Aboriginal health in the medical program in British Columbia:
A curriculum analysis
by

Gabriela de Castro Pereira
B.A., University of São Paulo, 2005

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Supervisory Committee

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Abstract

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It is well documented in the literature that Aboriginal peoples have a lower health status compared to the non-Aboriginal population in Canada. The underlining causes for this health disparity are found in the historical and contemporary practices of colonization and social, economic, and political deprivation. This thesis focuses on another of the complex factors which affect Aboriginal health status: the education and training provided to undergraduate medical students on Aboriginal health issues and the social determinants of health in British Columbia. I conducted a critical discourse analysis of the readings materials of three selected courses. I conclude from the analysis that although some of the themes covered by the courses critically present the historical, social and economic contexts for this health disparity, Aboriginal peoples are still characterized as a needy and sick population. Indigenous issues are far from being centrally positioned in the medical curriculum in British Columbia.

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To my mom and dad: Angela and Alberto de Castro Pereira Neto
To my sister Tata and her beautiful family
To my partner Yanier and Maria Isabel
Esse trabalho é dedicado a vocês, com carinho.

Chapter 1 - Introduction

1 - Introduction

This thesis is concerned with the undergraduate medical curriculum in British Columbia. The research examines the extent to which Medical Schools in British Columbia prepare their students to address the health issues facing Aboriginal[1] populations in Canada. Therefore, the courses in which Aboriginal health and the social determinants of health are addressed were selected, and an analysis of the assigned readings was conducted. Consequently, the readings were evaluated with the objective of gaining an understanding of the manner in which Aboriginal peoples and their health status are characterized and taught to future doctors.

The objective of this introductory chapter is to present an overview of the thesis. The first section presents a discussion of the purpose, objectives and significance of the research. The second section provides a review of the relevant literature. Section three outlines the structure of the thesis.

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[1] The term Aboriginal is being used to refer to the Indian (registered or not), Métis and Inuit peoples of Canada, as it is recognized in the *Constitutional Act, 1982*. In respect to Aboriginal peoples in Canada, I use the term First Nations instead of Indian. However, the term Indian is still being used here when I am referring to Government statistics and legislation.

1.1 – Purposes, objectives and significance of the research

1.1 a. Health Indicators and Inequality

It is well documented that Aboriginal peoples in Canada have a lower health status compared to the Canadian population in general (Health Council of Canada 2005; MacMillan et al. 1996; Tookenay 1996; Waldram et al. 1995; Young 1994). Statistical analysis has revealed this discrepancy, which is present in almost all of the health indicators collected by the Canadian Government (Canadian Institute for Health Information 2004, Statistics Canada 2010).

However, it is important to note that it is a challenge to identify the overall health status of Aboriginal peoples in Canada, especially because of the diversity of this population and the lack of data for non-status Indians (BC Ministry of Health Planning 2001; Health Council of Canada 2005). Notwithstanding this fact, the data collected at all levels (National, Provincial and Regional) reveals a gap between Aboriginal and non-Aboriginal populations' health status. Furthermore, analyzing data from the Canadian Community Health Survey2000/1, Tjepkema (2002) demonstrated that Aboriginal peoples living off-reserve also have a lower health status compared to the non-Aboriginal population.

In British Columbia, this scenario is no different. The Aboriginal population of the province also experiences a lower health status compared to the non-Aboriginal population (BC Ministry of Health Planning 2001; Government of British Columbia et al. 2005; Office of the Provincial Health Officer 2009; Stephenson et al. 1995). The life expectancy at birth for Status Indians born in British Columbia between 2001 and 2005 is 75 years, a deficit of 7 years compared to the other residents. The age standardized mortality rate, which measures

the number of deaths by 10,000 people, is 1.5 times greater for Status Indians than for other British Columbians (Government of British Columbia et al. 2005).Although suicide rates vary widely across British Columbia, it is a concern in many Aboriginal communities (Chandler and Lalonde 1998; Lalonde 2001). To date, youth suicide for Status Indians is 5 times greater than for other youth (Government of British Columbia et al. 2005). The prevalence rate of diabetes among Status Indians in British Columbia is 6.0%, as compared to 4.5% for other British Columbians (Government of British Columbia et al. 2005). HIV/AIDS is also a concern among Aboriginal groups (Lambert 1993; Health Canada 2003; Canadian HIV/AIDS Legal Network and the Canadian Aboriginal AIDS Network 1999). While the Aboriginal population comprises 4% of the population of British Columbia, Aboriginal people accounted for almost 15% of the new HIV cases reported between 1995 and 2001 (BC Ministry of Health Services and BC Ministry of Health Planning 2003).

These health indicators illustrate an undesirable scenario for Aboriginal populations in Canada and in British Columbia specifically, which is comparable to so-called underdeveloped nations. As observed by Anderson and Lavallee (2007), the United Nations Human Development Index for registered First Nations living in reserves in 2001 would be 0,765. This number is equivalent to that of Colombia and below the rankings of Mexico and Malaysia (Cooke et al. 2004).

A number of factors have been identified as the causes for this health disparity. The effects of colonization, such as loss of land, transformation of the diet and lifestyle of communities, and the legacy of residential schools are factors that still affect the mental and physical health of this population today (Kelm 1998; Kirmayer et al. 2001; Waldram et al.

1995). As a consequence, Aboriginal communities have experienced economic and social marginalization, which deeply influence their well-being today. (MacMillan et al. 1996; Moffat and Herring 1999; Adelson 2005).

In this regard, there is a vast literature which acknowledges the influence of social and economic conditions on the health status of individuals and communities (Raphael 2004; Graham 2004; Lynch and Kaplan 1997). In the case of Aboriginal peoples in British Columbia, this association is observed if we compare the social and economic indicators of this population to those of other British Columbians. In 2001, for example, 22% of the Aboriginal population was unemployed, compared to 8% of the non-Aboriginal population. There is also discrepancy in the employment income of the two populations. In 2001, 56.7% of Aboriginal people earned less than $20,000, compared to 40% of the non- Aboriginal population. The disparity between the percentages of employment income over $40,000 is even larger: 17.6% of Aboriginal people reached this level as compared to 31.2% of the non-Aboriginal population (BC STATS 2001). These indicators demonstrate a direct relationship between health and economic inequalities.

Thus, it is important to make clear that the efforts to close the gap between the health status of Aboriginal populations and other British Columbians need also to address social, political, and economic disparities present in Canadian society. This research focuses on one of the complex factors which affect Aboriginal health status: the education and training available to medical students in British Columbia.

1.1.b. Foundations of the Research

As observed by Kleinman et al. (1978), the clinical reality is a cultural construction, where the doctor and patient negotiate treatment based on their own explanatory models. Therefore, physicians should recognize the importance of cultural factors in the clinical encounter, as well as the influence of non-medical determinants of health, such as economic and political contexts.

In this regard, the Association of Faculties of Medicine of Canada is committed to a project titled "The Future of Medical Education in Canada" which is meant to lead to a medical education system that can better meet the needs of the population. As part of this initiative and as an attempt to minimize the health inequity of Aboriginal populations, the Indigenous Physician Association of Canada (IPAC) in conjunction with the Association of Faculties of Medicine of Canada (AFMC), developed and recommended a curriculum framework for undergraduate medical education (IPAC/AFMC 2009a). The recommendation was built on the CanMEDS[2] 2005 competencies framework (Frank 2005), which identified the physician's role as a medical expert supported by six core competencies: communication, collaboration, management, health advocacy, scholarship and professionalism. Therefore, IPAC and AFMC recontextualized all the core competencies to address the needs of Aboriginal populations, and the enabling competencies were shaped according to the required objectives to achieve the desired outcome (IPAC/AFMC 2009a).

In the case of communication, for instance, the key competency relates to the ability of the medical professional to create a culturally safe atmosphere when communicating with

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[2] Canadian Medical Education Directions.

Aboriginal patients. Among the enabling competencies is the ability to engage in a therapeutic relationship which shows respect, trust, understanding and empathy towards patients (IPAC/AFMC 2009a).

As part of the same initiative, IPAC and AFMC developed a Curriculum implementation toolkit (IPAC/AFMC 2009b). This document was developed to assist the Faculties of Medicine in Canada to engage in the process of moving towards adopting the recommended curriculum framework for undergraduate medical education. The premise is that collaboration and engagement of First Nations communities is essential to a successful enhancement of the curriculum. One of the important phases identified by IPAC and AFMC in the toolkit is to "map the current curriculum to identify where FN/I/M health themes are already being addressed" (IPAC/AFMC 2009b: 08). In this regard, a preliminary survey analyzing the Indigenous health curriculum content of the undergraduate medical curriculum in Canadian faculties was done by IPAC and AFMC (2008). The survey asked faculties to report which courses had aboriginal content and asked for information in six themes: 1) If indigenous health issues are specifically addressed; 2) The general topics covered in the component; 3) If there are teachings related to cultural information; 4) The methods by which information is obtained by learners; 5) The methods of evaluation; and 6) If there are opportunities to engage with Indigenous people.

While the study resulted in a list of the general topics covered in each component, the content of the courses were not, however, explored in detail. This level of analysis is necessary to reflect on the strengths and gaps of the current curriculum content, as suggested by IPAC and AFMC (2009b). As such, this research is concerned with an evaluation of the

curriculum content in British Columbia, by critically analysing the readings and resources of each relevant course. The research objectives were as follows:

1) To identify the courses of the undergraduate medical program in British Columbia which discuss Aboriginal health and the social determinants of health;

2) To evaluate the content of these courses by examining the assigned readings[3];

3) To outline the manner in which Aboriginal health is portrayed in the assigned readings;

4) To form an Advisory Committee composed of Aboriginal people to receive feedback concerning the current curriculum;

5) To present a critical evaluation of the curriculum content and discussion based on the seven core competencies developed by IPAC/AFMC (2009a).

This research seeks to build on the initiative of IPAC and AFMC to reduce the health disparities of Indigenous peoples in Canada. The ultimate goals of IPAC and AFMC are to increase the number of Aboriginal health care professionals and to improve the curricular content on Aboriginal health. This research intends to contribute to the second goal through the examination and analysis of the current undergraduate medical curriculum in British Columbia.

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[3] It is important to note that the analysis does not consider what is presented in lectures or in-class discussions.

2 - Literature Review

This research was informed by the literature related to three relevant areas: the development of medical education and its curriculum; the contributions that the social and behavioral sciences offer to the study of Medicine; and the manner that these perspectives are incorporated or not in the medical curriculum.

Medical Education and Curriculum

It is difficult to determine when and where a formal medical education began; it will depend on how one conceptualizes and defines the term. As observed by Hodges (2005), there are many and conflicting histories about medical education, representing different theoretical backgrounds and points of view. I discuss here the writings that link the history of medical education to a broader socio-historical context, such as the work of Ludmerer (1999) and Calman (2007). For the purpose and relevance of this research, I will start with an account of the changes which occurred from the 19th century until the present, and then present the main debates about curriculum content over the last 20 years.

In the 19th century, there was a change in the characteristic of the practitioner of medicine: from a highly educated person to a clinical scientist (Calman 2007). This change is linked to the emergence of modern medicine, the formalization of medical knowledge and professionalization of doctors. In the birth of the clinic, Foucault (1973) discusses this process, where the teaching of practical medicine is combined with the treatment of patients, forming a whole corpus of knowledge and medical experience. According to Foucault (1973), the act of seeing, or the medical "gaze", is the most important factor in the construction of medical scientific knowledge, which has a specific language, methods for teaching, learning

and categorizing diseases and diagnosis.

The consequences for medical education were the increasing importance of clinical examination; the establishment of the hospital as the focus of practice; an advancement and emphasis in the sciences, such as chemistry and physics; the development of the profession and its regulation; and a concern with public health and sanitary reform (Calman 2007). These changes, however, were part of a long process, happening differently in varied contexts and resulting in diverse developments. By the end of the 19th century, North American Medical Schools were neither regulated nor formally organized. There were many private institutions, which were at times intended mainly for profit (Dornan 2005).

According to Calman (2007), there were sporadic events that could be considered crucial for a change in this scenario in North America. One of these events was the formation of the American Medical Association (AMA), which was very important to the regulation of the requirements for a medical degree, licensing of Medical Schools, and the establishment of a code of ethics. Another important development was the establishment of John Hopkins School of Medicine in 1893, integrating John Hopkins Hospital and John Hopkins University.

This was the first combined system of Medical education and practice in the United States. The hospital was transformed "from an auxiliary part of medical college to an integral part of medical education. The change was from reading medicine to practicing it, and the laboratory became an aspect of medical education" (Calman 2007: 226-227). William Osler was one of the people responsible for the integration of scientific medicine into clinical practice, as the Chair of Medicine at John Hopkins. The clerkship system was introduced by him, giving to students a role in the clinical service (Dornan 2005).

Another occurrence was the publication of a report entitled "Medical Education in the

United States and Canada. A Report to the Carnegie Foundation for the Advancement of Teaching" by Abraham Flexner in 1910. In the report, he examined the education provided in the 155 existing medical schools in the United States and Canada. The following aspects were investigated: 1) the entrance requirements; 2) size and training of Faculty; 3) quality and adequacy of laboratories; 4) qualification of teachers; and 5) the relation between medical schools and hospitals.

His conclusion was that the conditions of medical education in North America were not acceptable and needed to change. He made a series of recommendations for these changes, using John Hopkins as a model to be followed. Some of his recommendations still have an impact on the undergraduate medical education nowadays, such as: that premedical education should consist of biology, chemistry and physics; the division of the curriculum in two pre-clinical years followed by two clinical years (2+2 model); the integration of medical schools within Universities; and the incorporation of research and clinical clerkships in the teaching program (Flexner 2003).

There are multiples interpretations of the impact of the Flexner Report on contemporary medical education. Some authors argue that his work was crucial to the changes which occurred in the 20th Century and to the foundation and standardization of American medical education (Beck 2004; Calman 2007; Diller 2010). Others affirm that the changes were already taking place and argue that Flexner had partial or no responsibility in this process (Hudson 1972, Ludmerer 1999). There are other interpretations which criticize the influence of the Report on the closure of Medical Schools for African Americans and women (Strong-Boag 1981; Leeson and Gray 1978; Harley 2006).

The Report "can be seen as only the initial salvo in what has been nearly a century of

successive reform proposals" (Christakis 1995). In other words, as some scholars pointed out, the Flexner Report is one among many reports and proposals to reform medical education (Bloom 1988, Enarson and Burg 1992, Fox 1990). However, decisive or not, one can argue that "Flexner`s ideas on medical education serve as lens through which one can observe and evaluate the many changes that have occurred in the past eighty years" (Barzansky and Gevitz 1992: xi).

In the 20th century, although the minimal requirements of the American Medical Schools were established by the standards proposed by Flexner, there were debates and proposals to further reform medical education and its curriculum. According to Calman (2007), some of the factors which contributed to a constant discussion on the curriculum content and teaching methods include: a substantial and continuous increase in the knowledge base; changes in the health care system and organization; and a growing importance of patient and public involvement.

Therefore, many other proposals and reports discussing the future of medical education followed Flexner (Rappleye 1940; Association of American Colleges 1984). Enarson and Burg (1992) reviewed 15 studies of medical education issues conducted between 1906 and 1992. They divided the recommendations proposed by these reports into three categories: the methods of instruction, such as curriculum content and teaching process; the internal structure of medical schools; and the relationship of medical schools with external organizations and agencies. Christakis (1995) also discusses trends in the proposals to reform medical education from 1910 to 1995.

Some of these trends and similarities present in these recommendations are of particular interest to an analysis of the development of teaching methods and curriculum, and

appeared almost continuously since 1910 (Christakis 1995). This includes proposals to increase the teaching of life-learning skills, values and attitudes instead of providing students with an extensive body of knowledge to memorize; increasing the emphasis on preventive medicine; the teaching of behavioral and social sciences; and an increasing exposure to ambulatory care (Christakis 1995, Enarson and Burg 1992). The most important question, however, is the extent to which these proposals impacted American medical education; in other words, were any of these suggestions implemented or not.

Enarson and Burg (1992) argue that although there were many recommendations to improve medical education, there has been a lack of major reform of the system. Some of the reasons pointed out by them are the broad nature of the reforms proposed and the lack of integration between clinical and science faculty, which tend to think exclusively of their own academic goals, rather than the school as a whole. Bussigel et al. (1988) also comment on the challenges to reform medical education and curriculum, in spite of many studies and proposals advocating for change.

Bloom (1988) hypothesizes that the problem of the resistance to change is due to the complex character of medical schools, which have now became submissive to the operational needs of research and clinical missions of academic medical centers. What this means is that promotion and status of faculty depends on research productivity and clinical practice expertise. The result is an insufficient number of educators wanting to participate in any attempt to reform medical programs.

Although reform of medical education and curriculum is presented by these authors as difficult, it is obvious that some changes have occurred since the implementation of Flexner's ideal model. Bussigel et al. (1988) note how the basic sciences curriculum content has been

transformed and expanded since the early 20th century: new subject areas and methods of instruction were incorporated; different forms of organizing and delivering curriculum content were created, such as the organ systems approach[4] and problem based learning[5]; and integration of research and teaching was increased.

According to Ludmerer (1999), the evolving character of medical curriculum content is due to the changes affecting the organization, financing and delivery of medical services in addition to the new methods, knowledge base and technologies of diagnosis and treatments of diseases. The original John Hopkins Medical School structure of two years of pre-clinical plus two years of clinical experience, however, has remained the same in most academic institutions in the United States and Canada.

The debate around medical education and curriculum continued in the passage of the 20th to the 21st century. In 1993, the CanMEDS 2000 (Canadian Medical Education Directions for Specialists) project was established as an initiative of the Royal College of Surgeons of Canada. The goal of this project was to ensure that postgraduate training programs attended the needs of society. The project had two main concerns to fulfill this objective: to change the focus of training from the abilities of the physician to the needs of society and to orient the programs to perceive the individual health needs in the context of the population`s health (Frank et al. 1996).

Two working groups were therefore established with the objective of discussing the needs of society and to determine the competencies and resources required to undertake them.

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[4] This approach divides the curriculum in organ systems, such as cardiovascular and pulmonary systems. Each relevant basic science is explored in order to study the systems. It is an interdisciplinary way of organizing content, other than by academic discipline.

5 Problem based learning is concerned with the way students learn. Rather than having to memorize large amounts of information, emphasis is given to the skill of problem solving through examples and simulations.

After broad consultation, the result was a report entitled "Skills for the new millennium: report of the societal needs working group" (Frank at al. 1996) released in 1996. In this document, the essential roles and key competencies of specialist physicians were identified as the following: medical expert; communicator; collaborator; manager; health advocate; scholar; and professional.

An outcome evaluation of the status of the implementation of the CanMEDS framework was commissioned by the Director of the Office of Education in 2001. One of the findings was that the incorporation of the CanMEDS framework was very extensive throughout Canada, having an impact not only on specialty training programs, but also on undergraduate and continuing education (Frank 2005). To ensure optimal wording for contemporary use and validity, a revision of the framework started and it was updated in 2005.

In this review, the key competencies were further explored. The intention was to make the "objectives and strategies for learning more explicit by consolidating and organizing them into a uniform framework that can be modelled nationally, across the medical specialty curricula" (Frank 2005). The key competencies remained the same; however, they were revised, updated and became more interconnected. A diagram was created to illustrate the intersections of the key competencies, having the Medical Expert as playing a central role (Frank 2005).

By defining the skills and roles that physicians should acquire to better meet the needs of patients, the CanMEDS framework intends to be a resource for planning and improving medical education. By expanding the roles and competencies that a physician should have, the consideration of non-medical determinants of health is evident. For example, in order to be a health advocate, one needs to identify the social determinants of health of the people they

serve, which entails recognizing health disparities and the influence of public policy on the health of populations (Frank 2005). In the case of communication, physicians are asked to facilitate the doctor-patient relationship, in which social, economic and cultural factors play a decisive role (Frank 2005). In the next section, I will review the literature which discusses the importance of non-medical determinants on the health of populations.

Social Sciences and Medicine

There are multiple factors to take into account to explain the meaning of health, disease and healing practices. The biomedical approach accentuates the importance of the physical and organic aspects of health, searching for the cure and explanation of diseases in the symptoms and dysfunctions present in the body. From a social sciences perspective, this is not enough. Scholars from different disciplines have studied the influence of non-medical determinants of health, including cultural, social, political, historical, economic, environmental, and psychological dimensions of the health of individuals and populations. I am going to explore here some of these contributions, and whenever possible, I will discuss authors who argue for the need to incorporate these perspectives into medical education.

When culture is the key explanatory concept to explain the health of individuals and populations, anthropological studies illuminate the debate. Since the earliest ethnographic studies, descriptions of body rituals, health, disease, and healing practices were a privileged domain to reveal how the beliefs, attitudes and practices of certain groups are influenced and determined by culture. (Evans-Pritchard 1937; Mauss 1973; Malinowsky 1922). These studies were concerned with the practices and rituals of the so called "primitive" societies, exposing how their beliefs in the supernatural, magic, witchcraft, and the sorcery, were

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coherent to their own way of thinking and being, and acted as an instrument of both social control and disease control and treatment.

In the beginning of 60´s and during the 70´s, studies discussing cultural and social aspects of health and wellbeing started to be labeled as "Medical Anthropology". The area established itself as an interdisciplinary discipline, "linking anthropology to sociology, economics, and geography, as well as to medicine, nursing, public health, and other health professions" (McElroy 2002). Since the early reviews of medical anthropology, authors divided the field in different areas of research, emphasizing different theoretical approaches and methods of research.

Analyzing reviews and medical anthropological studies, three basic paradigms are identified: ethnomedicine, or an interpretative/cultural approach; medical ecology, or social epidemiology; and political economy of health, or critical medical anthropology (Scotch 1963; Fabrega 1972; Colson and Selby 1974; Bhasin 2007). Ethnomedicine or an interpretative/cultural approach are concerned with the way people in different cultures and social groups explain and experience health, healing and disease (Eisenberg 1977; Kleinman et al. 1978; Edginton 1989; Landy 1977). The medical ecology or social epidemiological approach focus on the distribution of disease in relation to sociocultural and biological factors (McElroy and Townsend 1979). The political economy of health or critical medical anthropology approach highlights the historical, political, social, and economic relations and factors which affect health and well-being (Baer et al. 2003; Castro and Singer 2004).

This division of medical anthropology into three distinct paradigms is just a way of organizing different approaches which explore different themes. All the studies, however, make

use of similar concepts to inquiry about health, healing, medicine, and well-being. One of the most well known and used concepts of medical anthropology is the classic distinction between disease and illness proposed by Eisenberg (1977) and used in many studies thereafter (see Fabrega and Silver 1973; Kleinman et al. 1978; Helman 1984). The concept of disease would look for the dysfunction present in the organ, which is based on a biomedical classification and derived from the study of physiological symptoms and observation. The concept of illness, reflecting the patient's subjective perception and experience of being sick, is determined by his/her cultural background.

This distinction is then used by applied clinical anthropologists to explain the conflict of two divergent explanatory models at the clinical encounter: the doctor's and patient's world views. Therefore, according to this approach, medical training should include an understanding of this dichotomy, which constitutes the clinical reality. The consequence would be the ability of the doctor to better communicate with the patient, improving patient satisfaction, compliance and treatment outcomes.

Also important to this discussion is Kleinman's (1980) distinctions among the biomedical, the folk, and popular health systems. He affirms that these three sectors overlap in any complex society, creating different spheres of meaning which define and influence the relationship between patients and healers. The popular sector is the lay, non-professional domain of society where the ill health is first identified. Some of the treatments include self-medication, advice given by friends and relatives, and other forms of informal healing. The folk sector is comprised of sacred and secular traditional healers, most common in non-Western societies. The treatments vary according to the beliefs, traditions and practices of determined groups within societies. The professional sector constitutes the organized healing professions,

such as biomedicine and "alternative medicine" when professionally organized. Popular, folk and professional sectors have particular ways of viewing health and healing, therefore, distrust and suspicion can occur, especially between the folk and professional sectors. It is argued, however, that folk healers can bring benefits to patients, mainly when dealing with psychosocial problems (Kleinman 1980, Helman 1984)

Notwithstanding all these factors, there is also a concern about the divergences which may occur when the cultural background, race or ethnicity of the patient is different from the doctor´s. In this regard, the idea that practitioners should acknowledge, respect and deal with cultural diversity is presented in the nursing, medical and social science literatures (Cooper-Patrick et al. 1999; Cooper and Roter 2002; Kleinman et al. 1978; Lipson 1999; Lupton 2012). As such, various authors argue that medical professionals need better (or more) cross-cultural training. There are different opinions and ideas about the content, core components, educational approaches, and objectives of cross cultural education for medical students. For example, Smedley (2003) and Betancourt (2003) present an overview of the training in cross-cultural medicine divided into three conceptual approaches focusing on attitudes, knowledge and skills.

The first approach is the awareness/sensitivity approach, focusing on providers' attitudes. According to Betancourt "the goal is to increase provider awareness of the impact of sociocultural factors on individual patient´s health values, beliefs, and behaviors, and ultimately on the quality of care and outcomes" (Betancourt 2003: 561). Therefore, students would learn and reflect on racism, culture, and sexism in order to explore how these factors may have an impact on clinical decision-making.

The second approach is the multicultural/categorical approach, focusing on providers'

knowledge about the beliefs, values and behavior of certain cultural groups. As observed by Betancourt (2003), however, this focus has been criticized because it can lead to prejudice, stereotyping, and oversimplification of culture, as it does not consider culture's fluidity and the patient' s individual contexts. But the author emphasizes that this approach can be effective, if students learn to focus on specific and evidenced-based factors of the surrounding community. In this case, students would learn to research important aspects, such as: the community´s social and historic context, socioeconomic status, disease incidence/prevalence among the population, and the patient´s own sociocultural context and perspectives (Betancourt 2003).

The third approach is the cross-cultural approach, focusing on developing tools and skills for providers. This is a process oriented instruction, merging medical interviewing with sociocultural and ethnographic tools of medical anthropology. This includes models developed to provide frameworks to assess the patient´s beliefs and feelings about their health. These frameworks would help physicians to understand the patient´s point of view and to situate their own practice in this context. The last step is the strategies for negotiating the best treatment in collaboration with the patient and his or her family (see for example Berlin and Fowkes 1983; Carrillo et al. 1999; Flores et al. 2000; Levin et al. 2000).

There is also an emphasis on the concept of cultural competence, which according to Wear (2003) includes the multicultural and cross-cultural approaches. In a publication titled "Cultural Competence Education for Medical Students" in 2005, the Association of American Medical Colleges (AAMC) discusses the theme and presents the most widely accepted definition of the term "as a set of congruent behaviors, knowledge, attitudes, and policies that come together in a system, organization or among professionals that enables effective work in

cross-cultural situations" (Association of American Medical Colleges 2005:01). The publication also creates a tool for assessing cultural competence training (TACCT), which is intended to assist medical schools to integrate cultural competence content into their curriculum. It is divided into two parts: 1) content domains, divided in five themes: a) rationale, context and definition of cultural competence; b) key aspects; c) understanding the impact of stereotyping on medical decision making; d) health disparities and factors influencing health; and e) cross cultural clinical skills; and 2) specific components: attitudes, knowledge and skills (Association of American Medical Colleges 2005).

It is important to acknowledge that the definition of the domains proposed by AAMC recognizes some of the critiques that the concept of cultural competence received over the years. This includes: the recognition of physicians' own biases and culture; the problem of stereotyping and discriminating patients based on cultural differences; and the importance of historical and socioeconomic factors on health care disparities. Other concepts have also been created to address some of these critiques and aspects which were missing from the cultural competency model. The concept of cultural humility is one of them (Tervalon and Garcia 1998). The authors observe that cultural humility "incorporates a lifelong commitment to self-evaluation and self-critique, redressing the power imbalances in the patient-physician dynamic, and to developing mutually beneficial and nonpaternalistic clinical and advocacy partnerships with communities on behalf of individuals and defined populations" (Tervalon and Garcia 1998: 117).

Wear (2003) discusses Giroux's idea of insurgent multiculturalism. This concept changes the focus from memorizing and labeling cultural differences of non-dominant groups to a model that emphasizes how the unequal distribution of power creates health and social

disparities. This approach calls for a shift "away from an exclusive focus on subordinate groups, especially since such an approach tends to highlight their deficits, to one that examines how racism (and other forms of dominance and neglect) in its various forms is produced historically, semiotically, institutionally at various levels of society." (Giroux 2000 in Wear 2003:551)

Another example is the concept of cultural safety, which has its origins with the Maori People of New Zealand. Similar to the discussion presented above, the focus is not on cultural practices, "rather, it involves the recognition of the social, economical and political position of certain groups within society" (Smye and Browne 2002: 46). The case of New Zealand is illustrative, and helps to identify possible solutions and models to be followed. Similar to the case in Canada, the Aboriginal population in New Zealand presents a lower health status compared to its non-Aboriginal counterpart. The origin of this disparity is also found in the context of New Zealand's colonial history. And like in Canada and the United States, researchers have been critical of medical education in New Zealand. Ramsden (2002), for example, found that nursing students were not provided with information on the political context of Maori ill health. Instead, the education provided to nurses focused on a "biculturalist or multiculturalist" approach, with an emphasis on ethnicity and exotic cultural difference (Ramsden 2002).

As observed by IPAC and AFMC (2009a), the concept of cultural safety goes beyond, but do not exclude, cultural awareness, which is the acknowledgement of difference; cultural sensitivity, which is the recognition of the importance of respecting difference; and cultural competence, which focuses on the skills, knowledge and attitudes of practitioners. Cultural safety adds the skill of self-reflection, which implies the recognition of the historical, political

and economic context of the relationship between Aboriginal peoples and the Canadian Government.

Therefore, ultimately, these approaches are criticizing the use of a culturalist discourse, which perceives subjectivity as primarily cultural (McConaghy 2000). In other words, as observed by McConaghy (2000), a culturalist approach is "centrally about identity politics; it privileges 'culture' as an explanatory tool for knowing matters of social difference; and it uses 'culture' indiscriminately to explain issues in colonial contexts" (McConaghy 2000:43). Important to this debate is Lila Abu-Lughod's discussion of the implications of the concept of culture in anthropological discourse. She argues that the concept enforces separations that carry a sense of hierarchy, exaggerating the differences and timelessness of a society´s way of life. The result is a static view of culture which ignores its contested and changing nature (Abu-Lughod 1991).

Another important point here is Razack's (1998) discussion of how the cultural diversity and sensitivity approaches can obscure relations of power. Her focus is on the complex ways that systems of oppression and domination are constructed in the encounter between the white and non-white, particularly women in the context of courtrooms and classrooms. She argues that "people in reality are diverse and do have culturally specific practices that must be taken into account, but that its emphasis on cultural diversity too often descends, in a multicultural spiral, to a superficial reading of differences that makes power relationships invisible and keeps dominant cultural norms in place" (Razack 1998: 09). The result is the idea that these differences and characteristics can be known, studied, and managed accordingly to the desires of the oppressors.

The critique of the use of culturalist discourses goes beyond the field of medical

education. Browne and Fiske's (2006) analysis of health policy discourses on Aboriginal peoples in Canada is an example of the negative effects that the focus on cultural difference may have on communities. They argue that the use of "culturalist discourses displace attention from the citizen engaged in policy reform onto the medical subject whose needs can be met through cultural sensitivity that relies on acquiring knowledge of cultural differences" (Browne and Fiske 2006: 100).

Another alternative to this focus on cultural differences is the social determinants of health framework. This approach focuses on the social, economic and political factors which influence the health of individuals and populations. In this perspective, the primary factors that shape the health of individuals and populations are the living conditions they experience (Raphael 2004; Marmot and Wilkinson 2009; World Health Organization Regional Office for Europe 2008). In a recent publication, Mikkonen and Raphael (2010) discuss 14 key social determinants of health of Canadian society, including: Aboriginal status; disability; early life; education; employment and working conditions; food insecurity; health services; gender; housing; income and income distribution; race; social exclusion; social safety net; unemployment and job security. They argue that the effect of these determinants "are actually much stronger than the ones associated with behaviors such as diet, physical activity, and even tobacco and excessive alcohol use" (Mikkonen and Raphael 2010: 09).

Reading (2009) discusses some of the studies in which adult risk factors, such as smoking and obesity, are the main targets to control chronic diseases. He argues that when the risky lifestyle habits are grounded in poor socioeconomic status, this model is ineffective. Therefore, he advocates for a life course epidemiological model that acknowledges the long term effects of risk factors, during all phases of life. The advantage is a broader perspective,

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in which not only biological and behavioral, but also economic, social and political factors are taken into account. Therefore, in the context of Aboriginal peoples in Canada, the life course perspective "provides researchers with the tools to integrate scientific, cultural, and sociologic knowledge in a meaningful way; … secondly, life course research understands health in a holistic way (Lynch and Smith 2005), which complements Aboriginal conceptions of health and well-being that encompass the physical, mental, emotional, and spiritual domains (Bartlett 1998; Isaak and Marchessault 2008 in Reading 2009: 07).

Social Sciences and the Medical Curriculum

The perspectives presented above are examples of approaches that highlight the influence that cultural, social, economic, historical and political contexts have on the health and well-being of individuals and populations. Even though all the approaches demonstrate the importance of acknowledging these factors in medical school, they differ in the focus and manner in which these factors should be addressed and taught to future practitioners of medicine. In addition, some of the critiques discussed above also reveal some of the undesirable consequences of focusing on cultural differences.

These studies and perspectives, however, acknowledge the emergence of cross- cultural education in medical schools. Recent works have pointed to some factors which have influenced this process: an increasing diverse population within societies; the hypothesis that cross cultural education could improve the patient-practitioner relationship; the evident racial and ethnic disparities in health care; and the standards imposed by accreditation bodies and other agencies to require cross cultural curriculum as part of undergraduate medical education (Betancourt 2003; AAMC 2005; IPAC/AFMC 2009a).

The Liaison Committee on Medical Education (LCME), which is the recognized accrediting authority for medical education programs in the United States and Canada, introduced an accreditation standard in 2000 in relation to the educational content related to cultural diversity and competence. It states that "the faculty and medical students of a medical education program must demonstrate an understanding over the manner in which people from diverse cultures and belief systems perceive health and illness and respond to various symptoms, diseases, and treatments….To demonstrate compliance with this standard, the medical education program should be able to document objectives relating to the development of skills in cultural competence" (LCME 2010).

Yet scholars studying the impact of non-medical determinants in the health of populations continue to argue that the medical curriculum does not consider the nonmedical determinants of health sufficiently important (Carrillo et al. 1999; Wear and Castellani 2000; Gupta 2006). My research discusses the education provided to undergraduate medical students in British Columbia on Aboriginal health and the social determinants of health. Therefore, it is important to review studies that investigated to what extent Canadian and British Columbian medical education systems address Indigenous and social science content in their curriculum.

Four studies were found that discuss cultural issues and Aboriginal health in the medical educational system in Canada. Redwood-Campbell et al. (1999) developed a questionnaire administered to all Canadian family medicine program directors. The survey sought to find out if Aboriginal issues were taught in the family medicine programs in Canada. The author concluded that many programs give residents some content and experience in aboriginal health issues, but most of the content and experience occurred in elective courses—courses that students were not required to take. Also, as acknowledged by

the author, the "results might suffer a bias due to residency directors' tendency to overreport the availability of Aboriginal experiences" (1999: 329).

Flores et al. (2000) contacted the deans and directors of the Medical Schools in Canada and United States by telephone in order to find out the number of courses on cultural sensitivity or multicultural issues. A detailed set of information was collected, such as the course type, format and the ethnic group taught about. According to Flores et al. "a course was considered to meet the qualifications of teaching about cultural issues if it had one or more of the following topics as a central focus: culture, cultural differences, ethnicity, race or language and its relations to healthcare" (2000: 452). The conclusion was that most Canadians and U.S. medical schools provide inadequate education on cultural issues, especially concerning particular cultural aspects of different ethnic groups. It seems that this study is taking a culturalist perspective, since there are no questions about whether a critical medical anthropology or social of determinants of health approach to cultural differences is included. The manner in which the issues are taught is also an important aspect to be researched, but it was not discussed in this study. Furthermore, because the analysis was based on the deans and directors' responses about the courses content, the study suffers the same risk of bias stated above.

Spencer et al. (2005) examine the commitment to Aboriginal health in Canadian medical programs in several areas, including recruitment, admissions, support for Aboriginal students, and curriculum content. This study combined a web search and a questionnaire survey to find out to what extent Aboriginal related issues were contemplated and students supported. Although it is an interesting and broad study concerned with support offered to Aboriginal students in the Faculties of Medicine, the curriculum content analysis was not

extensive. This analysis was constrained by the exploration of the Faculties' website, where the detailed curriculum content, with a description of the courses' readings, could not be found.

Lastly, IPAC-AFMC (2008) distributed a questionnaire to all medical schools in Canada to obtain information on the current curriculum relevant to Aboriginal health issues. The relevant aspects included: social determinants of health; complexities in healthcare delivery, such as historical context and barriers to appropriate care; cultural information on First Nations concepts of health and disease; and recognition of diversity among Indigenous populations. In this case, differently from the other studies discussed above, there is a concern to find out whether a critical approach is present in the curriculum content.

The results were presented in a webpage, and pointed out that 8 courses addressed Aboriginal health issues in British Columbia. While the survey asked whether Aboriginal health and social determinants appear in the medical curriculum, it did not provide any details of the curriculum content. Important issues are missing from the analysis: how much time is dedicated to these issues? What materials are suggested for reading? How are Aboriginal issues taught? What approach is emphasized and discussed? A political economy of health approach? A culturalist approach? Or are some of these perspectives combined? How the concept of culture is defined? How are Aboriginal peoples and health represented/described? Does the curriculum focus on developing the skills, knowledge or attitudes of the practitioner to deal with Aboriginal patients?

To answer these questions would have required a detailed analysis of the courses outlines, materials and content, as well as an exploration of how these materials were presented and discussed in the classroom and how medical students understood the significance

of these approaches and what they took away from them. The IPAC/AFMC study did not carry out these more detailed studies. My research builds on the preliminary IPAC/AFMC study by focusing on the course outlines and readings. I also do not explore how these materials were presented and discussed in the classroom or how they were understood by medical students.

Moreover, unlike the previous studies in this area, this research will not suffer from the directors or program coordinators' bias. The content of courses will be analyzed and evaluated in conjunction with members of an Advisory Committee formed by Aboriginal people interested and/or expert in Aboriginal health. The intent is to make a critical assessment of the assigned readings and to discuss further recommendations for improvement. The perspectives discussed above will guide the discussion, and they will serve as models to identify the manner in which Aboriginal health issues appear in the medical curriculum.

3. Thesis overview

This research explores the education provided to medical students on Aboriginal health issues and the social determinants of health in British Columbia, Canada. The present chapter introduces the thesis, by stating the objectives, purpose and significance of the research. In addition, it presents the discussion of the relevant literature. The methodology utilized in the research will be reviewed in chapter 2. This chapter describes the strategies, phases and methods of this study. The objectives are to describe all the phases and research methods; to justify the selection of relevant courses; and to describe the process of the analysis of the course readings and the recruitment and discussion with the Advisory Committee.

Chapter 3 is my report on the undergraduate medical curriculum, prepared for analysis and review by the Advisory Committee members and the researcher. The report describes and

summarizes the content of the selected courses, and it served as an instrument for discussion and analysis. In chapter 4, a critical analysis is conducted. The idea is to identify to what extent the readings and resources suggested in the undergraduate medical curriculum address the First Nations/Inuit/Métis Core Competencies proposed by IPAC/AFMC (2009a). Chapter 5 is the conclusion of the thesis.

Chapter 2 – Methodology

The previous chapter described the influence of non-medical determinants on the health of individuals and populations. In the case of Aboriginal peoples in Canada and in British Columbia, it is very important to acknowledge historical, economic, political and social factors on their health status. As discussed previously, these factors have impacted and still influence their well-being nowadays. The need for medical students to be educated about Indigenous peoples and concerns was also discussed in the previous chapter. The province of British Columbia, as well as Canada as a whole, has a diverse population, including settler populations (recent and historical) and Aboriginal groups, which have different cultural backgrounds and social contexts. Therefore, understanding these differences is important to providing better health care services. Health practitioners should then recognize not only cultural differences, but also the diverse social contexts of their patients.

Thus, this research is concerned with the identification and critical analysis of the education provided to medical students in the province of British Columbia about Aboriginal health issues. The objective is to reveal the way that Aboriginal health and populations are represented and talked about in the reading materials used in the medical curriculum. More specifically, I am interested in identifying the perspectives utilized in the courses readings, such as a focus on the social determinants of health, cultural competency, or a more statistical approach.

Ultimately, my interest is to identify how language – in the form of written discourse – mediates relationships of power and dominance as manifested in medical education and its body of knowledge. In other words, I am assuming that discursive practices "can help to produce and reproduce unequal power relations between, for instance, social classes, women

and men, and ethnic/cultural minorities through the ways they represent things and position people" (Fairclough and Wodak 1997: 258). Therefore, I build on a Critical Discourse Analysis framework (CDA), an interdisciplinary approach which is concerned with the structural relationship of power and dominance as manifested in language (Blommaert & Bulcaen 2000; Wodak 1997).

The Critical Discourse Analysis paradigm is a means to integrate discourse analysis and social theory. The intention is to "describe, interpret, and explain ways in which discourse constructs, becomes constructed by, represents and becomes represented by the social world" (Rogers et al. 2005: 366). It has been used by scholars from different areas, but there is a common interest in understanding conditions of inequity and seeing language as social practice (Wodak 2002). Therefore, texts are considered as "sites of struggle in that they show traces of differing discourses and ideologies all contending and struggling for dominance" (Wodak 2002: 08).

A concrete example of the use of CDA that I am building on is Browne and Fiske's analysis of Canadian health care policies (2006). Their analysis combines an investigation of health policy public discourses in conjunction with women's experiences of these policies. Researchers conclude that there is a contradictory construction of Aboriginal women: as empowered citizens in dialogue with government in health policy consultations, and as medical discredited subjects in health care services (Browne and Fiske 2006).

In my research, medical curriculum discourse is considered as one of the ways power is exercised in society. What this means is that by analysing the way that Aboriginal health and peoples are characterized in the medical curriculum in BC, I am also revealing the position that Aboriginal peoples and their conception of health have in society. In addition, I

am examining the construction of scientific discourse as supposedly neutral and superior to "a series of knowledges that have been disqualified as nonconceptual knowledges, as insufficiently elaborated knowledges: naive knowledges, hierarchically inferior knowledges, knowledges that are below the required level of erudition and scientificity" (Foucault 1997:07), characterized by Foucault as "subjugated knowledges".

The work of Emily Martin (1998) highlights how anthropological studies can reveal the culturally conditioned character of science, by showing that "rather than being produced in an isolated, privileged realm and trickling out to inform the rest of us about what is "true," science is made -throughout-bubbles up from many places within- historically constituted human culture" (Martin 1998: 40). This perspective implies that scientific discourse is not neutral and permeates and it is permeated by society.

An illustration of this perspective is Martin's analysis of the discourse around women's bodies in medical texts. Martin (1987, 1991) shows how medical discourse reflects the cultural assumptions about and the roles and power relations of women in society. One of the important elements in her analyses is her search for the metaphors utilized in the textbooks and medical literature to describe the women's bodily functions and how these metaphors are connected to women's perceptions and feelings about their own bodies (Martin 1991). I similarly search for metaphors about Aboriginal health and populations, to reveal the manner in which they are characterized in the medical curriculum in BC.

My analysis is informed by the works and critical framework discussed above. Thus, I explore the terms, expressions, metaphors and themes associated with Aboriginal populations in the medical curriculum. The questions I considered when reading the materials include: How are Aboriginal health issues presented in the resources and readings? What images are

produced about Aboriginal populations and their health status? What are the interpretations presented to students to justify the lower health status of Aboriginal peoples? What is suggested to students as necessary to improve the health and well-being of Aboriginal groups? What is the vocabulary employed to describe the health of Aboriginal populations? Under what themes and topics are Aboriginal health and populations included in the curriculum? What are the suggested roles that Aboriginal peoples have in the improvement of their health status?

Consequently, I am considering the materials of the courses selected for analysis – all required and suggested readings, additional resources, and guides – as constituting a discourse or discourses. The analysis of readings is central, because they represent the manner in which Aboriginal health and populations are taught to medical students. It is important, however, to lay out other ways in which the analysis could have been constructed, such as through participant observation of how those materials were discussed and responded to in a classroom situation; conducting interviews or focus groups with medical students about what they thought about the readings and what they got out of them; asking instructors or program directors about the curriculum content. For the purposes of this particular research project, I am just doing the analysis of the readings materials. I am aware that relying just on written materials may cause an erroneous idea of the theme discussed, since some articles and texts are assigned in a course to generate controversy and discussion.

There are advantages, however, to focus just on the readings, since there are no variations in approaches, opinions and attitudes of students, instructors and program directors. Each group would represent their interest in criticizing or supporting the materials and I would not have a clear illustration of the curriculum content. For future research on the

impact of the curriculum content on the health care service delivered to Aboriginal peoples, it would be interesting to combine the analysis proposed here with considerations of different groups of students, residents, and practitioners. In this case, the research focus would be on the groups´ perceptions of their education on Aboriginal health and the impact that this education had or will have on their practice as doctors.

The University of British Columbia offers the only medical program in the Province, which is distributed across BC in four programs: the Island Medical Program at the University of Victoria in Victoria, the Northern Medical program at the University of Northern BC in Prince George, the Vancouver and Fraser Medical Program at the University of BC in the Greater Vancouver area, and the Southern Medical Program at UBC Okanagan campus in Kelowna. The program`s length is four years and it is composed of a mix of traditional lectures and laboratory sessions with small sessions of problem-based learning (UBC website).

In the first semester, students of the four programs have their classes at the University of British Columbia campus. Then, they are divided in four different sites, but the courses of the first and second years are taught simultaneously by video conference. Therefore, the curriculum content of these courses is the same for everybody but it may change from year to year. In the third year, students start clinical clerkships which will be different depending on the facility chosen by the student throughout British Columbia, being mandatory 4 weeks in a rural community. In the fourth year, students choose their 6 elective courses and obtain more experience through the preparation for medical practice (PMP) course.

In 2008, the Indigenous Physician Association of Canada and the Association of

Faculties of Medicine of Canada conducted a survey by means of a questionnaire of all Faculties of Medicine in Canada to investigate the undergraduate medical curriculum content relevant to Indigenous health (IPAC/AFMC 2008). No published report of this study was found except for a table showing the survey results by University (Appendix A) and a webpage containing a summary of the key findings. (www.afmc.ca/pdf/IPAC-AFMC_Indigenous_health_curriculum UGME_key_findings.pdf retrieved on April, 13th, 2011).

The table reveals the courses identified as having relevant Indigenous health content for each University and presents the following information: if Indigenous health issues are specifically addressed, the general topics covered in each component, if there are teachings related to cultural information, the methods by which information is obtained by learners, the methods of evaluation, and if there are opportunities to engage with Indigenous populations. The summary of the key findings presents statistics about this study. For example, it shows that 90% of the relevant curriculum of all the universities addressed the social determinants of health; 73% discussed the historical context; 82% provided cultural information, mostly linked to Indigenous conceptualization of health and disease. In addition, the webpage presents data on the educational methods, such as the percentage of learners who have the opportunity to engage with Indigenous communities (93%) and the percentage of learners receiving training in cultural competency or safety (52%).

Some questions, however, arise from the study developed by IPAC/AFMC. The survey presents information provided by the Faculty members of each Canadian medical school, but it seems that the accuracy of the information provided was not checked. In other words, the researchers did not review the materials of these courses to confirm where in the course

indigenous health issues were addressed and how. The IPAC/AFMC study provides a list of these courses and the topics discussed, but there are no details about the courses' content.

Important aspects were not investigated, such as the centrality of the topic under discussion; whether it was situated in an assigned or a supplemental reading; the time dedicated to indigenous health issues in relation to biomedical topics; the themes linked to Aboriginal health; if key concepts such as culture/cultural competence/cultural safety/social determinants of health are discussed and how they are defined; the kind of materials used in the courses (academic articles, newspapers and magazine articles, Government reports, websites); and the content of these materials.

As observed by IPAC/AFMC "these findings have helped to identify key resources and will serve as a stepping stone for the further development of Indigenous health curriculum across the continuum of medical education" (www.afmc.ca/pdf/IPAC-AFMC_Indigenous_health_curriculum UGME_key_findings.pdf retrieved on April, 13th, 2011). Eight courses in the UBC Medical Program were reported in the IPAC/AFMC survey to include discussions of Aboriginal health and the social determinants of health: Family Practice Continuum II; Advanced Clinical Electives I and II; Doctor Patient and Society 420 (2nd year); Doctor Patient and Society 410 and 420 (4th year electives), Preparation for Medical Practice (4th year); and IHHS 408 - Topics in Aboriginal Health - A Community-Based Elective.

Based on these results and on my research objectives and scope, I selected three courses for content analysis: Doctor Patient and Society 410; Doctor Patient and Society 420; and IHHS 408 - Topics in Aboriginal Health - A Community-Based Elective. These courses

were chosen because they are lecture courses with a set reading list of journal articles, websites, Government reports, and other materials. It would require a different kind of research method to explore the content and discourses of the practical and clinical courses; therefore, Family Practice Continuum II; Advanced Clinical Electives I and II; and Preparation for Medical Practice were not included in the analysis.

The program coordinators responsible for each of the selected courses in 2009 were contacted by email with the purpose of obtaining the courses outlines. The analysis of the content of the selected courses was made through a detailed consideration of the course materials specified in the respective course outlines. This included the collection of the required and suggested readings; a search of the recommended websites; and gathering any other resource suggested to students, such as Government reports, guides and tests. I did not access class lectures or discussion groups. My next step was to read all the collected materials, composed of academic articles (79); Government reports (54); websites (56); novels (2); magazines and newspaper articles (5); and other resources, such as guides, intervention forms, protocols, and reports from international and national health agencies (35). As a way of organizing this extensive material, a spreadsheet with relevant information was created for future reference.

For each of the readings and resources, I was interested in finding the following information to enter in the spreadsheet: title; author and year; abstract; headlines; key messages; if aboriginal peoples were discussed (yes/no); if non-medical determinants of health were discussed (yes/no); if alternatives forms of healing were discussed (yes/no). In addition, if these themes were discussed, I copied the selection of the passage when it occurred. Based on the spreadsheet, I produced a preliminary report summarizing the content

of the three selected courses.

The work of Klodawsky et al. (2002) was important in guiding me in the assembly of the spreadsheet. In this work, the authors present a discourse analysis of four years of media reporting on homelessness in the *Ottawa Citizen* newspaper. The media reports were then analysed and the key words "poverty", "homeless" and "low income" were used to compile the dataset (Klodawsky et al. 2002). To build the spreadsheet, and to collect the information I was looking for, I searched the words "Aboriginal", "Indigenous", "First Nations", social determinants", and "healing" to determine if Aboriginal peoples, non-medical determinants of health and alternative forms of healing were being discussed or not in the readings and to select relevant passages.

The intent of the report which I subsequently produced was to present a summary of the readings and course materials of Doctor Patient and Society 410; Doctor Patient and Society 420; and IHHS 408 - Topics in Aboriginal Health - A Community-Based Elective. In addition, the report gives a brief overview of my research aims and the undergraduate medical curriculum. The report is more descriptive than analytical and it contains a preliminary discourse analysis, as it identifies the terms of the discussion based on the search of the selected "key words". Therefore, the report serves as a starting point for discussion and analysis. The idea was to summarize the extensive spreadsheet in a manner that would provide an overview of the curriculum as a whole and the specific themes addressed in each section of the selected courses as a starting point for my discussions with members of the Aboriginal Advisory Committee.

The Report (see Chapter 3) begins with a list of questions suggested to the reader for discussion. The introduction explains the objectives and context of the research, situating the

study in the existing literature and outlining important concepts and the theoretical framework. Then, the medical curriculum is described through maps that illustrate the required courses divided by year. These maps show where the courses which have Aboriginal health content are located in the curriculum, and how much time is dedicated to these issues compared to other subject matters.

Subsequently, each of the selected courses is examined in the report. First, I included a brief description of each course, as it is presented to the medical students on the website or in the syllabus. Then, I summarized the suggested readings and resources, organized by each heading and/or theme included in the courses outline. For example, in the course Doctor, Patient and Society (DPAS 420), there is a block which discusses Mental Health and it is divided in two sections, *Mental Health I* and *Mental Health II – Severe Addiction and Concurrent Disorder.* I present a summary of the suggested and additional readings for this block, highlighting when Aboriginal health and populations are discussed.

To ensure that appropriate respect is given to the cultures, languages, knowledge and values of Indigenous peoples, the principles of partnership, protection and participation were part of my research process and protocols (Appendix B – Ethical Protocols and Principles for conducting the research). Built into the research was space for the participation of Aboriginal people in the initial development of the research proposal and in the analysis of the research findings.

In February of 2009, I applied for a NEARBC scholarship (Network Environment for Aboriginal Research British Columbia). One of the requirements was a reference letter from an Aboriginal Institution, stating their support for the proposed research. Seeking support, I contacted IPAC since my research builds on their original study and initiative to improve

Aboriginal content in the medical curriculum. The answer was a letter of support, which had three qualifications to ensure their support: to include Dr. Barry Lavallee, one of the members of the board of directors at the time, on my Advisory Committee; to ensure local Indigenous community participation; and to give opportunity for IPAC to have their own analysis accompanying my research if they have any disagreement with my findings[6].

I then established contact with Dr. Barry Lavallee, president of IPAC at the time through teleconference and emails. On his advice and with input from the Director of the Indigenous Studies Program at Uvic, it was decided that an Aboriginal Advisory Committee composed of three to five local individuals would be formed to assist in and comment on the curriculum analysis. This committee was anticipated to be a resource, which would contribute to the review of the preliminary results by providing a forum for discussion with Aboriginal people interested and/or expert in Aboriginal health. The plan was that the members of the Advisory Committee would share their expertise and experience with Aboriginal health, and assist in the evaluation of my research findings, providing me with their judgment, based on my preliminary report, of the three courses reviewed and recommendations for improvement.

Following the completion of the report, I began the process of recruitment of people to participate in the Aboriginal Advisory Committee. My first step was to contact Institutions and Associations that could help me to identify potential participants. For that reason, I

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[6] While I did not receive the NEARBC scholarship, I continued to discuss my research plans with Dr. Barry Lavallee.

contacted the Centre of Aboriginal Health Research (CAHR) and the Network Environments for Aboriginal Research British Columbia (NEARBC) and the Office of Indigenous Affairs at UVic by email. Robynne Edgar, the Programs Manager of CAHR and NEARBC, responded and sent me a list of people who might be interested in participating. Contact was then made with 12 individuals. I also sent my request for participants to the NEARBC/CAHR Newsletter, which is a weekly electronic bulletin that reaches nearly 1,300 people, providing information on the latest news in Aboriginal health research.

I believe that sending a request through the Newsletter was an important way to inform a broad audience of Indigenous and non-Indigenous peoples interested in Aboriginal health about the research project. In addition, one of the people who agreed to be part of the Aboriginal Advisory Committee was informed about the research through the newsletter. Other participants were selected through the network I established at the University of Victoria when participating in talks and conferences on Aboriginal health.

After first contact was made, I received three positive responses of interest in participating in the research. Then, I sent to the three potential participants a consent form approved by the ethics review board of the University of Victoria. The form explained the general aspects of the research, such as the objectives, purpose, benefits, roles and involvement of the Advisory Committee (Appendix C). In addition, participants would have to choose how they would participate, and the options were: 1) to participate in person in a working group session to discuss the content and analysis collectively with the researcher and other members of the Advisory Committee; 2) Provide written feedback on the content and the analysis to the researcher by email or mail; 3) Discuss the content and analysis with the researcher privately by phone or in person.

By signing the form, members were informed on all aspects of the research, and also chose one of the above options. In total, the three people who I sent the consent form decided to form the Aboriginal Advisory Committee. I am aware that it would have been even more productive to have more people participating in these discussions. However, I believe that time was an issue for many people who were invited to participate. The summary report on the undergraduate medical curriculum was then sent to these three individuals for their review and analysis. The report starts with a list of suggested questions for discussion. These questions were not necessarily considered one by one by members of the Aboriginal Advisory Committee. These questions were used to guide the discussion at the meetings rather than as part of a questionnaire to be answered. They were important to make clear to the members what I was looking for when I asked them to review and comment on the report.

Two participants gathered together in a working group session held at the University of Victoria on November, 15th, 2010. The meeting was recorded and the transcription was sent to them by email for any amendments or additional comments. The other participant gave feedback on the telephone on March, 04th, 2011 and the conversation was also taped, transcribed and sent for verification.

The objective of the meetings was to generate and encourage an exchange of ideas, insights and information. I think that what was most important was to make my research known and accessible for Aboriginal people to participate in and to give any feedback. The meetings were very important for the subsequent analysis, however, I take all the responsibility for anything written in this dissertation. The main points discussed were: the general manner in which Aboriginal peoples are referred in some of the readings; the importance to address diversity, historical background and protocols of Aboriginal

communities; the emphasis on the negative aspects and the depiction of a needy and weak population; the consequences of this detrimental image, such as stereotyping and racism; the alternative and importance of highlighting capacity, strength, community partnership and involvement. There were no points of disagreement; in general, our discussion was very productive and informative, since we all learned from each other and shared our knowledge and expertise.

It is important to critically reflect on how my background has influenced this research project and the interaction with committee members. Situating ourselves and considering any cultural biases and power differentials is essential to build trust and respect in the research encounter. Our own experiences and social positions are complex and they influence the relationship between the researcher and its object. In fact, the idea of an "objective observer" is already criticized by many scholars in anthropological research, and it is argued that both subject and object construct each other in the research process (Hayden 2009).

Therefore, I position myself as a Brazilian scholar, white, female, living in another country, as a student and immigrant. My status here makes me part of a minority group, with its own language, customs and culture. I see myself as privileged to recognize cultural characteristics as a natural attribute of groups and societies, and not as exotic and stigmatizing. This perception comes with my background in Anthropology and life experience of being away from my country, living in a different context and environment. I believe that this particular context was contributed to the research and interaction with committee members in a positive manner. Aboriginal peoples and communities here have suffered from being used as research objects without being consulted and respected. The purpose of the meetings was to give voice and opportunity to share the results and analysis with the

community. The conversations had an informal tone; there was no power differentials involved, since all of us have already had experiences in conducting research.

After the meetings I began my final discourse analysis, which is the result of a preliminary critical investigation of the readings and consequent production of the report combined with the discussion with the Aboriginal Advisory Committee. In the next two chapters, I will apply the methodology and theoretical approaches explored here and present the data collected and the analysis conducted. In Chapter three, I present the summary report on the undergraduate curriculum in BC, which was sent to the participants of the Aboriginal Advisory Committee for discussion and commentary. The chapter is not a reproduction of the Report, since I added a few sections to it, adding more context and information about the selected courses. Chapter four is dedicated to my final critical analysis of the material collected, and the theoretical and methodological approaches discussed here will be further explored.

Chapter 3 – Summary Report on the Undergraduate Medical Curriculum in British Columbia

The Summary Report reproduced in this chapter was sent to participants of the Aboriginal Advisory Committee to facilitate the discussion and share my preliminary findings. In the beginning of the Report, I suggested some questions for discussion, which were not necessarily addressed one by one by the Committee members. They were just intended to be a resource to guide the discussion. They were the following:

1) What is good/positive/helpful about this content?

2) What is not good/not helpful/negative or problematic about this content?

3) What images do you think the content creates about Aboriginal populations and/or Aboriginal health?

4) Do you think the content overgeneralizes about Aboriginal populations and/or health?

5) Are there any important points missing in this content? Which?

6) Do you think this content characterizes Aboriginal culture in a positive or negative way? Explain.

7) Do you think the social determinants of health are sufficiently explored in this content?

8) Do you think the content illustrates in a respectful manner traditional forms of healing?

9) Do you think the content provides an appropriate guide to enhance the communication between doctors and Aboriginal patients?

10) Do you think this content will help students to establish a positive therapeutic relationship with Aboriginal patients and their families, based on a mutual understanding, trust, respect, honesty and empathy?

11) Do the students receive enough knowledge to identify best practices in the provision of health care to Aboriginal patients?

12) In sum, what are the strengths of this content? And the weakness?

After these questions, I introduce the objectives, significance and context of my research. Then, I explain the purpose and structure of the Report, followed by a description of the courses that were analysed. In this Chapter, I expand on the Report by adding a more complete description of the medical undergraduate curriculum and selected courses.

The Report: *Introduction*

The objective of this research is to examine the extent to which Medical Schools in British Columbia prepare their students to address the health issues facing Aboriginal populations. As an attempt to minimize the health disparities of Aboriginal peoples, the Indigenous Physician Association of Canada (IPAC), in conjunction with the Association of Faculties of Medicine of Canada (AFMC), developed a curriculum framework for undergraduate medical education. Their recommendations were based on the development of core competencies, which are intended "to provide undergraduate medical educators with broad thematic domains around First Nations, Inuit, Métis (FN/I/M) health knowledge, skills and attitudes to engage in both patient and community-centered approaches to health care delivery with and for FN/I/M peoples" (IPAC/AFMC 2009a: 05).

These core competencies were based on the CanMeds framework (Frank 2005), and adapted to the context of Aboriginal populations. Accordingly, the concept of cultural safety becomes very important to the successful implementation of the curriculum framework developed by IPAC and AFMC (2009a). In this case, "cultural safety refers to a state whereby a provider embraces the skill of self-reflection as a means to advancing a therapeutic encounter with First Nations, Inuit, Métis peoples and other communities including but not limited to visible minorities, gay, lesbian, transgendered communities, and people living with challenges" (IPAC/AFMC 2009a: 09). Thus, by adding the skill of self reflection, the concept of cultural

safety goes beyond cultural awareness, which is the acknowledgement of difference; cultural sensitivity, which is the recognition of the importance of respecting difference; and cultural competence, which focuses on the skills, knowledge and attitudes of practitioners (IPAC/AFMC 2009a).

Consequently, self reflection implies the recognition of power differentials between health care provider and patient. Having this perspective, it is crucial to acknowledge the historical, political and economic factors that have had and still have an impact on the health and well being of Aboriginal populations in Canada. For that reason, it is important to recognize the social determinants of health which are the economic and social conditions that shape the health of individuals, communities and jurisdiction as a whole (Raphael 2004). In this perspective, the resources that society makes available to its members are crucial to determine the health statuses and well being of individuals and communities.

Therefore, building on IPAC/AFMC research (IPAC/AFMC 2009a), the intent of this report is to summarize the portion of the undergraduate medical curriculum where Aboriginal health and the social determinants of health are discussed. Consequently, the expectation is to gain a better understanding of the manner in which Aboriginal people and their health statuses are characterized and taught to future doctors. Thus, the goal of the research is threefold: 1) To identify the courses of the undergraduate medical program in British Columbia which discuss Aboriginal health; 2) to evaluate the content of these courses, examining the assigned readings and outlining the manner in which Aboriginal health is portrayed; and 3) to consult with Aboriginal people and receive feedback concerning the current curriculum and possible recommendations for improvement.

The undergraduate medical program in British Columbia is a four year program. In the first

two years, students are exposed to the principles of Human Biology (14 weeks) and the Foundations of Medicine (55 weeks). This part of the curriculum is divided into a series of system blocks: Host Defenses and Infections; Cardiovascular; Pulmonary; Fluids and Electrolytes and Renal; Blood and Lymphatics; Gastrointestinal; Musculoskeletal and Locomotor; Endocrine and Metabolism; Integument; Brain and Behavior; Reproduction; Grown and Development.

In addition, there are three longitudinal courses, which are taught continuously in the first two years. These courses are: Doctor, Patient and Society; Family Practice Continuum; and Clinical Skills. In Family Practice Continuum and Clinical Skills, students are exposed to some of the practical aspects of the medical profession, such as patient-interviewing and physical examination. Doctor, Patient and Society is a multidisciplinary course where students are assigned readings and have the opportunity to discuss themes such as the social determinants of health, multiculturalism, prevention, and Indigenous health issues. This course is intended to give students a broader view of health, acknowledging its non-medical determinants (UBC website).

The third year is dedicated to the Clinical Clerkships (49 weeks) and Rural Family Practice Clerkship (4 weeks). In the fourth year, students have two clinical blocks, the course Preparation for Medical Practice and six elective courses of their choice to complete. According to the UBC Faculty of Medicine's website, the purpose of this year is to prepare students to achieve exit competencies while the residency program allows for the exploration of possible career choices. Therefore, the program gives a solid background in Biology and Medicine in the first two years, combined with longitudinal courses which expose students to early practical experience and to some social and behavioral sciences content. The last two years focus on the clinical practice clerkships, but also have theoretical components, through the elective courses.

This thesis is concerned with the portion of the curriculum dedicated to Aboriginal health

and the social determinants of health. Thus, based on a questionnaire developed by IPAC and AFMC (2008) and on the scope and interest of this research, three courses were selected for further analysis: Doctor, Patient and Society (DPAS) 410 and 420 and Topics in Aboriginal Health – A community based elective (IHHS 408). Below there is a brief description of the courses and materials obtained.

The courses DPAS 410 and 420 are year long courses taught during the first and second years of medical school. They are delivered through lectures and small group tutorials, covering a broad selection of topics, such as the social determinants of health, epidemiology, health promotion and prevention. After contacted by email, the program assistant of DPAS 410 sent me the agendas for the portion of the course that concentrates on Aboriginal health and the social determinants of health. There were four sessions which addressed these issues. Each session was divided in two parts: one hour and fifteen minutes lecture followed by one hour and a half of tutorial group discussion. The objectives of the session, the required and recommended readings are listed in these agendas, in addition to the topics for discussion and for the reflective writing assignments. For DPAS 420 I received a complete course book, indicating the required and suggested additional readings and resources. The course is divided in theme blocks, such as "health promotion" and "epidemiology". Each block is subdivided in a different number of plenaries.

Topics in Aboriginal Health is an elective course offered to health professional students, in such areas as medicine, nursing and pharmacy. This elective combines clinical and academic learning components through an experiential community immersion program (Andrew 2009). The length of the course is 4 weeks, and it is delivered by presentations of community members, field trips, clinic visits, home visits, hands-on projects, workshops and cultural learning activities. According to the course outline, Aboriginal community partners have been essential in the

development, design, implementation, delivery and evaluation of the course. In 2009, four Bands were part of this project: Cowichan Band (near Duncan, BC), Mt. Currie Band (near Pemberton, BC), Seabird Island Band (near Agassiz, BC), and Esketemc Band (near Williams Lake, BC).

There are 16 students placed per course (4 per community). The time commitment is 6 hours per day, Monday to Friday. Evaluation and grading involve an inter-professional team project, an individual project, and attendance and participation in community and learning activities. For IHHS 408 I received a course outline and a reading list for 2009, which contains a detailed description of the course format, learning objectives, sample activities and suggested readings and resources. It is stated that the syllabus is a guide to the development of the course, being flexible to accommodate specifics needs of each community. Thus, the main component is to give students the opportunity to gain direct experience working with Aboriginal patients and community members.

Below you will find the curriculum map for the 2009/2010 Academic year. Note that Doctor, Patient and Society 410 and 420 are year long courses, taught during the whole academic year. Topics in Aboriginal Health (IHHS 408) is one of the electives that students can choose from in their 4th year and it is not a mandatory course.

Year 1 Curriculum Map for the 2009-2010 Academic Year

First Year

	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	Apr.	May	
Orientation Aug. 26-28	**Principles of Human Biology** PRIN 401 14 weeks Aug. 31 Dec. 4			Study Dec. 7-8	Exams Dec. 9-16	Vacation 2 weeks Dec. 17 Jan. 1	**Host Defenses & Infection** FMED 401 5 weeks Jan. 4 Feb. 5	**Cardiovascular** FMED 402 6 weeks Feb. 8 Mar. 19	**Pulmonary** FMED 403 5 weeks Mar. 22 Apr. 23	FMED 404	**Fluids, Electrolytes, Renal & GU** 5 weeks Apr. 26 May. 28	Exams / Study June 1-11

Doctor, Patient & Society (DPAS410), Clinical Skills (INDE410), Family Practice (FMPR401) / Introduction to Clinical Dentistry, Professionalism & Community Service (DENT410)

Year 2 Curriculum Map for the 2009-2010 Academic Year

Second Year								
Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	Apr.	May

GI
FMED 424

Blood & Lymphatics
FMED 421

Musculoskeletal & Locomotor
FMED 423

Endocrine & Metabolism
FMED 425

Study

Exams

Vacation

Integument
FMED 422

Brain & Behaviour
FMED 426

Reproduction
FMED 427

Nutrition, Growth & Development
FMED 428

Exams / Study

4 weeks
Aug. 31
Sept. 25

2 weeks
Sept. 28
Oct. 9

4 weeks
Oct. 13
Nov. 6

5 weeks
Nov. 9
Dec. 11

Dec. 14-15

Dec. 16-22

2 weeks
Dec. 23
Jan. 1

Jan. 4-8

9 weeks
Jan. 11
March 12

4 weeks
March 15
Apr. 9

5 weeks
Apr. 12
May 14

May 15-28

Doctor, Patient & Society (DPAS420), Clinical Skills (INDE420), Family Practice (FMPR420) / Introduction to Clinical Dentistry (DENT420)

Year 3 Description of the Curriculum for the 2009-2010 Academic Year

Rural Family Practice Clerkship (4 weeks)

Students are introduced to a clinical practice setting in order to participate in the practical aspects of life and medical practice outside the context of urban tertiary institutional settings.

Clinical clerkships (49 weeks)

Students act as Clinical Clerks in Anaesthesia, Dermatology, Emergency Medicine, Internal Medicine, Obstetrics and Gynaecology, Orthopaedics, Ophthalmology, Pediatrics, Psychiatry and Surgery. There is also a 2-week Elective period. Prior to the start of third year there is an orientation period for ward and clinical skills. During basic clerkships, students perform histories, physical examinations, identification and work-up of patient problems, using the biological-behavioral-population paradigm.

Year 4 Curriculum Map for the 2009-2010 Academic Year

YEAR 4 SCHEDULE 2009/2010 - CaRMS Interviews Jan 23rd - Feb14th, 2010

INDE 440	INDE 441	INDE 442		INDE 453 PMP		INDE 453	INDE 451	INDE 454		INDE 443	INDE 450	INDE 455
2009 (includes 1st clinical block)						2010 (includes 2nd clinical block)						
31 Aug - 27 Sept	28 Sep - 25 Oct	26 Oct - 22 Nov	23 Nov - Dec 18			Jan 4 - Jan 15	Jan 16 & 17	Jan 18- Feb 14	Feb 15- Feb28	Mar 1 - Mar 28	Mar 29- Apr 25	Apr 26- May 7
Elective 1*	Elective 2*	Elective 3*	Self-Study	PMP	Vacation	PMP	OSCE	Self-Study/CaRMS Interviews	Elective 4	Elective 5	Elective 6	Promotions & MCC
4 wks	4 wks	4 wks	1 wks	3 wks		2 wks		4 wks	2 wks	4 wks	4 wks	

I will present here the content of the selected courses – DPAS 410, DPAS 420 and IHHS 408, as it was sent to the members of the Aboriginal Advisory Committee. The report is organized by course, and for each course, I present a summary of the readings used to discuss each of the suggested topics. For a complete list of the readings, the courses outlines are attached (Appendices D, E, F, G, H). The objective of the report was to provide a summary of the content presented in the courses and to start a discussion on how Aboriginal health and the social determinants of health are presented in the selected readings. It is important to note that these courses were identified as discussing Aboriginal health and the social determinants of health. However, these topics are not present in all the readings. Through the report, I made it clear when direct reference to Aboriginal populations has been made.

DPAS 410 – Doctor, Patient and Society

BLOCK 2 – The context of DPAS

Block 2 was identified as presenting social determinants of health and Aboriginal health content. The sections headings included below are taken from the course outline.

1) Vulnerable populations

The readings focus on the same research study, which identified that individuals who had already been treated and cured of Hepatitis C (HCV) are 4 times less likely to get HCV again. One of the articles emphasizes the importance of research on specific segments of populations to improve the efficacy of treatment. In this case, the targeting population is Injection Drugs Users (IDU). Another variable of interest in the study included ethnicity. Aboriginal health and populations are cited once in reading (1), and it states that:

> A comparison of the participants without previous HCV infection with those with HCV clearance is shown in **Table** 1. The 2 groups were similar in sex ($P\_.41$) and housing status ($P \_ .84$); however, individuals with previous HCV clearance were older (43.7 years vs. 41.2 years, $P \_ .001$), more likely to be of Aboriginal ethnicity (50.3% vs. 29.0%, $P \_ .001$), more likely to have previous HBV infection (5.9% vs. 1.3%, $P\_.001$), and more likely to be coinfected with HIV 23.5% vs. 7.3%, $P \_ .001$) than those previously uninfected with HCV. (Conway et al. 2006: 1141).

Three points are given to students for discussion and reflective writing. The main point suggested for discussion is access to health care and disparities in medical care in British Columbia. The role of the individual health care practitioner in addressing these disparities is also suggested as a theme for discussion between sub-groups of two students.

2)   Global Health Issues

The required reading is a report on the global AIDS epidemic, organized by UNAIDS. The report is a very good source to discuss global health, through the AIDS epidemic example. However, it is not required for the students to read the whole report, and the selected pages are fragmented, making it more difficult to link the reading to the session's objectives. Nevertheless, the fragments are probably used as a starting point to the discussion on global health and the quality of the discussion would depend on the instructor and student´s involvement.

It is suggested, for example, that "effective action to address societal determinants of HIV risk and vulnerability must be taken" (UNAIDS 2008: 5). However, there is no further discussion on what are these societal determinants of HIV risk and vulnerability. No reference is made to Aboriginal health and/or Aboriginal's people exposure to the HIV/AIDS in either the selected pages, or in the entire report.

3)   Canada's Cultural and Linguistic Diversity

The readings explore the cultural and linguistic diversity present in Canada. The francophone minority is emphasized in one of the articles, which is the summary of a Master Plan for the establishment of an active provision of French-language health services. The importance of communication as a key factor in the health of individuals and communities is explored as well.

In the other articles and points for discussion, the concepts of cultural difference, culturally responsive care, and cultural competency are discussed. The objective is to present these concepts and to show that cultural differences exist among people and these differences will influence their health and well being. It is not clear in the readings how the concept of culture is defined. Besides the emphasis on the francophone community in Canada, the

differences between so-called Western and Eastern cultures are also discussed. Aboriginal peoples and cultures are not discussed in this section.

4)   Canada's Aboriginal Peoples

The health and well being of Aboriginal populations are discussed in terms of the broad historical, social, environmental, political and economic context. The required reading presents an overview of the health status of Aboriginal peoples in Canada and then discusses the social, economic and environmental factors that have had an impact on the health and well being of Aboriginal peoples. Some of the factors discussed include: the poorer social and economic conditions faced by Aboriginal peoples, the legacy of residential schools, climate change and contaminants, community control and self determination. The review identified that better data for surveillance and evaluation is required, as well as actions to address the determinants of health must be taken, such as the creation of institutions, and the establishment of new relations and roles within programs.

Students are introduced to a list of selected definitions, such as *Aboriginal* and *Band.* In addition, the class is taught at the First Nations House of Learning, and students are asked to reflect on their role as health care practitioners in Canadian society, and to situate themselves in relation to the residential schools scandals.

DPAS 420 – Doctor, Patient and Society

DPAS 420 is divided in winter and fall terms. The Blocks and Plenary headings included below are taken from the course outline.

WINTER TERM

BLOCK – Health Promotion

1)   Health Promotion: Skin

The required reading is a review of the effectiveness of interventions designed to impact cancer risk factors. The risk factors discussed are smoking, exposure to second hand tobacco smoke, overweight and obesity, unhealthy eating, physical inactivity, exposure to ultra-violet radiation, exposure to occupational and environment carcinogens, and exposure to infections. The article acknowledges that the social determinants of health influence these risks factors cited above. Therefore, the article discusses the influence of socioeconomic factors, socio-environmental context, and the socio-cultural context on the prevalence of risk factors.

The fact that Aboriginal peoples and communities have the highest rate of tobacco use is highlighted in the article, which also discusses that culturally-appropriate activities related to reducing tobacco misuse is of particular interest. However, the article emphasizes that evaluations of these programs are scarce. For the suggested readings, four websites are suggested and they are focused on skin cancer prevention.

BLOCK – Psychoactive Drugs

1)   Public Health Response to Tobacco

The required readings discuss the influence of behavioral interventions in addressing cancer risk factors. Although the focus is on individual behavior, environmental, political,

social and cultural factors are discussed in one of the readings where they are considered important factors of influence.

Two websites are suggested – BC Tobacco control strategy and the Health Canada Report on tobacco control. They present the strategies and measures adopted by the provincial and federal Governments to reduce tobacco misuse. The fact that Aboriginal populations have a high rate of smoking is highlighted, and the Health Canada website affirms that the Agency is working with communities to provide culturally based programs to address this issue.

2)   Alcohol

The required readings focus on the public health approach to alcohol policy. The first article discusses the concept of harm reduction when applied to alcohol intervention. The idea is that harm reduction can be incorporated into alcohol policy alongside other effective strategies, such as controls on the physical and economic availability of alcohol and the routine delivery of brief interventions in primary health care settings. In addition, it is concluded that the quantity of alcohol consumed per occasion is more important that simply reducing the quantity of alcohol consumed by the total population. The other required reading is a Provincial Health Office report, and it reviews in detail the intensity of alcohol consumption, the related health and social harms, the current cost-benefit profile of alcohol in BC, best practice policies for managing alcohol in society, and the status of current alcohol policies in BC relative to these best practices.

Aboriginal peoples and communities appear in the report as a distinctive group, more vulnerable to alcohol social harms and in need of a specific public policy to attend their needs. The report also states that more research and data collection is also needed, respecting OCAP principles.

In the suggested additional readings, other substances which cause social harm are

included in the discussion. The UK Misuse of Drugs Act classificatory system is contested and the social harm caused by alcohol and tobacco (legal substances) are compared to other illegal substances in a new and more scientific classificatory system. There is no reference to Aboriginal health and peoples.

3)   Public Health Framework for Psychoactive Drugs

The required readings and resources for this section focus on the debate around policy approaches for drug control. On one end, there is the legal drugs spectrum, related to the profit economy. On the other end, illegal drugs such as marijuana, heroin and cocaine exist in a criminal/prohibition, black-market economy. The studies and resources presented advocate for the creation of a regulatory system for currently illegal drugs in Canada, where a primarily criminal view of illegal drug use would be replaced by an approach that understands illegal drug use primarily as a health issue. The suggested additional readings and websites also support public policies on drugs which emphasize decriminalization, education, health and human rights.

BLOCK – Mental Health

1)   Mental Health I

The required readings and resources introduce the field and main issues to the students and offer to them resources where they can get more information and familiarize themselves with mental health and resources available in the community. The Mental Health Commission of Canada website is one of these resources, where students have access to important links, information and projects relevant to mental health. One of the main messages is to promote awareness of mental illness and stop stigma and marginalization.

Aboriginal health is discussed mainly through the Mental Health Commission of Canada website. There are eight Advisory Committees which support the Commission in

keeping it engaged with the broader stakeholder communities. One of them is the First Nations, Inuit and Métis Committee, created to help increase knowledge and understanding with respect to issues of cultural safety, social justice, ethical accountability and diversity competency. The historical issues and challenges that have destroyed the substance of family and community are acknowledged, and are discussed as the main factors which have contributed to mental health problems in the Aboriginal population.

2)   Mental Health II – Severe Addiction and Concurrent Disorder

The required readings explore how mental health is usually associated with other disorders and social problems, such as homelessness and severe addiction. The first article focuses on homelessness and provides the basis for constructive action to deal with the overlapping problems of homelessness and severe addictions and/or mental illness. The study indicates that about 50% to 70% of homeless people with severe mental illness also have substance use disorders. The report recognizes that this relationship is complex, and emphasizes that homelessness and mental illness have reciprocal effects.

 The report highlights that Aboriginal peoples are overrepresented among homeless populations in Canada. Many factors are pointed out as the causes for this overrepresentation: the historical and colonial legacy, economic and social marginalization, and low education and employment rates. In addition, the report also draws attention to the multi-generational experiences of residential schools, wardship through the child welfare system, stigma and discrimination.

The suggested additional readings and resources are the same for section I and II. The report by Senator Kirby on mental health, illness and addiction is an overview of policies and programs in Canada. The report presents a holistic population health model which emphasizes a complex set of health determinants – social, economic, cultural and environmental

conditions, including behavioral choices. The health of Aboriginal peoples is discussed in the report and it is recognized that it is common for communities and individuals to face mental health problems. The report emphasizes that most of the attempts of the Federal Government to address these issues failed because a more holistic solution is needed, and more autonomy and participation should be given to Aboriginal communities and organizations. A list of websites containing mental health resources, information and associations is provided.

BLOCK – Complementary and Alternative Medicine – (CAM)

1)   Good Medicine, bad medicine: equitable standards of evidence for health care providers

The readings explore the relationship between Mainstream and Alternative Medicine. The first article discusses three ethical models for this relationship: opposition, integration and pluralism. Pluralism is considered the most ethical model, encouraging research and communication between practitioners. However, pluralism does not mean relativism, and the article emphasizes that there are objective standards to compare therapeutic models. In addition, the other required readings reaffirm that therapies have to be subjected to scientific testing to be validated, and that CAM is considered alternative because it depends on subjectivity.

The suggested additional readings and resources present the debate on how to evaluate the efficacy of complementary and alternative treatments. On one hand, there is the point of view that CAM should be subjected to rigorous, controlled biomedical clinical trials in order to assess its efficacy. On the other hand, there is the point of view that this claim is problematic, since CAM and Mainstream Medicine have epistemological differences and different methods should be applied. A new research framework composed of a five-phase

strategy is suggested for assessing these treatment modalities. The phases are the following: context, paradigms, philosophical understanding and utilization; safety status; comparative effectiveness; component efficacy; and biological mechanisms.

2)   CAM Paradigms

The required readings discuss the concept of integrative medicine, described as "the practice of medicine that reaffirms the importance of the relationship between practitioner and patient, focuses on the whole person, is informed by evidence, and makes use of all appropriate therapeutic approaches, healthcare professionals and disciplines to achieve optimal health and healing" (Verhoef 2007). In addition, examples of good and questionable practices are presented to illustrate the integration of Alternative practices for cancer treatments.

The additional required readings and resources inform students about how to deal with patients who are using CAM. The proposed approach has 3 steps to be followed: preparation; dealing with uncertainty; and safety. The recommended websites are sources of information on CAM to support practitioners to be informed in these therapies.

BLOCK – Epidemiology

1)   Analytic Epidemiology including study designs

The required readings introduce epidemiology to the students, defined as the investigation and control of the distribution and determinants of disease. The main idea is that epidemiological studies count on factors other than those which are obviously medical to infer about a population's health. The social determinants of health are discussed, as well as the methods of a clinical epidemiological inquiry. An intervention study appraisal form is handed to students and it is suggested that it is a resource which can be used to determine the validity of epidemiological studies.

The additional readings and resources present examples of how epidemiological studies facilitate understanding in the context of sexual health and Alzheimer disease. In addition, a glossary for evidenced based public health introduces the next topic.

2)   Systematic Reviews

The plenary discusses the importance of systematic reviews, which are intended to summarize all the evidenced based studies on the same topic. Systematic reviews are important because it helps practitioners to be aware of all the research and methods about a specific topic. In addition, these reviews make possible a comparison between best practices and also work as a tool to bridge the gap between scientific evidence and its practical application.

Evidenced based medicine and the barriers for achieving evidenced based practices are also discussed in the additional readings. The articles discuss the barriers and challenges to implementing the newest scientific evidence. Many factors influence this gap, such as political, organizational, financial, cultural and scientific.

3)   Clinical Application of EBM Principles – Perspective on Diet

The plenary presents two examples of the application of evidenced based medicine on the context of dietary research. The articles discuss the relationship between diet and cardiovascular disease. Aboriginal health and populations are cited as an example of the benefits of a low-carbohydrate diet.

BLOCK – Determinants of Aboriginal Health

1)   Why History Matters

The required reading discusses the importance of adopting a population health approach on the Canadian health care system. The paper demonstrates that integrating the

social determinants of health framework into the analysis is a more effective way to highlight the gap between the health status of First Nations peoples and the broader Canadian population. A detailed analysis showing the direct correlation between social determinants and health status is presented in several areas, such as early life, food security and health care access.

The legacy of colonialism and residential schools is presented as having had a huge impact on the cohesion of First Nations communities, which also affects their present socioeconomic and health status. The report also emphasizes the negative effects of an unhealthy and vulnerable depiction of Aboriginal populations by health statistics. The importance of self government through reconciliation and recognition of Nationhood is discussed, and respect for Indigenous knowledge to prevent further marginalization is also emphasized.

For the suggested additional readings and resources, the same themes are presented in greater details. In Colonizing Bodies, Kelm discusses the provision of health care services to Aboriginal populations as being part of a process of assimilation and control of the Canadian Government over Aboriginal peoples (Kelm 1998). The book is a great resource about the effects of Colonialism on the health of Aboriginal peoples. International Indigenous experiences and cases are also discussed through the analysis of the social determinants of Indigenous health worldwide.

2)   Aboriginal Health Core Competencies

The required readings present the health disparities between Aboriginal and non-Aboriginal populations in British Columbia. Consequently, actions to change the present situation are needed and the documents discuss the challenges and key areas for improvement. The recurrent themes are the establishment of a new relationship between Aboriginal

communities and the Canadian Government, based on respect and recognition of Aboriginal Rights and Titles; and the need for the involvement and partnership with Aboriginal communities to implement and deliver better health care services.

The necessity to raise the number of Aboriginal health care professionals is discussed, and the education of future Aboriginal and non Aboriginal doctors is also mentioned as a critical issue, especially in the additional readings and resources. Through the discussion of the CanMeds framework (Frank 2005), the types of physician competencies are presented.

Thus, the medical expert should be capable of performing the following roles: communicator, collaborator, manager, health advocate, scholar, and professional. These competencies represent the abilities that physicians should acquire during Medical School. In addition, the same competencies are adapted to the First Nations, Inuit and Métis context through the document prepared by IPAC and AFMC (2009a). In this case, the medical expert should "demonstrate compassionate, culturally safe, relationship centered care for First Nations, Inuit and Métis patients, their families and communities" (IPAC/AFMC 2009a:11).

3)   Health Services for Remote Communities

The required readings discuss the main challenges and issues that remote and rural communities face to access health care services. The main challenges presented are: recruitment and retention of health care personal, lack of funding for services and research, and inadequate training of health professionals. The articles also discuss the health disparities between rural and urban populations by showing that one third of Canadians live on health care margins. Aboriginal peoples are included in this underprivileged group, and share most of the concerns of rural and remote communities.

The Kirby Panel Report (Kirby and LeBreton 2002) and the Romanow Report

(Romanow 2002) are presented as initiatives that have discussed and analyzed the issues of remote and rural areas. However, it is noted that the funding recommendations of these Reports were not addressed by the Federal Budget of 2003.

For the suggested additional readings and resources, two websites are suggested for consultation: the Aboriginal Branch of the BC Ministry of Health and the Assembly of First Nations. Documents and research papers on Aboriginal health can be found on the two websites.

4)   The Benefits of Traditional Style Diets

The required readings discuss the influence of the type of diet on health and quality of life. The first article shows that a low carbohydrate diet rather than a low fat diet is preferred to reduce inflammations and fatty acid composition. The second article discusses the health related quality of life among Aboriginal and non-Aboriginal diabetics. The study reveals that Aboriginal diabetics present the worst health related quality of care scores. The study uses a participatory approach and seeks to understand the impact of social determinants on the health of rural communities.

FALL TERM

BLOCK – Organization

1)   From person to population

The article discusses the importance of non-medical determinants of health on influencing the health of populations. Therefore, it advocates for a better involvement of medical students in health policy. It states that "Medical schools should structure their curriculum to expose all students to the various aspects of health policy. This would include not only focusing on the medical decision making process but also on examining how political, economic, and social policies influence health." (Gupta 2006)

2)	Major public health issues in BC

The required reading discusses the six health goals of the Ministry of Health for British Columbia. The goals are focused on the broad determinants of health, in which the quality of life and the environment play a crucial role in determining people's well being. Goal number 5 is directly related to Aboriginal peoples, and it highlights the need for action to reduce the health inequities present in Canadian society. The suggested additional readings and resources provide an extensive list of websites where students can explore current themes, initiatives and Government reports about public health. The list includes a 2007 annual report in which the health and well being of Aboriginal peoples are discussed.

3)	Overview of Public Health Functions

The required reading "A metaphor for physicians in training" (Mathias nd) puts the objectives of the course Doctor, Patient and Society in perspective through a metaphor of trying to saving people downstream of a river. It presents the view that is very important to determine the causes of disease, to verify the effectiveness of the treatment and to observe better ways to prevent injury in the first place. In addition, at the same time that the section recognizes the importance of other determinants on the health of populations, the other article discusses that these broad determinants of health require societal commitment and societal action, and cannot be achieved by public health alone. The additional resources introduce the health authorities' websites to students.

4)	Health Care Systems: The Canadian System in Context

The required readings discuss the Canadian Health Care system, its characteristics, structure, main challenges and debates. They provide an overview of the system, and present the public debate on the costs, coverage, service delivery, and sustainability. The suggested additional readings reinforce the debate and present in more details the discussion between the

public and private models of healthcare delivery. The complexity of the Canadian system is explored, and comparison with other health care systems around the world helps to expose its strengths and weakness.

5)   Benefits, costs and allocating resources to fund medical care: Should we seek to control costs?

This section discusses the challenge of funding medical care. The required readings discuss the dilemma of costly treatments, best practices of cost control, and consequent challenges of a high cost health care system. The reforms proposed by President Obama are discussed in one of the readings and a comparison of best practices for controlling costs is presented. For the suggested additional readings, a more technical and economic language sets the tone and the principles of cost-effectiveness analysis, resource allocation, and marginal analysis are applied to determine best practices.

6)   Improving Health Care: Challenges and approaches

The quality of care delivered in the United States is discussed in one of the required readings. The conclusion of the study is that US Americans receive about half of the recommended treatment, and that more research is needed to address this gap. The additional readings expand this discussion to more countries, but the United States appears as an example of a lower quality system. The main discussion is the disparity between the actual practice and best evidenced practices and how this gap could be addressed by producing more research and tools to measure performance.

BLOCK– Abuse in Society

1)   International Issues of Violence

The required readings discuss how violence against women has an impact on their health status. The fact that Indigenous women in Canada are five times more likely to die as a

result of violence than any other women of the same age is emphasized in one of the articles. The suggested additional readings and resources not only discuss the health impacts of violence against women, but also introduce the discussion of the importance of the involvement of physicians to promote human rights. Therefore, the relationship between health and human rights is explored. In addition, the influence of so-called traditional and cultural practices on the practice of violence against women is discussed, and the positive and negative aspects of some cultural beliefs are explored.

2)   Domestic Violence

This section provides resources for students to assess, identify, and deal with clinical diagnosis of abuse. In addition, it presents websites that contain information on programs and services designed for stopping violence against women. First Nations women are mentioned as a group which experiences an exacerbated level of violence because of the legacy of colonialism that has undermined and fragmented their communities.

3)   Abuse of Elders

The required readings and resources discuss the role of the physician in the assessment, recognition and treatment of cases of elder abuse. In addition, it provides practical advice and strategies for intervention. Special resources to prevent and respond to elder abuse in First Nations communities are presented to students. These interactive resources, educational and supportive materials are tools designed for health care providers by First Nations communities to respond to complex situations of abuse and neglect.

4)   Child Abuse and Neglect

The required reading is a resource developed by the BC Ministry of Child and Family Development to assist health care providers to deal with child abuse and neglect. The handbook presents the importance of the physician acting as a health advocate in cases of

child abuse, discussing the responsibility of reporting abuse to the accountable agency. In the case of Aboriginal children, there are special agencies to take care of these cases, and the handbook emphasizes that community involvement is very important, and that the identity of the child must be protected. The suggested additional readings and resources complement the information on how to proceed in cases of child abuse, and also discuss the existing situation of child abuse and neglect across Canada.

BLOCK – Environmental Health

1)   Risk Assessment and Risk Communication

The required readings explore two themes of the relationship between the environment and public health. The first article is a guide which provides an explanation of risk assessments that are used to determine if a particular chemical poses a significant risk to human health. The second article and the suggested additional readings explore the potential health benefits of some purpose-built environments. The idea is that communities can be designed to promote physical activity by, for example, offering healthier transportation choices. As a consequence, research affirms that seven public health outcomes would improve: Physical Activity and Obesity, Air Quality, Traffic Safety, Noise, Water Quality, Mental Health, and Social Capital.

2)   From Ecosystem to Food System

The required readings explore the importance of the ecosystem in promoting healthy communities. The first focuses on water as a vehicle for understanding the systemic context for human wellbeing, health promotion and disease prevention. The second article discusses food safety and security among northern First Nations communities. The importance of traditional food to the diet, culture, identity and well being of the communities is emphasized.

In addition, other factors that determine the intake of traditional food versus market food are discussed. Income level, food choices and preferences, education, food accessibility and availability, and lifestyle changes are considered the main barriers to food security. The suggested additional readings and resources include discussion of the impact of health contaminants in the food items that are important to the traditional diet of Aboriginal peoples in the Arctic.

3)   Environmentally Sustainable Health Care

This section discusses the importance of having a sustainable and environmentally responsible health care system. Strategies to reduce the impact of the health care system on the environment are discussed and resources and efforts to reduce it are exposed.

Topics in Aboriginal Health: A Community-based learning experience (IHHS 408)

The course is described in the syllabus in the following terms:

This course enables health discipline students to gain direct experience working with Aboriginal patients and community members. By situating academic learning within an intensive four-week immersion program, this course offers students a truly unique and memorable learning experience. This is an experiential community-based course and it includes both clinical placements and seminars.

Following is the course outline divided by week:

Week 1 – Introduction to Interprofessional Teamwork and Exploring Community Life

1)   Interprofessional Practice: Roles and responsibility of health care professions

2)   Respecting Aboriginal people

3)   Community health status

4)   Understanding Aboriginal perspective on health

Week 2 – Understanding the Social and Political Determinants of Health

1)   Colonization and its effects on health

2)   Health and wellness

3)   Social determinants of health

Week 3 – Community Strength and Healing

1)   Response to historical policies

2)   Integration of western healing

3)   Cultural activities

Week 4 – Providing service

1)   Bringing it all together

2)   How can you provide service?

3)   Other considerations as health care professional

In order to discuss these topics, diverse activities and lessons are planned in conjunction with community members. Consequently, each community involved with the course tailors it to their own requirements. Therefore, the resources and reading package are not necessarily applicable to all students. However, my analysis will present an overview of all these resources and readings, which I divided into themes to facilitate discussion.

Theme 1 – Reports and articles – Health status and health delivery[8]

The readings discuss the health status and the health care delivered to Aboriginal populations in Canada. Statistics that show the lower health status of Aboriginal populations

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[8] Readings 1, 7, 9, 11 in appendix G.

are presented throughout the readings, and actions to change the situation are considered. The health disparities between Aboriginal populations and non-Aboriginal populations in Canada are discussed in terms of the broader social determinants of health, and the debate acknowledges that the reduction of these disparities must address a larger political context. In addition, Aboriginal peoples are seen as active partners to change the actual circumstances, by participating in the planning, implementation and delivery of health programs and research initiatives.

Theme 2 – Cultural protocols and safety – Self-reflection on the health care practice[9]

The readings discuss procedures and recommendations for students to interact with Aboriginal patients, families and communities. The recognition of the impact of the larger socio economic system on the health of Aboriginal peoples is considered very important to the doctor and patient relationship. In addition, understanding the cultural diversity among Aboriginal peoples and different definitions of health and well being are presented as essential to providing a more culturally appropriate service. An important consideration is the introduction of the concept of cultural safety. This concept, elaborated in the context of nursing education in New Zealand, goes beyond cultural awareness and cultural sensitivity. In the case of cultural safety, the definition of a safe service is defined by those who receive the service. Consequently, it is important to the students to understand their own role, position and power relationship in relation to the patient and society as a whole. The section also provides resources to help students assess their competency and reflect on their own experiences and cultural background.

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[9] Readings 2-6; 16 in appendix G.

Theme 3 – Case Studies – Aboriginal Health Initiatives[10]

The articles are examples of collaborative studies involving First Nations communities and researchers. The studies show that the participation of First Nations is essential in all phases of the research process, from the planning to the evaluation. The Health Transfer Process, which permits the transfer of health care services to Aboriginal communities, is also examined. Nine cases of Aboriginal health systems are explored. The strengths and challenges of Aboriginally-controlled health systems are examined, and the diversity highlighted. Therefore, the importance of the involvement of First Nations communities as active partners in the process of changing current health disparities is emphasized.

Theme 4 – Understanding and Respecting Aboriginal Perspectives and Experiences[11]

In this section, Aboriginal peoples' experiences, relationships and worldviews are presented through fiction, stories and personal narratives. The relationship between Aboriginal peoples and Euro-Canadian society is discussed mainly by Native authors, who present their experiences of being part of a group which was marginalized and oppressed by outsiders. The texts present an historical account of this relationship, by bringing the consequences that the government policies of assimilation and control had on the health and well‑being of these individuals, families and communities. The readings expose the distress caused by the loss of land, abduction of Native children to residential schools and foster care homes, problems with drugs and alcohol, racism and discrimination.

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[10] Readings 10, 14, 15 in appendix G.
[11] Readings 8, 12, 13, 17-19 in appendix G.

Three readings in particular call the reader´s attention because of the sensibility, clarity and complexity in which the theme is explored. Elizabeth Furniss (Furniss 1999) presents an extensive ethnography of Williams Lake community, where the relationship between Aboriginals and non-Aboriginals is marked by tension and conflict. The assumption that the assimilation of Aboriginal peoples into mainstream Canadian society is the solution for the land conflicts and resolution of diverse interests in the area still affects the relationship between community residents. *Monkey Beach* (Robinson 2000) is a great novel narrated by Lisamarie, a Haisla girl who is suddenly disturbed by the disappearance of her brother in a boat accident. The narrative unfolds to a mixture of past and present events, revealing a spiritual world which has the same importance and realism as the physical one. The story reveals her world where losses are part of life and where the teachings of her grandmother and interaction with the environment and spirituality are very important. Lastly, *The truth about stories* (King 2003) discuss the importance of storytelling for Aboriginal peoples and how the construction of an "Indian" character by whites has influenced Native identity and pride. The problematic relationship between distinctive ways of looking at the world is presented in a very compelling way and we are exposed to various stories that question the supremacy of the so-called western society.

Chapter 4 – Critical Analysis

In this chapter I will present a critical evaluation of the Aboriginal health and the social determinants of health content present in the undergraduate medical curriculum of British Columbia. This analysis is informed by my preliminary research, theoretical background and discussion with the Aboriginal Advisory Committee. The courses' readings and materials will be analysed based on the seven health core competencies developed by IPAC/AFMC Aboriginal Health Curriculum Subcommittee in 2009 (IPAC/AFMC 2009a).

1. The Health Core Competencies

The CanMEDS is a competency-based framework developed by the Royal College of Physicians and Surgeons of Canada in 1996 and updated in 2005. This document is intended to be a resource for improving medical education and consequently, patient care. One of the goals of this resource is to situate individual health needs in a broader framework, to meet the needs of society. It is stated in the CanMeds competency framework (Frank 2005) that this model is based on skills and roles to be obtained by medical practitioners, moving away from standards documents that used to provide a list with topics for medical students to learn. This shift reflects an emphasis for preparation for practice, focusing on essential roles and key competencies that physicians should achieve for optimal patients outcomes. The competencies are the following: medical expert; communicator; collaborator; manager; health advocate; scholar; and professional (Frank 2005).

As discussed previously, IPAC-AFMC (2009a) used this framework to suggest the skills and roles that physicians should have when working with First Nations, Inuit and Métis peoples. I will discuss here how the class readings helped or not students to acquire and have the knowledge to achieve the proposed core competencies. First, I will present each role and

core competency, as they are discussed at the IPAC-AFMC curriculum framework (2009a). Then I will consider the manner that the selected courses address or do not address the expected competencies.

1.1 Medical Expert: "The graduating   student will demonstrate compassionate, culturally safe, relationship-centred care for First Nations, Inuit, Métis patients, their families or communities" (IPAC/AFMC 2009a: 11).

This key competency is supported by five enabling competencies, or objectives:

- Knowledge of historical and current government practices, such as colonization and treaties and the health outcomes generated by them.

- Knowledge of health care services delivered to Aboriginal peoples and their historical basis.

- Knowledge of the cultural diversity among local First Nations, Inuit and Métis peoples.

- Knowledge of how medical, social and spiritual determinants of health affect First Nations, Inuit, and Métis' health.

- Knowledge of healing and wellness practices present in local First Nations, Inuit, and Métis communities.

In a general manner, the historical and social context of the health status of Aboriginal peoples today is discussed. In DPAS 420, there is a whole block with four sessions dedicated to the determinants of Aboriginal health. The required reading of the first session (Reading et al. 2007) discusses that a population health approach is necessary to understand the current health disparities between Aboriginal and non Aboriginal populations. According to the Population Health Agency of Canada,

> Population health refers to the health of a population as measured by health status indicators and as influenced by social, economic and physical environments, personal health practices, individual capacity and coping skills, human biology, early childhood development, and health services. As an approach, population health focuses on the interrelated conditions and factors that influence the health of populations over the life course, identifies systematic variations in their patterns of occurrence, and applies the resulting knowledge to develop and implement policies and actions to improve the health and well-being of those populations (http://www.phac-aspc.gc.ca/ph-sp/approach-approche/index-eng.php).

Some of the readings in this block advocate for integrating a social determinants of health framework in the analysis (Erasmus and Dussalt 1996; Reading et al. 2007; Thommasen et al. 2005; World Health Organization Commission on the Social Determinants of Health 2008). This includes accounting for a complex set of health determinants, such as social, economic, political, cultural, environmental, nutritional, and behavioural. This perspective expands the meaning of health and consequently the doctor´s role and responsibilities and it is presented throughout the selected courses.

The legacy of residential schools and colonialism are discussed in the readings of the three courses. They are described as main factors which contributed to the actual health gap impacting Aboriginal communities until today (Adelson 2005; Canadian Institute for Health Information 2004; Fournier and Crey 1997; Furniss 1999; Erasmus and Dussalt 1996; IPAC/AFMC 2009a; Kelm 1998; Office of the Provincial Health Officer 2009; Reading et al. 2007; World Health Organization Commission on the Social Determinants of Health 2008). There is also recognition that the unhealthy and negative depiction of Aboriginal peoples presents negative effects for this population (Adelson 2005; Reading et al. 2007).

The need for self-government and the establishment of a new relationship based on partnership with the Canadian authorities are some of the themes discussed. A relevant document to understand the relationship between First Nations and the Canadian government concerning health is the paper, "The transformative change accord: First Nations health plan" (Government of British Columbia et al. 2005). The document calls for a new relationship between federal and provincial governments and First Nations in BC, based on trust, recognition and respect for Aboriginal rights and titles. It also delineates action plans to address the main challenges and priority areas.

Respect and recognition of Indigenous knowledge, involvement of Indigenous peoples in the development of policies, programs and research are also suggested (Government of British Columbia 2007; BC Ministry of Health 1997; Canadian Institute for Health Information 2004; Caron 2005; Centre for Indigenous Peoples Nutrition and Environment 2004; Erasmus and Dussalt 1996; IPAC/AFMC 2009a; BC Ministry of Health Services 2005; Patterson et al. 2008; Reading et al. 2007; Senate of Canada 2004).

The training and education provided to medical students to take care of this population is also highlighted, with the curriculum framework prepared by IPAC-AFMC (2009a) as a suggested reading. Raising the number of Aboriginal medical professionals is another aspect explored (Government of British Columbia 2007; Reading et al. 2007; Senate of Canada 2004; Smylie 2001).

One particular reading, a book entitled *Colonizing bodies* (Kelm 1998), provides historical context of the provision of health care service for Aboriginal peoples in British Columbia from 1900 to 1950. The book is a detailed and excellent resource to inform students on past government policies and the effects on the health and well being that these policies have produced. The reading, however, does not cover the current policies and services delivered to Aboriginal peoples. In addition, it is important to note that the book is suggested as an additional reading, and it is probably not read by most students.

Aboriginal health and populations are not discussed in the session on cultural and linguistic diversity of DPAS 410. In the lecture entitled "Canada's Aboriginal Peoples", one of the required readings (unknown 2009) states that "multicultural issues are distinct from Aboriginal issues". The reading discusses how Aboriginal peoples prefer not to be considered ethnicities equivalent to recent ethnic immigrants, but as Indigenous Nations. In Canada, this is an important distinction, which acknowledges the Treaty Rights of Indigenous Peoples. The diversity amongst Aboriginal peoples, however, cannot be ignored or denied. The same reading in DPAS 410 (unknown 2009) explores briefly the diversity. The list defines, among others, the terms "Aboriginal", "Inuit" and "Métis".

Other readings also refer to First Nations, Inuit and Métis peoples instead of using the general term Aboriginal (Caron 2005; Government of British Columbia 2007; BC

Ministry of Health Services 2004; Health Canada 2005; IPAC/AFMC 2009a; Oostdam 2005; Senate of Canada 2004; Volek et al. 2008). Some readings discuss in more details the cultural diversity present amongst Indigenous groups in Canada and relate this diversity with the necessity of targeting health services and programs according to specific needs of a community (Canadian Institute for Health Information 2004; Lemchuk-Favel and Jock 2004; Office of the Provincial Health Officer 2009; Reading et al. 2007; Smylie 2001).

The readings do not cover the diversity and characteristics of localized and nearby communities. Aboriginal cultures and populations in Canada are so diverse that it would be impossible to learn about all groups. Engaging with Aboriginal peoples and organizations is necessary to gain knowledge of their needs, health concerns and protocols to follow. In addition, with this involvement, students would learn about the context and reasons for any difficulties and health issues present in a certain community or group. The elective course IHHS 408, however, is an opportunity to engage with four communities in British Columbia and become aware of their expectations and health concerns.

A few readings (Erasmus and Dussalt 1997; Office of the Provincial Health Officer2009; Reading et al. 2007) mention examples of traditional healing and wellness practices, such as the use of plant medicines and sweat baths. There are also some readings that highlight the importance of traditional diet for health and well being of Aboriginal communities (Arctic Monitoring and Assessment Programme 2009; Centre for Indigenous Peoples Nutrition and Environment 2004; Government of Canada et al. 2006; Oostdam 2005). These examples describe the importance of traditional nutrition to their health and well being.

One session is also dedicated to a general discussion of complementary and alternative medicine (CAM). Some readings included in this session (Kaptchuk and Miller

2005; Beyerstein 2001; Lett 1990; Miller et al. 2004; Deng 2008) tend to emphasize scientific analyses of the efficacy of these therapies while they conclude that a plural model of healthcare is possible and suggest that research and communication are essential to establishing an ethical relationship between practitioners. In addition, students are told that they can deal with patients using CAM through dialogue and understanding of the possible benefits of some of these therapies. The objective standards of science, however, are considered more efficient and reliable.

1.2 Communicator: "The graduating student will demonstrate effective and culturally safe communication with First Nations, Inuit, Métis patients, their families and peers." (IPAC/AFMC 2009a: 12)

This key competency is supported by three enabling competencies, or objectives:

- Working knowledge of cultural safety;

- Engage in culturally safe communication and care;

- Establish a positive therapeutic relationship based in trust, understanding, respect, honesty and empathy.

The concept of cultural safety suggests that physicians should not only be aware and sensitive to cultural differences but also recognize their own biases and prejudices when dealing with culturally diverse patients and communities. According to IPAC/AFMC, "cultural safety refers to a state whereby a provider embraces the skill of self-reflection as a means to advancing a therapeutic encounter with First Nations, Inuit, Métis peoples and other communities including but not limited to visible minorities, gay, lesbian, transgendered

communities, and people living with challenges. Self-reflection in this case is underpinned by an understanding of power differentials (IPAC/AFMC 2009a: 09).

In DPAS 410, there is a portion of the course dedicated to discussing the meaning of culturally sensitive health care, cultural competency, multiculturalism and multilingualism, cultural differences between Caucasian and non-Caucasian populations and ways to explore the relationship between culture, health and health care. There are three required readings for the session and they do not define these concepts, which are r e p o r t e d l y discussed in class and then further explored by the student in the reflective writing component. One of the readings (Societé Santé en Français 2007) shows the challenges and initiatives to achieving French-language service for francophone communities. The other reading (Trang nd), is an overly simplified discussion of cultural differences from an "Asian point of view". The author provides some contrasting statements, which are assumed to represent Asian and Western, societies.

Analysing the terms that are used in the course syllabus, the focus here is on the French-English bilingualism present in Canada, and there is no allusion to Indigenous languages. In addition, cultural differences are being generalized and linked to race by one of the required readings (Trang nd) and in one of the questions for reflective writing.[12] The critical reflexive component of the next session of DPAS 410, however, offers an opportunity for students to think about their own role and responsibilities as practitioners of medicine.

The themes suggested for discussion and reflective writing are to compare the major public health concerns of the Aboriginal and non-Aboriginal populations, to reflect on how learning about health disparities between Aboriginal and non Aboriginal populations affects

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[12] The question suggests students to discuss cultural differences in health outcomes, meaning of health and conceptions of doctor in between Caucasian and non-Caucasian populations.

their role as health care providers in Canadian society, and to situate themselves in relation to the residential schools scandals. It is difficult to determine if the concept of cultural safety is addressed by the course instructor, since it is not present in any of the required readings. But the idea of self reflection in relation to their role as health care practitioners in an unequal society is present in this component.

Four readings in DPAS 420 and IHHS 408 directly address the concept of cultural safety (IPAC/AFMC 2009a; Mental Health Commission of Canada website; Nursing Council of New Zealand 2005; Reading et al. 2007). In the "Guidelines for Cultural Safety, the Treaty of Waitangi and Maori Health" (Nursing Council of New Zealand 2005), the context in which cultural safety is situated in nursing education and practice is explored. Here, the concept of culture is defined in broad terms and it includes but is not limited to age, gender, ethnic background, and religious beliefs. The idea is that nurses should reflect on their own cultural identity and recognise the impact of these characteristics on their practice. This document is an excellent source that gives students an example of how culturally safe practice might be.

Another resource provided in the course IHHS 408 to help with reflecting upon their own cultural background and cultural diversity is the cultural competence self-test (Goode 2000). The document is a self assessment tool which contains 30 statements that students are asked to rate (A=things they do frequently; B=Things they do occasionally; C=Things they do rarely or never). It is designed for physicians to identify areas for improvement in their own service for diverse populations. This tool does not focus on Aboriginal populations, but on diversity in general, such as gender, age, and culture.

The discussion of white privilege (McIntosh 1990) is another very important debate that changes the focus from the "disadvantaged other" to the "advantaged self". The reading is part of the course IHHS 408 and it discusses white privilege as an invisible system of

oppression which confers dominance to this group and obscures relations of power. This reading is an excellent source to make students reflect on the meaning of being a health care professional in a diverse and unequal society and the implicit power differential that may occur in the clinical encounter.

Other required and additional readings in DPAS 420 suggest and acknowledge the necessity and importance of providing culturally appropriate services and programs for Aboriginal populations. There is not much discussion or details about what a culturally appropriate service or program might actually mean, but the idea of participation and community involvement is often emphasized (H. Krueger & Associates Inc. 2005; Reading et al. 2007; Smylie 2001). This is evident in the readings which address strategies for dealing with the use of tobacco (H. Krueger & Associates 2005; BC Ministry of Health Services 2004), alcohol (Office of Provincial Health Officer 2002), homeless and mental health services (Mental Health Commission of Canada website; Patterson et al. 2008; Senate of Canada 2004), support for victims of child abuse and neglect (Government of British Columbia 2007), HIV treatment (BC Centre for disease control website). Aboriginal peoples are described as a distinct group, with culturally specific needs which require appropriate services to be effective. Yet here, "the health needs" of Aboriginal peoples are presented mostly in terms of health challenges, creating a stigmatizing perception of the overall health and well being of these populations.

In most of the readings, there is no description of the culturally appropriate service or program. In one example included in "Housing and Support for Adults with Severe Addictions and/or Mental Illness in British Columbia" (Patterson et al. 2008), however, the authors suggest how "culturally appropriate" housing might look like,

One could envision Aboriginal supported housing that contains a communal area (based on the long-house concept, for example) where tenants could practice their culture and rituals on-site; [and] liaison [with] workers who specialize in providing mental health and addictions treatment to this population [and with] vocational rehabilitation workers who help tenants develop job skills while maintaining culturally-relevant skills. Trades training could also be linked to the construction of new housing units. While current services tend to treat the individual, the Aboriginal perspective would address the health of the entire community, and how it affects the individual. Moreover, the role of elders should not be overlooked, as they are highly respected among First Nations people; they could play a significant role in addressing the multi-faceted problems of homelessness even if they are not formally recognized by mainstream social service agencies. (Patterson et al. 2008: 66).

In this case, a holistic understanding of Aboriginal cultures is emphasized, in addition to the importance of elders in many of these communities. Although the proposed project is somewhat open and does not specify any particular practice or ritual that could be done to address the mental health needs of an individual or the entire community, a generalizing view of Aboriginal cultures is evident for example, not all aboriginal communities had or still have long houses now.

Other readings expose the idea that some cultural and traditional practices can cause negative effects to the health and well being of individuals, especially women – although these readings were not focused on Aboriginal peoples. In the session on abuse and violence, for example, two articles (Unicef Innocenti Research Centre 2000; United Nations 2006) suggest that factors such as discriminatory traditions, customs, stereotypes, patriarchal structure, social conformism, and religious beliefs are considered a threat to the well being

of women, who may be kept in subordinated positions and at risk of violence. In one of the suggested websites "ending violence against women", there is recognition that the patriarchal structures found in Aboriginal communities and political organizations are actually the result of the adoption of a patriarchal European structure.

Another interesting example of the different uses of the concept of culture can be found in the report known as the Kirby Report (Senate of Canada 2004). In the report, Aboriginal peoples are described as a specific population group with a higher prevalence of mental disorders. The following passage illustrates a very stereotypical and erroneous description of factors which are considered cultural that have an effect on the health and well-being of Aboriginal populations,

> Experts in the field suggest that, while many of the causes of mental illness, addiction and suicidal behaviour in Aboriginal and non-Aboriginal communities may be similar, there are added cultural factors in Aboriginal communities that affect individual decision-making and suicidal ideation. These cultural factors include sedentary lifestyle, the impact of residential schools, racism, marginalization and the projection of an inferior self-image (Senate of Canada 2004: 111).

It is interesting that these aspects are described as "cultural factors", as they should be described as consequences of contact, colonization and discriminatory government policies towards Aboriginal cultures and lifestyle or even as cultural factors, not of Aboriginal communities, but of the dominant society of which they are a part.

1.3. Collaborator: "The graduating student will demonstrate the skills of effective collaboration with both Aboriginal and non-Aboriginal health care professionals, traditional/medicine peoples/healers in the provision of effective health care for First Nations, Inuit, Métis patients/populations." (IPAC/AFMC 2009a: 13)

This key competency is supported by three enabling competencies, or objectives:

- Identify key principles to develop collaborative and ethical relationships;

- Knowledge of types of healers and traditional medicine people;

- Know how to ask about the use of traditional herbs or traditional medicine and how to integrate them into patient's care.

Overall, this competency is not explored in depth in the course readings; however, a few resources of DPAS 420 and activities proposed in the course outline of IHHS 408 explore some aspects of this competency. In "Metaphor for Physicians and Surgeons in Training" (Mathias nd), the author suggests through a metaphor that prevention and collaboration between health care professionals are essential to the provision of an efficient health care service. In a required reading of DPAS 420, in the section on the determinants of Aboriginal health, the life of Aboriginal people pre-contact is discussed and some traditional forms of healing, such as the use of plant medicines, sweat lodge and pipe ceremonies are briefly mentioned (Office of Provincial Health Officer 2009).

One of the objectives of the course IHHS 408 is developing collaborative and ethical relationship with Aboriginal peoples through community immersion. Some activities proposed in the course syllabus are meant to help students to understand Aboriginal perspectives on health and to work collaboratively to provide a better service, which is culturally safe and respectful. Some examples of these activities include: learning about

traditional Aboriginal plant and medical knowledge in relation to contemporary society and western medicine; explore and generate ideas of how health professionals and institutions can modify practices to provide a positive impact on health and health professional community relationships; participate in elder activities and other health related community events.

The issue of integrating traditional care in patient´s care is discussed in a general manner through the readings on Complementary and Alternative Medicine (CAM). The required readings (Kaptchuk and Miller 2005; Beyerstein 2001; Lett 1990; Deng 2008) suggest a plural ethical model between practitioners of CAM and mainstream Medicine. In this model, communication and research are encouraged, following objective and scientific standards for comparison between the two practices. Definitions and principles of integrative medicine are discussed, which involves taking into account the whole person (body, mind, and spirit) and using all appropriate therapies, both conventional and alternative.

In "Integrative cancer care in a US academic cancer center: the Memorial Sloan-Kettering experience", Deng discusses the example of an academic health center that is exploring alternative forms of healing in cancer care. Patients are encouraged to try alternative forms of healing, such as acupuncture, meditation, hypnotherapy and various types of massage. These complementary therapies, however, are subject to scientific research to determine their value and efficacy and patients are cautioned to avoid harmful alternative therapies (Deng 2008).

Other readings discuss integration in the context of Indigenous traditional practices. In "Aboriginal Health Systems in Canada: Nine Cases Studies" (Lemchuk-Favel and Jock 2004), a required reading of IHHS 408, the synergy of traditional and western health philosophies is discussed. The authors argue that both traditional and western traditions have

their own limitations and strengths, and collaboration is necessary. The example of Health Centres in Ontario is presented, where there is an option to include traditional healers in the multidisciplinary team of health care providers (Lemchuk-Favel and Jock 2004). In a required reading of DPAS 410 which discusses Aboriginal People´s health (Canadian Institute for Health Information 2004), examples of community operated systems are presented, and one of the positive outcomes of these systems are the holistic focus and integration of mainstream and traditional approaches.

In another reading of IHHS 408, it is stated that: "health professionals should respect traditional medicines and work with Aboriginal healers to seek ways to integrate traditional and western medicine" (Smylie 2001). Reading et al. also discuss the integration of traditional healing and western practices,

> First Nations traditional knowledge and healing practices are perhaps the quintessential expressions of a social determinants of health approach. This reinforces the need to consider a blend of traditional and Western practices in program and services delivery aimed at First Nations. While traditional practices vary greatly across the diversity of First Nations in Canada, many are based on the belief that each individual has his/her own constitution and social circumstances that result in different reactions to the "cause of diseases" and "treatment" (Reading et al. 2007:26).

It is not clear, however, how integrative medicine would work in practice and what is the role of the physician in delivering alternative methods of healing. In some readings (Canadian Institute for Health Information 2004; Lemchuk-Favel and Jock 2004), students are exposed to examples of health care systems that integrate alternative and mainstream medicine. In other reading, however, students are told that "rather than a system of health

care, integrative medicine provides a set of values to guide clinical practice" (Sladden, 2006 in Verhoef 2007:05). Collaboration would require more than just acknowledgement and respect; it requires trust and recognition of the value and efficacy of traditional healing practices, its methods, and practitioners and perhaps training in those practices.

1.4. Manager: "The graduating student will be able to describe approaches to optimizing First Nation, Inuit, Métis health through a just allocation of health care resources, balancing effectiveness, efficiency and access, employing evidence based and Indigenous best practices." (IPAC/AFMC 2009a: 14)

This key competency is supported by three enabling competencies, or objectives:

- Knowledge of the concepts of community development, ownership, consultation, empowerment, capacity building, reciprocity and respect;

- Recognize key contacts and organizations in provision of health care for First Nations, Inuit and Métis;

- Knowledge of best practices and successful initiatives implemented to improve the health of First Nations, Inuit and Métis at the local, regional and national levels.

The use of appropriate research ethics is discussed in two readings (Office of the Provincial Health Officer 2002, Reading et al. 2007) and the concepts of ownership, control, access, and possession are mentioned, but not explained in details. In addition, the same principles are mentioned in the course syllabus of IHHS 408, as they are listed under the topic "other considerations for health care professionals". In the course DPAS 420, two sessions are

of particular interest in the understanding of this competency in broad terms, but not in the context of Aboriginal peoples. In the readings for the session entitled "Benefits, costs and allocating resources to fund medical care: should we seek to control costs?", there is a discussion of the benefits of cost effectiveness analysis, resource allocation and marginal analysis to determine best practices in the context of health care (GreB et al. 2005; Gibson et. al. 2005; Cohen 1994). In the session about the Canadian health care system, the costs, coverage, service delivery and sustainability are debated, however, there is no allusion to the funding and jurisdictional issues related to the delivery of services to Aboriginal peoples (Health Canada 2005; Simpson 2004; Davis et al. 2007; Chodos and McLeod 2005; Steinbrook 2006; Canadian Health Services Research Foundation 2005 and 2007; Dhalla 2007; World Health Organization 2006).

Nevertheless, there is more information and discussion of Aboriginal best practices and the gaps and inadequacies created by the multi-jurisdictional health care system for First Nations in some other readings (Government of British Columbia et al. 2005; Health Canada 2005; Office of the Provincial Health Officer 2009; Reading et al. 2007; Senate of Canada 2004). These readings acknowledge the shared responsibility for health care services by federal, provincial and Aboriginal organizations to Aboriginal peoples and communities. In Reading et al., the authors recognize and explain the context behind the mix of federal, provincial and Aboriginal run program and services. This would be the result of two conflicting views: on one hand, First Nations communities believe that the provision of health care by the federal government is a treaty obligation, on the other hand, the Canadian Government states that this provision is voluntary (Reading et al. 2007).

The roles and initiatives of some key contacts and organizations are considered. This is the case for the National Aboriginal Health Organization, the Institute of Aboriginal Peoples Health and the Aboriginal Healing Foundation (Adelson 2005; Canadian Institute for Health Information 2004; Senate of Canada 2004). In addition, a few websites[13] are suggested as additional readings and resources where students can find information on Aboriginal health initiatives and programs.

Some readings and resources present examples of best practices and programs which were successful in various Aboriginal communities (Office of the Provincial Health Officer 2009; Adelson 2005; VCHA website; AFN website; Lemchuk-Favel and Jock 2004; MacNab et al. 2008; World Health Organization Commission on the Social Determinants of Health 2008). The required reading of IHHS 408 "Aboriginal Health Systems in Canada: Nine Case Studies" is a great article that give details of Aboriginally-controlled health care systems. Lemchuk-Favel and Jock (2004) discuss the strengths and challenges of these systems and they conclude that the differences in cultural expectations, jurisdictional complexity and location have an effect on the manner in which these systems operate and develop.

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[13] BC Ministry of Health – Aboriginal Health; Assembly of First Nations; Health Authorities and Hot Peaches page.

1.5 Health Advocate: "The graduate student will be able to identify the determinants of health of Aboriginal populations and use this knowledge to promote the health of individual First Nations, Inuit and Métis patients and their communities." (IPAC/AFMC 2009a: 15)

This key competency is supported by two enabling competencies, or objectives:

- Describe the facts that contribute to the unequal access to health care and information for First Nations, Inuit and Métis;

- Identify ways to address this issue.

There is a whole block in DPAS 420 to discuss the determinants of Aboriginal health. There are good resources, but in some readings (Arctic Monitoring and Assessment Programme 2009; BC Centre for disease control website; Conway et al. 2006; Senate of Canada 2004) there is an overemphasis on Aboriginal ill health, which could contribute to stigma and marginalization. Structural factors that impact Aboriginal health, however, are discussed throughout the readings. The legacy of colonization, past government policies towards assimilation, the consequences and trauma of residential schools, land and resources deprivation are examples of the issues discussed in the curriculum.

Students are asked to discuss access to health care and their role and responsibility as Canadian health care practitioners in global health. This is part of the reflective writing component of the course DPAS 410. The strategies to address health disparities are also part of the discussion; however, the readings in the session do not consider those questions. In the context of Aboriginal populations, there are recommendations about what can be done to improve the health status of Aboriginal peoples and communities. Some of the solutions discussed are: to ensure self-determination (BC Ministry of Health 1997); to have Aboriginal peoples and communities involved in the design, delivery and evaluation of health programs

(Caron 2005; Office of Provincial Health Officer 2009); to address the social determinants of Aboriginal health (Canadian Institute for Health Information 2004; Reading et al. 2007). Because most of the readings highlight the complex political, economic, and historical factors which impact Aboriginal health, it could create the impression that it is impossible for health care practitioners to act or do anything to improve the health and well being of Aboriginal patients (or it is out of their scope of possibilities). Students are taught that non medical determinants of health have a great impact on the health and well being of Aboriginal and non Aboriginal populations, and physicians should engage in addressing and understanding these factors. What is missing in the readings is a more detailed discussion on how to contribute to implementing necessary changes.

For example, in the required reading: "Why should medical students care about medical policy?", Gupta (2006) stresses the weight and importance of non medical determinants on the practice of medicine but it is not clear how to address these issues in the medical practice. He states that "political, economic, social, and medical policies of transnational agencies, governments, and the private sector are equal (and sometimes greater) guiding forces in the practice of medicine. We must involve ourselves in these determinants of health as early as possible" (Gupta 2006:1697).

There is also the suggestion that physicians should be involved in the promotion of human rights, such as in cases of violence and abuse. Doctors are encouraged to act at an individual level, not only in the clinical context, but also as health advocates by reporting cases of abuse to the responsible authority. This is suggested in the cases of torture (Audet 1995); domestic violence against women (Mackay 2005; John Hopkins University School of Public Health and CHANGE 1999; Unicef Innocenti Research Centre 2000), elder abuse and neglect (Ahmad and Lachs 2002; Lachs and Pillemer 1995) and child abuse (Trocmé and

Wolfe 2001; College of Physicians and Surgeons of BC 2009).

In addition, there is the discussion of how the provision of health care services impact the health and well being of Aboriginal peoples and communities. As stated in one of the additional readings in DPAS 420,

> Aboriginal people have often not had a positive experience receiving health care services. Many studies have examined and documented the experience of Aboriginal people with the health care system. For example, a study in a reserve community in BC found that Aboriginal patients felt that their concerns were not taken seriously and that health care providers had negative stereotypes and had no consideration for the personal circumstances of the patients (Browne, Fiske, & Thomas 2000 in Office of the Provincial Health Officer 2009: 195).

> Despite the acknowledgement that negative stereotypes may have an impact on the doctor and patient relationship, there is limited discussion of the impact of stigma and marginalization on the health and well being of Aboriginal patients. This theme is mostly discussed in the session on mental health and addictions, where it is stated that Aboriginal peoples are among the groups that suffer more stigma when dealing with substance abuse (BC Partners for Mental Health and Addictions Information 2005). Aboriginal women and children are also cited as more vulnerable to cases of domestic abuse and violence (Morrow & Varcoe 2000; United Nations 2006; Unicef Innocenti Research Centre 2000; World Health Organization 2006). There is also the idea that the depiction of Aboriginal poor health impacts this population, creating a stigma to the group (Reading et al. 2007).

> My concern is that the negative stereotype presented in the curriculum could influence practitioners in diagnosing cases of abuse and violence in Aboriginal patients. As stated by

the First Nations Longitudinal Health Survey, and reproduced in Reading et al. 2007 "[l]inguistic and cultural barriers, as well as racism and stereotypes, lead not only to misunderstandings and frustrations, but can result in inferior diagnosis, care, and outcomes" (RHS 2002/2003 in Reading et al. 2007:80).

1.6 Scholar: "The graduating student will be able to contribute to the development, dissemination, critical assessment of knowledge/practices and dissemination related to the improvement of First Nations, Inuit and Métis health in Canada." (IPAC/AFMC 2009a: 16)

This key competency is supported by four enabling competencies, or objectives:

- Knowledge of ways to work in partnership with First Nations, Inuit and Métis peoples in order to recognize their health concerns and needs;

- Acquire effective and participatory approaches to share and disseminate health information with First Nations, Inuit and Métis peoples.

- Describe respectful and transparent manners to acquire information about First Nations, Inuit and Métis peoples and communities.

- Discuss the strengths and limitations of using available key indicators of Aboriginal health in Canada.

Although some of the readings affirm that partnership is important to address Aboriginal health needs, there are just a few readings that provide case studies of participatory research and discussion on how to engage in this type of research (Centre for Indigenous Peoples Nutrition and Environment 2004; World Health Organization Commission on the Social Determinants of Health 2008; MacNab et al. 2008; Smylie 2001; Thommasen et al.

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2005). In "Understanding relationships between diabetes mellitus and health-related quality of life in a rural community", Thommasen et al. (2005) describe the steps taken to engage with the community, which involved a consultation process, request of support and ethical approval.

A more detailed guideline is presented in the additional reading "Documenting Traditional Food Systems of Indigenous Peoples: International Case Studies" (Centre for Indigenous Peoples Nutrition and Environment 2004). The document discusses principles to be considered when working in partnership with Indigenous Peoples. They are:

♦ Deal with community concerns and involvement. To be successful, this work should be a priority for the community.

♦ Request clear community guidance in the process to develop the research goals and techniques employed.

♦ Involve local community residents to assist the research process, employ them whenever possible, and train them in the research methods.

♦ For individual interviews request a signed informed consent statement. If signatures are not possible, request local leaders to advise you on how the elements of informed consent are guaranteed to respondents.

♦ Contribute to the community in other ways with expertise of the researchers—for example, offer to assist at the health center or to give special class to the school.

♦ Be sure to return something relevant to the community, in consultation with them - for example, desired medicines or food supplies, or documents on the food system that can be used in local schools.

♦ A document on participatory health research with Indigenous Peoples has been

published by the World Health Organization, and is available at www.cine.mcgill.ca.

♦ Give timely progress reports of the results back to the community leaders; ask for their advice if a procedure needs to be changed.

♦ Return all results to the community, and request input on your interpretation of the results.

♦ Consider a firm research agreement. If written agreements are not possible in the area, have a witnessed verbal understanding with the village leader. Be sure to discuss the disposition of the resulting data, and the benefits that will accrue to the community. (Centre for Indigenous Peoples Nutrition and Environment 2004: 17)

In addition, the curriculum offers a practical experience with First Nations communities. The elective course IHHS 408 is an opportunity for students to engage with Aboriginal communities that are participating in the delivery and planning of the course (Andrew 2009). According to the course syllabus, students are asked to identify the community needs and to produce a team project to address these health concerns. Another theme suggested for discussion in the course syllabus are the issues and concerns that need to be addressed when doing research with Aboriginal communities.

In one of the required reading for the course IHHS 408 entitled "The embodiment of Inequity: Health Disparities in Aboriginal Canada", the anthropologist Naomi Adelson discusses the need for decolonizing methodologies, where researchers engage in a meaningful dialogue with Aboriginal peoples and communities, establishing their priorities to engage in a collaborative research process. The author also argues that the use of statistics alone just depicts that health disparities existent, without showing the context and causes behind the inequality.

Most of the time, the key indicators of Aboriginal health used throughout the

readings create an image of a sick and problematic population. The titles of some lectures reveal the construction of a negative image of Aboriginal populations and patients. This is the case in the sessions: Vulnerable Populations; Canada's Aboriginal Peoples; Public Health Response to Tobacco; Alcohol; Mental Health I; Mental Health II – Severe Addiction and Concurrent Disorder; International Issues of Violence; Domestic Violence; Abuse of Elders; and Child Abuse and Neglect. The topics in discussion and the vocabulary utilized emphasize negative aspects and low health indicators of Aboriginal peoples.

In one of the required readings (Reading et al. 2007) in the section on Aboriginal health, however, there is a discussion of the negative effects of such representations. The authors argue that an "epidemiological paradox" arises,

> because it is in the public health interest to raise awareness concerning legitimate health risks, yet in the longer term, the same depiction leads to a social construction that is essentially unhealthy. Such a population level pathology is an insidious, pervasive and subtle form of structural racism and discrimination; once a group is identified with a distinctive pattern of unhealthy behaviour, a bias toward that group seems to perpetuate itself expressed as a racial profile with embedded lower expectations which, in turn, can become a self fulfilling prophesy for future generations (Reading et al. 2007:08).

1.7 Professional: "The graduating student will demonstrate a commitment to engage in dialogue and relationship building with First Nations, Inuit and Métis peoples to improve health through increased awareness and insights of First Nations, Inuit, Métis peoples, cultures and health practices" (IPAC/AFMC 2009a: 17)

This key competency is supported by four enabling competencies, or objectives:

- Acknowledge one´s own response to the histories and contemporary situation of First Nations, Inuit and Métis peoples and provide respectful opinion.

- Reflect on one's own knowledge limitations and incorporate First Nations, Inuit and Métis perspectives of health practice.

- Describe manners to engage and exchange with First Nations, Inuit and Métis peoples.

- Demonstrate ethical behavior in all exchanges with First Nations, Inuit and Métis individuals, workers and communities.

The reflective writing component in the course DPAS 410 is a resource that can be used by instructors to support students in reflecting on their own response to the histories and contemporary situation of First Nations, Inuit and Métis peoples. Another great resource to encourage a reflective space to consider prejudice and racism is the reading "White Privilege: Unpacking the invisible Knapsack" of IHHS 408. In this article, McIntosh discuss racism and discrimination by putting the "advantage self" in perspective. She brings many examples of how there is a subtle mechanism that privilege white people in their daily lives. Students can relate the statements to their own experience and reflect on their own response to this system of dominance.

As discussed previously, there is not much discussion in any of the class readings of Indigenous perspectives of health practice. In addition, when readings are discussing the integration and collaboration of alternative and mainstream medicine, there is an emphasis that these alternative methods must be evaluated to test their validity (Beyerstein 2001; Lett 1990; Kaptchuk and Miller 2005). There is no discussion about how one's knowledge is limited and that one's perspective is one among many others. Mainstream medicine and epidemiological studies, which are evidence based, are considered the guides for clinical practice (Cook et al. 1997; Stephenson and Babiker 2000)

As discussed before, there are readings that discuss that participation and engagement of Aboriginal peoples and communities are very important to overcome the actual health gap between Aboriginal and non-Aboriginal populations. In addition, it is essential to create opportunities for students to engage with communities, such as in the elective course IHHS 408. The course itself is an example of an active involvement of Aboriginal peoples in their own affairs, since they participate in the planning, development and delivery of the course (Andrew 2009).

2.   Final Considerations

In a general manner, the readings do cover most of the enabling competencies and objectives proposed by IPAC/AFMC (2009a). One of the issues, however, is that most of the critical perspectives are condensed in a few readings (Adelson 2005; Canadian Institute for Health Information 2004; Caron 2005; Fournier and Crey 1997; Furniss 1999; Gupta 2006; IPAC/AFMC 2009a; Kelm 1998; Lemchuk-Favel and Jock 2004; McIntosh 1990; MacNab et al. 2008; Office of the Provincial Health Officer 2009; Reading et al. 2007; Smylie 2001; World Health Organization Commission on the Social Determinants of Health 2008). In

addition, most of them are not mandatory, either because they part of the elective course (Adelson 2005; Caron 2005; Fournier and Crey 1997; Furniss 1999; Lemchuk-Favel and Jock 2004; McIntosh 1990; MacNab et al. 2008; Smylie 2001) or are additional suggested readings (IPAC/AFMC 2009a; Kelm 1998; Office of the Provincial Health Officer 2009; World Health Organization Commission on the Social Determinants of Health 2008).

For example, the paper "First Nations Wholistic Policy and Planning Model: Discussion paper for the World Health Organization Commission on the Social Determinants of health (Reading et al. 2007) presents a critical perspective about many aspects in almost all the competencies explored, with the exception of the professional competency. On one hand, there is the advantage of having many points explored in the same reading. Therefore, if students read this paper, they would have all these themes covered. On the other hand, if they do not read it they would miss a lot of useful information.

Other great resources are part of the reading list of the elective course IHHS 408. Two required readings, *Monkey Beach* (Robinson 2000) and *The truth about stories* (King 2003) are very good books, written by Native authors, that explore in a unique way the question of Native identity and worldview. In *The embodiment of Inequity: Health Disparities in Aboriginal Canada*, Adelson (2005) presents adverse health indicators of Aboriginal populations throughout the article. These indicators, however, are discussed in terms of broader social and historical contexts. In the article, the author exposes the difference between talking about health disparities and health inequities. The second would explore "the underlying causes of the disparities, many if not most of which sit largely outside of the typically constituted domain of 'health'" (Adelson 2005:45).

The readings and materials suggested in the sessions and courses which are specifically addressing Aboriginal issues are very good and most of them present a critical perspective about Aboriginal health and well-being. My concern is with the depiction of Aboriginal health and populations in the sessions of the curriculum that address challenging areas and/or themes. Some of the terms used to describe Aboriginal health and populations create a very negative image of Aboriginal peoples and communities. This is the case in the sessions: Vulnerable Populations (Conway et al. 2006); Public Health Response to Tobacco (H. Krueger & Associates 2005; Health Canada 2002); Alcohol (BC Ministry of Health Planning 2001); Mental Health I (Mental Health Commission of Canada website; Senate of Canada 2004); Mental Health II – Severe addictions and Concurrent Disorder (Patterson et al. 2008); International issues of violence (Unicef Innocenti Research Centre 2000; United Nations 2006); Major Public Health Issues in BC (BC Centre for disease control website); Domestic Violence (Ending violence against women website; Morrow and Varcoe 2000); and Child Abuse and Neglect (Trocmé and Wolfe 2001); Environmental Health (Arctic Monitoring and Assessment Programme 2009; Government of British Columbia et al. 2005).

Some examples of these derogatory terms used in the readings of the sessions above include: "high risk populations"; "vulnerable to alcohol social harms"; "particularly affected by Fetal Alcohol Spectrum Disorder (FASD)"; "common to face mental health problems"; "suffer more stigma when dealing with substance abuse"; "marginalized populations"; "disproportionately represented among absolutely homeless and at-risk populations"; "reality of substance abuse"; "experience discrimination"; "vulnerable women, more likely to die as the result of violence"; "increasing risk of chronic disease, such as obesity and diabetes"; "disproportionately affected by environmental contaminants"; "lower life expectancy at birth"; "higher infant mortality"; "much higher incidences of injuries and suicide"; "higher

rate of tuberculosis"; "most disenfranchised and poorest members of the larger society or nation".

One of the consequences of this characterization is the creation of certain stereotypes about Aboriginal peoples which are reproduced in the provision of health care services for Aboriginal patients. In a recent article published online in the Ottawa Citizen, Craig and Marc Kielburger (2013) argue that Aboriginal women suffer the effects of unfair stereotypes and cultural misunderstandings in the Canadian health care system. In the article, they consider a study conducted by Sarah Wolf, a registered midwife, and Dr. Don Wilson, who practices obstetrics and gynecology, where they suggest that stereotypes are getting in mainstream health care. In this research, Wolf and Wilson (in Kielburger 2013) advocate for the incorporation of education about Aboriginal health issues into the curriculum of medical schools in Canada. In a survey conducted by them, they concluded that residents do not have enough background about Indigenous women's health issues. I argue here that it is very important to incorporate Aboriginal health content in the medical curriculum; however, this content must be evaluated and elaborated to avoid the construction of the same stereotypes that are criticized in the health care system into the education provided to the future practitioners. In this research, I have demonstrated that these terms that are reproduced in the clinical setting are found throughout the undergraduate medical curriculum in British Columbia.

Chapter 5 – Conclusion

My research was concerned with reviewing and analysing the Aboriginal health and social determinants of health content present in the undergraduate medical curriculum in British Columbia. I did this through examining the readings of the courses in which these issues were discussed and providing a critical assessment of this content. This evaluation had two important components taken into account: the recommendations suggested by IPAC/AFMC in the undergraduate curriculum framework (IPAC/AFMC 2009a) and the discussions held with the Aboriginal advisory committee during the research process.

In this conclusion, I will briefly provide an overview of the research. I will also discuss methodological choices and how they affected the research process, the results and findings. Then, I will present the results and relate it to the greater context and literature.

The first step in my research was to conduct a literature review, which had the objective of situating this project within the field of medical anthropology. Three relevant areas of study were identified: the development of medical education and its curriculum; the relevance and contribution of social science perspectives to medicine; and the inclusion of these perspectives in the medical curriculum. I conclude from this literature the importance of having social sciences perspectives and understandings included in the medical curriculum and also investigate the historical and contemporary aspects of the inclusion of these perspectives in North America and Canada specifically.

I have shown the contributions that social science perspectives can offer to the study of Medicine. For example, the influence of political and economic factors on the health and well-being of individuals and populations; the impact that socio-cultural factors can have on the patient and physician communication; and the difference between a culturalist approach and a critical medical anthropology approach. The first approach privileges cultural

characteristics as a tool to explain social differences and health inequalities while the second highlights structural factors, such as economic and political ones.

In the case of Indigenous peoples in Canada and elsewhere, the adoption of a critical perspective that recognizes the influence of political, economic, and historical determinants on the health and well-being of individuals and communities is even more important. The health status that Indigenous peoples and communities present today is a consequence of these structural factors that need to be recognized in the clinical encounter. For that reason, the education provided to medical students needs to incorporate social science perspectives and Indigenous content that discuss the issues of economic deprivation, colonization, racism, the power of biomedicine and white privilege.

The literature acknowledges the importance of including social sciences perspectives in the medical curriculum, but I found just a few studies that investigate the extent that these perspectives were incorporated or not. A survey developed by IPAC/AFMC (2008) was of particular interest. In this study, the Directors of the Faculties of Medicine in Canada were asked to report on the courses that had content relevant to Indigenous health issues and to provide details about those courses. Did the courses address Indigenous health issues? What topics related to Indigenous health were covered in each component of the course? And were there opportunities for students to engage with Indigenous populations?

The IPAC/AFMC survey identified several courses as part of the medical school curriculum in British Columbia which incorporated Indigenous issues into the courses. My research drew on this survey but expanded the analysis by critically analysing the course readings resources and suggested materials – both required and supplemental. The purpose of this review of the course materials was to have a clearer picture of not only what was being taught about Aboriginal health but also how relevant issues were presented. I selected three

courses for this expanded analysis (DPAS 410, DPAS 420 and IHHS 408). These courses were selected because they had extensive reading lists while courses, which were taught only through practical experience, were excluded from my analysis.

My analysis focused only on the assigned readings for course, not on class lectures. As such I did not collect information about any additional discussion and content delivered through the lectures in DPAS 410 and 420 or in any of the activities proposed in the elective course IHHS 408. Therefore, using other methods and variables in similar research could reveal different aspects about the curriculum content that were not explored in this research. For example, I could have chosen to conduct participant observation and attend the courses in which these themes were discussed. In this way, I would have been exposed to the exchange of ideas inside of the classroom, and could have recorded the reactions and opinions of the students and faculty members when discussing Aboriginal health issues.

Another possibility was to interview medical students and to enquire about their understandings of Aboriginal health issues and how they came to those understandings. More specifically, I could have examined the influence that the courses had on the students' perceptions of Aboriginal health issues by interviewing the students about their course experience. This could have also given me a better idea of the extent to which the students engaged with the class materials: did they actually attend the classes; did they read the required and suggested readings; did they participate in the class discussions of the courses' readings and materials; and how were these resources discussed and presented by the courses' instructors. I believe, however, that having a detailed description of the courses readings is the

first step to better understand and evaluate the Aboriginal health content present in the undergraduate medical curriculum. Further research could explore the two aspects mentioned above and broaden the collective understanding of this research topic. Another suggestion to expand this knowledge is to review and analyse the curriculum used elsewhere in Canada and then to compare their curriculum in relation to their approaches to and coverage of Aboriginal health issues.

After selecting the courses, I gathered all the required readings and suggested resources for further analysis. Then, I wrote a report that summarized the readings for each session, which is reproduced in chapter 3. The next step was to form an Advisory Committee, which consisted of Aboriginal people who were interested in providing their opinion on my report and on the readings and curriculum content. In total, three people agreed to participate in the committee and two meetings were held where we had productive discussions that guided the final critical analysis presented in chapter 4. I choose to have members of an Aboriginal Advisory Committee comment on and guide my final analysis as a means to ensure the principles of Partnership, Protection and Participation of Indigenous peoples in my research (see Appendix B).

It is important to note that it would have been even more productive to have more people participating in the Advisory Committee, sharing their experiences, histories and perspectives. I believe that finding time to participate was a constraint for most of the people I made contact with, so I was unable to expand the membership of the Advisory Committee. I believe, however, that there will be more opportunities to make this research accessible and available for more discussion within the community, for instance, through the publication of articles in academic journals

and through my participation in activities to share the research, such as the UBC learning circles[14].

In my analysis of the data (presented in chapter 4), I explored the extent to which the First Nations, Inuit and Métis Health Core Competencies developed by IPAC/AFMC (2009a) were evident or not in the courses readings. As discussed above, I did conclude that the FN/I/M Health Core Competencies were addressed in a very general manner in the courses readings of the three courses analysed. As such, it is very important that medical students continue to have access to these materials, to read them, and discuss these themes raised. My research also revealed that the curriculum content takes a critical perspective when specifically addressing Aboriginal health issues. This critical approach is presented in most of the readings in these sessions by highlighting the historical, social and economic contexts behind the "poor health status" of Aboriginal peoples and communities.

My research also revealed several areas of concern. One of the concerns is that some of the best resources and materials for discussion are part of the elective course IHHS 408 or are suggested as additional readings or resources in DPAS 420. Therefore, only students who take the elective course IHHS 408 are going to have the opportunity to read these materials. In addition, considering the heavy work load faced by medical students, it is not realistic to think that students are going to read all the suggested and additional readings, especially when that includes reference to a whole book. It is out of the scope of this research, however, to determine what resources were emphasized by the courses' instructors and if they were being read by the majority of the students. I suggest here, however, that the fact that this content is

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[14] The UBC Learning Circle is partnership among the UBC Division of Aboriginal People's Health, the First Nations Health Council and the First Nations and Inuit Health to encourage sharing of information and educational resources to the community through the web.

not compulsory reveals the power that the biomedical education has to determine what it is important and what is supplemental.

Another concern is the repeated association in the course materials of Aboriginal peoples with negative images and challenges. This is demonstrated in frequent references to Aboriginal peoples and their "ill health" in all the sessions and to the emphasis on health issues or problem areas, such as tobacco use and mental illness. As discussed previously, the terms used to describe Aboriginal health and populations contribute to building an image of despair and crisis among individuals and communities, which could lead to increased stigma and marginalization. In addition, this characterization helps to reproduce the legal, political, economic and social structure that denies Aboriginal peoples power and privilege.

Other authors have discussed the effects of this negative depiction of Aboriginal peoples. For example, Elliot and deLeeuw (2009) also comment on the education provided to medical students on Aboriginal issues. They discuss the dangers of learning these "facts" of Aboriginal poor health status and inferior socio-economic conditions without understanding the historical and social contexts that led to these circumstances. One of the main consequences of this portrait is the erroneous perception that the condition of being Aboriginal results in having a vulnerable position in society, which creates a negative stereotype (Elliot and deLeeuw 2009).

Browne and Fiske (2006) detect the same issue in their analysis of Aboriginal governance in provincial health authorities. They observe that the Provincial Government of British Columbia acknowledges the importance of including Aboriginal peoples in health

planning and decision making only in specific priority areas: HIV/AIDS; substance abuse; tobacco reduction; mental health and diabetes, but not in health planning and decision making. Similarly to what I uncovered in relation to the medical curriculum, the overall needs of Aboriginal peoples are seen to be linked to specific concerns of ill health, creating negative stereotypes about the health of Aboriginal peoples and the organization of their communities. As a consequence, Aboriginal political aspirations of self governance and their capabilities to deal with their own issues are put into question (Browne and Fiske 2006).

The same image of a sick and disorganized population is uncovered by O´Neil´s et al. (1998) during their analysis of the epidemiological discourses about Aboriginal health in Canada. They observe how an image of misery and sickness acts as a social instrument for the construction of Aboriginal identity, which can then be used to justify paternalism and dependency. They also observe that the result of these discourses is to limit the full and equal participation of Aboriginal peoples in Canadian society (O'Neil et al. 1998).

These are examples of how Aboriginal identity is being shaped by the lenses of colonizers and which emphasizes certain "problematic" aspects which ignoring the strengths and successes of Aboriginal communities. Presenting this image of Aboriginal peoples to medical students may result in their future stigmatizing and stereotyping of their Aboriginal patients and consequent reproduction of health inequalities. Some studies have shown that Aboriginal patients have negative experiences with the service provided by physicians in the clinical setting (Benoit and Carrol 2001; Browne, Fiske, & Thomas 2000; O'Neil 1989; Towle et al. 2006). As such, it is very important to identify how Indigenous issues are being taught to future practitioners of medicine.

One of the members of the Advisory Aboriginal Committee observed that this negative representation of Aboriginal health and communities is often constructed by people

who never been to any Aboriginal community. He noted that the creation of a racial profile, which is then applied to all Aboriginal peoples, can be very harmful in a number of ways, including in the construction of Aboriginal identity. He also considered the damaging effects on youth when moving out from their communities, when they realize that the "outside world" perceives them differently.

As much social science research argues and some of the readings reviewed suggested, Aboriginal ill health needs to be understood in context, in the conditions that Aboriginal peoples and communities faced in the past and face today. The question is how to present the challenges that Aboriginal peoples encounter without creating an image of a sick and weak population. One way is to highlight community strengths and capabilities to deal with their own affairs. Another significant solution is to make known the historical and social context behind the "poor health status".

This leads to yet another concern with some aspects of the undergraduate medical curriculum in British Columbia. As discussed before, many of the class readings on Aboriginal health did in fact address contextual factors underlying the actual health status of Aboriginal peoples and communities. Colonization, the legacy of residential schools, and other past government policies towards Aboriginal populations were touched upon in many of the readings. What was often not clearly addressed in most of the readings was the fact that colonization is an ongoing process, that Aboriginal peoples in Canada are still colonized and that poverty and racism still affect and will continue to affect the lives of the generations to come unless significant changes are implemented.

Furthermore, none of the readings addressed the power of biomedicine and the implications that this power and privilege have on the life of Aboriginal peoples today. I argue here that we need to interrogate Medicine and its privilege; we need to interrogate white

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innocence; and we need to interrogate the creation and settlement of Canada. Aboriginal peoples are dying and suffering the consequences of this system that define them as inferior, sick and incapable. Faculties of Medicine are not doing enough to place Indigenous health as the most important challenge to the medical system. This can only be achieved if there is a real questioning and changing of the power structures and relationships and recognition that everyone is part of the problem and has responsibility in changing it.

Applying a decolonizing lens to the study of Aboriginal health issues and populations is, therefore, decisive. Aboriginal rights to self determination and governance need to be recognized, and different images need to be created, without stereotypes and prejudice. To assist non-aboriginal medical students to start to see and treat their Aboriginal patients in a different light, these students must engage in self-reflection exercises that allow them to be critical. This includes the discussion of difficult themes, such as racism, discrimination, white privilege, innocence and power. The course DPAS 410 provides a space for self-reflection through the reflective writing activities proposed in the lectures. I cannot determine just by looking at the themes proposed in the course outline, however, how instructors approached these topics or even if these topics were incorporated into any of the activities.

Another important component is to respect, understand and value Indigenous perspectives and knowledge. Medical students must be encouraged to acknowledge Indigenous ways of knowing as equally important and as valid as Western knowledge. Therefore, it is crucial for students to have opportunities to connect with Indigenous peoples and go to their communities. The undergraduate curriculum provides opportunities for this engagement. The elective course IHHS 408 is a community-based course where students can learn about Indigenous worldviews and protocols.

In addition, the IPAC/AFMC (2008) study reported that the course Family Practice

Continuum II also offers a 1 to 2 month experience at the Vancouver Native Health Centre for 5 to 6 undergraduate students. These are valuable opportunities that should be central part of the curriculum, required of every student in order to graduate. Unfortunately, they are not mandatory and it will be up to the student to engage or not in these learning activities. If they do choose to take up these opportunities, they would have the chance to learn about the health concerns and traditional approaches of health directly from Aboriginal individuals and communities. Also, these experiences may help to eliminate negative stereotypes and prejudices by bringing awareness and familiarity with Aboriginal health issues through practical learning.

I end with an excerpt from *Indigenous Methodologies. Characteristics, Conversations and Contexts,* a book written by the Indigenous scholar Margaret Kovach (2010), which summarizes in a powerful way, what it means to apply a decolonizing lens to ourselves and to Institutions. This quote made me reflect on the task that Faculties of Medicine as institutions need to complete to truly achieve a curriculum that respects and acknowledges Indigenous knowledge and perspectives on health. In addition, it is also related to my self-reflection about my own personal position as a non-Indigenous researcher studying the representation of Aboriginal issues in the medical curriculum:

> The relationship begins with decolonizing one's mind and heart. Non-Indigenous
> academics who have successful relationships with Indigenous communities
> understand this. This means exploring one's own beliefs and values about
> knowledge and how it shapes practices. It is about examining whiteness. It is
> about examining power. It is ongoing. It is only after carrying out this personal
> and institutional examination that scholars and disciplines can be in a position to
> acknowledge Indigenous knowledge and what it means in changing an

organizational culture (Kovach 2010: 169).

Appendix A

IPAC-AFMC Summary of Key Findings
Questionnaire on Indigenous Health Curriculum in Canadian
Undergraduate Medical Education Programs

In March 2008, a questionnaire was distributed to faculty at each of the Canadian medical schools to obtain information on existing curriculum in undergraduate medical education relevant to Indigenous Health Issues. We had an overall response rate of 68% (39/57). From these respondents, 77% (30/39) of the curriculum components identified contained specific Indigenous Health content. The following is a summary of the data collected through this questionnaire.

Content

Most relevant curriculum touched on determinants of health 97% (social (90%), medical (87%), environmental (73%) and spiritual (70%)). In addition, curriculum also touched on complexities in healthcare delivery (73%), historical context (73%), disease prevalence/health status (70%) and barriers to appropriate care (67%). 82% of relevant curriculum components provided cultural information, usually related to the Indigenous concept of health and disease (96%) or diversity among Indigenous populations (70%). Information for the curriculum components came from a variety of Indigenous and non-Indigenous sources. Usually information came from Indigenous authors (63%) and/or through consultations with Indigenous communities (47%). Non-Indigenous sources tended to be academic (53%) or governmental publications (47%).

Educational Methods

Educational methods were varied with most curriculum components containing practical experiences (63%) and/or small group learning (60%) followed by didactic lectures (47%) and/or guided discussion groups (47%). Methods of evaluating learners also varied greatly, the most common methods were written exams or evaluation by supervising physician (27% each), or "other" (53%). Most learners (93%) have the opportunity to engage with Indigenous individuals, usually in the general (non-academic, non-medical) community (57%) or in specific community programs (50%). Learners most often encountered Indigenous people as community leaders or healers (64%), academic instructors (61%) or patients (54%). Only (52%) of learners engaging with Indigenous persons specifically received any kind of cultural competency/safety training. When it was provided, the training varied in content, depth, timing in relation to the encounter and in many other respects.

These findings have helped create a cross-country picture of the current state of Indigenous health curriculum in undergraduate medical education. Along with similar work done at the postgraduate and continuing education levels and additional research into National Aboriginal Associations, these findings have helped to identify key resources and will serve as a stepping stone for the further development of Indigenous Health Curriculum across the continuum of medical education

Appendix B

Protocol and principles for conducting the research: "Aboriginal Health in the Medical Program in British Columbia: A Curriculum Analysis"

As a researcher, I recognize that I have the power to construct legitimating arguments for or against ideas, theories or practices. I am a collector of information and producer of meaning, which can be used for, or against Indigenous interests. As such, to avoid negative aspects of externally driven research, I recognize the principles of ownership, control, access and possession (OCAP). These principles are expressed in this research protocol and will be followed to ensure protection, partnership and participation of Aboriginal people. These principles will be pursued to avoid concerns of First Nations of research conducted about Aboriginal culture[1], such as:

• lack of meaningful community involvement in the research process;
• lack of individual and community benefit from research;
• lack of informed community consent;
• research agendas dictated by personal or academic interests rather than First Nations priorities or interests;
• lack of community ownership of data and research results (no control over analysis, interpretation or reporting; no review or say in who has access to data);
• community stigmatization and stereotyping of First Nations; and,
• lack of respect towards First Nations culture and beliefs, including misinterpretation of traditional knowledge and practices.

This protocol is based on the protocol sponsored by the Faculty of Human and Social Development, to ensure that appropriate respect is given to the cultures, languages, knowledge and values of Indigenous peoples, and to the standards used by Indigenous peoples to legitimate knowledge.

My research will examine what is being taught about Aboriginal health and Aboriginal peoples in the medical curriculum in British Columbia and will include Aboriginal members on an Advisory Committee which will assist and advise me in the evaluation of my research findings in relation to a content analysis of medical school curriculum.

Consultation with the appropriate Indigenous organization occurred. The Indigenous Physician Association of Canada (IPAC) is giving support to this research to ensure indigenous participation, partnership and protection. These principles are:

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[1] First Nations Centre. (2007). *OCAP: Ownership, Control, Access and Possession*. Sanctioned by the First Nations Information Governance Committee, Assembly of First Nations. Ottawa: National Aboriginal Health Organization.

Partnership: Where Indigenous people are major participants in research or they have a major interest in the outcome of a research project focused on an issue of relevance to Indigenous people, then working relationships based on collaboration and partnership should be established between the researcher and these participants. This will include collaboration and consultation with the Advisory Committee and the sharing of research outcomes with the Advisory Committee and with IPAC.

Protection: In accordance to working relationships based on collaboration and partnership, the researcher must ensure the protection of Indigenous participants and Indigenous resources in the research process, including as far as possible protection from any negative impact that might result from the findings of the project being made public. This may include placing a moratorium on the research material for an agreed period of time or on keeping confidential certain material. In addition, participants will be given a copy of their transcribed comment for review of its accuracy or to clarify or amend any of their comments. These comments will be incorporated into my final analysis and research findings only if participants agree.

Participation: Indigenous people will participate in and enjoy the benefits that might result from this research. This participation will occur through the participation of Indigenous people in the Advisory Committee. The benefits of participating in the research include: Increasing knowledge about what is being taught in the undergraduate medical curriculum in British Columbia about Aboriginal people and their health. Also, it is an opportunity to give an opinion about the content, and comment on my analysis and findings based on that content. A summary of these findings will be submitted to the Indigenous Physicians Association of Canada and may be subsequently consulted by that Association or other parties interested in suggesting improvements to the medical curriculum such that doctors get trained to better take care of Aboriginal people.

Ethics

The consent of the people involved in the research, where such people are identifiable, will be sought and confirmed before the research commences as well as on an ongoing basis. Appropriate institutional advice will be made available to guide the consultation process.

The aims of the research, which is to serve as a resource in the improvement of the medical curriculum concerning Aboriginal health in British Columbia, will be conveyed to the participants of the Advisory Committee involved in the research in a clear, concise and appropriate way.

Research tools and techniques, which are open, direct and transparent, will be used at all times. All participants will be fully informed that they are involved in a research study before the study begins.

The people participating have control over the results of the research process and as such have an absolute right to exercise control over the information they have volunteered. This includes the right to control it, to restrict access to it, or to withdraw part or all of the information from the actual research project findings. It is the researcher's responsibility to clarify with research participants how this control might be exercised.

The researcher will not exploit informants, or the information gathered from the research, for personal gain or aggrandisement. Where possible and appropriate, fair return should be given for participants' help and services, which should be acknowledged in the final output.

All the ethical principles outlined in the University of Victoria Human Research Subjects Ethics Policy #1250 will be adhered to in this policy, including the right of research participants to remain anonymous.

An important aspect of the question of ethics is values. Indigenous values must be acknowledged by incorporation within the research design and methodology of a project. These values are such things as:

• Ensure that Indigenous values are upheld at all times
• Ensure that Indigenous people are consulted and have given clear direction on research activity before, during and after research.
• Ensure that appropriate aspects of Indigenous peoples are understood, acknowledge and upheld
• Indigenous culture is strictly upheld and observed
• Ensure there are no conflicts of Indigenous values, culture and tradition
• This process runs throughout the project when and where appropriate.

All individuals or groups involved in the research process will be given a copy of this protocol.

Accountability
It is my main responsibility and accountability will be to the people involved in the activities being researched, who will be considered as having an equal interest in the project.

The people participating have an absolute right to know as far as can be anticipated what will become of the information they have volunteered as well as its possible use and application.

The contribution of any individual or group consulted will be acknowledged in the final research report, except that all individuals or groups taking part in the research have a right to remain anonymous.

Research Outcomes

The research will make a positive contribution to Indigenous needs, aims and aspirations as defined by Indigenous people and the enhancement of Indigenous values. It is my responsibility to ensure that Indigenous participants are clear about the aim of the research.

A summary of the final research report will be made available to any individual or group who provided information used in the final research report. A full report of the research (M.A Thesis) will be held by the University Of Victoria's library.

Appendix C
Participant Consent Form

"Aboriginal Health in the Medical Program in British Columbia: A Curriculum Analysis"

You are invited to participate in a study entitled *Aboriginal Health in the Medical Program in British Columbia: a Curriculum Analysis*, which is being conducted by Gabriela Pereira. Gabriela Pereira is a Graduate student in the department of Anthropology at the University of Victoria and you may contact her if you have further questions by emailing gabipere@uvic.ca.

As a Graduate student, I am required to conduct research as part of the requirements for a M.A degree in Anthropology. This research is being conducted under the supervision of Margo Matwychuk. You may contact my supervisor at (250) 721-6283.

Purpose and Objectives
The purpose of this research project is to understand how medical schools in British Columbia prepare their students to address the health issues facing Aboriginal peoples. The objective is to conduct a curriculum analysis, in order to gain an understanding of the manner in which Aboriginal people are characterized in the course reading materials. This analysis will be made through an examination of the assigned readings of the courses which have Aboriginal health as a subject matter. The results of the analysis will be subsequently reviewed and further analysed with the assistance of an advisory committee formed by Aboriginal individuals.

Importance of this Research
Research of this type is important because the education provided to future doctors will influence the quality of care given to patients. In the case of Aboriginal health, little is known about the way students are prepared to address issues facing Aboriginal populations and how much of their education is dedicated to the social determinants of health. Consequently, to have a good understanding of the manner in which Aboriginal health and the social determinants of health are being taught is essential for suggesting potential areas for improvement. In addition, this research will contribute to the field of medical anthropology, emphasizing the significance of doctor patient interactions as part of the social determinants of health.

Participants Selection
You are being asked to participate in this study because you have an Aboriginal ancestry and are interested in and/or are an expert on Aboriginal health. As a member of the advisory committee and with your expertise and experience with Aboriginal health, I will be asking you to review and evaluate selections of course content, my analysis of those materials, and my research findings, providing me with your judgment on aspects of the current curriculum and recommendations for improvement.

What is involved
If you agree to voluntarily participate in this research, you will be part of an advisory committee, which will be formed to assist in the analysis of and conclusions about the medical curriculum content on Aboriginal health. A report outlining the content of the courses which have aboriginal

health as a subject matter was prepared by the researcher. This report is 21 pages long and it describes the content of the course materials, and includes my preliminary analysis of that content. The report will be sent to you for review and feedback and you can choose the way you want to participate. The options are: 1) to participate in person in a working group session to discuss the content and analysis collectively with the researcher and other members of the Advisory Committee; 2) Provide written feedback on the content and the analysis to the researcher by email or mail; 3) Discuss the content and analysis with the researcher privately by phone or in person. Therefore, the time committed to this project will vary according to your availability, but will likely require two to four hours of your time. In option 1 and 3, if you consent, I will record on audiotape your or the groups' comments on the content and analysis. Once these comments are transcribed, I will provide you with a copy of the transcript for your review of its accuracy or to clarify or amend any of your comments. These comments will then be incorporated into my final analysis and research findings.

Risks
There are no known or anticipated risks to you by participating in this research.

Benefits
The potential benefits of your participation in this research may include increasing your knowledge about what is being taught in the undergraduate medical curriculum in BC about Aboriginal people and their health, giving you an opportunity to give your opinion about the content, and advising the researcher in her analysis and findings based on that content. A summary of these findings will be submitted to the Indigenous Physicians Association of Canada and may be subsequently consulted by that Association or other parties interested in suggesting improvements to the medical curriculum such that doctors get trained to better take care of Aboriginal people.

Compensation
As a way to compensate you for any inconvenience related to your participation, if you chose to participate in the advisory committee meeting, your parking fee on campus will be covered if necessary. Also, refreshments will be served during the meeting. If you agree to participate in this study, this form of compensation to you must not be coercive. It is unethical to provide undue compensation or inducements to research participants. If you would not participate if the refreshments and or parking were not offered, then you should decline.

Voluntary Participation
Your participation in this research must be completely voluntary. If you do decide to participate, you may withdraw at any time without any consequences or any explanation. If you do withdraw from the study your data will be used only with your permission.

Anonymity
Anonymity cannot be fully guaranteed if you chose to participate in the advisory committee meeting or if you meet with me individually. However, you may choose to provide feedback by mail. In that case, your comments may be anonymous only if several other members of the Advisory Committee also chose to submit their comments anonymously by mail.

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Confidentiality
Your confidentiality and the confidentiality of the data will be protected if requested. You will be given a pseudonym if you do not want to be identified as a member of this advisory committee.

Dissemination of Results
It is anticipated that the results of this study will be shared with others in the following ways: M.A Thesis, presentations at scholarly meetings, internet, published articles, media, summary reports.

Ethics guidelines
This research will follow the ethical principles of conducting research with and about Aboriginal populations. As such, a protocol containing the values which will be followed during the research was prepared and is attached for your information.

Disposal of Data
Data from this study will be disposed off 5 years after the completion of the research. Electronic data will be erased; paper copies will be shredded and discarded in confidential recycling bins.

Contacts
Individuals that may be contacted regarding this study include the researcher, Gabriela Pereira at gabipere@uvic.ca. ; and the researcher supervisor at mmatwych@uvic.ca.

In addition, you may verify the ethical approval of this study, or raise any concerns you might have, by contacting the Human Research Ethics Office at the University of Victoria (250-472-4545 or ethics@uvic.ca).

Your signature below indicates that you understand the above conditions of participation in this study and that you have had the opportunity to have your questions answered by the researcher.

Please indicate your option of participation _____(See the session *what is involved* in this form)

_____
Name (Print)

_____
Signature

_____
Date

Doctor, Patient and Society
DPAS 410

Wednesday, September 30, 2009

Block 2: The Context of DPAS

Lecturers: Dr. Brian Conway, Dr. Barbara Fitzgerald and Students

Agenda:

1:00 – 2:15 PM:
- Vulnerable Populations

2:30 – 4:00 PM:
- Tutorial Groups

Session Objectives:

1. To become familiar with the need for health care professionals to identify and address health disparities in order to promote health equity for vulnerable populations.
2. To explore ways in which you will be able to address these issues throughout your training.

Required Readings:

1. Conway B, Tossonian HK, Raffa JD, Storms M, Duncan F, Grebely J. A Systematic Approach to the Treatment of Hepatitis C Virus Infection in Injection Drug Users: Where Are We Now? *Future Virology*, in press.
2. UBC Public Affairs. UBC Discovery Reverses Thinking About Hep C Treatment for Drug Users. November 8 2006.
3. Grebely J, Conway B, Raffa J, Lai C, Krajden M, Tyndall M et al. Hepatitis C Virus reinfection in Injection Drug Users. *American Association for the Study of Liver Diseases.* August 2006; 1139-1145.

For Discussion and Reflective Writing:

1. For your reflective journal entry today (up to 30 minutes), write about how we could modify Canadian society to address the specific challenges around access to medical care by vulnerable populations. Write about the problems, how they came to be, what you feel about them, how they are limiting the health status of our vulnerable populations and what types of strategies we can use to address them. CONGRATULATIONS, YOU ARE NOW FULL-FLEDGED REFELCTIVE WRITERS!.
2. Are you aware of any programs aimed at addressing disparities in medical care in British Columbia?
3. Divide the group into sub-groups of two students to discuss the role of the individual health care practitioner in addressing disparities in access to health care?

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DPAS 410

Wednesday, October 7, 2009
LSC 1

Block 2:   The Context of DPAS

Lecturers: Dr. Brian Conway & Students

Agenda:

1:00 – 2:15 PM:	• Global Health Issues
2:30 – 4:00 PM:	• Tutorial Groups

Session Objectives:
1. Using HIV infection as a specific example, to become familiar with the key determinants of global health that is most relevant in the twenty-first century.
2. To examine and discuss the role and responsibilities of Canadian health care practitioners in global health.

Required Readings:
1. 2008 Report on the Global AIDS Epidemic: Executive Summary. UNAIDS; July 2008. Pgs 3-5, 8, 10, 17-18, 23, 27.

For Discussion and Reflective Writing:
1. For your reflective journal entry today, discuss your role and responsibility as a "global citizen".
2. Is it realistic to expect that there will ever be "universal access" to HIV treatment? Why even set such a goal?
3. Has Canada done its fair share in dealing with the AIDS pandemic? Should every Canadian physician be involved in this endeavour in some way? Debate this issue as you see fit…

Doctor, Patient and Society
DPAS 410

Wednesday, October 14, 2009
LSC 1

Block 2:   The Context of DPAS

Lecturers: Dr. Brian Conway & Students

Agenda:

1:00 – 2:15 PM: • Canada's Cultural and Linguistic Diversity

2:30 – 4:00 PM: • Tutorial Groups

Session Objectives:
1. To examine the relationship between culture (including professional culture), health and health care.
2. To explore the meaning of culturally sensitive health care.

Required Readings:
1. Trang MV. Cultural Differences.
2. Buscher L. Current Issues: Culturally Responsive Practice - Considerations for Dietitians. 2007 Sept.
3. Société santé en français, Summary Master Plan 2008-2013.

For Discussion and Reflective Writing:
1. For your reflective journal entry today, write about whether French-English bilingualism is relevant to you. Or is Multilingualism or Multiculturalism the more relevant concept? Or both?
2. What is "cultural competency", and is it important for you to achieve it before you graduate?
3. Drawing on multi-lingual or multi-cultural members of your group, discuss cultural differences in health outcomes, meaning of health, and conceptions of doctor between Caucasian and non-Caucasian populations of which you are aware, and then discuss them with your group. It may be useful to divide the group into those who are unilingual Anglophones and those who are not…

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DPAS 410

Wednesday, October 21, 2009
First Nations House of Learning
1985 West Mall

_____

Block 2:   The Context of DPAS

Lecturer: James Andrew & Team

Agenda:

1:00 – 2:15 PM: • Canada's Aboriginal Peoples

2:30 – 4:00 PM: • Tutorial Groups

Session Objectives:
1. To become familiar with health disparities that exist between Canada's Aboriginal peoples and the general Canadian population, and how they are being addressed.
2. To understand the lessons learned from the residential school movement.

Required Readings:
1. Chapter 4: Aboriginal Peoples' Health. *Improving the Health of Canadians*. September 2004: 73-104.
2. Selected Definitions
3. Introduction to the First Nations House of Learning & Longhouse.

For Discussion and Reflective Writing:
1. What are the major public health concerns of the Aboriginal communities? How do they differ from those of the non-Aboriginal communities?
2. How does this session affect your role as a health care practitioner in Canadian society?
3. Do you have a role to play in responding to the residential school scandals of the past century?
4. AFTER this session (between now and next week), write a reflective journal entry that is as comprehensive as you can make it about what you saw, heard and felt today.

SELECTED DEFINITIONS

Aboriginal - people indigenous to North America. They contrast their indigenous status with that of immigrant groups and their pre- and post-contact political status of those immigrants who left their nations of origin.

Band - a body of Indians for whom the government has set aside lands for their common use and benefit; for whom the government is holding monies for their common use and benefit; or which has been declared a band by the governor-in-council. The band does not own reserve land. In 1869 local governance was instituted with chiefs and band councils elected by a process defined by the federal government rather than traditional custom.

Ethnic group - a group socially distinguished by themselves (self ascription) or by others primarily based on cultural characteristics or national origin. Aboriginal peoples prefer to distinguish themselves as indigenous Nations in contrast to early and recent ethnic immigrants. Multicultural issues are distinct from Aboriginal issues.

Indian Act - originally passed in 1876, and revised several times, it defines who is a "legal," or "status" Indian, the nature of legislative and administrative control of the federal government, and who has access to services (see Frideres 1998:30-32).

Indian (Native) Ancestry - ethnicity based on Native kinship, participation in Native social and cultural activities; distinct from the legal status of Indian as defined by the Indian Act. May include those who were not allowed or refused to make arrangements with the Crown, or those who lost or gave up their Indian Status (Frideres 1998:29-30).

Inuit –- Aboriginal peoples who live in Nunavut, Northern Quebec, Northern Labrador and Northwest Territories.

Metis - communities that grew out of the symbiotic relationships between Natives and European immigrants. They developed distinct social, political, and economic identities in regions of Manitoba (particularly the Red River), Alberta, and Saskatchewan. In Alberta, they were recognized by the provincial government and were able to negotiate land settlements (Frideres 1998:35-36). Recognition of the legal status of Metis varies according to particular treaties and common law in different provinces.

Potlatch - a ceremonial exchange of wealth. Gifts are given to those who witness or are present to acknowledge the investiture of a hereditary title, or acquisition or acknowledgment of a social status or identity.

Reserve - (Canadian term - called a *reservation* in the US) land set aside and held in trust for the use and benefit of a band and its members who are status Indians. Because legal title is invested in the crown, reserve land or other resources cannot be used as collateral for loans or mortgages. In BC, reserves were not based on the surrender of land in treaties, while in many places in eastern Canada reserves were established through surrender of aboriginal title and treaty.

Status Indian - the legal status of individual under the terms of the Indian Act (Frideres 1998:25-27). The definition has changed considerably from time to time. Between 1868 and 1986 the following have been defined at times as Indian and at other times as White:
- Indian women married to non-Indian men
- Indian men married to non-Indian women
- Indians who resided outside Canada for more than 5 years
- Indians with a university degree
- Indians who have left the reserve to obtained the right to vote in federal and provincial elections

Treaty - an agreement between nations. In Canada, treaties established formal relationships between the British (and subsequently Canadian) governments and aboriginal peoples. Treaties usually resulted in the surrender of lands. With the exception of several small areas of Vancouver Island, treaties were not signed with the Aboriginal peoples in BC nor were lands surrendered (Frideres 1998:28-29).
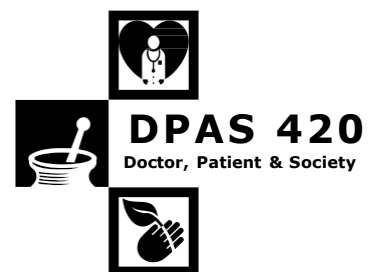
DOCTOR, PATIENT AND SOCIETY 420

Course Book

WINTER TERM
January 5th to May 11th, 2009

UBC Faculty of Medicine
Undergraduate Medical Program

DPAS 420
Doctor, Patient & Society

BLOCK: HEALTH PROMOTION

PLENARY #1:   Health Promotion: Skin

REQUIRED READINGS:

1. Risk Factor Interventions: An Overview of their Effectiveness. July 26, 2005. pp 147-161. Report prepared for Canadian Cancer Society (BC/Yukon) and BC Cancer Agency by H. Krueger & Associates Inc.
    http://www.bccancer.bc.ca/NR/rdonlyres/DD092EFB-5BDA-4505-A110-0B69A5740598/15774/RiskFactorEffectiveInterventions_Cancer_.pdf

➔   **Also review the materials from the Integument block that relate to skin cancer (PBL).**

SUGGESTED ADDITIONAL READINGS/RESOURCES:

Listed below are some web sites you may find of interest:

1. Cancer Prevention Institute of Canada - Overview of cancer risk factors, including chronic disease risk factors such as obesity, lack of exercise, tobacco etc.
    www.preventcancer.ca

2. Sun Awareness and Skin Cancer Prevention Strategy for British Columbia
    http://www.bccdc.org/downloads/pdf/rps/reports/strategy.pdf

3. Canadian Dermatology Association   www.dermatology.ca

4. SunTips   www.suntips.ca

BLOCK: PSYCHOACTIVE DRUGS

PLENARY #1:   Public Health Response to Tobacco

REQUIRED READINGS:

1. Gotay CC. Behavior and Cancer Prevention. *Journ of Clin Onc* 2005; **23**(2): 301-310.
   http://jco.ascopubs.org/cgi/content/full/23/2/301

2. Miller AB. Primary Prevention of Cancer: Needs and Opportunities for Research.
   Enviro Health Perspectives 1995; **103**(Suppl 8): 313-317.
   http://www.ehponline.org/members/1995/Suppl-8/miller-full.html

SUGGESTED ADDITIONAL READINGS/RESOURCES:

Listed below are some web sites you may find of interest:

1. BC's Tobacco Control Strategy – Targeting Our Efforts
   http://www.tobaccofacts.org/pdf/bc_strategy.pdf

2. Health Canada – 2000-2002 Report on Tobacco Control – Update
   http://www.hc-sc.gc.ca/hl-vs/pubs/tobac-tabac/report-rapport/index_e.html

BLOCK: PSYCHOACTIVE DRUGS

PLENARY #2:   Alcohol

REQUIRED READINGS:

1. Stockwell T. Alcohol supply, demand, and harm reduction: What is the strongest cocktail?
    Int J of Drug Policy 2006; **17**(4): 269-277.
    http://www.sciencedirect.com/science?_ob=MImg&_imagekey=B6VJX-4JWFGTY-2-
    1&_cdi=6106&_user=1022551&_orig=search&_coverDate=07%2F31%2F2006&_sk=99982
    9995&view=c&wchp=dGLbVlb-
    zSkWb&md5=19e0172911f1960765648fd4001e2af9&ie=/sdarticle.pdf

2. Public Health Approach to Alcohol Policy: A Report of the Provincial Health Officer
    (BC Ministry of Health Planning)
    http://www.healthservices.gov.bc.ca/pho/pdf/alcoholpolicy.pdf

SUGGESTED ADDITIONAL READINGS/RESOURCES:

1. A Public Health Approach to Drug Control in Canada – Health Officers Council of British
    Columbia. (Discussion Paper October 2005).
    http://www.spph.ubc.ca/mathias/Framework_for_Drug_Control.pdf

2. Nutt D et al. Development of a rational scale to assess the harm of drugs of potential
    misuse. *Lancet* 2007; **369**: 1047-1053.
    http://www.sciencedirect.com/science?_ob=MImg&_imagekey=B6T1B-4N9XF65-19-
    1&_cdi=4886&_user=1022551&_orig=search&_coverDate=03%2F30%2F2007&_sk=99630
    0433&view=c&wchp=dGLzVlz-
    zSkWz&_valck=1&md5=7d74386ada126fd34d387cd903e7feee&ie=/sdarticle.pdf

BLOCK: PSYCHOACTIVE DRUGS

PLENARY #3: Public Health Framework for Psychoactive Drugs

REQUIRED READING AND RESOURCES:

<u>**Web Site**</u>

Familiarize yourself with the following web site:

1. Keeping the Door Open – Dialogues on Drug Use
   - this is a Vancouver Consortium with several interesting links on their site.
   http://www.keepingthedooropen.com/Resources/EventsResources/tabid/62/Default.aspx

<u>**Reading**</u>

2. A Public Health Approach to Drug Control in Canada – Health Officers Council of British Columbia. (Discussion Paper October 2005).
   http://www.spph.ubc.ca/mathias/Framework_for_Drug_Control.pdf

SUGGESTED ADDITIONAL READINGS/RESOURCES:

Listed below are some web sites you may find of interest:

1. Every Door is the Right Door – A British Columbia Planning Framework to Address Problematic Substance Use and Addiction
   http://www.vch.ca/publications/docs/info/industry/Every_Door.pdf

2. Cannabis: Our Position For A Canadian Public Policy - Report Of The Senate Special Committee On Illegal Drugs
   http://www.parl.gc.ca/37/1/parlbus/commbus/senate/com-e/ille-e/rep-e/summary-e.pdf

3. Canadian Foundation for Drug Policy   http://www.cfdp.ca/

4. Drug Policy Alliance Network   http://www.drugpolicy.org/homepage.cfm

BLOCK: MENTAL HEALTH

PLENARY #1:   Mental Health I

REQUIRED READINGS/RESOURCE:

<u>Web Site</u>

Familiarize yourself with the following web site:

1. Mental Health Commission of Canada. Out of the Shadows Forever.
    http://www.mentalhealthcommission.ca/english/pages/default.aspx

<u>Readings</u>

2. Johnston AD. Stalking a Silent Killer. *MacLean's* Nov 2005, page 109 -
    http://www.mentalhealthroundtable.ca/nov_2005/Stalking%20a%20silent%20killer.pdf#255
    F9.pdf

3. A Guide to BC's Mental Health Resources
    http://www.cmha.bc.ca/files/VancouverCoastalMentalHealthGuide.pdf
    **This handy newsprint guide walks a reader through the range of community
    supports available in BC for mental health care. Extremely useful for someone new
    to BC or to the mental health system.**

SUGGESTED ADDITIONAL READINGS/RESOURCES:

Listed below are some web sites you may find of interest:

1. Mental Health, Mental Illness and Addiction: Overview of Policies and Programs in Canada
    http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-e/soci-e/rep-
    e/report1/repintnov04vol1-e.pdf
    Excellent report by Senator Kirby. Section on Stigma especially worth reading.

2. Stigma and Discrimination in Canada (Visions Journal)
    http://www.heretohelp.bc.ca/sites/default/files/images/6.pdf

3. Canadian Mental Health Association   www.cmha-bc.org

4. BC Government - Mental Health and Addictions   www.healthservices.gov.bc.ca/mhd

5. AnxietyBC   www.anxietybc.com

6. Mood Disorders Association of BC   www.mdabc.net

7. BC Schizophrenia Society   www.bcss.org

Monday, February 9, 2009

BLOCK: MENTAL HEALTH

PLENARY #2:   Mental Health II – Severe Addiction and Concurrent Disorder

REQUIRED READINGS:

1. Patterson M et al. Housing and Support for Adults with Severe Addictions and/or Mental Illness in British Columbia. Centre for Applied Research in Mental Health and Addiction. February 2008. pp 8-14 (Executive Summary).
http://www.carmha.ca/publications/resources/pub_hsami/Housing_SAMI_BC_FINAL_(pre-desk).pdf

2. Krausz M et al. Comorbidity of Opiate Dependence and Mental Disorders. *Addictive Behaviours* 1998; **23**(6): 767-783.
http://www.sciencedirect.com/science?_ob=MImg&_imagekey=B6VC9-3V5458H-5-1&_cdi=5949&_user=1022551&_orig=search&_coverDate=12%2F31%2F1998&_sk=999769993&view=c&wchp=dGLzVlz-zSkWb&md5=79e310c329dc8208557731e44ac7a2e6&ie=/sdarticle.pdf

3. Kessler RC et al. Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication. Arch Gen Psychiatry 2005; **62**: 593-602.
http://archpsyc.ama-assn.org/cgi/reprint/62/6/593

SUGGESTED ADDITIONAL READINGS/RESOURCES:

Listed below are some web sites you may find of interest:

1. Mental Health, Mental Illness and Addiction: Overview of Policies and Programs in Canada
http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-e/soci-e/rep-e/report1/repintnov04vol1-e.pdf
Excellent report by Senator Kirby. Section on Stigma especially worth reading.

2. Stigma and Discrimination in Canada (Visions Journal)
http://www.heretohelp.bc.ca/sites/default/files/images/6.pdf

3. Canadian Mental Health Association
www.cmha-bc.org

4. BC Government - Mental Health and Addictions
www.healthservices.gov.bc.ca/mhd

5. Anxiety Disorders Association of BC   www.anxietybc.com

6. Mood Disorders Association of BC   www.mdabc.net

7. BC Schizophrenia Society   www.bcss.org

BLOCK: COMPLEMENTARY AND ALTERNATIVE MEDICINE (CAM)

PLENARY #1:   Good medicine, bad medicine: equitable standards of evidence for
                    health care providers

REQUIRED READINGS AND RESOURCES:

<u>**Readings**</u>

1. Kaptchuk TJ, Miller FG. What is the Best and Most Ethical Model for the Relationship
    Between Mainstream and Alternative Medicine: Opposition, Integration, or Pluralism?
    Academic Medicine 2005; **80**(3): 286-290.
      - this article is accessible through the UBC E-Journals web page
        http://toby.library.ubc.ca/ejournals/ejournals.cfm

2. Beyerstein BL. Alternative Medicine and Common Errors of Reasoning. *Academic
    Medicine* 2001; **76**(3): 230-237.
      - this article is accessible through the UBC E-Journals web page
        http://toby.library.ubc.ca/ejournals/ejournals.cfm

The following paper has been provided for review (it also appeared in your Fall Term DPAS 420
course book):

3. Lett, James. A Field Guide to Critical Thinking. *Skeptical Inquirer.* Winter 1990.
    http://www.csicop.org/si/9012/critical-thinking.html

<u>**Web Site**</u>

Familiarize yourself with the following site:
(attend one or more of the *Vancouver Skeptics in the Pub* nights)

4. BC Skeptics – BC Society for Skeptical Enquiry
    http://www.bcskeptics.info/index.cgi

SUGGESTED ADDITIONAL READINGS/RESOURCES:

1. Tonelli M, Callahan T. Why alternative medicine cannot be evidence-based. *Academic Medicine* 2001; **76**(12): 1213-1220.
    - this article is accessible through the UBC E-Journals web page
      http://toby.library.ubc.ca/ejournals/ejournals.cfm

2. Miller FG et al. Ethical Issues Concerning Research in Complementary and Alternative Medicine. *JAMA* 2004; **291**(5): 599-604.
   http://jama.ama-assn.org/cgi/reprint/291/5/599

3. Fonnebo V et al. Researching complementary and alternative treatments – the gatekeepers are not at home. *BMC Medical Research Methodology* 2007; **7**(7).
   http://www.biomedcentral.com/content/pdf/1471-2288-7-7.pdf

4. Haskins GR. A Practical Guide to Critical Thinking.
   http://www.skepdic.com/essays/haskins.pdf

Listed below are some web sites you may find of interest:

5. Dr. James Lett's web site (see Publications)
   http://faculty.ircc.edu/faculty/jlett/

6. The Skeptic Society   http://www.skeptic.com/

7. Quackwatch   http://www.quackwatch.org/

BLOCK:　　　　　　COMPLEMENTARY AND ALTERNATIVE MEDICINE (CAM)

PLENARY #2:　　　　CAM Paradigms

REQUIRED READINGS:

1. Integrative Medicine (CAM in UME)   http://www.caminume.ca/drr/resources/pod_028.doc

2. Deng G. Integrative cancer care in a US academic cancer centre: the Memorial Sloan-Kettering experience. *Curr Oncol* 2008; **15**(Suppl 2): S68-71.
   http://www.current-oncology.com/index.php/oncology/article/view/276/238;

3. Questionable cancer practices in Tijuana and other Mexican border clinics. *CA: A Cancer Journal for Clinicians* 1991; **41**(5): 310-319.
   http://caonline.amcancersoc.org/cgi/reprint/41/5/310

SUGGESTED ADDITIONAL READINGS/RESOURCES:

1. The CAM in UME Project
   http://www.caminume.ca/drr/

2. Approaching Patients who are using both CAM and conventional medicine (CAM in UME)
   http://www.caminume.ca/drr/resources/pod_026.doc

3. Balneaves LG et al. Bridging the gap: decision-making processes of women with breast cancer using complementary and alternative medicine (CAM). *Supportive Care in Cancer* 2007, **15**(8), 973-983.
   http://www.springerlink.com/content/612503127u683963/fulltext.pdf

4. Web sites for information sources:

   CAMLINE – The Evidence-Based Complementary and Alternative Medicine Website for Healthcare Professionals   www.CAMLINE.ca

   The Research Council for Complementary Medicine   www.rccm.org.uk

5. A couple of other interesting sites:

   Alternative medicine and fallacious arguments. Wandering Primate Blogspot.
   http://wanderingprimate.blogspot.com/search?q=fallacious+arguments

   Healthwatcher (you need to scroll down to the bottom of the page past all the advertisements to get the topics)
   http://www.healthwatcher.net/

BLOCK: EPIDEMIOLOGY

PLENARY #1:   Analytic Epidemiology including study designs

REQUIRED READINGS:

1. Aschengrau A, Seage GR. Chapter 6: Overview of Epidemiologic Study Designs. In
    Essentials of Epidemiology in Public Health; Jones and Bartlett Publishers: Sudbury, 2003; pp
    135-162.
    http://publichealth.jbpub.com/aschengrau/Aschengrau06.pdf

2. Taubes G. Do We Really Know What Makes Us Healthy? *New York Times* Sept 16, 2007.
    http://www.nytimes.com/2007/09/16/magazine/16epidemiology-
    t.html?_r=1&oref=slogin&pagewanted=all

The following form has been provided to you as a reference/resource:
UBC Intervention Study Appraisal Form

SUGGESTED ADDITIONAL READINGS/RESOURCES:

1. Stephenson JM, Babiker A. Overview of study design in clinical epidemiology. *Sex Transm Inf*
    2000; 76: 244-247.
    http://sti.bmj.com/cgi/reprint/76/4/244

2. Mortimer JA, Borenstein AR. Tools of the Epidemiologist. *Alzheimer Dis Assoc Disord* 2006;
    20(Supp 2): S35-S41.
      - this article is accessible through the UBC E-Journals web page
        http://toby.library.ubc.ca/ejournals/ejournals.cfm
3. Rychetnik L et al. A glossary for evidence based public health. *J Epidemiol Community Health*
    2004; **58**: 538-545.
    http://jech.bmj.com/cgi/reprint/58/7/538

Listed below is a web site you may find of interest:

4. A ScHARR Introduction to Evidence Based Practice on the Internet
    http://www.shef.ac.uk/scharr/ir/netting/

UBC INTERVENTION STUDY APPRAISAL FORM

Reference:

Assessment
☐ excellent ☐ good ☐ fair ☐ poor

WHY

☐ Is sufficient evidence presented to justify the study?
☐ Is there a CLEAR statement of the purpose of the study?
☐ Is there a CLEAR statement of the study hypothesis?
☐ Is it clearly outlined whether the study is considering
      ☐ EFFICACY, or
      ☐ EFFECTIVENESS?

comments

HOW

Study design
1 ☐ controlled trial   2 ☐ cohort   3 ☐ case-control
4 ☐ before-after   5 ☐ cross-sectional   6 ☐ case series

☐ If it is a controlled trial, is the allocation of subjects **TRULY** randomized?

Blindness
☐ unblinded
☐ single-blind   ☐ double-blind   ☐ triple-blind

☐ Was prognostic stratification used?

comments

WHO

☐ Is the population from which the sample is drawn CLEARLY described?

☐ Are inclusion and exclusion criteria specified and replicable?

☐ Do the inclusion and exclusion criteria match the goals of the study?

☐ Do the authors account for every patient who is eligible for the study but does **not** enter it?

☐ Is the baseline comparability of the treatment and control groups documented?

comments

WHAT

☐ What is the intervention? Is it clearly defined and replicable?

☐ Was compliance with intervention(s) measured and were non-compliers analyzed correctly?

☐ Were **contamination** and **co-intervention** considered?

☐ Were all patients who entered the study accounted for?

☐ Were withdrawals, dropouts, cross-overs and poor compliers analyzed in accordance with the aims of the study?

☐ What outcome measures were utilize? Were all the relevant outcomes reported?

comments

HOW MANY

☐ Was statistical significance considered?

☐ Were statistical tests applied appropriately?

☐ How many tests of hypothesis (p-value) appear in the article?

☐ Did the authors consider sample size requirements prior to the study?

☐ Was the study large enough to detect important outcomes?

☐ When no differences were found, was there any consideration of possible **beta error**?

comments

SO WHAT

☐ If differences were detected, were they clinically significant?

☐ Were the patients **entered** and **analyzed** in the study sufficiently representative that the results can be generalized to other patients?

☐ Was the intervention as performed by those in the study sufficiently representative that the results may be generalized to other settings?

☐ Were the outcomes assessed in the study sufficient to guarantee which of the therapy(ies) under study does the greatest good?

comments

BLOCK: EPIDEMIOLOGY

PLENARY #2:   Systematic Reviews

REQUIRED READINGS AND RESOURCES:

1. Cook DJ, Mulrow CD, Haynes RB. Systematic reviews: synthesis of best evidence for clinical decisions. *Ann Intern Med* 1997; **126**: 376-80.
    http://www.annals.org/cgi/content/full/126/5/376

Listed below is a web site you may find of interest:

2. The Cochrane Collaboration   www.cochrane.org

SUGGESTED ADDITIONAL READINGS/RESOURCES:

1. Grol R, Wensing M. What drives change? Barriers to and incentives for achieving evidence-based practice. *MJA* 2004; **180**: S57-S60.
    http://www.mja.com.au/public/issues/180_06_150304/gro10753_fm.pdf

2. Bosse G et al. The resistance to changing guidelines – what are the challenges and how to meet them. *Best Practice & Research Clinical Anaesthesiology* 2006; **20**(3): 379-395.
    http://www.sciencedirect.com/science?_ob=MImg&_imagekey=B6WBC-4KV2H38-4-5&_cdi=6707&_user=1022551&_orig=browse&_coverDate=09%2F30%2F2006&_sk=999799996&view=c&wchp=dGLbVlz-zSkWA&md5=056617d0e7371f3af9fae5fc810d4138&ie=/sdarticle.pdf

BLOCK: EPIDEMIOLOGY

PLENARY #3: Clinical Application of EBM Principles – Perspectives on Diet

REQUIRED READINGS:

1. Volek JS et al. Dietary carbohydrate restriction induces a unique metabolic state positively affecting atherogenic dyslipidemia, fatty acid partitioning, and metabolic syndrome. *Progress in Lipid Research* 2008; **47**(5): 307-318. http://www.sciencedirect.com/science?_ob=ArticleURL&_udi=B6TBP-4S2F5GX-1&_user=1022551&_coverDate=09%2F30%2F2008&_rdoc=1&_fmt=full&_orig=search&_cdi=5148&_sort=d&_docanchor=&view=c&_acct=C000050484&_version=1&_urlVersion=0&_userid=1022551&md5=76f038a2796ab2d4516c6c0ea043723a&artImgPref=F

2. Hu FB. Diet and Cardiovascular Disease Prevention. *Journ of the Am Coll Cardio* 2007; **50**(1): 22-24. http://www.sciencedirect.com/science?_ob=ArticleURL&_udi=B6T18-4P0N236-C&_user=1022551&_coverDate=07%2F03%2F2007&_rdoc=1&_fmt=full&_orig=search&_cdi=4884&_sort=d&_docanchor=&view=c&_acct=C000050484&_version=1&_urlVersion=0&_userid=1022551&md5=67b1f3c299ee56ae0a56727e29a8bc61&artImgPref=F

SUGGESTED ADDITIONAL READINGS/RESOURCES:

1. FiLCHeRS
   http://flchrs.com/

BLOCK: DETERMINANTS OF ABORIGINAL HEALTH

PLENARY #1: Why History Matters

REQUIRED READINGS:

1. Reading J et al. *First Nations Wholistic Policy and Planning Model: Discussion Paper for the World Health Organization Commission on Social Determinants of Health*. April 2007. Ottawa: Assembly of First Nations. pp: 4-35.
http://www.afn.ca/cmslib/general/07-05-28_AFN_Paper_to_WHO_Commission_on_Social_Determinants_of_Health.pdf

SUGGESTED ADDITIONAL READINGS/RESOURCES:

1. Kelm M-E. Colonizing Bodies: Aboriginal Health and Healing in British Columbia, 1900–1950. Vancouver: UBC Press, 1988.

2. Indian and Northern Affairs Canada – Royal Commission on Aboriginal Peoples
http://www.ainc-inac.gc.ca/ch/rcap/index_e.html

3. World Health Organization Commission on the Social Determinants of Health. 2008. *Social determinants and Indigenous health: The International experience and its policy implications.*
http://www.who.int/social_determinants/resources/indigenous_health_adelaide_report_07.pdf

4. World Health Organization Commission on the Social Determinants of Health. 2008. Latest Publications. http://www.who.int/social_determinants/resources/latest_publications/en/

BLOCK: DETERMINANTS OF ABORIGINAL HEALTH

PLENARY #2:   Aboriginal Health Core Competencies

REQUIRED READINGS:

1. The Transformative Change Accord: First Nations Health Plan: Supporting the Health and Wellness of First Nations in British Columbia. 2006. BC Government. http://www.health.gov.bc.ca/library/publications/year/2006/first_nations_health_implementation_plan.pdf

2. The Health and Well-being of the Aboriginal Population in British Columbia – Interim Update. Feb 2007. Office of the Provincial Health Officer. http://www.health.gov.bc.ca/pho/pdf/Interim_report_Final.pdf

3. WHO Indigenous Peoples' Health – Health and Human Rights. http://www.who.int/hhr/Indigenous%20Health%202006%20work%20sheet.pdf

SUGGESTED ADDITIONAL READINGS/RESOURCES:

1. C2LEO. Considerations for Cultural-Communication, Legal, Ethical and Organizational Aspects of the Practice of Medicine. http://www.mcc.ca/Objectives_Online/objectives.pl?lang=english&loc=c2leo

2. CanMEDS 2005 Framework. The Royal College of Physicians and Surgeons of Canada. pp 9-24. http://rcpsc.medical.org/canmeds/CanMEDS2005/CanMEDS2005_e.pdf

3. Association of the Faculties of Medicine of Canada – Core Competencies http://www.lcme.org/db0708section2.doc

4. Report On The Health Of British Columbians: The Health and Well-being of Aboriginal People in British Columbia. 2001. Office of the Provincial Health Officer. http://www.health.gov.bc.ca/pho/pdf/phoannual2001pres.pdf

5. First Nations, Inuit, Métis Heath – Core Competencies. A Curriculum Framework for Undergraduate Medical Education. Feb 2008. IPAC/AFMC. http://www.afmc.ca/pdf/CoreCompetenciesEng.pdf

BLOCK: DETERMINANTS OF ABORIGINAL HEALTH

PLENARY #3: Health Services for Remote Communities

REQUIRED READINGS:

1. Nagarajan KV. Rural and remote community health care in Canada: beyond the Kirby Panel Report, the Romanow Report and the federal budget of 2003. *Can Journ of Rural Med* 2004; **9**(4): 245-251.
    http://www.cma.ca/multimedia/staticContent/HTML/N0/l2/cjrm/vol-9/issue-4/pdf/pg245.pdf

2. Hay D, Varga-Toth J. A Third of Canadians Live on Health Care Margins. The Tyee Nov 2, 2006.
    http://thetyee.ca/Views/2006/11/02/HealthCare/

SUGGESTED ADDITIONAL READINGS/RESOURCES:

Listed below are some web sites you may find of interest:

1. BC Ministry of Health – Aboriginal Health
    http://www.healthservices.gov.bc.ca/aboriginal/index.html

2. Assembly of First Nations
    http://afn.ca/article.asp?id=3

BLOCK: DETERMINANTS OF ABORIGINAL HEALTH

PLENARY #4: The Benefits of Traditional Style Diets

REQUIRED READINGS:

1. Forsythe CE et al. Comparison of low fat and low carbohydrate diets on circulating fatty acid composition and markers of inflammation. *Lipids* 2008; **43**(1): 65-77. http://www.springerlink.com/content/r1x1143pl42737u8/fulltext.pdf

2. Thommasen HV et al. Understanding relationships between diabetes mellitus and health- related quality of life in a rural community. *Rural and Remote Health* 2005; **5**: 441-. http://www.rrh.org.au/publishedarticles/article_print_441.pdf

The Volek paper from **March 30**[th] is another good resource for this topic.

SUGGESTED ADDITIONAL READINGS/RESOURCES:

Listed below are some web sites you may find of interest:

1. BC Ministry of Health – Aboriginal Health http://www.healthservices.gov.bc.ca/aboriginal/index.html

2. Assembly of First Nations http://afn.ca/article.asp?id=3

DOCTOR, PATIENT AND SOCIETY 420
Course Book

FALL TERM
August 31st to December 7th, 2009

DPAS 420
Doctor, Patient & Society

UBC Faculty of Medicine

BLOCK: ORGANIZATION

PLENARY #1:   From Person to Population / Introduction to Fall Term Assignment

REQUIRED READING:

Gupta R. Why Should Medical Students Care about Health Policy? *PLoS Medicine* 2006;
3(10): 1696-1698.
http://www.plosmedicine.org/article/info:doi/10.1371/journal.pmed.0030199

BLOCK: ORGANIZATION

PLENARY #2: Major Public Health Issues in BC

REQUIRED READINGS:

1. Health Goals for British Columbia. BC Ministry of Health. Dec 1997.
http://www.health.gov.bc.ca/library/publications/year/1997/healthgoals.pdf

   - Health Goals for British Columbia (pp 4-5) - **PROVIDED**

2. BC Government H1N1 Flu Virus Information
http://www.gov.bc.ca/govt/swine_flu.html

SUGGESTED ADDITIONAL READINGS/RESOURCES:

Listed below are some web sites you may find of interest:

1. BC Ministry of Health. BC Health Act (Bill 23 – Revised 2008)
http://www.leg.bc.ca/38th4th/1st_read/gov23-1.htm

2. BC Ministry of Health – Provincial Health Officer's site
http://www.hls.gov.bc.ca/pho/index.html

   - All of the Annual Reports

      - See following as well:

        Pathways to Health and Healing – 2nd Report on the Health and Well-being of Aboriginal People in British Columbia – Provincial Health Officer's Annual Report 2007 http://www.hls.gov.bc.ca/pho/pdf/abohlth11-var7.pdf

   - All of the Special Reports

3. ActNowBC   http://www.actnowbc.ca/

4. A Framework for Core Functions in Public Health - Resource Document. Population Health and Wellness. Ministry of Health Services. Province of British Columbia. March 2005.
http://www.health.gov.bc.ca/prevent/pdf/core_functions.pdf

5. Public Health Agency of Canada   http://www.phac-aspc.gc.ca/new_e.html

6. BC Centre for Disease Control   http://www.bccdc.ca/default.htm

7. Centers for Disease Control and Prevention (including international travel)
http://www.cdc.gov/

8. World Health Organization (including international travel)   http://www.who.int/en

BLOCK:　　　　　ORGANIZATION

PLENARY #3:　　　Overview of Public Health Functions

REQUIRED READINGS/RESOURCES:

<u>**Readings**</u>

1. Mathias R. A Metaphor for Physicians in Training. **PROVIDED**

2. A Framework for Core Functions in Public Health – Resource Document. Population Health and Wellness. Ministry of Health Services. Province of British Columbia. March 2005. <u>http://www.health.gov.bc.ca/prevent/pdf/core_functions.pdf</u>

    – Pages 1-4, 8-12, 15-21, 23-24, 43, 47-48

<u>**Web site**</u>

1. Ten Great Public Health Achievements in the 20th Century – CDC website
   <u>http://www.cdc.gov/about/history/tengpha.htm</u>

SUGGESTED ADDITIONAL RESOURCES:
  Listed below are some web sites you may find of interest:

1. Vancouver Coastal Health Authority　　<u>http://www.vch.ca/</u>

2. Vancouver Island Health Authority　　<u>http://www.viha.ca/</u>

3. Northern Health Authority　　<u>http://www.northernhealth.ca/</u>

A Metaphor for Physicians and Surgeons in Training by Dr. Richard Mathias

As physicians and surgeons in training, there are many demands placed upon you for the skills, knowledge and attitudes expected of a graduating medical student. In DPAS we add to these demands and it is not always clear to you, the recipient and objective of these demands, just where they fit into clinical practice. This story is an attempt to put this into some perspective.

The outline of this story is far from uniquely mine, but some of the expansions are my own.

One fine day, you are out for a stroll beside a river. In looking at the water you see someone coming down the river calling out for help. You assess your skills and realize that you are capable of attempting a rescue of this person so you plunge into the water and pull the person to shore. They are now safely on shore but before they can do more than thank you another person is calling for help in the river so you plunge in again to pull that person to shore, again effecting a rescue. Again and again a person is coming down the river so fast that you have no time except to keep trying to rescue persons who are at risk.

You are now also at risk from the effort you are expending to rescue the people from the river. But you have colleagues who can help and you quickly organize a team so that each person coming down the river can be rescued while allowing each rescuer time to recover so that they can be ready for the next rescue. And this is good and necessary.

You can now take some time to look at the river and try to determine if the river currents are such that they would have been carried to shore without your efforts or whether there is a way to use the strength of the flow to get them to shore with less effort or more effectively. Using the efforts of the team most efficiently and effectively. And this is good and necessary.

Once the team is large enough to give you some time, you can now go to those who have been rescued to make sure that they are all right and that the rescue has been successful. Making sure that they do not have adverse consequences of the rescue effort itself and that they are recovering successfully from being immersed in the water. Evaluating whether the rescue was successful is one of the tasks you need to do. And this is good and necessary.

With a successful rescue, you now have time, because the other members of the team can rescue people from the river and make sure that the rescue is successful, to find out why these people were in the river in the first place. What is going on upstream that gets them into the river and into difficulty? Are they rafting down the river but getting into rapids that overturn the raft and throw them into the water? Is there some structural defect in the bridge upstream that is throwing them into the water without their consent? Is someone persuading them that getting in the river is a good idea and is without risk? You now have time to talk to this population at risk to find out the upstream issues and to determine if you can intervene in those risks to reduce the number of people coming downstream at risk of drowning. If they need to be in the river to get food or water, can it be done more safely? If they must travel down the river, can you make that trip safer?

Not everyone can go upstream to try to prevent the need for rescue but if someone does not make that effort, then rescues will be required as long as the conditions have not changed.

DPAS is a course that describes how you can determine if your rescue is successful by looking at the outcomes of the rescues. How do we determine if our rescue is needed and how do we determine if our rescue is successful? It is also a course that looks at the population needing rescue to try to determine the upstream causes of the need for rescue and maybe, if we do that well, how we can prevent the conditions that will require rescue downstream.

Ultimately we all travel down the river to reach the end of our journey. As physicians and surgeons we can help with the journey and be there at the end to make rescue unnecessary and unwanted by those on their journey. We can concentrate on rescue when the journey goes wrong or try to make the journey as smooth as possible by making sure that what we do is of more benefit than harm, that the people we rescue need and want our help, and that we are there by their consent for their journey as they want to make it.

BLOCK: ORGANIZATION

PLENARY #4:   Health Care Systems: The Canadian System in context

REQUIRED READINGS:

1. Health Canada. Canada's Health Care System. Her Majesty the Queen in Right of Canada, 2005; HC Pub: 5912; Cat: H21-261 / 2005E_PDF. http://www.hc-sc.gc.ca/hcs-sss/alt_formats/hpb-dgps/pdf/pubs/2005-hcs-sss/2005-hcs-sss-eng.pdf

2. Simpson J. Post-Romanow, post-Kirby; has anything changed? *Can Fam Phys* 2004; **50**: 208-212. http://www.cfp.ca/cgi/reprint/50/2/208

SUGGESTED ADDITIONAL READINGS:

1. Health Canada. Health Care System http://www.hc-sc.gc.ca/hcs-sss/index-eng.php

2. Davis K, et al. Mirror, mirror on the wall: An international update on the comparative performance of American health care. The Commonwealth Fund 2007. http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2007/May/Mirror--Mirror-on-the-Wall--An-International-Update-on-the-Comparative-Performance-of-American-Healt.aspx

3. Chodos H, MacLeod JJ. Examining the Public/Private Divide in Healthcare: Demystifying the Debate. Canadian Political Science Association. 2005. http://www.cpsa-acsp.ca/papers-2005/MacLeod.pdf

4. Steinbrook R. Private Health Care in Canada. *NEJM* 2006; **354**(16): 1661-1664. http://content.nejm.org/cgi/reprint/354/16/1661.pdf

5. Canadian Health Services Research Foundation. Myth: A parallel private system would reduce waiting times in the public system. March 2005. http://www.chsrf.ca/mythbusters/html/myth17_e.php

6. Canadian Health Services Research Foundation. Myth: Canada's system of healthcare financing is unsustainable. December 2007. http://www.chsrf.ca/mythbusters/html/myth28_e.php

7. Dhalla I. Canada's health care system and the sustainability paradox. *CMAJ* 2007; **151**(1): 51-3.   http://www.cmaj.ca/cgi/reprint/177/1/51

8. World Health Organization – Engaging for Health http://whqlibdoc.who.int/publications/2006/GPW_eng.pdf

BLOCK: ORGANIZATION

PLENARY #5: Benefits, costs and allocating resources to fund medical care:
Should we seek to control costs?

REQUIRED READING:

1. Kolata G, Pollack A. Costly cancer drug offers hope, but also a dilemma. *The New York Times*, July 6, 2008. http://www.nytimes.com/2008/07/06/health/06avastin.html

2. Marmor TM, et al. The Obama administration's options for health care cost control: Hope versus reality. *Ann Intern Med* 2009; **150**: 485-489.
http://www.annals.org/cgi/reprint/150/7/485.pdf

   NOTE: Skim the Marmor article, paying attention to the section entitled "**Lessons from abroad: What works and what does not work?**"

SUGGESTED ADDITIONAL READINGS:

1. Eddy DM. Clinical decision making: from theory to practice. Cost-effectiveness analysis. A conversation with my father. *JAMA 1992;* **267**(12): 1669-1675.

2. Greß S, et al. Criteria and procedures for determining benefit packages in health care: A comparative perspective. Health Policy 2005; 73:78-91. At:
http://www.sciencedirect.com/science?_ob=ArticleURL&_udi=B6V8X-4DXJYTS-1&_user=1022551&_rdoc=1&_fmt=&_orig=search&_sort=d&_docanchor=&view=c&_acct=C000050484&_version=1&_urlVersion=0&_userid=1022551&md5=e8bfb8cade9d7736ef4f48ac75069533

3. Mitton C, Donaldson C. Health care priority setting: principles, practice and challenges. *Cost Effectiveness and Resource Allocation* 2004; **2**:3. BioMed Central.
http://www.resource-allocation.com/content/pdf/1478-7547-2-3.pdf

4. Gibson JL, et al. Evidence, Economics and Ethics: Resource Allocation in Health Services Organizations. *Healthcare Quarterly* 2005; **8**(2): 50-59.
http://www.utoronto.ca/cpsrn/html/documents/EthicsEconomicsGibson_000.pdf

5. Cohen D. Marginal analysis in practice: an alternative to needs assessment for contracting health care. *BMJ* 1994; **309**:781-785. http://bmj.bmjjournals.com/cgi/content/full/309/6957/781

BLOCK: ORGANIZATION

PLENARY #6:   Improving Health Care: Challenges and approaches

REQUIRED READINGS:

1. McGlynn EA et al. The quality of health care delivered to adults in the United States.
   NEJM 2003; **348**(26): 2635-45.
   http://content.nejm.org/cgi/reprint/348/26/2635.pdf

2. Institute for Healthcare Improvement. Improvement methods.
   http://www.ihi.org/IHI/Topics/Improvement/ImprovementMethods/

   NOTE: Review this page and links from this page to consider **strategies** we can use to improve quality and safety

SUGGESTED ADDITIONAL READINGS:

1. Schoen C et al. Toward higher-performance health systems: Adults' health care experiences in seven countries, 2007. *Health Affairs Online* 2007; **26**(6): w717-w734.
   http://www.commonwealthfund.org/Content/Publications/In-the-Literature/2007/Nov/Toward-Higher-Performance-Health-Systems--Adults-Health-Care-Experiences-in-Seven-Countries--2007.aspx

2. Steinberg EP. Improving the quality of care – Can we practice what we preach?
   NEJM 2003; **348**(26): 2681-83.
   http://content.nejm.org/cgi/reprint/348/26/2681.pdf

3. Grol R, Grimshaw J. From best evidence to best practice: Effective implementation of change in patients' care. *Lancet* 2003: **362**: 1225-30.
   http://www.ebm-netzwerk.de/wir_ueber_uns/image/lancet.pdf

BLOCK: ABUSE IN SOCIETY

PLENARY #1:   International Issues of Violence

REQUIRED READINGS:

1. Costa D. Health care of refugee women. *Austr Fam Phys* 2007; **36**(3): 151-154.
   http://www.racgp.org.au/Content/NavigationMenu/Publications/AustralianFamilyPhys/2007issues/afp200703/200703costa.pdf

2. Ending violence against women: from words to action – Study of the Secretary-General.
   United Nations. 9 October 2006.

   - Violence against women: unmet needs, broken promises
     http://www.un.org/womenwatch/daw/vaw/launch/english/v.a.w-unmetE-use.pdf

   - Violence against women: forms, consequences and costs
     http://www.un.org/womenwatch/daw/vaw/launch/english/v.a.w-consequenceE-use.pdf

   - Fighting violence against women: what works
     http://www.un.org/womenwatch/daw/vaw/launch/english/v.a.w-fightE-use.pdf

SUGGESTED ADDITIONAL READINGS/RESOURCES:

Readings

1. Audet A-M. The Role of the Physician and the Medical Profession in the Prevention of International Torture and in the Treatment of Its Survivors. *Annals of Internal Medicine* 1995; **122**(8): 607-613. http://www.annals.org/cgi/content/full/122/8/607

2. Willis BM, Levy BS. Recognizing the Public Health Impact of Genocide. *JAMA* 2000; **284**(5): 612-614. http://jama.ama-assn.org/cgi/reprint/284/5/612

3. Ellsberg MC. Violence against women: A global public health crisis. *Scandinavian Journal of Public Health* 2006; **34**(1): 1-4. http://dx.doi.org/10.1080/14034940500494941

4. Ending Violence Against Women. *Population Reports*, published by the Population Information Program, Center for Communication Programs, The Johns Hopkins University School of Public Health in collaboration with CHANGE, December 1999. http://www.infoforhealth.org/pr/l11/violence.pdf

5. Domestic Violence against Women and Girls. Unicef Publications – Innocenti Digest (June 2000). No. 6. http://www.unicef-icdc.org/publications/pdf/digest6e.pdf

6. Mann JM et al. Health and Human Rights. *Health and Human Rights* 1994*;* **1**(1): 6-23. http://www.jstor.org/stable/pdfplus/4065260.pdf

Web Sites

Listed below are some web sites you may find of interest:

Liu Institute for Global Issues   http://www.ligi.ubc.ca/

Physicians for Social Responsibility   http://www.psr.org/site/PageServer?pagename=Home

BLOCK: ABUSE IN SOCIETY

PLENARY #2: Domestic Violence

REQUIRED READINGS/RESOURCES:

<u>**Reading**</u>

1. Mackay K. Identification and Assessment of Abused Persons. June 2005. **PROVIDED**

<u>**Web Site**</u>

Familiarize yourself with the following web sites:

BC Ministry of Community Services
http://www.cd.gov.bc.ca/women/stopping-violence/index.htm

Domestic Violence Program. VCH Programs and Services
http://www.vch.ca/programs/domestic_violence.htm

SUGGESTED ADDITIONAL READINGS/RESOURCES:

<u>**Readings**</u>

1. Morrow M and Varcoe C. Violence Against Women: Improving the Health Care Response. Ministry of Health, Women's Health Bureau. Government of British Columbia. (2000). http://www.llbc.leg.bc.ca/public/PubDocs/bcdocs/341635/violence00.pdf

2. Ed. Ferris LE et al. A Handbook Dealing with Woman Abuse and the Canadian Criminal Justice System: Guidelines for Physicians. Nat. Clearinghouse on Family Violence. 1999.

<u>**Web Sites**</u>

Listed below are some web sites you may find of interest:

Family Violence Prevention Fund http://www.endabuse.org/

Ending Violence Against Women http://www.springtideresources.org/

Hot Peach Pages: World-Wide List of Agencies Against Domestic Violence
http://www.hotpeachpages.org/

Minnesota Center Against Violence and Abuse http://www.mincava.umn.edu/

IDENTIFICATION AND ASSESSMENT OF ABUSED PERSONS

DOMESTIC VIOLENCE PROGRAMS

VANCOUVER GENERAL HOSPITAL
&
PROVIDENCE HEALTH CARE

VANCOUVER B.C. CANADA

Kathleen Mackay MSW
Vancouver General Hospital/
Providence Health Care
855 West 12th Avenue, V5Z 1M9
604-875-5458(phone) 604-875-5460 (fax)
dvclinic@vanhosp.bc.ca

June 2005

NAMING THE VIOLENCE

Domestic Violence is:

  • Abuse that occurs between and among persons related by affection, kinship and/or trust

Domestic Violence can include:

  • Physical assault/ Sexual assault

  • Psychological/ Emotional abuse

  • Neglect

  • Verbal abuse

  • Financial abuse

Domestic Violence is a pattern of violence by an intimate partner or family member in the context of coercive control. Anyone can be abused, but most often the abused is female, the abuser male.

EXAMPLES OF ABUSE:

Verbal:

  Threats, yelling, making insulting remarks

Mental:

  Telling her she is crazy or stupid, mocking her, blaming her unjustly.

Emotional:

  Using guilt, telling her she is a bad mother/partner/person, ignoring/neglecting her, using jealously to control her

Sexual:

  Preventing choice about sex, birth control or STD protection, forcing unwanted sex

Social:

  Isolating her from friends or family, controlling her whereabouts and associates

Financial:

  Controlling decisions about finances, not allowing access to money, stealing from her, committing fraud

Spiritual:

  Belittling her religion, keeping her from practicing her faith

Cultural:

  Belittling her culture, making racial insults

FACTS ABOUT DOMESTIC VIOLENCE

- From 1994-1999, 8% of females and 6% of males faced spousal violence (Stats Can 2000)

- 29% of ever-married Canadian women experience wife assault (Stats Canada 1994)

- experienced by women of all cultural groups, ages and economic classes (Stats Canada, 1993)

- Between 1974 and 1992 1,435 Canadian women were killed by their husbands. This constitutes 38% of the total number of female homicide victims over the age of 15. It is 9 times more likely that a woman will be killed by her spouse than by a stranger. (Statistics Canada 1993)

- is likely to be repeated once it occurs (Stats Canada, 1993)

- often escalates after separation or divorce from the abuser (Ellis, 1992)

- 43% of all wife assaults result in medical attention. (Statistics Canada 1993)

GENERAL INDICATORS

- A delay between time of injury and time of seeking help.

- The injuries sustained are not likely to be caused by the accident reported.

- Repeat visits to the health agency especially with increasing frequency and severity.

- An overprotective or overbearing partner, family member or friend.

- Inconsistencies or changes in the woman's story.

- Minimum response to a serious injury

- Treatments not yielding expected outcomes

INJURY PRESENTATIONS

- Often bilateral
- Patterned injuries / patterns of injuries
- Multiple injuries in various stages of healing
- Common head and neck injuries:
  - periorbital hematoma/ nasal fractures
  - perforated tympanic membranes - deafness
  - lacerations and contusions
  - fractured mandibles/dental damage
- Neurological trauma
- Shaken adult syndrome
- Strangulation/choking and resulting bruising
- Arm injuries:
  - bruising to upper arms
  - bruising along ulnar side of arm
  - ulnar vs radial fractures
- Back and spine injuries
- Burns: cigarettes, appliances/friction (rug)

HEALTH IMPACT OF ABUSE

- Trauma: injury, disability, death
- Threats to maternal and/or fetal health from trauma
- Port traumatic stress disorder
- Depression, anxiety disorders, suicidal ideation, suicide attempts, suicide
- Exacerbation of chronic medical conditions (asthma, diabetes, angina, pain)
- Lack of control over reproductive decision making
- Threatened abortions, abortion requests, spontaneous abortions
- Gynecological disorders, pelvic non-specific pain, PID, STDs
- Sleeping disorders/Eating disorders
- Chest pain, heart palpitations
- Frequent headaches, especially migraines
- Gastro-intestinal symptoms
- Dizziness, numbness, tingling of extremities

WHY DOES SHE STAY?

- Fears retaliation if she leaves
- Financial constraints
- Family pressure to remain in relationship
- Father role very important
- Faith community very important
- Forgives the abusive partner and believes he will change
- Fatigued and unable to plan a way to escape from the situation

SCREENING FOR ABUSE

Conditions

- discussing the situation in private is necessary/ensure confidentiality
- do not press for a disclosure
- be aware of your own values and feelings
- obtain consent prior to making any referrals

Approach

- respectful, supportive/non-threatening, non-blaming, non-judgemental
- acknowledge her feelings and provide support
- refer to someone else if necessary

ASKING THE QUESTION

If someone presents with injuries that are suggestive of abuse, here are some options:

- "The injuries you have suggest to me that someone hit you. Is that possible?"

- "It seems that the injuries you have could have been caused by someone hurting or abusing you. Did someone hurt you?"

When there are no obvious injuries, or the person comes with non-traumatic symptoms, you might approach the topic of abuse in the following ways:

- "From my experience as a health worker, I know that abuse and violence at home is a problem for many people. Is it a problem for you in any way?"

- "Because violence is common in women's lives, we have begun asking all clients about abuse."

- "We know abuse and violence in the home effects many women and that it directly affects health. I wonder if you ever experience abuse and/or violence at home?"

- "I don't know if this is a problem for you, but many of the women I see as clients are dealing with tensions at home. Some are too afraid or uncomfortable to bring it up themselves, so I've started asking about it routinely."

- "As you may know, it's not uncommon these days for a person to have been emotionally, physically, or sexually victimised at some time in their life, and this can affect their health many years later. Has this ever happened to you?"

- "Are you currently or have you ever been in a relationship where you were physically hurt, threatened, or made to feel afraid?"

- "In the past year have you been hit, slapped, kicked or otherwise physically hurt by a current or former partner?"

SUPPORTIVE STATEMENTS

- I'm sorry that happened to you. You don't deserve to be treated that way.

- Thank you for telling me. I know it is hard to talk about this.

- It is not your fault. He is hurting you and breaking the law.

- What he has done to you is against the law.

- It takes a lot of courage for you to tell me this.

- I believe you.

- I am here to support you in the decisions you make.

- You are not responsible for his behaviour. It is not your fault.

SAFETY PLANNING

1. Are you safe now?

2. Practice how to get out of your home safely. Identify which doors, windows, elevator or stairwell would be best.

3. If an argument seems unavoidable, try to have it in a room or an area that you leave easily. Stay away from any room where weapons might be available.

4. Decide where you will go if you have to leave home and have a plan to get there.

5. Have a packed bag ready with spare keys, money, important documents, and clothes. Keep it at the home of a relative or friend, in case you need to leave your home in a hurry.

6. Devise a code word to use with your children, family, friends, and neighbours when you need emergency help or want them to call the police.

7. If you are in crisis and need a safe place, go to an Emergency Department.

REPORTING ABUSE

- Child abuse is reportable to the Ministry of Children and Families.

- Vulnerable adults in need of protection under Part 4 of the Guardianship Act: report to Vancouver Coastal Health **(http://www.qp.gov.bc.ca/statreg/stat/A/96006_01.htm#part4)**

- Abuse of an adult is not reportable to police UNLESS the abused person has given consent.

RESOURCES

- Know the resources in your community.

- Provide numbers for transition houses, crisis lines, support groups.

- Provide information about legal assistance, social support and housing.

- Have posters and information on resources in your office/health facility.

WEB RESOURCES

www.endabuse.org   www.womanabuseprevention.com

www.hotpeachpages.org   www.mincava.umn.edu

BLOCK: ABUSE IN SOCIETY

PLENARY #3:   Abuse of Elders

AGENDA:

REQUIRED READINGS/RESOURCES:

<u>Reading</u>

1. Ahmad M, Lachs MS. Elder Abuse and neglect: What physicians can and should do.
    Clev Clin Journ of Med 2002; **69**(10): 801-808. http://www.ccjm.org/pdffiles/Ahmad1002.pdf

<u>Web Sites</u>

Please familiarize yourself with the following sites:

VCH Re: Act – Adult Abuse & Neglect Response Resource
http://www.vchreact.ca/index.htm

Resource and Training Kit for Service Providers:
Abuse and Neglect of Older Adults. Public Health Agency of Canada.
http://www.phac-aspc.gc.ca/ncfv-cnivf/publications/agekit-eng.php

> *Although this link is for a VCH program there is a lot of valuable information for students at all sites - including assessment tools, links to resources around the Province and other useful data.*

SUGGESTED ADDITIONAL READINGS/RESOURCES

<u>Reading</u>

1. Gordon RM. Adult protection legislation in Canada: Models, issues and problems.
    Intl Journ of Law & Psychiatry 2004; **24**: 117-134.
    http://www.sciencedirect.com/science?_ob=ArticleURL&_udi=B6V7W-43C5BYF-
    2&_user=1022551&_rdoc=1&_fmt=&_orig=search&_sort=d&_docanchor=&view=c&_acct=
    C000050484&_version=1&_urlVersion=0&_userid=1022551&md5=49f4f18ab642b95b367e
    a600ebce3936

2. Lachs MS, Pillemer K. Abuse and Neglect of Elderly Person. *NEJM* 1995; **332**: 437-443.
    http://content.nejm.org/cgi/content/full/332/7/437

Web Sites

Listed below are some web sites you may find of interest:

Abuse and Neglect of Older Adults. Public Health Agency of Canada.
http://www.phac-aspc.gc.ca/ncfv-cnivf/age-eng.php

Public Guardian and Trustee of BC   http://www.trustee.bc.ca/

Canadian Network for the Prevention of Elder Abuse - Canadian Laws on Abuse
and Neglect   http://www.cnpea.ca/canadian_laws_on_abuse_and_negle.htm

The Canadian Centre for Elder Law – A Division of the BC Law Institute
http://www.bcli.org/ccel

The Canadian Bar Association – BC Branch (Elder Law, Elder Abuse & Seniors' Rights)
http://www.cba.org/BC/public_media/rights/239.aspx

College of Physicians and Surgeons of BC – Resource Manual for Physicians
https://www.cpsbc.ca/cps/physician_resources/publications/resource_manual

Stop Bad Therapy   http://www.stopbadtherapy.com/

BLOCK: ABUSE IN SOCIETY

PLENARY #4: Child Abuse and Neglect

REQUIRED READING:

This is an <u>excellent</u> resource for physicians.

1. BC Handbook for Action on Child Abuse and Neglect – For Service Providers
http://www.mcf.gov.bc.ca/child_protection/pdf/handbook_action_child_abuse.pdf

SUGGESTED ADDITIONAL READINGS:

1. Child Abuse: Reporting and Classification in Health Care Settings. Health Canada. 1999.
http://www.phac-aspc.gc.ca/cm-vee/publicat/pdf/child_e.pdf

2. Child Abuse and Neglect: The International Journal ed. Richard D. Krugman, University of Colorado.
http://www.sciencedirect.com/science?_ob=JournalURL&_cdi=5847&_auth=y&_acct=C000050484&_version=1&_urlVersion=0&_userid=1022551&md5=6ec2d10b6093072598e614ec08bf62aa

3. Canadian Incidence Study of Reported Child Abuse and Neglect: National Clearinghouse on Family Violence, Health Canada.
http://www.phac-aspc.gc.ca/publicat/cissr-ecirc/pdf/cmic_e.pdf

4. Child Abuse & Neglect Guidelines. College of Physicians and Surgeons of BC.
https://www.cpsbc.ca/files/u6/Child-Abuse-and-Neglect-Guidelines-3.pdf

5. Ed. Meyers JB et al. The APSAC Handbook on Child Maltreatment. 2002.

BLOCK: ENVIRONMENTAL HEALTH

PLENARY #1:   Risk Assessment and Risk Communication

REQUIRED READINGS:

1. A Guide to Health Risk Assessment. California Environmental Protection Agency.
   http://www.oehha.ca.gov/pdf/HRSguide2001.pdf

2. Frank LD et al. Stepping towards causation: Do built environments or neighbourhood and travel preferences explain physical activity, driving, and obesity? *Soc Sci Med* 2007; 65: 1898-1914.
   http://www.sciencedirect.com/science?_ob=MImg&_imagekey=B6VBF-4P6TH5F-1-9&_cdi=5925&_user=1022551&_orig=search&_coverDate=11%2F30%2F2007&_sk=999349990&view=c&wchp=dGLbVlb-zSkzk&_valck=1&md5=56988dfeb7753081044b41df2641f3c1&ie=/sdarticle.pdf

SUGGESTED ADDITIONAL READINGS:

1. Policy Statement: The Built Environment: Designing Communities to Promote Physical Activity in Children. Committee on Environmental Health. American Academy of Pediatrics. *Pediatrics* 2009. 123(6): 1591-1598.
   http://aappolicy.aappublications.org/cgi/reprint/pediatrics;123/6/1591.pdf

2. Frank L et al. Promoting public health through Smart Growth. Report prepared for SmartGrowthBC. http://www.vtpi.org/sgbc_health.pdf

BLOCK: ENVIRONMENTAL HEALTH

PLENARY #2:   From Ecosystem to Food System

REQUIRED READINGS:

1. Parkes, MW et al. Water, ecology and health: ecosystems as settings for promoting health and sustainability. *Health Promotion International* 2009; **24**(1): 94-102.
http://heapro.oxfordjournals.org/cgi/reprint/24/1/94

2. Chan LHM. 2006. Food Safety and Food Security in the Canadian Arctic. Meridian. Canadian Polar Commission. http://www.polarcom.gc.ca/media.php?mid=113

SUGGESTED ADDITIONAL READINGS/RESOURCES:

1. Oostdam JV et al. Human health implications of environmental contaminants in Arctic Canada: A Review. *Science of the Total Environment* 2005; **351-352**:165-246.
http://www.sciencedirect.com/science?_ob=ArticleURL&_udi=B6V78-4HK5SJN-1&_user=1022551&_rdoc=1&_fmt=&_orig=search&_sort=d&_docanchor=&view=c&_acct=C000050484&_version=1&_urlVersion=0&_userid=1022551&md5=2142becb383cc695abf10436be1ac687

2. Documenting Traditional Food Systems of Indigenous Peoples: International Case Studies. Guidelines for Procedures   http://www.mcgill.ca/files/cine/manual.pdf

3. Mapping North American Environmental Issues
http://www.cec.org/naatlas/index.cfm?varlan=english

4. Children's Health and the Environment in North America: A First Report on Available Indicators and Measures
http://www.cec.org/pubs_docs/documents/index.cfm?varlan=english&ID=1917

5. AMAP 2009 Assessment of Arctic Pollution Status
http://amap.no/documents/index.cfm?action=getfile&dirsub=&filename=SOAER%5F2009.pdf&sort=default

BLOCK: ENVIRONMENTAL HEALTH

PLENARY #3:   Environmentally Sustainable Health Care

REQUIRED READINGS:

1. Hancock T. <u>Doing Less Harm: Assessing and Reducing the Environmental and Health</u> Impact of Canada's Health Care System. Ontario: The Canadian Coalition for Green Health Care, 2001. pp 1, 6-9, 12, 16, 17, 20-21.
    http://www.sc.edu/sustainableu/TrevorHancockInfo.pdf

2. Potera C. Drugged Drinking Water. *Environmental Health Perspectives 2000*; **108**(10): A446.
    http://www.pubmedcentral.nih.gov/picrender.fcgi?artid=1240146&blobtype=pdf

3. Miller A. The design of healthy and sustainable health-care environments. *Hospital News Feb 2008;*
    http://www.hospitalnews.com/modules/magazines/mag.asp?ID=3&IID=104&AID=1353

ADDITIONAL RESOURCES:

1. Health Care Without Harm   http://www.noharm.org/

2. Canadian Association of Physicians for the Environment   http://www.cape.ca/

3. The Canadian Coalition for Green Health Care   http://www.greenhealthcare.ca/

Appendix G

IHHS 408 TOPICS IN ABORIGINAL HEALTH – A Community Based Experience

RESOURCES AND READING PACKAGE – June 2009

Course Guides

Student Manual for Esketemc – 2009

Reports – Health Status and Health Delivery

1. The Transformative Change Accord: First Nations Health Plan. Supporting the Health and Wellness of First Nations in British Columbia. November 2006.

Guides – Cultural Protocols and Safety

2. SOGC Policy Statement. A Guide for Health Care Professionals Working with Aboriginal Peoples. Janet Smylie, BA, MD, CCFP. April 2001.
3. The Teaching of the Elders. Health and Welfare Canada. 1980.
4. The process toward achieving cultural safety in healthcare practice. Nursing Council of New Zealand, 1992.
5. Cultural Competence Self-Test.
6. Tips for Working Effectively with Aboriginal People.

Articles/Excerpts

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Appendix H

University of British Columbia – College of Health Disciplines

Interprofessional Health and Human Services IHHS 408

Topics Course in Aboriginal Health: Community-based learning experience - 6 credits

Course Format:

This course is an experiential community immersion program that combines clinical and academic learning components.

UBC and Community Instructors

James Andrew, UBC   james.andrew@ubc.ca

Leanne Kelly, Catherine Williams, James Andrew, Carolyne Neufeld, Gracey Kelly, Irene Johnson, Joyce Johnson

Length of Course: 4 weeks

Delivery Mode: Presentations by community members, field trips, clinic visits, home visits, hands-on projects, workshops, cultural learning activities.

Course Timing and Location: Cowichan Band (near Duncan, BC), Mt. Currie Band (near Pemberton, BC), Seabird Island Band (near Agassiz, BC), and Esketemc Band (near Williams Lake).

Time Commitment: 6 hours per day, Monday – Friday

Description/Rationale:

Interprofessional education (IPE) and collaborative patient-centered care (CPCP) have increasingly been recognized as an essential aspect of sustainable health care reform. However, very few opportunities for students to participate in interprofessional learning within an Aboriginal community setting have been established. This course addresses this need by enabling health discipline students to gain direct experience working with Aboriginal patients and community members. By situating academic learning within an

intensive four-week immersion program this course offers students a truly unique and memorable learning experience.

Key objectives of this course are to (1) address the lack of education in Aboriginal health across health professions by recognizing Aboriginal communities as partners in health education and professional training and (2) promote students' understanding of the roles and responsibilities of other professions when working with Aboriginal patients and communities. This course will enhance student learning at both the general and discipline-specific levels by utilizing a combination of community-based, immersion activities (enabling students to become more caring, reflective practitioners as a whole) and student-preceptor models of learning (thereby enabling students to become better technical practitioners of their discipline).

Relation to Other IHHS Offerings

This course provides an ideal complement to extant IHHS Aboriginal health courses (namely IHHS 301 and IHHS 404), by enriching students' academic knowledge with an opportunity to learn about and explore topics in Aboriginal health within a real-life setting.

Course Specifics

The Aboriginal community partners for this course are Mount Currie Health Centre, Cowichan Band (Ts'ewulthun Health Centre), Seabird Island Health Centre and Esktemec First Nation Health Centre. These communities have been and will remain essential contributors to all aspects of course development, including curriculum design, course implementation, course delivery and evaluation. This course is directed toward health professional students particularly in the areas of medicine, nursing, pharmacy, social work, rehabilitation sciences and dentistry at the undergraduate level. Graduate students and medical residents are also welcome to take this course. Course takes place in June with a maximum of 16 student placements (four per community).

Learning Objectives

1. **Reflect** on personal attitudes, beliefs and assumptions, gaining insight on how these can affect care in the context of Aboriginal communities.

2. **Demonstrate understanding** of and **respect** for Aboriginal perspectives on health and wellbeing.

3. **Explore** and **generate ideas** for how health professionals and university can modify practice to provide a positive impact on health and health professional-community relationships.

4. **Consider** the importance of interprofessional teamwork when working with communities.

5. **Gain understanding** of, **acknowledge** and **explore** the implications of specific processes of colonization and related social policies for the health of Aboriginal peoples.

6. **Examine** and **identify** patterns of health and illness from multiple perspectives: epidemiology, interdisciplinary health, community and Aboriginal knowledge.

7. **Identify** positive and negative factors influencing health and wellness in Aboriginal communities.

8. **Explore** approaches to health services and practice that demonstrate an understanding of cultural safety.

9. **Demonstrate** respectful communication with Aboriginal peoples.

10. **Develop** rapport, establish trust and effective listening skills; acknowledge differences and similarities in perceptions in recommending treatment and negotiating agreement.

11. **Demonstrate** understanding of the value of the unique contributions of each profession.

12. **Demonstrate** effective interprofessional teamwork in the provision of quality care.

13. **Explore** the influence of personal and professional values and beliefs on interprofessional teamwork and practice; and **apply this understanding** in practice.

<u>Evaluation and Grading</u>:

25%   Interprofessional team project

25%   Individual project

50%   Attendance and participation in community and in learning activities

Course Outline

This experiential community-based course will include both clinical placements and seminars. The syllabus is intended as a guide to the learning objectives of the course while allowing enough flexibility to accommodate community/health specific needs. The course is intended to evolve in conjunction with participating community members and clinical preceptors who will develop lessons/activities based on the learning objectives delineated below. The following are sample activities based on the course objectives.

Week 1 – Introduction to Interprofessional Teamwork and Exploring Community Life

Topic	Lessons/Activities
Interprofessional Practice: Roles and responsibility of health care professions	▪ Interactive workshop to introduce students to each other, course instructors, and community members; learn about basic scope of each discipline; and pre-conceived ideas of health professions. _Sample activities:_ ▪ Job shadow two different interprofessional students and their preceptors throughout the course. ▪ Attend regular interprofessional meetings within community.
Respecting Aboriginal people	▪ Introduction to principles of cross-cultural communication; learning to listen; identify cultural biases and assumptions. ▪ Familiarization with basic knowledge of local community, including: appropriate names for community members, language and geographic

	territory, sociodemographics, historical encounter with colonization and residential schools, basic government policies/legislation affecting community health service. *Sample activities:* ▪ Reflective journaling throughout the course. ▪ Reading and reacting to readings in seminar. ▪ Case study analyses. ▪ Cultural exploration assignment with the use of art, cultural activity, etc.
Community health status	▪ Examine local health status from multiple perspectives, including epidemiology, interdisciplinary health, Aboriginal perspectives on health and wellbeing, western medicine. ▪ Introduction to the health concerns within local community; familiarization with available local health services and support networks. *Sample activities:* ▪ Introduction to health centre; working one-on-one with preceptor in clinical setting; home visits. ▪ Write a proposal for a group project, i.e. interprofessional student team identifies community health need(s) and produces project to address this need. Students will give the project to the community at the end of the course.
Understanding Aboriginal perspective on health	▪ Deconstructing generalizations of Aboriginal patients; listening to the experiences of other health workers; learning about the impact of imposing personal cultural values compared to community values. ▪ Learning about traditional Aboriginal plant and medical knowledge in relation to contemporary society and western medicine. *Sample activities:* ▪ Attendance at Elders events; spending time with Elders; producing self-evaluations about what was learned, and how it resonated with your personal and professional views; involvement in regular talking circles; debriefing with other students in a safe way; discussion with preceptor around performance along with discussing thoughts and feelings of clients after clinical visits.

Week 2 – Understanding the Social and Political Determinants of Health

Topic	Lessons/Activities
Colonialization and its effects on health	- Using film, texts and guest speakers to provide perspective and a more comprehensive understanding of specific policies related to the health of Aboriginal policies; effects of residential schools; intergenerational influences and the impact on care, health and wellbeing. - Students will examine their own perspectives and views of Aboriginal peoples and reflect on the dominant political and ideological perspectives that shape views of Aboriginal peoples and Aboriginal "issues" in Canada. - Examine the health transfer process and its impact on self-determination in First Nations communities. *Sample activities:* - Readings from the Indian Act followed by seminar discussion; readings from Furniss, E. (1999) followed by seminar discussion; reflective journaling; case study analyses; involvement in clinical and home visits with a different health professional than your own program; discuss contemporary effects of colonialization on health with preceptor.
Health and wellness	- Exploration of positive and negative factors influencing health and wellness in Aboriginal communities; familiarization with the impact of government legislation on Aboriginal health and wellbeing. *Sample activities:* - Investigating on-reserve/off-reserve resources; reading fiction novel, Robinson, E. (2000); seminar discussion of readings from Smylie, J. (2001) SOGC.
Social determinants of health	*Sample activities:* - Within the student interprofessional team setting, students will reflect on the effects of colonization, residential schools and other historical events as they have seen and experienced within their own clinical visits. - Case study analyses. Spending time with chronic disease patients during clinical appointments;

	community-based talks.

Week 3 – Community Strength and Healing

Topic	Lessons/Activities
Response to historical policies	▪ Introduction to successful interventions and healing programs developed within the community; role of traditional healers in Aboriginal communities. *Sample activities:* ▪ Work with group in seminar setting to list strengths of community and Aboriginal healing programs available. ▪ Guest speaker from community members involved in local healing programs; traditional healer and other community-appropriate guest speakers; visit clinics specific to interventional healing programs; meeting with local youth.
Integration of western healing	▪ Compare and contrast western and Aboriginal traditional views of health and medicine. *Sample activities:* ▪ Investigate programs/hospital/clinics in Canada that offer both traditional Aboriginal and western medicine.
Cultural activities	▪ Students will be involved in a number of cultural activities as a means of introducing and exposing them to the strengths of the community. *Sample activities:* ▪ River walk; Great house; introduction to medicine wheel.

Week 4 – Providing service

Topic	Lessons/Activities
Bringing it all together	▪ Explore and generate ideas for how health professionals and institutions can modify practice to provide a positive impact on health and health professional-community relationships. ▪ What are effective ways to approach health services and practice while demonstrating an understanding of cultural safety?

	Sample activities: ▪ Visit and job shadow in other clinics, possibly outside of community, which provide specific services to Aboriginal community members; involvement in talking circle, Elder activities and other health (both social and physical)-related community events.
How can you provide service?	▪ Investigate developing rapport, establishing trust; recommending treatment and negotiating agreement; acknowledging differences and similarities in perception. Sample activities: ▪ Involvement in clinical activities; self reflective discussion with preceptor with regards to self-awareness, cultural competency and cultural safety.
Other considerations as health care professional	▪ What are the issues and concerns that need to be addressed when collaborating with communities in research? ▪ Participatory action research and community driven research (principles of Ownership, Control, Access, and Possession). ▪ Other questions, activities or issues identified by interests and needs of community and students.

Required Readings:

King, Thomas. (2003). The Truth About Stories: A Native Narrative. Anansi Press: Toronto.

Other readings will be provided by the instructor at a cost to the student (e.g., relevant research articles, policy documents, practical guidelines, etc.).

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