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Évaluation d'un stage à option longitudinal sur la santé autochtone en médecine familiale

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Article abstract

Background: In response to the Truth and Reconciliation Commission of Canada Calls to Action 22 to 24 around health, the Department of Family Medicine at the University of Calgary piloted a novel Indigenous Health Longitudinal Elective (IHLE) to give first year residents longitudinal experiences in Indigenous healthcare environments. The purpose of this evaluation was to capture the successful qualities and identify areas for improvements to ensure feasibility of the IHLE pilot program.

Methods: Between November 2022 and April 2023, semi-structured interviews were completed with seven participants of the IHLE and included a mix of residents, preceptors, and clinic staff members. Qualitative thematic analysis was used to gain an in-depth understanding of the IHLE program experiences of all participants.

Results: Benefits of the IHLE program include a deeper understanding of the values and priorities critical to working in healthcare with Indigenous peoples in Southern Alberta. Areas for improvement include clarity around IHLE program structure; clearly defining roles and responsibilities for preceptors; increased opportunities for reciprocity and relationality; and a deeper self-reflection process.

Conclusion: Recommendations for future iterations of the IHLE include ensuring preceptors are trained and engaged, while providing residents more opportunities for relationality and peer debriefing. Results from this study may also help inform future Indigenous health programming in family medicine.

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Brief Reports

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Abstract

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Conclusion: Recommendations for future iterations of the IHLE include ensuring preceptors are trained and engaged, while providing residents more opportunities for relationality and peer debriefing. Results from this study may also help inform future Indigenous health programming in family medicine.

Résumé

Contexte : En réponse aux appels à l'action 22 à 24 de la Commission de vérité et de réconciliation du Canada concernant la santé, le département de médecine familiale de l'Université de Calgary a piloté un nouveau stage à option longitudinal en santé autochtone (SOLSA) afin de procurer aux résidents de première année des expériences longitudinales dans des environnements de soins de santé autochtones. L'objectif de cette évaluation était d'identifier les compétences atteintes et les points à améliorer pour assurer la faisabilité du programme pilote de SOLSA.

Méthodes : Entre novembre 2022 et avril 2023, des entretiens semi-structurés ont été menés avec sept participants au SOLSA, dont des résidents, des superviseurs et des membres du personnel clinique. Une analyse thématique qualitative a été utilisée pour comprendre en profondeur les expériences de tous les participants dans le cadre du programme de SOLSA.

Résultats : Les avantages du programme de SOLSA comprennent une meilleure compréhension des valeurs et des priorités essentielles pour travailler dans le domaine des soins de santé avec les populations autochtones dans le sud de l'Alberta. Les points à améliorer sont la clarté de la structure du programme de SOLSA, une définition claire des rôles et des responsabilités des superviseurs, une augmentation des possibilités de réciprocité et de relationnalité, et un processus d'auto-réflexion plus approfondi.

Conclusion : Les recommandations pour les versions ultérieures du SOLSA consistent à s'assurer que les superviseurs sont formés et mobilisés, tout en offrant aux résidents davantage d'occasions de relationnalité et de débreffage entre collègues. Les résultats de cette étude peuvent également aider à améliorer de futurs programmes sur la santé autochtone en médecine familiale.

Introduction

The Truth and Reconciliation Commission of Canada (TRCC) created 94 Calls to Action to guide our journey of reconciliation, seven of which focus on the health and wellness of Indigenous peoples.[1] In 2019, the Association of Faculties of Medicine of Canada (AFMC) responded to these calls and prepared a Joint Commitment to Action on Indigenous Health.[2] Furthermore, the College of Family Physicians of Canada (CFPC) released the CanMEDS-Family Medicine: Indigenous Health Supplement with core competencies to guide and inform culturally appropriate and safe care for Indigenous peoples.[3]

Rashid et al. completed a recent scoping review of Indigenous health curriculum in residency programs in graduate medical education and found ongoing challenges with misunderstandings towards Indigenous people, as well as with the implementation of culturally competent Indigenous health care and curricula.[4] Their results suggest community-driven Indigenous partnerships need to be a priority to ensure safe environments are created. In addition, a lack of research exists around the evaluation of Indigenous health education.

In a commitment to reconciliation in health education, the University of Calgary's postgraduate family medicine (PGFM) program introduced a pilot Indigenous Health Longitudinal Elective (IHLE) for family medicine (FM) residents in 2021-2022. The purpose of this evaluation was to capture the successful qualities and identify areas for improvements to increase feasibility of the IHLE program.

Methods

The outline and content of the IHLE is shown in Table 1.

Table 1. Indigenous health longitudinal elective program structure

Task	Who	Description of activity
Introduction of IHLE	IHWG	R1s were provided with an introduction and overview of the IHLE from Indigenous Health Working Group (IHWG) representatives. In Year 1 of the program, the IHLE was introduced during FM Core. In Year 2 of the program, an IHLE info notice was sent to all incoming R1s in May. If interested, R1s submitted a schedule to the IHLE scheduler and answered the following questions: Do you identify as Indigenous/Metis/Inuit? If yes, is there a specific Indigenous environment around Calgary in which you would like to pursue your IHLE? Are you considering practicing in an IH environment? If yes, is there a specific Indigenous environment around Calgary in which you would like to pursue your IHLE? Which community and what interests you about this community? Are you willing to travel to the outskirts of Calgary for this elective? If you answered no to the previous questions, why are you interested in pursuing an IHLE?
Assignment of R1s	IHWG	Members of the IHWG determined assignment of R1s prioritized as per the following criteria: Self-declared Indigenous heritage with connection to specific Indigenous community which is participating in the elective; Self-declared Indigenous heritage; Self-declared intent to practice in/serve Indigenous community after residency program completion; and All others.
Preceptor Matching of R1s	Scheduler	The IHLE Scheduler matched each selected resident with one preceptor from an IH environment around Calgary including: Siksika Health Services; Stoney Community Health Services, Eden Valley; Elbow River Healing Lodge; or Tsuut'ina Health Centre.
FM Block and Self-Reflection	Resident and Preceptor	Residents had ten full days in the IH environment throughout Year 1. In each FM block in R1, the resident spent two full days in a specific IH environment. They saw patients with an MD or with allied health practitioners in clinics, or external environments. On Days 1, 4 and 9, the resident was excused mid-afternoon to engage in a reflective writing exercise. Their experiences guided the content of writing. Reflections were submitted to their preceptor to stimulate discussion the following day in clinic together. The reflections were collated to accompany an In-Training Evaluation Reports (ITER) at the end of the program.
Assessment	Preceptor	An assessment (FM-Electives ORITER) was completed by the preceptor following the conclusion of the elective.

We sent an email to all residents, preceptors, and clinic staff participating in the IHLE pilot program inviting them to participate in the evaluation process. Between November 2022 and April 2023, we interviewed seven participants (Table 2). We obtained verbal informed consent from participants prior to the interview, and they received a $25 honorarium. The interview questions were developed by the study team who have experience in primary care provision, medical education, Indigenous health and Indigenous health education to gain a deep understanding of the benefits and areas for improvement for this educational intervention. We piloted the interview guides with two initial participants and reviewed the responses with the project team for understanding of the interview questions. The project team understood the interview questions; therefore, we determined no changes were needed to the guide and the pilot interviews were included in the data set. Additional review and feedback of the interview guides were obtained from the Family Medicine Indigenous Health Education Working Group–made up of clinical and non-clinical faculty, Indigenous medical learners, and Indigenous community family physicians.

The senior (last) author is a Métis health systems researcher with experience in Indigenous health research and health education. She was formally the Director of Indigenous Health Education for the medical school where this study was completed. The first author (LZ) is a non-Indigenous researcher with experience working with Indigenous communities to advance understandings of dementia and brain health. The second author (RC) is a settler with a background working in qualitative research, Indigenous health, and anti-racism. The third author (MWB) is a settler family physician with a clinical practice on Treaty 6 and 8 Territories. She is the current Program Director for the Enhanced Skills in Health Equity Program and the Domain Lead for Health Equity in Family Medicine at the University of Calgary. The fourth author (AG) is a rural family physician practicing in Indigenous Communities. She is the Director of Community Engaged Learning in the Indigenous, Local and Global Health Office, and is also the Director of Health Equity and Structural Competency in Undergraduate Medical Education at the Cumming School of Medicine.

We completed all interviews on Zoom and audio-recorded them for transcription purposes. Following transcription and verification of data, we uploaded interviews into NVivo to organize the data and the entire project team supported the thematic qualitative analysis process.[5] Two research assistants did the initial analysis in conjunction with feedback from the Principal Investigator, followed by a discussion of the results and feedback with the Family Medicine Indigenous Health Education Working Group for member checking. Thematic analysis was the most appropriate choice as this is a new area of medical education and it is important to gain an in-depth understanding of the experiences of all individuals without constraining the analysis to pre-determined concepts. This study received ethics approval through the University of Calgary Conjoint Health Research Ethics Board (REB22-0385).

Table 2. Participant Demographics

	Gender	Role
P1	F	Preceptor
P2	M	Resident
P3	F	Clinic Staff Member
P4	F	Resident
P5	M	Resident
P6	M	Resident
P7	M	Preceptor

Results

Participant quotes are shown in Table 3. The IHLE pilot program provided participants with an experience that increased their knowledge around Indigenous health. In addition, results highlight four areas for improvement: 1) clarity around program structure, content, and administration; 2) clear roles and responsibilities for preceptors; 3) increased opportunities for reciprocity and relationality; and 4) deeper self-reflection and debriefing process.

Participants shared some of their most important takeaways from the IHLE including increased knowledge and confidence working with Indigenous peoples; greater insight, sensitivity, and safety when engaging with Indigenous peoples; recognition of the importance of human connection, trust, and relationship building with the patient; and re-affirmation of their interest in working with Indigenous peoples in their future practice.

Program structure, content, and administration

Participants shared their disappointment that the IHLE was only one year in length. In addition, participants found the continuity and longitudinal component of the IHLE to be challenging (building relationships with patients). Participants shared frustrations around miscommunication around scheduling. Some participants were not informed of cancelled shifts, and it was unclear who was responsible

for rescheduling. This was especially important for clinic staff due to ongoing costs of paying for each user associated with the electronic medical record. Participants expressed interest in working at multiple locations for the IHLE to build on and expand their experiential learning. Interestingly, participants spoke about not finding the lectures very helpful; however, lectures were not part of the IHLE program content, suggesting more clarity is required. Participants posed the following suggestions for improvement:

- Offer the IHLE for two years;
- Change days to be closer together;
- Allow the experience to take place in blocks beyond FM, such as during off-service rotations;
- Offer flexibility in placement location so residents can experience both on-reserve and off-reserve; and
- Clarify roles and responsibilities around structure, scheduling, and communication.

Preceptor roles and responsibilities

It is important to note that there was variation among preceptors in understanding of their roles and responsibilities. Similarly, some residents shared their gratitude for their relationship with preceptors, while others identified having less support and guidance. Some preceptors reported feeling underprepared, not engaged, and unclear on what the objectives of the IHLE were even though they were sent an invitation to participate which outlined goals, structure, and expectations of roles and responsibilities. The following were suggested as improvements:

- Clearly define the roles and responsibilities of the preceptors;
- Offer a formal onboarding process for all preceptors through an in-person training session; and
- Find ways to bring more preceptors onboard.

Increased reciprocity and relationality

Participants shared their desire to find ways to be more involved in community to practice reciprocity and build ongoing relationships with patients and the community beyond IHLE. This included having support from IHLE to find ways to create a bridge between the IHLE and the community. Some ideas put forth included:

- being invited to attend other clinic programming;
- building relationships with other staff members at the clinic and in the community;
- being invited to events such as cultural events and ceremonies, when appropriate;
- having time and space to meet and talk with Elders; and
- participating in home visits.

Increased debriefing opportunities

Participants discussed their feelings of discomfort working with Indigenous patients during the IHLE. Furthermore, participants spoke about how emotionally intensive the work was and how much of an emotional toll it had taken on them. Participants identified the self-reflection process as extremely important for processing their own experiences, while understanding and recognizing the emotional toll the IHLE had. Some participants were able to discuss this with their preceptor, while others did not have the same opportunity. Furthermore, the most important part of the self-reflection process was the conversations and dialogue that came with it. Participants highlighted the importance of ensuring time is set aside for formal debriefing, whether through individual conversations with preceptors, or as a group in a sharing circle format.

Table 3. Participant quotes

Important Takeaways	*"I felt it would be necessary to get better at learning more about some of the systemic issues that Indigenous people have suffered to better serve the populations there." P5* *"The most meaningful thing I can take away from this program is to never underestimate, I guess the power of societal level discrimination and by extension then the ability that you have to change it and then see those societal level benefits than being passed down." P6*
Program Structure, Content, and Administration	*"I'm a bit on the fence about the timing. I do like that it goes over the year, but maybe it needs to be in a block at the beginning of the year, where its once a week for four weeks, and then a block later on, just so that you're developing a bit of flow, a bit of rapport." P1* *"It would be helpful for you to always know when someone's going to be starting." P3* *"I think it would be nicer if we could get one week in a row when we go there or two weeks in a row when we go there, rather than have it so spread apart." P4* *"I think something a bit more regular would be helpful because then you might be able to see patients in follow up, you might be able to build more relationships with these people rather than just seeing somebody new every single time." P6* *"I think one of the things we could do is just perhaps making sure that everybody's aware of where they're supposed to be and when they're supposed to be there with a regular kind of update." P7*
Preceptor Roles and Responsibilities	*"If I had a little bit more of an idea what I was getting into, that would've been helpful." P1* *"I don't really know that much about the reflection process." P2* *"Haven't had too much of an opportunity yet to go over it…." P6*
Increased Reciprocity and Relationality	*"Having an Elder on staff, I think, is super important. He has so much knowledge and so much wisdom, and him just being there every day and available is amazing." P1* *"If the program supported me or other future learners to integrate some sort of way to give back to the community, I think that would be more sustainable for them as well as improve the quality of learning experience." P2* *"I feel like there needs to be a little bit more integration with the community." P3* *"… we learn what to do in clinic for the rest of our residency, but this is a very special, unique experience. And so, I just want to learn more about the culture and would've liked to do that to be honest. I would have loved to attend a powwow." P4*
Increased Debriefing Opportunities	*"Could not fully wrap my head around everything that was going on in their life and was not able to provide all the health that I wanted to." P2* *"I appreciate the reflections. I just think maybe we don't necessarily have to submit them. That would be nice." P4* *"I guess there is the emotional toll. Actually, you know what? I would say that's the most difficult part because it is definitely more emotionally draining and more heavy on your mind at the end of the day." P5* *"There's a fair degree of trepidation and nervousness when working with these populations for the first time, given how complex they are." P6* *"I think the big benefit is when we have the possibility of debriefing, right? Debriefing for me is where it's at." P7*

Discussion

The purpose of this evaluation was to capture the successful qualities and identify improvements that could be made to increase feasibility of the IHLE program. Residents shared the IHLE increased understanding of the values and priorities critical to working in healthcare with Indigenous peoples in Southern Alberta.

Results indicate there are two important points to consider going forward. First, it is crucial that preceptors are engaged and clearly understand their role and responsibility in the IHLE. Systemic institutional barriers such as resource allocation, placements, and time may have an impact on the Indigenous health curricula.[6] Preceptors play a critical role in the resident's journey in Indigenous health, and both preceptors and residents felt preparedness cannot be overlooked. This insight aligns with a study conducted by Aggarwal and Abdelhalim who found early career family physicians were underprepared to provide care with appropriate cultural humility with Indigenous populations.[7] One way preparedness was increased was through engagement with preceptors. In fact, family physicians have indicated "preparedness for practice could have been improved by more concerted efforts to have preceptors provide longitudinal exposure to patients from various populations and work settings to help develop their knowledge, skills, competencies and capabilities".[7]

Second, the idea of peer and group debriefing warrants further exploration. Our findings around the desire for more debriefing aligns with the literature that suggests group discussions with peers are an important teaching tool to foster conversation, dialogue, and critical thinking.[4,8] Research highlights the importance of having residents engage in introspection, reflexivity, and cultural safety to build awareness of and decrease their own bias of

Indigenous peoples and care.[4,9,10] Furthermore, research highlights the importance of ongoing evaluation of IH curricula to ensure unintended consequences of such teaching such as negative attitudes can be addressed as quickly as possible.[11,12]

There were two major limitations of this study. First, we had a small sample size. There were only seven participants who expressed interest in participating in the evaluation process which is why there were no further interviews. Although this allowed for a rich analysis of the data, an increased number of participants would have added more depth to the experiences of participants. A second limitation of this study was the grouping of residents, faculty, and clinic staff for the purpose of analysis. It is possible that some participants had prior training, education, and/or experiences that influenced their response to the interview questions. Future evaluations could benefit from increasing the number of participants and considering the experiences of residents, faculty, and clinic staff individually.

Family medicine physicians have a responsibility to ensure their work and actions are supporting the TRC Calls to Action around health. As stated in the CanMEDS Indigenous health supplement, "application of the TRC directives then calls on everyone to nurture a safe and ethical clinical space that respects Indigenous patients, engaging with body, mind, heart, and soul".[3] Results from the IHLE pilot program reveal participants are experiencing and learning what it means to work with Indigenous patients in a safe and ethical space; however, it is important to continually reflect and find ways to improve the IHLE to ensure ongoing reach and positive impact.

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References

1. Truth and Reconciliation Commission of Canada. *Truth and Reconciliation Commission of Canada: Calls to Action*. Winnipeg MB; 2015. Available from: https://ehprnh2mwo3.exactdn.com/wp-content/uploads/2021/01/Calls_to_Action_English2.pdf. [Accessed Sept 2, 2023].
2. Anderson M, Crowshoe L, Linda M, et al. *Joint commitment to action on Indigenous health as approved by the AFMC Board of Directors prepared by writing working group on behalf of the Indigenous Health Network*. 2019. Available from: https://www.afmc.ca/wp-content/uploads/2022/10/AFMC_Position_Paper_JCAIH_EN.pdf. [Accessed Aug 30, 2023].
3. Kitty D, Funnell S, eds. *CanMEDS-FM Indigenous Health Supplement.* The College of Family Physicians of Canada. Mississauga, ON; 2020. Available from https://www.cfpc.ca/CFPC/media/PDF/CanMEDS-IndigenousHS-ENG-web.pdf. [Accessed Sept 28, 2023].
4. Rashid M, Nguyen J, Foulds JL, Dennett L, Cardinal, N, Forgie, SE. A scoping review of Indigenous health curricular content in graduate medical education. *J Grad Med Educ.* 2023;15(1):24–36. https://doi.org/10.4300/JGME-D-22-00180.1
5. Clarke V, Braun V, Terry G, Hayfield N. Thematic analysis. *Handbook of research methods in health and social sciences*. In: P. Liamputtong, ed. 2019: 843-860.
6. Pitama SG, Palmer SC, Huria T, Lacey C, Wilkinson, T. Implementation and impact of Indigenous health curricula: a systematic review. *Med Educ.* 2018;52(9):898–909. https://doi.org/10.1111/medu.13613
7. Aggarwal, M, Abdelhalim, R. Are early career family physicians prepared for practice in Canada? A qualitative study. *BMC Med Ed*. 2023;23 (1): 370. https://doi.org/10.1186/s12909-023-04250-z
8. Laine-Gossin J, DeKoven S, Bordman R. Making connections: exploring residents' perspectives on a virtual World Café as a novel approach for teaching Indigenous health issues. *Can Med Educ J.* 2022;13(2):92-95: https://doi.org/10.36834/cmej.73098
9. Rame A, Kelly-Turner K, Roze des Ordons A, et al. Informing critical Indigenous health education through critical reflection: a qualitative consensus study. *Health Educ J.* 2023;82(5):569–582. https://doi.org/10.1177/00178969231174872
10. Vogel L. Residency programs grapple with new Indigenous cultural safety training requirements. *CMAJ.* 2018;190(25):e778-e779. https://doi.org/10.1503/cmaj.109-5616
11. Melro CM, Landry J, Matheson, K. A scoping review of frameworks utilized in the design and evaluation of courses in health professional programs to address the role of historical and ongoing colonialism in the health outcomes of Indigenous Peoples. *Adv Health Sci Ed.* 2023. https://doi.org/10.1007/s10459-023-10217-y
12. Melro CM, Matheson K, Bombay. Beliefs around the causes of inequities and intergroup attitudes among health professional students before and after a course related to Indigenous Peoples and colonialism. *BMC Med Ed.* 2023;23(277):1-14. https://doi.org/10.1186/s12909-023-04248-7