships and Community Engagement
TRC	Truth and Reconciliation Commission
UME	Undergraduate Medical Education

1. Executive Summary

1.1. Background

With the release of its report and 94 calls to action in June 2015, the Truth and Reconciliation Commission of Canada (TRC) formalized a responsibility for Canada to confront and craft a path to remedy the legacies of its colonial past. In defining key directions for generating transformation, the seven Calls to Action related to Indigenous health challenge medical schools to examine and improve their existing strategies and capacities for realizing the aim of improving Indigenous health outcomes within the areas of education, research, and clinical services. Outlined here is a process by which a strategic working group within the Cumming School of Medicine (CSM) at the University of Calgary came to identify key action areas around which to mobilize investments and energies, namely in: 1) promoting authentic inclusion of Indigenous people and knowledge systems, and 2) building institutional capacity to address the underlying causes of health disparities arising from colonization.

Within the CSM, several important Indigenous health-focused educational initiatives, research projects, and service innovations exist; however, across the faculty, these are generally disconnected from one another and from the CSM leadership, highlighting the need for cross-faculty partnerships to achieve integration and collaboration among the school's mandated areas of education, research, and service innovation. In an effort to bridge these gaps, the Indigenous Health Dialogue (IHD) has, since 2016, aimed to build capacity for promoting principles of social accountability, cultural safety, and equitable partnerships. In a push to strengthen coordination around Indigenous health initiatives within the CSM, the IHD has actively explored what the TRC Calls to Action may mean for our school and community partnerships, as means of building faculty and community capacity for aligning goals and outcomes.

1.2. Process

Grounded in Indigenous principles that promote collaboration, non-hierarchy, and non-coercion in decision-making processes, the IHD carried out a series of internal and community engagement activities to strategically bring together CSM faculty and leadership with Indigenous community stakeholders (i.e. leaders, planners, educators, and service professionals) to challenge, clarify, refine, and define directions for Indigenous health initiatives within the CSM. Through these activities, the IHD has involved input from some 250 individuals whose ideas contribute to the vision outlined here.

1.3. Directions

The following directions emerge from our engagement process as key for the CSM to pursue:

1. Focus on engagement and advocacy with key stakeholders in shared goals of advancing Indigenous health;
2. Promote inclusion of Indigenous people and knowledge, ensuring dismantling barriers and bias within the institution;
3. Build Indigenous health education content and facilitation excellence across all educational units to ensure all graduates and faculty are equipped with critical Indigenous health knowledge and skills;
4. Foster ethical and rigorous Indigenous health research within our institution that effectively responds to community-identified priorities; and
5. Facilitate development of innovations of critical health care approaches and models through collaboration with community, health systems, and health research stakeholders.

2. Introduction

Widespread health inequities experienced by Indigenous people in Canada stem from historical and ongoing impacts of colonization (1–3). This is due to disparities in health status and health care that arise from social and political systems that took root during the early colonial period, and continue to impact Indigenous people. For example, multi-generational trauma perpetrated throughout much of the twentieth century by educational, social services, and health systems – via residential schools (4), the Sixties' Scoop (5), segregated Indian hospitals (6), and legalized forced sterilization of Indigenous women (7) – remains an important driver of chronic disease and behavioural health outcomes across the age spectrum (8,9). Importantly, at a population level, achieving health equity is twofold, requiring that we address social and political determinants of Indigenous health in addition to unequal treatment that occurs within existing health care systems.

Health systems are often culturally unsafe for Indigenous people, "owing to the ways that health law, health policy and health practice continue to erode Indigenous cultural identities" (10). Nevertheless, medical schools are accountable to addressing health and health care disparities among the populations that they serve (11). In system-wide efforts to achieve health equity, health professional schools are foundational partners of health care institutions, as each reflects on and seeks to shift outdated educational and service models that perpetuate adverse health outcomes. One key institutional responsibility is listening and responding to hard truths around the complicity of health care and other systems in perpetuating harms against certain groups of people. This report outlines findings from a multi-year process to take stock within our school of such practices impacting Indigenous people.

In 2015, the Truth and Reconciliation Commission (TRC) of Canada released a final report (12) and 94 Calls to Action (13) calling on all sectors of Canadian society to address the ongoing social and institutional legacy of residential schools. The Commission's work was deeply grounded in community perspectives and experiences from across the country, offering critical directions for all public institutions, including medical schools, to engage in deep exploration around how to reach equity-oriented transformation. Outlined here is the process, discoveries, and vision developed by a strategic working group, formed in 2016 within the Cumming School of Medicine (CSM), with the aim of catalyzing transformation inspired by the TRC. The Indigenous Health Dialogue (IHD) remains a working group with multiple partners within and beyond the CSM. The intention of this report is to encourage investment in strategic Indigenous health priorities within the faculty.

2.1. What is the Truth and Reconciliation Commission?

Reconciliation involves a process of restoring or forging good relationships after discord. A core principle identified by the TRC for achieving this end is to recognize that reconciliation is "a process of healing of relationships that requires public truth sharing, apology, and commemoration that acknowledge and redress past harms" (14). Importantly, reconciliation is not possible without the sharing of truth, the public or open recognition of harms done, and the ongoing commitment to acknowledge and seek to amend these.

The TRC was established following the Indian Residential Schools Settlement Agreement to settle a class action lawsuit against the Canadian government for its part in the cultural genocide of First Nations, Métis, and Inuit (FNMI) people. Throughout much of the twentieth century, the government-funded and largely church-operated schools forcibly separated children from their families and communities, purportedly for vocational training, though in practice these were seldom educational but rather primarily assimilationist in their intent (15). Beginning in 2008, three commissioners travelled across Canada listening to the testimonies of Indigenous people who had been taken from their families as children and placed in residential schools. Over 6,000 witnesses –

largely survivors of the schools – shared their experiences. In June 2015, the TRC published a 527-page summary report (12) that included all testimonies, establishing a public record of truth around the schools. The Commission also delineated 94 Calls to Action for Canadian society to pursue in efforts to reconcile with Indigenous people. The TRC's 94 Calls to Action are thematized into diverse domains of Canadian society where transformation is needed. Seven of those calls (#18-24) address the health legacy of residential schools, each raising a distinct and critical issue for health systems to address (*See Table 1*).

These seven calls structured the deep exploration undertaken by the IHD to identify truths and explore opportunities for reconciliation through activities and resources specific to the CSM. They begin by challenging us to first acknowledge that health inequities are deeply connected to previous Canadian government policies. The calls then shift to health research gaps; the need for greater health service coordination, funding, and inclusion of Indigenous approaches in practice; and finally, the imperative of critical Indigenous health training for health professionals.

Table 1. TRC Health Legacy Calls to Action and Contextualization to Medical School Mandates (Education, Research, and Service)

Calls to Action		Contextualization
18	We call upon the federal, provincial, territorial, and Aboriginal governments to acknowledge that the current state of health in Canada is a direct result of previous Canadian government policies, including residential schools, and to recognize and implement health-care rights of Aboriginal people as identified in international law, constitutional law, and under the treaties.	*Reinforces a social causation model where outcomes of colonization are perpetuated at all levels of society, including within medicine. Highlights need to understand IH through a social justice and advocacy lens.*
19	We call upon the federal government, in consultation with Aboriginal peoples, to establish measurable goals to identify and close the gaps in health outcomes in between Aboriginal and non-Aboriginal communities, and to publish annual progress report and assess long-term trends. Such efforts would focus on indicators such as: infant mortality, maternal health, suicide, mental health, addictions, life expectancy, birth rates, infant and child health issues, chronic diseases, illness and injury incidence, and the availability of appropriate health services.	*Focuses on research ethics and provides an important lens for practitioners on the nature of knowledge, relationships, engagement, and respect.*
20	In order to address the jurisdictional disputes concerning Aboriginal people who do not reside on reserves, we call upon the federal government to recognize, respect, and address the distinct health needs of the Métis, Inuit, and off-reserve Aboriginal peoples.	*Highlights inequities between Indigenous groups, noting those that may experience distinct health and service disparities. Advocates capacity to address jurisdictional gaps and barriers.*
21	We call upon the federal government to provide sustainable funding for existing and new Aboriginal healing centres to address the physical, mental, emotional, and spiritual harms caused by residential schools, and to ensure that the funding of healing centres in Nunavut and the Northwest Territories is a priority.	*Focuses on trauma healing as critical for improving health outcomes. Emphasizes cultural approaches and investments in health service resources.*
22	We call upon those who can effect change within the Canadian health-care system to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients.	*Focuses on the need to integrate Indigenous healing practices, performed by Indigenous healers and Elders, within wider healthcare.*
23	We call upon all levels of government to: (i) increase the number of Aboriginal professionals working in the health-care field; (ii) ensure the retention of Aboriginal health-care providers in Aboriginal communities, and (iii) provide cultural competency training for all health-care professionals.	*Places the impetus on medical schools to evaluate their admissions, hiring, curriculum, and training to ensure inclusion and capacity-building of Indigenous learners and leaders within a culturally safe environment.*
24	We call upon medical and nursing schools in Canada to require all students to take a course dealing with Aboriginal health issues, including the history and legacy of residential schools, the United Nations Declaration on the Rights of Indigenous Peoples, Treaties and Aboriginal rights, and Indigenous teachings and practices. This will require skills-based training in intercultural competency, conflict resolution, human rights, and anti-racism.	*Is explicit in its application to all medical learners, Indigenous and non-Indigenous, to understand the impact of colonization on Indigenous cultures and to develop appropriate skills to work with Indigenous people.*

3. Background to TRC Responses in Medical Schools

3.1. Landscape of Directives

Institutions throughout Canadian society – including medical schools – have been openly invited to contextualize the TRC Calls to Action to their specific realities. National, regional, and local organizations are in the process of acknowledging and redressing truths around colonization within their operations, resulting in actions and directions that have implications for medical schools.

In 2019, the Association of the Faculties of Medicine of Canada (AFMC) has released a Joint Commitment to Action on Indigenous Health which provides a "roadmap for concrete institutional change that will best enable Canadian Medical Schools to respond to the TRC Calls to Action."[2] In 2017, the Alberta Medical Association (AMA) approved their Indigenous Health Policy Statement, developed in response to the TRC Calls to Action. The AMA is committed to advocating for innovative approaches to cultural education, ensuring "every physician, medical student and resident in Alberta complete professional development related to Indigenous health" and "safe learning environments in medical training for Indigenous students."[3] Furthermore, the Canadian Medical Association (CMA), the Royal College of Physicians and Surgeons of Canada (RCPS), the College of Family Physicians Canada (CFPC), the Indigenous Physicians Association of Canada (IPAC), the Association of American Medical Colleges (AAMC), and the Medical Council of Canada (MCC) all are engaging with the TRC. Similarly, each will likely describe roles of the medical school in achieving their directions related to Indigenous health.

Within Alberta, the Alberta Medical Association (AMA), Alberta Health Services (AHS), the AHS Indigenous Health Program (IHP), First Nations and Inuit Health (FNIH), Treaty 6, 7, and 8, and the Métis Nation of Alberta inform Indigenous health education and practice.

At the local level, the University of Calgary's 2017 Indigenous Strategy[4] named *ii' taa'poh'to'p (a place to rejuvenate and re-energize during a journey)* guides the CSM in establishing and maintaining relationships with Indigenous communities grounded on principles of Indigenous philosophies, epistemologies, and pedagogies. These relationships promote initiatives and activities to grow capacity and contextualize needs for health equity transformation across the CSM and beyond. (*See* *Appendix B, Locating the Indigenous Health Dialogue within Local, Regional, National, and International Strategies of Indigenous Health Equity*).

3.2. Indigenous Health in Canadian Medical Schools

Over four decades, Canadian medical schools have begun to develop policies and initiatives to encourage and support the recruitment and admission of FNMI students. For example, the University of Manitoba began its pre-medical, nursing and health professions ACCESS Programs in 1975; the Faculty of Medicine and Dentistry at the University of Alberta founded the Indigenous Initiatives program in 1988; and the University of British Columbia began their Indigenous medical training programing in 2002. Of the western medical schools, the CSM has been the last to mobilize policy and programming to support the training of Indigenous physicians. In 2008, the CSM approved the *Policy for the Recruitment of Applicants of Aboriginal Background to University of Calgary Faculty of MD Program'*.

[2] https://afmc.ca/en/priorities/indigenous-health
[3] https://www.albertadoctors.org/Indigenous-Health/ama-indigenous-health-policy-statement.pdf
[4] https://www.ucalgary.ca/indigenous/ii-taapohtop

3.3. TRC Responses in Canadian Medical Schools

In response to the TRC, most of the 17 medical schools across Canada have begun to address their Indigenous health capacity through specific policies, curricular programming, and other initiatives (*See Appendix C, Canadian Medical School Indigenous Health Initiatives at a Glance*). While several schools have begun their engagement with Indigenous peoples through reconciliatory practices, many are still in the early stages of designing and implementing full IH responses. Some schools have undertaken specific TRC responses worth deeper description. These offer possibilities for consideration of policies, programs, and initiatives within the CSM.

3.3.1. Northern Ontario School of Medicine

Since its inception in 2005, the Northern Ontario School of Medicine (NOSM) has engaged with rural, remote, Indigenous, Francophone, and urban communities of Northern Ontario to best serve a diverse cultural and geographic area. Built into the school's structure and its program are an Indigenous Affairs Unit and an Indigenous Reference Group.[5] Major gatherings and yearly meetings between the school and community honour the continued commitment to developing relationships. The NOSM serves over 90 communities spread over 800,000 km^2 of land spanning north of the Golden Horseshoe (i.e. the populous urban centres clustered around the Great Lakes of Lake Erie and Lake Ontario).

The NOSM has also created a framework to address 19 of the 94 calls to action put forth by the TRC. The curriculum provides opportunities to engage and learn with Indigenous communities, addressing Indigenous cultural competency through: a mandatory 4-week student placement in an Indigenous community; workshops and one-on-one sessions with Elders; and specific opportunities related to the course of studies. Indigenous applicants may apply to the MD program through an Indigenous application stream, where four seats are guaranteed for Indigenous students. An expert panel provides advice on the relations, structures, and policies enacted between the university and Indigenous community, both within and outside the university; a final set of recommendations was completed September 2018.

3.3.2. Queen's University

Soon after the release of the TRC, Queen's University formed a task force and – in September 2016 – conducted a five-month consensus-based decision-making consultation process to address the calls to action. In March 2017, a report that included 25 recommendations was released. One of the recommendations explicitly addressed education: "In support of Call to Action 24, the task force encourages the work underway in the Faculty of Health Sciences to significantly enhance training in cultural competencies and expand Indigenous-focused curricula for all students within the Schools of Medicine, Nursing, and Rehabilitation Therapy."[6] Initial additions to the curriculum were implemented in 2018/19, with new courses starting in 2019/20.

In response to the specific health needs of Indigenous peoples in Canada, as well as to the health legacy calls to action of the TRC, the School of Medicine at Queen's developed a third-year option for postgraduate medical education in Family Medicine to focus specifically on understanding and addressing Indigenous health. In order to offer mentorship to Indigenous trainees, as well as a platform from which to share, learn, and plan among current and emerging IH scholars, Queens has organized an Indigenous Mentoring Network Hub. The Queen's hub is part

[5] https://www.nosm.ca/our-community/indigenous-engagement/indigenous-reference-group/

[6] https://www.queensu.ca/inclusive/sites/default/files/assets/%28WEB%20VERSION%29%20Final%20Report%20of%20the%20Truth%20and%20Reconciliation%20Commission%20Task%20Force.pdf

of the Indigenous Health Network, a Canada-wide mentorship initiative funded by the Canadian Institute for Health Research. Indigenous students are also presented with an alternate assessment for entry to the medical school with up to four seats reserved annually for qualified applicants.

3.3.3. University of British Columbia

The University of British Columbia's (UBC) 2018 Indigenous Strategic Plan[7] builds on its 2009 Aboriginal Strategic Plan[8] and aligns with the TRC calls to action. In general, the 2018 plan emphasizes collaborative and equal partnerships between Indigenous community and the university. In addition to the 2018 Indigenous Strategic Plan, the UBC *Inspire* Strategic Plan calls specifically for faculties and other units to develop a TRC Action Plan. A notable IH initiative at UBC is the Centre for Excellence in Indigenous Health (CEIH), which opened on 1 January 2014. Housed in The School of Population and Public Health, the CEIH develops respectful relationships with Indigenous peoples and their communities. Moreover, two advisory councils – a University Advisory Council and a Community Advisory Council – provide guidance to the university as to Indigenous communities' objectives and intentions. It is through the CEIH that most of UBC's IH policies, programs, and initiatives are coordinated.

Though the medical school at UBC has no specific education track for students who wish to specialize in Indigenous health, a number of programs exist through the CEIH. These include the Aboriginal Health Program, an Aboriginal MD Admissions Program; Indigenous Public Health Training Institutes; and Aboriginal Health and Community Administration Program. The programming is intended to train and provide experience for both Indigenous and non-Indigenous students who want to, or are working with, Indigenous health. Under the Indigenous MD admissions program, up to five percent of seats annually are reserved for qualified Indigenous students. Under the Masters of Public Health program, two seats are held annually for Indigenous students. Pre-admission workshops geared toward all Indigenous students who are interested in health care also exist. For those in health care and the general public, there is an Indigenous speaker series, the CEIH UBC Learning Circle that provides an online forum to engage with developments in IH and by Indigenous health care providers, the Indian Residential School History and Dialogue Centre, and a Massive Open Online Course (MOOC) provided by the Faculty of Education titled "Reconciliation through Education."

3.3.4. University of Manitoba

Of all Canadian medical schools, the University of Manitoba has the most developed response to the TRC. After an 18-month consultation period of responding to the TRC, the University of Manitoba launched *Ongomiizwin*[9] *(clearing a path for generations to come)*, the largest Indigenous education and health unit in Canada, on 2 June 2017. *Ongomiizwin* brings together the Manitoba Centre for Aboriginal Health Research, the Centre for Aboriginal Health Education, and the J. A. Hildes Northern Medical Unit, promoting a focus on medical research, education, and health services. The Institute is supported by Indigenous and non-Indigenous health care leaders and is guided by Knowledge Keepers and Elders to help achieve the health and wellness of Indigenous Peoples.

The curricular programming – through the Max Rady College of Medicine at the University of Manitoba – promotes awareness by faculty of issues that will make a difference in establishing equitable opportunities for Indigenous peoples within an environment that recognizes and respects the diversity of the Indigenous community. There are three core tenets. First is curriculum development of a longitudinal program in Indigenous Health. Second is

[7] https://indigenous.ubc.ca/indigenous-engagement/indigenous-strategic-plan/
[8] https://indigenous.ubc.ca/indigenous-engagement/indigenous-strategic-plan/aboriginal-strategic-plan/2009-aboriginal-strategic-plan/
[9] http://umanitoba.ca/faculties/health_sciences/indigenous/institute/

education and training with faculty and staff that promotes awareness of health issues relevant to Indigenous peoples. Lastly, development of student programs that recognize the challenges that may be faced by Indigenous peoples seeking a degree in medicine.

3.3.5. University of Toronto

Though there are no set number of reserved seats or quotas at the University of Toronto, the Indigenous Student Application Program is specifically designed to increase the number of Indigenous students in the medical program. Within the Faculty of Medicine, the Office of Indigenous Medical Education offers a variety of programs for Indigenous students. These include application assistance, student scholarships and bursaries, development of Indigenous programming, mentorship and advocacy, and developing and maintaining community connections. The Dalla Lana School of Public Health at the University of Toronto also houses the Waakebiness-Bryce Institute for Indigenous Health.[10] Led by Suzanne Stewart, the institute conducts research and academic training opportunities targeted towards innovative interventions that address Indigenous health inequities and contribute to thriving Indigenous communities in Canada and across the world.

The University of Toronto MD Program has developed and implemented a response to Calls 22 through 24 of the TRC. In terms of recognizing the value of Indigenous healing methods and practitioners (i.e. Elders and healers), the University of Toronto supports a collaborative and integrated approach to healing. The University of Toronto is also committed to recruiting and retaining Indigenous students and staff in a culturally-safe environment. Curriculum has been updated to include at least one full course plus opportunities for additional workshops on Indigenous health issues, the history and legacy of residential schools, the United Nations Declaration on the Rights of Indigenous Peoples, treaties and Indigenous rights, and Indigenous teachings and practices. The curriculum also includes skills-based training in intercultural competency, conflict resolution, human rights, and anti-racism.

3.4. Themes in Indigenous Health and TRC Responses across Medical Schools

Policies: Admission policies, generally predating TRC engagement, are the most common response to encouraging the inclusion and application of Indigenous students. Also, most medical schools in Canada reserve seats for qualified Indigenous students, with the number ranging from two to seven, or 5% to 10% of total enrolment; six schools offer alternate assessment of potential Indigenous students.

Programs: Seven of the 16 medical schools (aside from CSM) offer a program, component, or an option in Indigenous health. Six schools have specified ties with local Indigenous communities that students can build on and work with. Most schools also have Indigenous student support within their departments, be it in the form of application assistance, mentorship, or a handbook outlining Indigenous student centres. As for recruitment, four medical schools host Indigenous high school students to introduce them to possible careers in health sciences. The most common program offer through all universities are Indigenous Student Centres. Though some medical schools offer programs for students working with IH or in Indigenous communities, we observe that since TRC's calls to action the impetus has been for deeper engagement with Indigenous communities to ensure that initiatives are guided by local priorities and needs.

Initiatives: Initiatives take the form of unique offerings that may become part of a regular program. Three universities host IH interest groups; four medical schools host public lectures, recurring talks, or symposia on IH; and two medical schools have developed curriculum unique to IH.

[10] http://www.dlsph.utoronto.ca/institutes/wbiih/

4. University of Calgary Strategy and Existing Initiatives within the CSM

4.1. The University of Calgary's Indigenous Strategy

The Indigenous Strategy developed by the University of Calgary recommends: 1) developing campus-wide intercultural capacity for students through integrated curricula weaving Indigenous histories, epistemologies, philosophies, and methodologies; 2) creating experiential opportunities; and 3) expanding educational opportunities for Indigenous and non-Indigenous students through innovative programming. In an effort to foster institutional transformation within a shared, ethical space, the four principles of ii' taa'poh'to'p include: 1) ways of knowing (teaching, learning, and research); 2) ways of doing (policies, procedures, and practices); 3) ways of connecting (relationships, partnerships, connections to land, and place); and 4) ways of being (campus identity, inclusivity, leadership, and engagement). These four principles act as collections of checklists that recognize (and possibly realize) CSM's commitments to the overall Indigenous Strategy.

Figure 1. The University of Calgary Indigenous Strategy

Source: Office of Indigenous Engagement, University of Calgary

The Indigenous Strategy has defined 33 recommendations for achieving the path of transformation aligned with the TRC Calls to Action. A quick comparison of the CSM's initiatives measured against the Strategy's recommendations shows that the CSM is active in 10 areas (to varying degrees), revealing serious resource, policy and infrastructure gaps within the medical school. Similar to the IHD's engagement with the TRC, a deep exploration is required by the CSM to fully realize the transformative potential inherent within ii' taa'poh'to'p.

4.1.1. Way of Knowing (Teaching, Learning, and Research)

Transforming ways of knowing promotes decolonization as a fundamental aspect of education and research, while building Indigenous research capacity and preserving Indigenous cultures. Ways of knowing brings together Indigenous epistemologies with CSM management. Indigenous ways of knowing provides an explorative lens for defining the nature of Indigenous health within core mandates of the medical school, including developing infrastructure for impact in education, research, and clinical service.

Table 2. ii' taa'poh'to'p Ways of Knowing

Specific Recommendations by ii'taa'poh'to'p	Active Initiatives in CSM
Pursue Indigenous Research Chairs, post-doctoral positions and graduate student opportunities for the University of Calgary.	✓
Strategically identify, recruit, hire and support emerging Indigenous scholars at the University of Calgary.	
Develop and implement additional professional learning opportunities, training, and mentorship in Indigenous ways of knowing, including methodologies and pedagogies, ceremony, and cultural protocols.	
Develop policies and procedures that incorporate guidance from Traditional Knowledge Keepers and Indigenous ethics organizations for research ethics approval involving Indigenous communities to ensure appropriate application of protocols.	
Review and update criteria for merit and promotion for researchers involved in community-driven research to better support Indigenous ways of sharing and transferring knowledge, recognizing the time and trust it takes to engage in community-based research, and the effect that this has on annual performance reviews.	
Create a Centre for Oral Traditions and Languages as a platform for research and learning, and to ensure that all students have opportunities to preserve traditional Indigenous languages.	
For relevant professional schools (i.e., Education, Business, Social Work, Medicine, Nursing, Environmental Design, Engineering and Law), complete specific responses to the calls to action articulated by the Truth and Reconciliation Commission.	✓
For graduate degrees, broaden thesis procedures and guidelines to better incorporate Indigenous languages, oral traditions, pedagogies and research methodologies and methods.	
Resource opportunities to routinely include Indigenous Traditional Knowledge Keepers in the university's learning processes. Ensure that appropriate cultural protocols are understood and practiced during these teaching processes.	
Expand educational opportunities for Indigenous and non-Indigenous students through innovative programming such as Indigenous exchange programs within Canada and land-based learning.	

4.1.2. Ways of Doing (Policies, Procedures, and Practices)

Transforming ways of doing focuses on improving the experience of Indigenous students, faculty, and staff by restructuring existing infrastructure to ensure cultural inclusion and respectful engagement. Ways of doing invokes decolonizing community-based engagement methods while developing a path forward. Dialogue between Indigenous community and CSM leadership is based in Indigenous ethical principles of reciprocity, narrative process, and non-interference. These three pillars offer the opportunity for all to challenge, clarify, refine, and define directions for the short- and long-term infrastructure necessary to build the CSM IH strategy.

Table 3. ii' taa'poh'to'p Ways of Doing

Specific Recommendations by ii'taa'poh'to'p	Active Initiatives in CSM
Review and enhance university business procedures and practices, to both minimize barriers to Indigenous research community and student engagement and acknowledge cultural protocols in teaching, learning, research, and event planning.	
Develop physical acknowledgements and recognition of Indigenous people's history and relationship to the land, such as plaques that tell the history of Treaty 7 and Métis peoples, inclusion of Indigenous art and architecture, outdoor ceremonial spaces, and landscaping/ traditional gardens.	
Work with Indigenous communities, governments and external partners to strengthen financial supports available to Indigenous students.	✓
Engage with Indigenous communities and post-secondary institutions as key partners in creating and sustaining strong Indigenous educational programs and pathways to further education.	✓
Examine student appeals processes and determine ways to incorporate Indigenous perspectives.	
Develop procedures and standards to appropriately reflect Indigenous inclusion and representation in University of Calgary communications and marketing materials.	
Review Convocation procedures to ensure we are inclusive of Indigenous perspectives.	

4.1.3. Ways of Connecting (Relationships, Partnerships, Connections to Land, and Place)

Transforming ways of connecting brings a focus to relationships between the University of Calgary and Indigenous communities through reciprocity and the land. Ways of connecting generates equitable and ongoing partnerships with Indigenous community members, community stakeholders, and key institutional leadership academics to foster safe knowledge exchange. In a decolonizing ethic, the Indigenous experience is privileged while still considering the realities and constraints of the Western institution. Research and education is geared to reach beyond campus while promoting and supporting Indigenous inclusion in the academy.

Table 4. ii' taa'poh'to'p Ways of Connecting

Specific Recommendations by ii'taa'poh'to'p	Active Initiatives in the CSM
Design and construct a new building dedicated to Indigenous peoples' knowledges and education. This space would house Indigenous programs, promote Indigenous knowledges in learning, teaching and research, and provide ceremonial space that welcomes Indigenous and non-Indigenous academic staff, staff, students, and guests; and house the Centre for Indigenous Oral Traditions and Languages, promoting this work across disciplines.	✓
Engage with Indigenous communities and post-secondary institutions as key partners in the development of strong Indigenous educational programs and pathways to further education.	✓
Continue the *Gathering Stories* community dialogues series and further develop a sustainable and ongoing plan for community engagement, an important aspect to mark the progress, set and check direction, and monitor the evolution of the strategy.	
Engage Indigenous alumni and develop a specific alumni mentorship program for Indigenous students.	✓
Provide annual progress reports regarding Strategy progress to the General Faculties Council and the Board of Governors.	
Commit to a full-circle community dialogue at least once every four years to assess the progress on the recommendations of the Indigenous Strategy.	

4.1.4. Ways of Being (Campus Identity, Inclusivity, Leadership, and Engagement)

Ways of being promotes principles of inclusion and representation. The U of C and CSM are both working to celebrate Indigeneity as a core component of the institution's ethos. Key to achieving this goal is defining strategic policies to populate the institution with a critical mass of Indigenous people, from learners to leaders, while building institutional capacity for incorporating Indigenous perspectives and approaches into policies and programs.

Table 5. ii' taa'poh'to'p Ways of Being

Specific Recommendations by ii'taa'poh'to'p	Active Initiatives in the CSM
Increase inter-cultural capacity, competency, and knowledge at the University of Calgary with respect to Indigenous peoples' histories, cultures, and ways of knowing.	
• Develop campus wide inter-cultural capacity through integrated professional development for members of the Board of Governors, Senate, university leaders, faculty, and staff.	
• Develop campus-wide inter-cultural capacity for students through integrated curricula that weaves Indigenous histories, epistemologies, philosophies, and methodologies into all credit programs.	
• Create experiential opportunities for all members of the University of Calgary to learn about Indigenous histories, epistemologies, philosophies, and methodologies.	✓
• Conduct a review of all programs relating to Indigenous peoples, communities, histories, and contemporary realities to ensure that program content and pedagogies do not perpetuate stereotypes and are respectful and inclusive of Indigenous perspectives	
Create a more inclusive campus by increasing Indigenous representation in teaching, learning, and leadership through recruitment and retention of students, staff, and academic staff.	
• Develop and implement a wise practice employment recruitment strategy to attract and retain Indigenous people in MaPS and AUPE positions in all faculties and staff units through incentives, reviews, and the development of a welcome and respectful workplace environment.	
• Ensure representation of Indigenous peoples in the governing structure of the university.	
• Increase representation of Indigenous academic staff, with tenure, in all faculties. This will require concomitant creation of supportive pathways to tenure-track positions for Indigenous scholars and amendments to tenure criteria that recognize Indigenous ways of knowing and being, including obligation to community and recognition of research methodologies.	
• Review and enhance recruitment, support, and mentoring activities for Indigenous learners so that they feel a sense of belonging and experience success at the University of Calgary	✓
Create a Traditional Knowledge Keepers' Advisory Circle that brings Indigenous spiritual and cultural leaders together with senior university leadership in an ethical space that allows for ongoing dialogue about decolonization and Indigenization at the University of Calgary.	
Create an Indigenous Student Advisory Circle to provide advice, input, and insight into improving the overall student experience at the University of Calgary.	✓

4.2. Indigenous Health Initiatives at the Cumming School of Medicine

At present, there are some strengths and gaps in terms of the current initiatives and available infrastructure in Indigenous health throughout CSM. Generally, strengths relate to existing and emerging leaders in Indigenous health (champions, networks and relationships, a few committed educators, connection to other leaders in Indigenous education), curricular content (IH education, AHP initiative, UME Family Medicine, PGME), infrastructure and policy (AHP initiative and admissions, CSM Indigenous health student admissions policy and innovations in policy and process, Pathways to Medicine scholarship), relationships and networking opportunity (committed educators, AIM HI mentorship program, connection to leaders in Indigenous education, international relationships through UME, Educating for Equity, links to the Royal College through a current Métis/ Indigenous scholar, engagement with national and international IH education, and Indigenous health working groups with AFMC and CFPC), and innovation in research and health services.

Although commendable, existing Indigenous health initiatives are not strategically positioned to support broad institutional impact; they are under-resourced, underrepresented, and highlight attitudes of apathy and resistance that result in limited outcomes. Currently, there are multiple, coexistent activities by individual units within the CSM without the benefit of institutional-level vision, leadership, or infrastructure. The Departments of Family Medicine, Medicine, and Community Health Sciences are the only clinical departments to develop and implement a curriculum with an Indigenous focus. As such, the current medical education may not adequately prepare CSM graduates to effectively address Indigenous health needs. Furthermore, the resulting shortage of Indigenous faculty and staff creates challenges for sustaining existing programming or implementing any new such initiatives. Active recruitment of Indigenous faculty with purposeful leadership development is needed (*See Appendix D, Indigenous Health in the Cumming School of Medicine at a Glance*).

The CSM can be a culturally unsafe place for Indigenous learners, faculty, and community due to institutional, epistemic, and personally-mediated acts of racism (16). As a result of societal processes of exclusion manifested within educational institutions, Indigenous people and perspectives are underrepresented within all aspects of the CSM. Also, bias, coupled with limited knowledge of the social contexts that drive poor health outcomes among Indigenous people, translates into apathy and resistance to Indigenous health initiatives within the institution. (*See Appendix E, Indigenous Students across Educational Programs in the Cumming School of Medicine*).

Various departments, organizations, and programs in CSM have been developing IH content and fostering connections through networks involving community members, students, and health practitioners. By developing paths, content through programming, community networks in IH education, research, and health care innovations, the CSM can promote equity of access and inclusion, dismantle institutional barriers and bias, and be a key facilitator through engagement and advocacy. Several CSM initiatives are highlighted below.

4.2.1. Group for Research with Indigenous Peoples (GRIP)

The Group for Research with Indigenous Peoples (GRIP), organized through the O'Brien Institute for Public Health, is a network of health researchers and students, Indigenous community members and organizations, health systems providers, and government agencies focusing on Indigenous population health. GRIP fosters relationships through multiple scales to facilitate knowledge transfer leading to effective and appropriate policy and programming. Each year GRIP holds a forum to bring together their involved and interested members to share active research and findings. GRIP also hosts a journal club.

4.2.2. Alberta Indigenous Mentorship in Health Innovation (AIM-HI)

The Alberta Indigenous Mentorship in Health Innovation (AIM-HI) Network connects First Nations, Métis, and Inuit mentees to established Indigenous and non-Indigenous health researchers throughout Alberta. The objectives of the AIM-HI Network are as follows:

1. Identify supports for success and resilience while overcoming barriers that impact FNMI learner success and new investigator transitions from study to workforce that largely neglects the socio-political histories caused by colonization and colonialism.
2. Reorganize health research mentorship around cultural and community principles and values to address the dynamic, transactional facets of career development for FNMI learners.
3. Expand and enhance an intergenerational mentorship network among FNMI mentees, in relation to Indigenous and non-Indigenous community and academic mentors, to build an interdisciplinary community of practice committed to Indigenous health research.
4. Develop a knowledge base on wise mentorship practice for the training of FNMI health researchers that leads to better career outcomes, as well as sustained professional and community relationships.
5. Advocate for continued systemic change necessary to equitably promote FNMI health researchers for success in academia and beyond.

4.2.3. Aboriginal Health Program (AHP)

The Aboriginal Health Program (AHP) was designed in 2008 to promote the recruitment of Indigenous students in the CSM at the University of Calgary, addressing the severe under-representation of Indigenous people within the medical profession. Additionally, the AHP includes an implementation of Indigenous health education for all undergraduate medical learners to address the health inequities facing Indigenous populations across Canada and improve health service quality for Indigenous peoples in Alberta. To support these goals, the AHP aims to:

1. Support the development of a pool of qualified potential Indigenous applicants for medical training.
2. Support Indigenous applicants during their admissions process.
3. Provide support and professional development initiatives for Indigenous medical students.
4. Provide effective training opportunities regarding Indigenous health for ALL undergraduate medical learners.
5. Promote awareness of, and advocate for, First Nations, Métis and Inuit health issues within the Faculty of Medicine.

The guiding principles of the AHP are to honour the traditional knowledge and practices of Indigenous individuals, families and communities with regards to well-being; respect the diversity of First Nations, Métis, and Inuit peoples; comprehend the social, political, economic, and historical circumstances affecting the health, healing, and wellness among Indigenous peoples; recognize and access the experiences and abilities of health professionals committed to working with Indigenous populations; and advocate for culturally safe and appropriate policies, perspectives, and practices.

Within the AHP, there are supports in place for Indigenous medical students. Mentorship and support is offered to all Indigenous medical students. Opportunities are available for the students to maintain a link to cultural supports such as Cultural Advisors (Elders) and ceremonies. Activities such as sweat lodge ceremonies, movie nights, speakers' forums, cultural camps, and more (these are open to all medical students as well as interested faculty members and staff). Once completed, there is a graduation celebration for the graduating Indigenous medical students.

The AHP is situated within the CSM at the University of Calgary's Undergraduate Medical Education (UME) program. They are responsible to the UME Dean and report to the AHP Advisory Committee through the AHP Director. Within the program, the AHP coordinator reports to the director.

4.2.4. Indigenous Health Admissions: Policy and Outcomes

To facilitate recruitment of Indigenous medical students and concurrently increase the representation of Indigenous physicians throughout Alberta and Canada, there are a few modifications to the application process such that all self-declared Indigenous applicants with a GPA of at least 3.2 are advanced to an interview. The following modifications are:

1. All Indigenous applicants will be considered residents of Alberta for the purposes of meeting application criteria.
2. All Indigenous applicants who meet the application criteria will be invited for an interview.
3. The scores assigned to various components of the application process will be adjusted to ensure the same score distribution as non-Indigenous applicants in areas where historical data shows Indigenous applicants have been consistently disadvantaged.
4. Indigenous applicants will be invited to include a personal statement in their application about their connection to the Indigenous community. This will not be scored, but will be used by the file reviewers in understanding the applicant within their social context.

4.2.5. Pathways to Medicine Scholarship

Pathways to Medicine Scholarship supports the enrolment and success of future MD students from traditionally under-represented groups throughout Alberta. The CSM recognizes the marked under-representation of FNMI individuals within the medical profession and the importance of producing a medical workforce that represents the demographic diversity of the population we serve. In recognition of these facts, certain modifications to the application process for Indigenous applicants are currently in place (see AHP and IH Admissions). The Pathways to Medicine Scholarship program focuses on high school students from these backgrounds with an explicit interest in pursuing a career in medicine. Financial support is provided in the form of tuition and fees for four years of undergraduate program, a relocation allowance, and a paid third-year summer internship, while support and mentorship is provided by faculty and medical students as well as an enrichment program. Students in the Pathways to Medicine program will also be given access to a sponsored MCAT preparatory course and have the course and exam fees covered. Upon completion of their undergraduate degree, participants will be granted guaranteed admission to the University of Calgary MD program, subject to successful completion of other predefined MD admission requirements (GPA, MCAT, and interview).

4.2.6. Undergraduate Medical Education (UME) and Indigenous Health Education (IHE)

The formal AHP curriculum is delivered to all medical students as an integrated part of the core curriculum; these include lectures and small groups during the first- and second-year courses, summer electives, and project and shadowing opportunities. Elective clinical training experiences in Indigenous health are available within urban, rural, and on-reserve community teaching sites. Many rural placements, including the Rural Integrated Community Clerkship, provide experience with on-reserve populations as well.

Indigenous Health Education (IHE) focuses on the development of three key themes related to the social and historical impacts on Indigenous health. These themes include: 1) the influence of social determinants of health on Indigenous peoples, 2) the influences of Indigenous worldview and perspectives in relation to contemporary

perspectives on health behaviours and outcomes and, 3) the impact of historical and contemporary relationship issues between Indigenous peoples and dominant society arising from both social exclusion and multigenerational trauma.

Curriculum as implemented by Dr. Lynden (Lindsay) Crowshoe, the director of the AHP, focuses on education of the deep causes of the health inequities faced by Indigenous populations, bringing an understanding of how multigenerational trauma from colonization and residential school experiences continues to influence health outcomes. Dr. Crowshoe brings in a balance of social, cultural, and biomedical knowledge implemented within a clinical context where medical learners will be able to situate themselves within the social constructs framing Indigenous health outcomes and task learners to critically examine societal causes as well as those inherent within the medical approach. Further, medical learners are engaged with a narrative approach that utilizes cognitive dissonance, reflection, humour, humility, and Indigenous traditional decision-making approach to facilitate a deeper and more insightful exploration and understanding of Indigenous health.

4.2.7. Other Educational Outreach

SHINE (Students for Health Innovation and Education) is a student-run group composed of both Indigenous and non-Indigenous members. Many of the events they organize revolve around topics such as decolonization.

The Engagement Hub (SPaCE) offers some community-engaged learning opportunities. These include the Elbow River Healing Lodge (medicine walk), Bow Valley Palliative Care Association, Stoney Nakoda, Renfrew Educational Services in Morley, and Niitsitapi studies at Red Crow Community College. SPaCE also supports microbiology science outreach to Indigenous schools with Dr. Zenobia Ali, as well as the Power to Choose summer camp for Indigenous youth with Dr. Wendy Hutchinson.

4.2.8. Clinical Outreach by Department in CSM

Clinical outreach by department members within the CSM creates possibilities for clinical service innovation and contextualization of primary and specialist services within Indigenous contexts in Alberta. *Table 6* provides a summary of clinical services from the CSM.

A notable example, the Department of Medicine established the position of Vice Chair for Indigenous Health Initiatives in 2018, held by Dr. Cheryl Barnabe. Priorities are to ensure the Department of Medicine members and trainees provide high quality care to Indigenous patients, respecting community needs and approaches; aligning the Department of Medicine activities to advance Indigenous Health with those of the Strategic Partnerships and Community Engagement Office of the CSM, departments within Alberta Health Services comprising of the Indigenous Wellness Program, the Zone 2 Indigenous Health Action Plan, and the Indigenous Health Strategic Clinical Network, the University of Calgary's Indigenous Strategy ii' taa'poh'to'p, and the Royal College of Physicians and Surgeons of Canada; and to prepare a platform for emerging Indigenous health leaders and the future work of an Office of Indigenous Health in the Department of Medicine.

Table 6. Clinical Outreach Activities by Division and Location

Division	Clinical Activity Location(s)
Dermatology	Siksika
Echo Program for Hepatitis	Telehealth
Endocrinology	Siksika
Family Medicine	ERHL
	Siksika
	Eden Valley
	Tsuut'ina
General Internal Medicine	Elbow River Healing Lodge
	Siksika
	Stoney Nakoda
	Tsuut'Ina
Nephrology	Elbow River Healing Lodge
	Kainai
	Siksika
Neurology	Elbow River Healing Lodge
Rheumatology	Elbow River Healing Lodge
	Kainai
	Siksika
	Tsuut'Ina
	Stoney Nakoda
	Piikani

4.2.9. Indigenous Students, Staff and Faculty in CSM

Several members of the CSM identify as Indigenous persons: two full academic medical faculty, one clinical associate faculty member, and at least two staff identify as Indigenous. At present, there are 21 Indigenous medical students enrolled in UME and 4 Indigenous graduate research students (*See Appendix D-E*).

4.2.10. Current Indigenous Health Research

Table 7 lists current Indigenous health research led by investigator(s) from the CSM.

Table 7. Current Indigenous Health Research and (Co-)Principal Investigator(s)

Project Title	(Co-)Principal Investigator(s)
Alberta Indigenous Mentorship for Health Innovation (AIM-HI) Network	Dr. Cheryl Barnabe Dr. Lindsay Crowshoe Dr. Rita Henderson
An Initiative to Address Indigenous Patient and Community Educational Needs in Rheumatic Diseases	Dr. Cheryl Barnabe
Arthritis Care for Indigenous Populations	Dr. Cheryl Barnabe
Building Partnerships to Address First Nations Members' Emergency Medical Services Transitions in Care	Dr. Cheryl Barnabe
Community and Structural Supports for Healthy Life Trajectories in First Nations People: Roundtables and Scan to Build Alberta FN DOHaD Cohort	Dr. Cheryl Barnabe
Educating for Equity	Dr. Lindsay Crowshoe
Innovating Indigenous Primary Care in Alberta	Dr. Lindsay Crowshoe
Indigenous Primary Health Care and Policy Research Network	Dr. Lindsay Crowshoe
Innovating Models of Care and Prescribing Practices around Opioids and Indigenous Peoples in Alberta	Dr. Rita Henderson
Integration of Indigenous Healing Practices in Patient Care Plans	Dr. Cheryl Barnabe
Interrupting Toxic Stress in Indigenous Communities	Dr. Lindsay Crowshoe Dr. Rita Henderson Dr. Aleem Bharwani Dr. Jennifer Hatfield
Platform for Dementia Research	Dr. Lindsay Crowshoe Dr. Pamela Roach
PRECISION: Preventing Complications from Inflammatory Skin, Joint, and Bowel Conditions	Dr. Cheryl Barnabe
Rheumatoid Arthritis and Autoimmune Diseases	Dr. Cheryl Barnabe
Social Accountability in Medical Schools for Indigenous Health	Dr. Rita Henderson Dr. Lara Cooke Dr. Rachel Ward
Trickster Warrior	Dr. Lindsay Crowshoe Dr. Rita Henderson
Understanding and Defining Quality of Care in the Emergency Department with First Nations Members in Alberta	Dr. Cheryl Barnabe
Understanding Intergenerational Trauma: Developing Gender and Culturally Safe Interventions for Indigenous Families Experiencing Homelessness	Dr. Katrina Milaney Dr. Rita Henderson
Validation of the Canadian Indigenous Cognitive Assessment Tool	Dr. Lindsay Crowshoe

5. The Indigenous Health Dialogue

5.1. Background

Noting Indigenous health-focused research, service and educational initiatives have existed but are not formally integrated with CSM leadership, in 2015, the Indigenous Health Dialogue (IHD) was launched within the Office of the Associate Dean, Strategic Partnerships and Community Engagement (SPaCE), with the mandate to support the CSM in its commitment to improving the health status of Indigenous persons and their communities. Promoting the principles of social accountability, cultural safety, and equitable partnerships, the IHD proposed the following initiatives:

1. Develop and implement a longitudinal engagement and partnership strategy with local Indigenous communities for informing the role and scope of the CSM's commitment to Indigenous health improvement;
2. Build a critical knowledge base from literature and international medical school experiences of Indigenous health engagement strategies and institutional approaches for promoting Indigenous health;
3. Play a central, yet complementary role in engagement with community and existing CSM Indigenous health initiatives relating to teaching, research, and service;
4. Support, build upon, and better connect existing CSM Indigenous health initiatives;
5. Foster a deepening of the capacity for the CSM as an advocate for Indigenous health;
6. Facilitate the development of critical institutional policies, processes, and programs for Indigenous health within the CSM, and;
7. Support the development of new and innovative initiatives for Indigenous health within the CSM.

Upon the release of the TRC Report, the IHD envisioned that achieving its stated CSM mandate on Indigenous health and developing relevant initiatives, meant deeply engaging with the report and health legacy calls to action. A multi-phased approach was taken, harnessing strategies focused on knowledge building, knowledge exchange, and community engagement.

5.2. Crafting the TRC Critical Reflective Framework

From June to October 2016, the IHD convened a working group to explore and engage with the TRC calls to action using a critical collaborative consensus-building process grounded in Indigenous and decolonizing methods. The intent of this exploration was to generate a response from the CSM to the TRC and, in the process, identify key directions that would frame an Indigenous health strategy grounded in the principles of the TRC and the health legacy calls to action. The process was critical, as it asked all participants to reflect on their role and situation within their structural, social, political, cultural, and economic contexts; collaborative, as it derived on the experiences of different participants to contribute to building a body of knowledge that will benefit all; and consensus-building, as it brought together these diverse perspectives with the expectation that all alternatives will be explored to satisfy all participants before a consensus is truly reached.

5.2.1. TRC Response Working Group

The TRC Response Working Group consisted of six members and strategically represented perspectives from leadership, Indigenous faculty, trainees in Indigenous health research, and trainees in medical education. Seven small group discussions were held in June and July 2016, each to explore a single health legacy call to action. Each discussion followed a consistent format that included: 1) interpretation of the call to action within the context of

a medical school (open discussion); 2) identification of main and secondary directions of the call for the CSM within the domains of global response, research, education, clinical service, and leadership (talking circle); 3) exploration and clarification of emerging concepts (open discussion); and 4) summative statements of directions for the CSM (talking circle). Describing action themes related to each context, the working group developed a framework that connected truths and reconciliation concepts within five domains. This framework was developed as a critical reflective tool for fostering deeper engagement and generating action within the CSM.

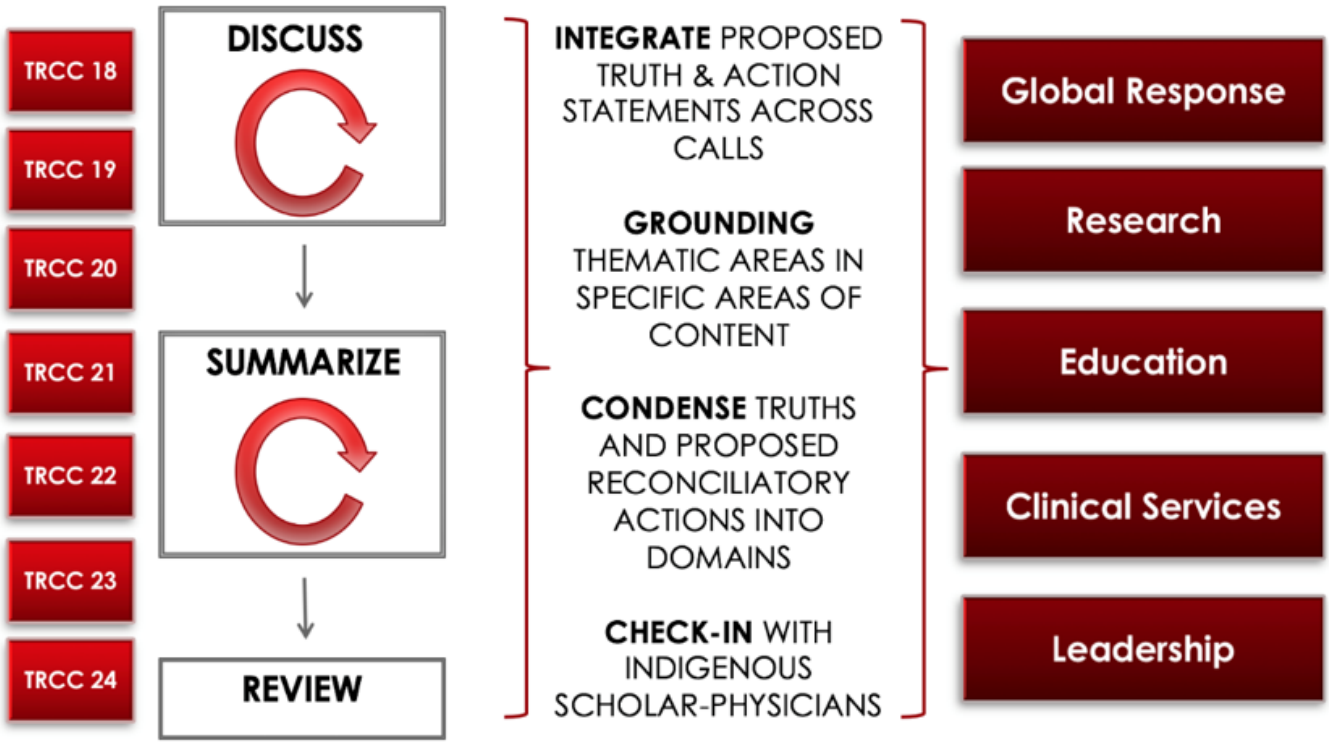


Figure 2. Critical Collaborative Consensus-Building Method. Visual created by Dr. Cheryl Barnabe.

5.2.2. Critical Reflective Framework

The critical reflective framework (*See Figure 3*) emerged directly from the critical collaborative consensus-building framework (*See Figure 2*). From these discussions, the working group concluded that achieving Indigenous health equity required the medical school to *foster capacity of Indigenous health as a distinct discipline*, and *promote and support Indigenous inclusion within academy*. In addition, three principle truths and three institutional truths related to Indigenous health and health care inequity emerged that were to be applied to the contexts of leadership, medical education, research, and clinical service within the CSM.

Figure 3. Critical Reflective Framework

5.2.3. Principle Truths

From analysis of the working group's perspectives, **three principle truths** emerged related to the impacts of health and health care inequity experienced by Indigenous populations in Canada. These principles serve to describe critical contexts from which any initiative for Indigenous health improvement ought to be grounded within:

1. *Health inequities experienced by Indigenous people are rooted in determinants specific to their social, cultural, and political contexts. Colonization is a prime driver of ongoing social and health inequities.*
2. *Healing involves addressing impacts from multi-generational adverse life experiences, rectifying ongoing social resource inequities and reconnecting with Indigenous culture and healing practices.*
3. *Complicity with ongoing colonization manifests as a health care system that is too often **under-resourced** and **ill-equipped** to address the health disparities specific to Indigenous populations.*

5.2.4. Institutional Truths

Grounded on the principle truths described above, the CSM experiences enduring **truths within the institution** that contributes to health care inequity towards Indigenous populations. These institutional truths serve as contextual reminders for members of the CSM to continually reflect and act upon Indigenous health care needs within and outside the academy:

1. *Indigenous health education initiatives exist, with notable strengths and innovations, but are not strategically positioned or resourced to support broad institutional impact.*
2. *As a result of societal processes of exclusion manifested within educational institutions, Indigenous people are underrepresented within all aspects of the CSM.*
3. *The CSM can be a culturally unsafe place for Indigenous learners, faculty, and community due to institutional, epistemic, and personally-mediated acts of racism.*

5.3. Engaging with the TRC Critical Reflective Framework

Over three years, the IHD working group held over 25 events that reached approximately 500 people. Attendees included CSM leadership, faculty and staff, health system leadership, chiefs, elders, Indigenous community members, researchers, physicians, other health professionals, and CSM graduate and undergraduate students. Attendees spoke from their respective places and experiences to assist the IHD working group in defining context, need, and potential actions to address the health legacy TRC Calls to Action in the CSM. In addition to the internal engagement events, members of the IHD have externally engaged with over 1000 individuals through various provincial and national presentations. From our engagement process, we see evidence of activation within the CSM within many units, often with middle leadership including department heads, institute directors and associate deans. Below is a table summarizing the description of the events related to the IHD.

Table 8. Key Events and Descriptions of the Indigenous Health Dialogue

Event	Date	Key Details
FLAG Meeting	September 2015	Formation of the leadership advisory to the IHD.
Calls to Action Consensus Building IHD TRC Working Group	June – October 2016	Group based, iterative and Critical Collaborative Consensus Building process. Emerging from this process was a Critical Reflective Framework of reconciliation themes, truths, and potential action areas for the CSM.
IPH Rounds	September 2016	The Critical Reflective Framework, focusing on research domain, was presented for the IPH rounds.
OHMES Med Ed Journal Club	September 2016	Overview of the IHD initiatives and the Critical Reflective Framework.
Fall CSM Leadership Retreat	October 2016	Overview of the IHD initiatives and the Critical Reflective Framework.
TRC Engagement within the CSM: AHS Listening Day	October 2016	From a broader health perspective, achieving health service equity for Indigenous people is fundamental to reconciliation. Equity in health service demands that resources be distributed based on need and effective at addressing complex health issues arising from the multi-generational impacts of colonization.
IHD TRC Pipe Ceremony	November 2016	This Blackfoot ceremony, led by Dr. Reg Crowshoe, was to provide a blessing of our intention, signifying the physical and spiritual integration of our commitment as an act of reciprocity with the Creator and Indigenous community.
Clarence Guenter Lecture on Global Health: A Focus on Indigenous Health	November 2016	1. Keynote by Dr. Wilton Littlechild, TRC Commissioner, chief, residential school survivor, and lawyer who has worked both nationally and internationally including with the United Nations to advance Indigenous rights and Treaties. In this lecture, he publicly acknowledged the launch of our institution's commitment to responding to the Calls to Action. 2. World Café post lecture debrief of each domain of the Critical Reflective Framework.
Mobilizing for Indigenous Health Equity through Strategic Education	February 2017	Explore resources, opportunities, and barriers to meeting TRC calls.
DFM Grand Rounds: TRC and Indigenous Primary Care	March 2017	Opportunity for the DFM to engage with the TRC and begin to provide input into directions for our institution and the department.
Indigenous Health Education in Post Graduate Medical Education	April 2017	Explored our school's engagement with Indigenous health education and frame opportunities for educational transformation. The workshop will begin with a review of key themes from our Institutions' TRC working group process and a presentation by Dr. Karlee Fellner on **Poo'miikapii,** a graduate program focused on Niitsitapii (Blackfoot) approaches to wellness.
Inclusion within the Cumming School of Medicine: Supporting Indigenous Learners	May 2017	Grounding exploration within TRC Call to Action 23 around increasing recruitment and retention of Indigenous trainees.
Group for Research with Indigenous Peoples (GRIP)	May 2017	Develop capacity for research innovation.
Master Teacher Journal Club	May 2017	Presentation on IH education domain of the TRC intended to engage Master Teachers.
Learning from Leadership: Retreat	November 2017	IHD TRC Critical Reflective Framework explored in small group format with CSM leadership.

Indigenous Health Office Proposal Meeting	January 2018	Meeting with senior CSM leadership supported by the SPaCE associate dean, UME associate dean and IHP director.
Master Teacher Retreat	January 2018	A half day exploration of the TRC with intention in building teaching and learning capacity in IH education.
OHMES: Achieving Institutional Competency through Truth and Reconciliation Engagement	February 2018	Ensure graduates and faculty are equipped with the critical IH knowledge and skills to become leaders in IH education.
Department of Medicine MSEC: Mobilizing Reconciliation in the Cumming School of Medicine	April 2018	Presentation to the DOM on the role of the CSM in building a decolonizing research methodology to engage with Indigenous community and work with their priorities.
CCME 2018: Achieving Institutional Competency through Truth and Reconciliation Engagement	April 2018	Workshop for Indigenous health educators within the CSM, is intended to explore our school's engagement with Indigenous health education and frame opportunities for educational transformation.
GRIP Research Forum and the AIM-HI Community Research Showcase 2018	May 2018	Deeper review of research domain of the Critical Reflective Framework with intent to develop capacity for research innovation.
Interrupting Toxic Stress: A Social Congress for Indigenous Health	June 2018	Innovative forum activating civil society in addressing toxic stress with Indigenous youth.
ACES Presentation	September 2018	Overview of the IHD TRC outputs and review of existing IH education resources for providing direction in building an integrated IH curriculum in CSM.
Consensus Forum: Building an Indigenous Health Strategy for the Cumming School of Medicine	December 2018	Invite conversation and critical feedback from Indigenous communities to refine concepts, inform directions, and develop enduring partnerships during the conception of an IH strategy for CSM.
AIMHI	July 2019	This session intended to provide overview of IHD TRC Critical Reflective Framework and ongoing initiatives to this Indigenous Mentorship Network.

5.4. Outcomes of Engagement

Through the course of internal and external engagement events led by the IHD, the IHD has invited conversation and critical feedback in order to refine concepts, inform directions, and develop enduring relationships toward an IH strategy in line with reconciliation. Internal engagement has highlighted key areas to develop Indigenous health within the CSM to begin to address the disparities for Indigenous health across Canada. Indigenous health education, Indigenous health research, and Indigenous health service innovation emerged as core domains of responsibilities where inquiry and action can be directed. Additionally, support and inclusion of Indigenous students within the academy as core domain formally explored (*See Appendix F: Critical Reflective Framework Domains*).

5.4.1. Indigenous Health Education

In achieving reconciliation, the TRC calls to action 23 and 24 are most directed towards educational aims. Call 23 focuses on increasing the number of Indigenous health care professionals and the provision of Indigenous health training for all. Call 24 specifies the nature of that training. Unfortunately, medical schools are often under-resourced resulting in Indigenous health education initiatives that are not strategically positioned to support broad educational impacts across all learning domains (17). They also often lack Indigenous people and perspectives within all aspects of the medical school from learners to administrative staff, faculty, and leadership. As a result, many medical schools are challenged in building and sustaining effective IH education initiatives that can achieve the noted calls to action.

Indigenous health education within CSM has both strengths and critical gaps (*See Table 9*). Rigorously developed core curriculum for medical students is grounded in Indigenous and decolonizing content and methods. A small but committed group of faculty members, led by an Indigenous faculty member, all work to support, advocate, develop, and deliver existing curriculum. More educational initiatives and student assessment approaches are required for the pre-clinical years and are urgently needed for the clinical years. Unfortunately, bias coupled with limited knowledge of the social contexts that drive poor health outcomes among Indigenous people translates into apathy and resistance within the institution. Throughout the CSM, educational capacity is not consistent across learning units and may not adequately prepare CSM graduates to effectively address Indigenous health.

A key element identified by the education group is the need for medical trainees to receive teaching about Indigenous cultures and history, including before contact, during colonization, through the present realities facing Indigenous populations. Understanding Indigenous history has two potential impacts on the education of medical trainees. First, by knowing the history of policy that impacts Indigenous people, one can understand the structural impacts on health status and outcomes. Second, by understanding how health was constructed and maintained by Indigenous populations before contact, there is no need for deficit modeling around the current health status of Indigenous people, rather one understands the context. A deficit model is counterproductive to identify disparities in Indigenous health when in relation to the structural forces, the focus should be on how Indigenous people are experts in their own healing. Who should be the educator is a question, however, because Indigenous history should be delivered by an Indigenous voice but at present there are not enough self-identified Indigenous faculty within the medical school. Within Indigenous communities, Elders are the experts on Indigenous healing and if they are brought in to teach should be compensated at the same level as a PhD or medical expert. Furthermore, participants emphasized the basis of Indigenous health education be from a local, Blackfoot perspective, and incorporate teachings in the Blackfoot language. However, a crucial question raised is whether the medical school is actually ready for the bold truth of this transformational education.

Table 9. Current Activities and Infrastructure Associated with Indigenous Health Education

Strengths	Gaps
• Content • Infrastructure – Policy • People & Champions • Relationships (18) • Innovations • Committed Educators (few) • AHP Initiative – Admissions/Renee Huntley, UME • CSM Indigenous Health Student Admissions Policy and Innovations in Policy and Process • Pathways to Medicine Scholarship • Mini-med school (19) • AIM-HI (Mentorship, Graduate Students) • Vice Chair IH for Department of Medicine Education Mandate • Curriculum in UME Family Medicine • Connection to Leaders in Indigenous Education • International Relationships UME • Educating for Equity (cross-cutting) • Equity focused modules in BHSc – Global Health & other courses • Royal College Cheryl Barnabe – strong links and relationships; Henderson education committee • Education leadership UME • Interest in PGME (pockets of activity) • Emerging education leaders • Engagement with National and International AFMC IH Education and new AFME • CFPC Indigenous Health Working Group (policy)	• Indigenous Perspectives • Methods of Indigenous Education evaluation of teaching and learning • Ad hoc – no resources that inform new Indigenous initiatives • IH not embedded across curriculum of all education units • Limited community experiences and partnerships • Lack of CME and professional development; no standards • Population health focus • No training for students or faculty on anti-racism • Clinical training aversive • Faculty development opportunities • Indigenous ombudsperson (*Bev Adams) • UME Master Teacher

5.4.2. Indigenous Health Research

Call 19 most explicitly speaks to the role of research in promoting health equity. Yet, all of the TRC's health legacy calls to action imply a diversity of contexts from which Indigenous health and health care inequity arises. For each call, health research is a critical means to address disparity and inequity and eventually close the gap. In medical schools, there often a limited Indigenous Health (IH) research capacity and paucity of research relevant to all Indigenous groups due to a lack of investment and the persistence of structural barriers. Of note, Western research is rooted in colonization and tends to perpetuate explanatory frameworks that focus on deficits in Indigenous people over problems in wider systems and society. As a result, community-identified research priorities are unaddressed due to internal capacity, financial, and opportunity limitations. Reconciliation through research means adhering to rigorous Indigenous and decolonizing methodologies and principles in partnership with community.

CSM has a number of strengths from which to build IH research initiatives (*See Table 10*). In addition to Indigenous health research focused faculty, the Group for Research with Indigenous Peoples (GRIP) brings together a network of health researchers and students, Indigenous community members and organizations, health systems providers,

and government agencies focusing on Indigenous population health. GRIP fosters relationships through multiple scales to facilitate knowledge transfer leading to effective and appropriate policy and programming. Another initiative, the Alberta Indigenous Mentorship in Health Innovation (AIM-HI) exists to enhance capacity in health research led by Indigenous scholars in Alberta. These activities are designed to support Indigenous graduate students and new investigators who are in health research disciplines, recruit Indigenous students to health research careers, generate evidence on wise practices for Indigenous mentorship, and advocate to institutions to enable Indigenous promotion and success in academic and in health research more broadly.

Research domain engagement discussions centered on how community presence and interests should be at the forefront of medical research. Academic goals are often at odds with community priorities, though they do not need to be (20). Increased strategic planning between the medical school and community will alleviate much of the potential conflict. One way to do so is active recruitment of Indigenous students, staff, and faculty. At present, few Indigenous students, staff, and faculty self-identify as Indigenous because of a lack of safety generally throughout the CSM. Bringing in more students, staff, and faculty would not only create a safe community but also contribute towards normalizing and validating Indigenous methods in research.

Along the same lines, individuals – both Indigenous and non-Indigenous – need to be connected with community for sustained and sustainable research. The Group for Research with Indigenous Peoples (GRIP) has been effective at connecting Indigenous health research and researchers, but it could be expanded as a locus of capacity building for the medical school to connect research and community from the inception of research and all the way through the process. Additionally, the incorporation of community-based research goals will lend a transformative aspect to the existing definition of research, from academically-based and accumulative to an active part of the people from which it is derived, beyond simply health and survival but to a thriving resilience.

Table 10. Current Activities and Infrastructure Associated with Research

Strengths	Gaps

• Approximately $5 million in grants for IHR under Drs. Crowshoe, Barnabe, Henderson, Hemmelgarn, and Brydon
• Research initiatives
  ○ Models of care
  ○ Evina
• GRIP through O'Brien Institute for Public Health
	• Human resources to support research growth
	• Finance and administrative support for researchers
	• Ethics training and Board knowledge
	• Grad studies supervisors
	• Ability to respond to community priorities due to lack of partnerships and engagement
	• Capacity building for Indigenous Health across the 7 Institutes

5.4.3. Indigenous Health Service Innovation

Clinical service innovation occurs at multiple levels. The domain of service innovation cannot be kept separate from the other domains but should be viewed as an integrated theme that must be spread throughout. This integration includes greater knowledge exchange between institutions (e.g. Alberta Health Services) to better know what resources and people are out there to mobilize in our health services. For example, the pillars of research and education within CSM work together to transform and drive clinical service innovation for Indigenous communities. An essential component of developing excellent Indigenous health service is the need to advocate for quality and equitable health service grounded in the social and cultural contexts of Indigenous people's lives. Equity in health service demands that resources be distributed based on need and effective at addressing complex issues arising from multi-generational impacts of colonization.

The examples of Indigenous health service initiatives in the CSM listed in *Table 11* highlight the diverse approaches the institution makes to health services, systems, leadership, and Indigenous communities. The goals of these projects are to align clinical service innovation with the TRC calls to action. All of these initiatives incorporate Indigenous advisory groups and oversight to ensure the alignment of innovation with Indigenous communities and leadership for enhanced accountability and sustainability.

Table 11. Project Descriptions Addressing the Call to Action(s) within Indigenous Health Service Innovation

Project	Description	Addresses Call to Action(s)	
Educating for Equity (E4E)	This project focuses on health professional education for Indigenous equality through the modality of diabetes education for service providers. The outcomes will be integrated in clinical practice guidelines in Canada for providing diabetes care to Indigenous peoples. Forthcoming outcomes include the expansion of the implementation of educational opportunities to primary care providers in Alberta, and clinical practice guidelines for Indigenous populations and obesity.	***18***: Working in the domains of medical and nursing education to recognize colonization as a driver of diabetes outcomes and clinical relationships in care.	***24***: Incorporate knowledge of call to action 18 in all health professional education.
Innovating Models of Care and Prescribing Practices around Opioids and Indigenous Peoples in Alberta	This project aims to build more appropriate and responsive models of health care and social supports to address the current opioid crisis in Indigenous contexts in Alberta.	***19***: Establish and recognize measurable goals to address the gaps in health outcomes related to opioids, particularly inappropriate prescription and limited access to agonist opioid therapy.	***20 and 22***: Work with several community sites to recognize perceived barriers to accessing appropriate models of care due to jurisdictional disputes, and create opportunities for community to connect Indigenous healing practices to existing health care resources, respectively.
Integration of Indigenous Healing Practices in Patient Care Plans	This project assesses the openness of Canadian rheumatologists to integrating Indigenous healing practices into their patient care plans and perceived barriers to integration.	***22***: Develop culturally-appropriate treatment guidelines, training programs, and the delivery of rheumatology services to Indigenous populations both on a local and national level.	
Platform for Dementia Research	This project aims to innovate health systems and the delivery of health services. Two projects were created to fulfill these objectives: (1) Dr. Pamela Roach of the Hotchkiss Brain Institute is using a realist approach to a qualitative review of the literature to understand the lived experience of Indigenous persons with early onset dementia and (2) Dr. Lynden Crowshoe of the CSM is working to develop a valid and culturally-adapted Canadian Indigenous Cognitive Assessment (CICA) tool to accurately diagnose dementia in Indigenous populations in Canada.	***19***: Potentially identify goals that can close the gaps in health outcomes between Indigenous and non-Indigenous peoples, and develop measurable outcomes for these goals as discussed in call 19.	
Innovating Indigenous Primary Care in Alberta	This project's core activity is the generation of research and academic knowledge to grow the Department of Family Medicine's capacity as a leader in primary care innovation in Alberta. The CIHR and Alberta Innovates have provided a development Network Environment for Indigenous Health Research (NEIHR) grant that allows the department to establish multi-year research in partnership with Alberta Health Services'	***18***: Recognize government policy as a driver of Indigenous health outcomes. Moreover, understand that action is required at upstream, population-level determinants of health, including barriers	***22***: Recognize primary care as an opportune level within health systems for the integration of Indigenous healing practices.

	Population, Public, and Indigenous Health Strategic Clinical Network.	to access of appropriate and safe care, and transitions within health systems to community-based health promotion opportunities.	
Interrupting Toxic Stress in Indigenous Communities	This project stresses the need for the public to become more aware, engaged, and networked in identifying options available in preventing and mitigating toxic stress which impact Indigenous communities. Guests who have the capacity and engagement to better serve local Indigenous communities through education, policy, sports, and arts were invited to participate in a civil society forum. This forum allows health systems to rethink where health promotion and disease prevention can occur, moving the point of intervention from the clinical to the population level.	***20***: Engage the public to fill gaps in health services and systems which can overcome jurisdictional barriers.	***22***: Allow arts and sports to be potential sites for the incorporation of land-based healing and traditional arts and ceremony.
Trickster Warrior	This project has developed a Popular Theatre intervention strategy based on techniques used in Theatre of the Oppressed that takes a holistic approach to suicide prevention in Indigenous youth. Popular Theatre allows Indigenous youth to develop a critical conscience about oppression and the wider systems that shape suicide in their communities. This project operates at a local level in the domains of health services, medical education, and youth development services.	***18***: Recognize the role of residential schools and intergenerational trauma in Indigenous youths' mental health through forum theatre.	***21***: Forum theatre allows participants to think about sustainable opportunities for Indigenous youth healing from multigenerational trauma that connect a person's physical, mental, emotional, and spiritual health.
Social Accountability in Medical Schools for Indigenous Health	This project aims to promote social accountability to Indigenous health in medical schools. Researchers have conducted interviews with Indigenous students to gain their experiences in medical school.	***23***: Develop an understanding of Indigenous medical students' experiences to be able to increase the recruitment and retention of Indigenous students in both local medical schools and medical schools across Canada.	
Understanding Intergenerational Trauma: Developing Gender and Culturally-Safe Interventions for Indigenous Families Experiencing Homelessness	This project aims to develop an adaption to the 'Housing First' intervention to end homeless that was originally developed in the Mental Health Commission of Canada's national research study called At Home Chez Soi. The goal of the adaptation developed in the present study is to make the intervention reflective and inclusive of Indigenous gendered and cultural experiences of trauma and to recognize these experiences as drivers of homelessness in Indigenous women.	***18***: Recognize the history of colonialism in Canada as a driver of homelessness.	***19***: Recognize the potential to close gaps in health outcomes produced by homelessness through the availability of appropriate health and social services at a local and national level.

From discussions, a theme centered on the nuances of an Indigenous hub within the CSM as outlined in the Indigenous Strategy's directives. Participants believed that the hub should be shifted to be an interdisciplinary network that is connected to communities. A network would offer another degree of transformation as resources are distributed and more broadly interfaced to inherently create connections while a hub has only one engagement strategy. Participants also debated how the idea of a central hub poses the risk of Indigenous health becoming a siloed field rather than being present across the school. If an Indigenous health network was a formalized component of the CSM it would be a more powerful construct. This formalization would allow greater alignment between the CSM and Indigenous faculty, community, and research goals so that the institution can come to the table at events and not just individuals for mobilization.

Table 12. Current Activities and Infrastructure Associated with Health Service Innovation

Strengths	Gaps
• Core AHS Strategic Clinical networks committee representation • Inter-professional practice • Clinical outreach	• ARP issues and fee for service models • Integrate Indigenous perspectives in innovation

Participants agreed that the domain of health service innovation needs specific outputs that recognize the constructs of equity which require connections to Indigenous communities, Indigenous worldviews, and acknowledgment of racism as a driver of Indigenous health outcomes. Equity cannot be achieved through the meeting of target numbers for Indigenous positions and faculty within the CSM alone, but requires community engagement and directives.

5.4.4. Indigenous Student Inclusion and Support

The Indigenous students related that they carry a burden within the CSM. One facet of this burden was the pressure for them to teach their non-Indigenous peers about Indigenous histories and realities, which led to the idea that the school needs to place a greater emphasis on Indigenous health education for all students. A second facet of the burden that the students felt was due to having to teach their professors and justify their research that is grounded in Indigenous methodologies and ways of knowing. Indigenous trainees should not be made to feel that they should have found a more Indigenous-focused program. The CSM requires greater inclusion across all of its programs because the ask of the TRC is to increase Indigenous student recruitment and retention across the school. When faculty find what the student brings to the table unfamiliar, students can feel that they should have registered in a different program. The CSM requires a strategy to buffer the power dynamic between faculty and Indigenous students so that the default response is not that the student should find a better place, but that the school shifts towards greater inclusivity.

Participants in this group expressed the need for a clear tool for departments and units to reflect on their resources, structures, and policies to check-in with their Indigenous students to identify gaps in student supports and facilitate collaboration between departments to achieve a shared mandate. For this tool to be effective it requires oversight and mandatory reporting back to the Dean of each department.

Of note, the CSM has approved renovation within SPaCE for an Indigenous Hub. The current Indigenous student support coordinator position has been transferred to SPaCE from UME and increased in FTE from 0.5 to 1.0. The intent of this transition is to expand the activities of community engagement and Indigenous student recruitment and support beyond just UME.

6. Toward Indigenous Health Equity

The TRC provides a roadmap to a more equitable destination; however, the institution must assess its capacities and determine the specific path forward. Engagement with the TRC is currently in its incipient stages; the CSM needs a strategy for facilitating health equity with Indigenous people as directed by the TRC calls to action. At present, the CSM has a few resources and specific IH initiatives that can be further developed to help build IH capacity. A warning offered in the TRC is repeated here, the calls to action are not intended to be reduced to a checklist, but rather, to build capacity for deep, structural transformation.

Positive action for change is essential to pave the path toward reconciliation. Reconciliation requires unique skills, principles, and structural support to foster excellence, innovation, and best practice across Indigenous health education, research, and clinical service. To achieve excellence and innovation, critical investment is needed to grow capacity for equity and promote Indigenous-based approaches within the CSM. Fundamental to achieving Indigenous health care equity is fostering *Indigenous health as a distinct discipline,* and *promoting and supporting Indigenous inclusion within the academy.* Furthermore, reconciliation compels the dismantling of institutional barriers to the meaningful involvement of Indigenous people and knowledge systems. This is done by: 1) engaging in a formal institutional decolonization process, and 2) investing in foundational strategies for equity of access and authentic inclusion of Indigenous perspective and people within all levels of the CSM.

6.1. Cross Cutting Themes

The following are common themes that cut across and link the domains, contributing to the creation of a cohesive IH strategy.

Engagement: In building capacity within the CSM, direction from community is essential to mobilize transformation through identifying and leveraging existing resources and focusing investment in newly identified structures and strategic initiatives. Not only will building a longitudinal IH strategy solidify partnerships with community, it will also hold the CSM socially accountable to promoting IH initiatives. The emerging directives developed from an intentional engagement within our institution, also derive from the voices of local Indigenous stakeholders. Of importance is that the IH strategy be informed by community and maintain community priorities through not only its inception but to build it permanently into the ethos of the CSM.

Table 13. Current Activities and Infrastructure Associated with Community Engagement

Strengths	Gaps
• Indigenous Health Dialogue • Science outreach to high school students • Summer camp program • Forums engaging communities (i.e. Interrupting Toxic Stress – June 4, 2018) • Relationship with Elbow River Healing Lodge • Cultural opportunities (Blackfoot Crossing tours) • Student-led initiatives	• Ad-hoc relationships with community • Mechanism for engagement of thought leaders • Mechanism for engagement of Indigenous perspectives in all aspects of the CSM • Mechanism for engagement of Indigenous leaders • Student-led initiatives

Presence: Active recruitment and retention of Indigenous people, from learners through leaders, is essential to all aspects of an Indigenous health strategy in the CSM. Promoting increased numbers of Indigenous people, students through leaders, within the academy would push for policy change and identifying bias and supporting institutional change. Students would not need to be a trailblazer for perspectives and methods that go against

those of their instructors when Indigenous perspectives and methodologies are part of the educational curriculum. For research, increased Indigenous presence within the CSM leads to meaningful community connections with health research focusing on community identified priorities. Similarly, Indigenous health service innovation is strengthened by the building students, faculty, and community into an Indigenous health network. Increasing the presence of Indigenous people and perspectives within CSM bolsters the capacity for a robust Indigenous Health Strategy.

Knowledge: Academic motivations are often at odds with community research priorities. With an Indigenous health strategy, there would be a shift from a merit-based system that privileges academic emphasis to a flexible agenda to allow the time and opportunity to build relationships and deeper, more sustainable projects with community. Research here is reframed as inherently accountable to the communities it is part of, and transformative with its emphasis on thriving and resilience. With a strong background in Indigenous history, students would understand the historical and current social and political factors that have impacted Indigenous health outcomes while developing the knowledge and critical skills for effectively addressing the needs and priorities of Indigenous peoples and populations. Partnerships between Indigenous community and medical researchers with a background in Indigenous culture, history, and health, permit the development and implementation of high-quality health service that is responsive to the specific needs of Indigenous peoples. Knowledge is a critical, and transformative, component of the Indigenous Health Strategy.

Space: A physical space is central to the creation of an Indigenous health strategy through facilitating safe knowledge exchange. A space would allow Indigenous student, staff, faculty, and community to gather with non-Indigenous learners, researchers, and faculty who are all interested in building Indigenous health. Formal events could highlight active research, innovative and Indigenous research methods, and vision building while also connecting community to interested researchers and building relationships. At the same time, the informal opportunity to connect in this space would additionally foster relationship building. Whether a hub or a network, the Indigenous Health strategy requires a physical space to coordinate and bring together research and researchers, learners and educational events, and community participation.

Transformation: Transformation, as identified by the University of Calgary Indigenous strategy, refers to the process of inclusion and integrated growth with Indigenous peoples and knowledge within the space of the University of Calgary; in this way transformation is the goal of the CSM in terms of Indigenous health leadership, education, research, and service innovation.

6.2. Recommendations for a Path Forward

Grounded in the three principle and institutional truths generated throughout the critical collaborative consensus-building process, **Five Directions** for our institution have been identified. These directions, emerging from the critical reflective framework, outline pathways for the CSM to be an effective champion, collaborator, facilitator, and advocate for Indigenous health. These directions focus on building capacity within our institution in Indigenous health:

1. **Focus on engagement and advocacy with key stakeholders in shared goals of advancing Indigenous health.**
2. **Promote inclusion of Indigenous people and knowledge, ensuring dismantling barriers and bias within the institution.**
3. **Build Indigenous health education content and facilitation excellence across all educational units, with aim to ensuring all graduates and faculty are equipped with critical Indigenous health knowledge and skills.**

4. **Foster ethical and rigorous Indigenous health research within our institution that effectively responds to community identified priorities.**
5. **In collaboration with community, health systems and health research stakeholders, facilitate development of innovations of critical health care approaches and models.**

7. Conclusion

We have illustrated numerous critical avenues as means for our medical school to effectively impact the health of Indigenous populations as called for by the TRC. These pathways include strong directions that can generate clear actions within the CSM. Evident from our engagement process, is activation by middle leadership within numerous clinical departments, educational units and institutes. Examples include the Department of Medicine Indigenous Health Chair, increasing scope of Indigenous student recruitment and support and the development of an Indigenous engagement and student support hub within SPaCE. This is highly commendable but at risk without a cohesive and resourced strategy within the CSM to support, connect and foster emerging initiatives.

The above 5 Directions are intended to inspire the creation and formalization of a strategy. Framing a strategy within a formal logic model is required. We feel that a strategy working group is needed to define and advocate for the implementation of that strategy. Foundational resources are critical for realizing a strategy due to the reality of very limited capacity within existing CSM resources. Foundational resources include an Indigenous health office and an appropriate community and CSM leadership advisory. The office requires critical infrastructure including an appropriate faculty leadership position, operations management, administrative support, space and core operational funding.

Appendix A: Glossary of Definitions

Numerous tribes, hundreds of reserves, and three treaty zones contribute to a diverse Indigenous population in Alberta. Differences between Indigenous groups are cultural, historical, and geopolitical. The definitions presented here, unfortunately, tend to homogenize differences between groups and minimize the nuances in terms of individualized approach.

Indigenous: A noun or adjective for the first inhabitants of a land and those recognized as their descendants.

Indigenous Peoples: A collective name for the original peoples of Canada and their descendants, including status and non-status First Nations, Inuit, and Métis Nations. FNMI - First Nations, Métis, and Inuit - may be used to indicate Indigenous peoples collectively.

Indigenous People: Refers to more than one Indigenous person, but not the collective group of Indigenous peoples. In this document, the term "Indigenous" is meant as synonymous.

Inuit: One of the three Indigenous Peoples of Canada, as recognized by the Constitution Act of 1982. This term refers to the Indigenous Peoples of Arctic Canada and the circumpolar region.

Métis: Similarly refers to one of the three groups of Indigenous Peoples recognized by the constitution. The Royal Commission Report defines Métis as every person who identifies themselves as Métis, and is accepted as such by the nation of Métis people with which that person is associated, on the basis of the criteria and procedures determined by that nation be recognized as a member of that nation of the purposes of nation-to-nation negotiations as a Métis for that purpose.

Non-Status First Nations: People who consider themselves to be Indigenous or members of a First Nation, but who are not recognize as such by the Federal Government.
Status First Nations: People who are entitled to have their names included on the Federal Government's Indian Register.

Decolonization: Decolonization is a necessarily "unsettling" process that requires a critical social justice approach for dismantling institutional arrangements that perpetuate the legacy of colonization. The "repatriation of Indigenous land and life" is a central tenet of decolonization (21), which for institutions requires meaningful inclusion of Indigenous people, perspectives and practices at all levels. A key to decolonization is anti-racism.

Anti-racism: Anti-racism is an active process of examining and eliminating power imbalances between racialized and non-racialized people Those power imbalances benefit whole groups with unearned privilege, in turn disadvantaging others through acts (overt and invisible) that reproduce oppression through social hierarchies structured on diverse markers of difference.[11] In Canada, racism against Indigenous people is a significant driver of negative health outcomes (2,16). Further, an antiracist pedagogy "seeks to provide students with the ability to critically reflect on the ways in which oppressive power relations are inscribed in their own lives, as well as the lives of others" (22).

Structural competency: Structural competency highlights the limits of biomedical and social determinants to health if it does not address the wider socio-political and systemic factors. It signals "the trained ability to discern

[11] https://www.racialequitytools.org/resourcefiles/mcintosh.pdf

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" (23).

Structural competency includes the following key endeavours:

1. Recognizing the structures that shape clinical interactions
2. Developing an extra-clinical language of structure
3. Rearticulating "cultural" presentations in structural terms
4. Observing and imagining structural intervention
5. Developing structural humility

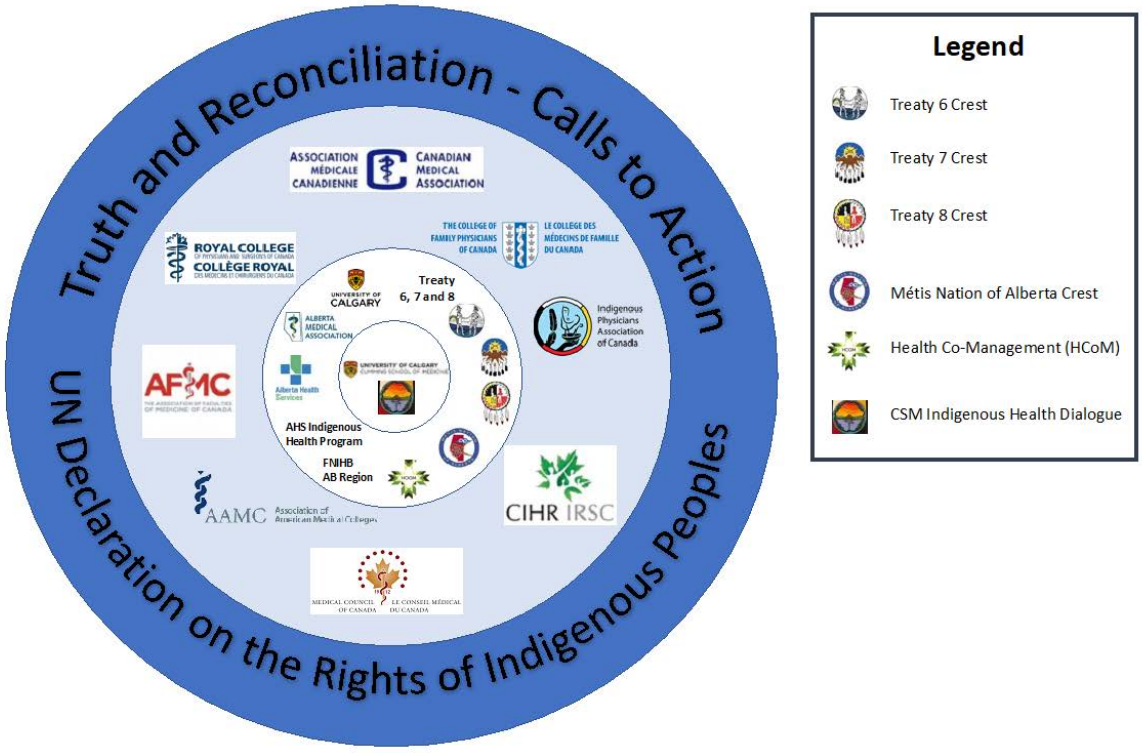
Cultural safety: A core value of IH education is developing cultural safety within all aspects of health care and health care education. Cultural safety is the care required on the part of health-care providers and decision-makers for the cultural values and norms of people (i.e., patients, communities, colleagues) from diverse ethno-cultural backgrounds. Cultural safety shifts health care focus away from provider competencies alone (e.g., cross-cultural awareness, sensitivity) towards the risks for the patients and personnel associated with the absence of such competency (24). Cultural safety builds into it an understanding of postcolonial theory and the perpetuation through health care of colonial inequities in new forms (25).

Health inequity: Those underlying causes of health disparities that may be outside the general purview of what constitutes good health. Health inequities arise from a variety and intersection of cultural, economic, political, and social strains that impact two or more populations differently (1).

Health disparity - An obvious difference in carrying the burden of disease and ill health between two populations. The indicators of health disparities, for example, are the presence and absence of ill health between two populations. "Scholars across all sectors of Aboriginal health studies concur that, despite inadequacies in the health care delivery system and regardless of peoples' relative access or use of the biomedical system, the problems are entrenched in the history of relations between Aboriginal people and the nation-state" (1).

Social accountability: "The concept of social accountability widens the scope of innovations to include the relevant planning of human resources for health and the proper insertion of graduates in a supportive working environment. The term 'social responsibility', applied to an institution, implies awareness of duties regarding society; the term 'social responsiveness' implies engagement in a course of actions that respond to social needs. 'Social accountability', in turn, implies a justification for the scope of the actions undertaken and asserts that the attaining of anticipated outcomes and results will be verified" (11).

Appendix B: Locating the Indigenous Health Dialogue within Local, Regional, National, and International Strategies of Indigenous Health Equity

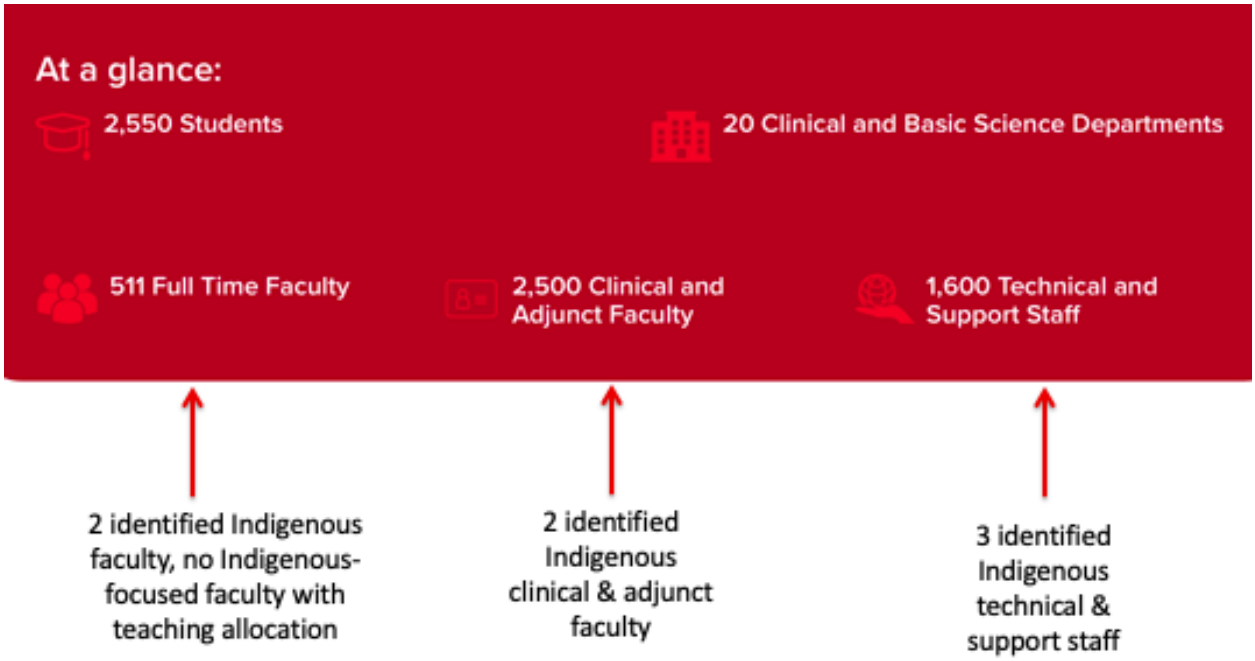


Appendix C: Canadian Medical School Indigenous Health Initiatives at a Glance

Medical School	TRC and Indigenous Health Initiatives		
	Policies	***Programs***	***Initiatives***
Dalhousie University	No information available	• Campus-wide Indigenous Student Centre; provides cultural activities, academic support, and financial help • Indigenous Health Sciences Summer Camp	• Aboriginal Health Sciences Initiative (AHSI) • Indigenous Health Interest Group (IHIG)
McMaster University	Equitable admission for Indigenous students in line with the TRC Calls to Action	Indigenous Students Health Sciences Office provides support to Indigenous students and connects with Indigenous community	Indigenous Health Task Force (IHTF)
Memorial University of Newfoundland	Aboriginal Health Initiative reserves 3 seats for Indigenous applicants from Newfoundland and Labrador	• Pre-Med Summer Institute for Aspiring Aboriginal Students • Healers of Tomorrow Gathering summer camp offered every two years to Indigenous students (grades 9-12)	• Aboriginal Health Initiative • Aboriginal Health Symposium
Northern Ontario School of Medicine	MD Program Indigenous Application Stream (4 seats per year for Indigenous students)	• Indigenous Affairs Unit • Indigenous Reference Group	• TRC curricular response and community integration • Collaborative relationships with community
Queen's University	Alternate assessment for Indigenous applicants holds up to 4 seats per year for Indigenous students	• Postgraduate Medical Education: Family Medicine, Indigenous Health – 3rd year option • Four Directions Indigenous Student Centre	• Queen's Truth and Reconciliation Commission Task Force • Indigenous Mentorship Network Hub • Summer Institute to provide training for Indigenous communities • Library guide on Indigenous health • Aboriginal Council
Western University	5 seats designated for Indigenous students	• Application assistance for Indigenous students • Indigenous Mentorship Network of Ontario (IMN-Ontario)	• Indigenous Health and Well-Being • FORGE AHEAD • SOAR: Pathway to Wellness
University of Alberta	Indigenous students who meet all eligibility requirements	• The Division of Community Engagement: Indigenous Health Initiatives	Indigenous and Global Health Research Group

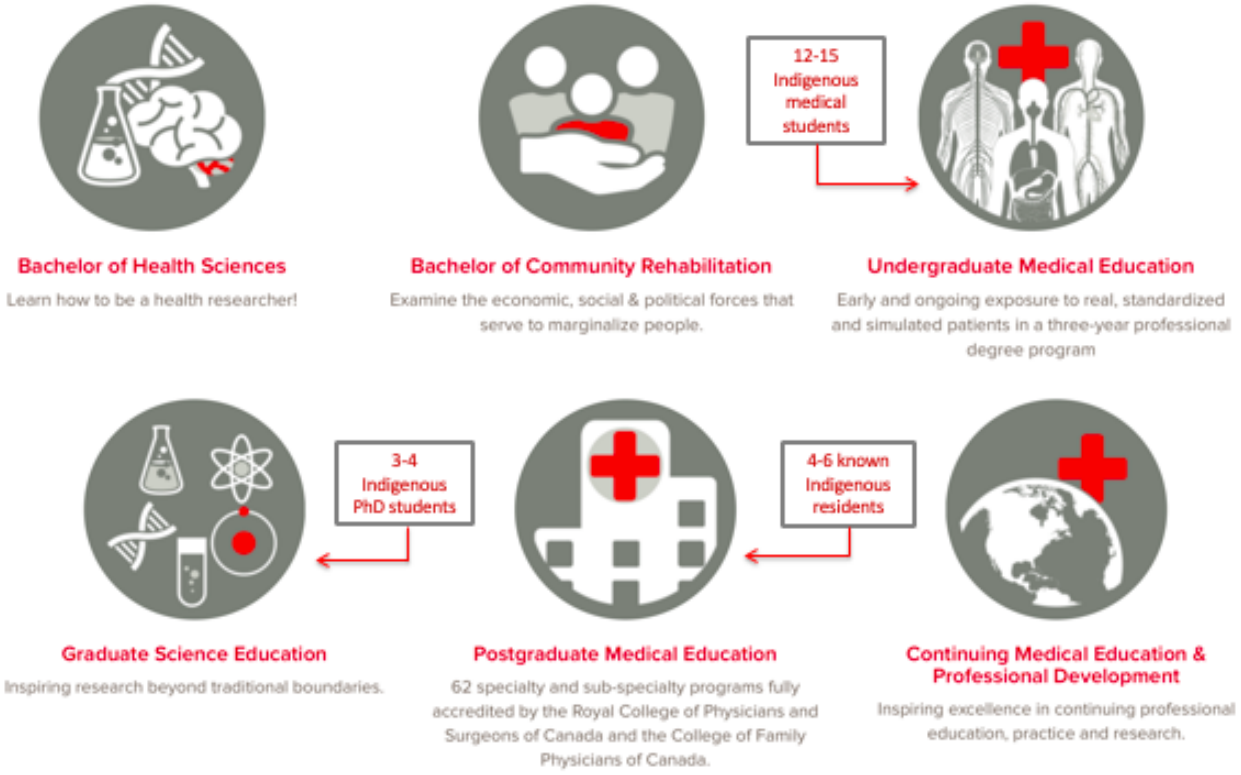
	through the Indigenous Health Initiatives Program (IHIP) will be offered a place	• Indigenous Health Initiatives Program	
University of British Columbia	5% of seats held for qualified Indigenous students	• Centre for Excellence in Indigenous Health (CEIH) • Aboriginal Health Program • Aboriginal MD Admissions Program • Aboriginal Residency Program • Indigenous Public Health Training Institutes	• Indigenous Research Support Initiative (IRSI, campus-wide) • Institute for Community Engaged Research (UBC Okanagan campus) • Interdisciplinary course through the CEIH on Indigenous cultural safety • CEIH UBC Learning Circle • Summer Science Program for FNMI students (grades 9-12) • Pre-admissions workshop for FNMI students interested in health sciences • Indigenous Speakers Series
University of Manitoba	No quota	• Indigenous Institute of Health and Healing – Ongomiizwin • Deep support during admissions for Indigenous students	• Aboriginal Health Research Group • Community integration
University of Ottawa	Up to 7 seats reserved for Indigenous students	• Indigenous Program • Supports for Indigenous students through the Indigenous Program • Scholarships	Mini Medical schools for Indigenous high school students considering a career in health services
University of Saskatchewan	10% of seats annually reserved for Indigenous students	• Aboriginal Admissions Program • Aboriginal Student Mentorship Program • Aboriginal Student Achievement Program – STEM Pathways	• Indigenous Health Speaker Series • Pre-Admissions Workshop • Medicine and Health Career Exploration for Indigenous high school students
University of Toronto	No quota	• Indigenous Student Application Program • Office of Indigenous Medical Education • Waakebiness-Bryce Institute for Indigenous Health	• Community of Support to support students, Indigenous included, along their med school journey • Indigenous Student Handbook • Indigenous Health Elective • Annual public lecture on Indigenous health
McGill University	Quebec First Nations and Inuit Faculties of Medicine Program: Up to 4 seats held for Indigenous students who are residents of Québec	Indigenous Health Professions Program provides outreach and support	Indigenous Health Interest Group
Université Laval		No information available	No information available
Université de Montréal			
Université de Sherbrooke			

Appendix D: Indigenous Health in the Cumming School of Medicine at a Glance



Source: Cumming School of Medicine

Appendix E: Indigenous Students across Educational Programs in the Cumming School of Medicine



Source: Cumming School of Medicine

Appendix F: Critical Reflective Framework Domains

1. Education

Reconciliation Statement	Action Themes	Initiatives
Reconciliation means graduating all trainees with competencies for addressing the specific needs and priorities of Indigenous populations	Ensure that clinical and research graduates and current faculty are equipped with the critical knowledge and skills for effectively addressing the needs and priorities of Indigenous peoples and populations.	• Innovative Indigenous health education curriculum aligned within clinical and research education streams, as well as within faculty development. • Clinical and community-based educational opportunities that are culturally safe for Indigenous people.
	Become a leader in Indigenous health education research grounded in decolonizing educational practices, community needs, evidence, and Indigenous-focused theory	• IH teaching capacity within educational programs, Indigenous and non-Indigenous faculty, community preceptors, and community members. • IH educational research hub for developing innovations and best practices in content, learning methods, facilitation, and assessment approaches.

2. Research

Reconciliation Statement	Action Themes	Initiatives
Reconciliation means adhering to rigorous Indigenous and decolonizing methodologies, in partnership with affected communities	Foster capacity for ethical and rigorous Indigenous health research.	• Policy and supports for achieving institutional concordance decolonizing and Indigenous health research ethics and methodologies. • High-performance Indigenous health research through nurturing the next generation of Indigenous health research leaders.
	In partnership with community and health systems stakeholders, enable research that effectively responds to community-identified priorities.	• Engagement strategy and process focused on exploring research priorities and developing meaningful research relationships with local Indigenous communities and health service stakeholders. • Indigenous health research methods hub for innovations in IH research measures and tools.

3. Service Innovation

Reconciliation Statement	Action Themes	Initiatives
Reconciliation involves advocating for quality and equitable health service grounded in the social and cultural contexts of Indigenous people's lives	Advocate for equitable and high-quality health service that is responsive to the specific needs of Indigenous people.	• Partnership with Indigenous community and key health systems stakeholders for mobilizing service innovations. • Policy and systems engagement for equitable and innovative health systems outcomes for Indigenous people.
	Facilitate innovations in decolonized health services, grounding these in the social and cultural contexts of Indigenous people.	• Evidence base of policy, systems, models of care, clinical approaches, and evaluation strategies for innovations of Indigenous health service. • Indigenous health service research hub for innovations in care models and evaluation.

4. Inclusion

Reconciliation Statement	Action Themes	Initiatives

Reconciliation compels the dismantling of institutional barriers to the meaningful involvement of Indigenous people and knowledge systems	Engage in a formal institutional decolonization process to dismantle institutional barriers against Indigenous people.	• Develop and implement a formal policy for addressing anti-Indigenous sentiment within the academy. • Develop decolonization, cultural safety and anti-racism teaching capacity and approaches within the faculty.
	Invest in foundational strategies for equity of access and authentic inclusion of Indigenous people and perspectives at all levels.	• Support leadership and faculty change through focused and strategic professional development activities based in decolonization, cultural safety, and anti-racism. • Develop a leadership position and infrastructure for related policy and programmatic activities.

5. Distinct Discipline

Reconciliation Statement	Action Themes	Initiatives
Reconciliation requires unique skills, principles, and structural supports to foster excellence, innovation and best practice across Indigenous health education, research and clinical service.	To achieve excellence and innovation, critical investment is needed to grow capacity for equity and promote Indigenous based approaches within the CSM.	• Nurture institutional expertise and innovations through building knowledge, collaborations, and leveraging of resources. •
	The CSM has a role and responsibility for community development through advocacy, engagement and knowledge exchange with Indigenous community and non-Indigenous health stakeholders.	• Foster critical linkages between the CSoM, Indigenous, provincial, and national health service stakeholders and policy-makers for addressing Indigenous health needs • Develop, implement, and sustain an Indigenous community engagement strategy to guide the CSoM in achieving Indigenous health equity.

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ii' taa'poh'to'p

(a place to rejuvenate and re-energize during a journey)