First Nations, Inuit, Métis Health CORE COMPETENCIES
A Curriculum Framework for Continuing Medical Education
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Indigenous Physicians Association of Canada

Association des Médecines Indigènes du Canada

The Royal College of Physicians and Surgeons of Canada

Le Collège royal des médecins et chirurgiens du Canada
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This should be considered a ‘living document’ which will continue to be updated, revised and improved upon over
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For Feedback and enquiries:
info@ipac-amic.org
ipac-rcpscproject@rcpsc.edu
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Editors:
Marcia Anderson, MD, FRCPC, President, Indigenous Physicians Association of Canada; Assistant Professor, Departments of Community Health Sciences and Internal Medicine, University of Manitoba
Penny Arsenault, Project Coordinator, Royal College of Physicians and Surgeons of Canada
Lorne Clearsky, MD, FRCPC, Co-Chair, IPAC-RCPSC Project Advisory Committee; Calgary Health Region; Assistant Professor, University of Calgary; Board Member, Indigenous Physicians Association of Canada;
Margaret Kennedy, Assistant Director, Accreditation and Liaison, Royal College of Physicians and Surgeons of Canada
Kandice Léonard, Executive Director, Indigenous Physicians Association of Canada
Alex McComber, Project Coordinator, Indigenous Physicians Association of Canada
Dean Sandham, MD, FRCPC, Co-Chair, IPAC-RCPSC Project Advisory Committee; Dean of Medicine, University of Manitoba; Chair, Manitoba Health Research Council;

Contributors

**IPAC-RCPSC Advisory Committee Members**

*Improving the Health of First Nations, Inuit and Métis Populations Through Enhancements to PGME & CME Programming (March 2007)*

Thomas Dignan, MD, Co-Chair Advisory Committee; Public Health Physician; Board Member, Indigenous Physicians Association of Canada

Dean Sandham, MD, FRCP, Co-Chair Advisory Committee; Dean, Faculty of Medicine, University of Manitoba

Marcia Anderson, MD, MPH, FRCP, President, Indigenous Physicians Association of Canada

Penny Arsenault, Project Coordinator, Royal College of Physicians & Surgeons of Canada

Nadine Caron, MD, FRCS, General Surgeon, PGRH, BC Northern Health Authority, Asst. Prof., Surgery, UBC

Lorne Clearsky, MD, FRCP, Deputy MOH/Medical Director;

Ted Cohen, Manager, Continuing Professional Development, Royal College of Physicians & Surgeons of Canada

Deborah Danoff, MD, FRCP, FACP, Director, Office of Education, Royal College of Physicians & Surgeons of Canada

Michael Green, MD, MPH, CCFP, Queen’s University, College of Family Physicians of Canada

Margaret Kennedy, Manager, Educational Standards Unit, Royal College of Physicians & Surgeons of Canada

Rosella Kinoshameg, President, Aboriginal Nurses Association of Canada

Barry Lavallee, MD, CCFP, FCFP; Board Member, Indigenous Physicians Association of Canada

Anne-Marie MacLellan, MD, CM, FRCPC, Collège des médecins de Québec

J.W. McDonald, MD, FRCP, Royal College of Physicians & Surgeons of Canada

Alan Neville, MD, FRCP, Assistant Dean, MD Program, McMaster University

Marilee Nowgesic, Manager, Aboriginal Health Initiatives, Society of Obstetricians and Gynaecologists of Canada (SOGC)

Alan Pavilanis, MD, CCFP, College of Family Physicians of Canada

Ian Peltier, Acting Director, Aboriginal Affairs, Northern Ontario School of Medicine

Paul Rainsberry, PhD, Associate Executive Director, College of Family Physicians of Canada

Vyta Senikas, MD, FRSCS, Associate Executive Vice-President & CPL Division Director, SOGC

Barbie Shore, Project Manager, Association of Faculties of Medicine of Canada

Danielle Soucy, Senior Research Officer, National Aboriginal Health Organization

Maureen Topps, MD, CCFP, Postgraduate Dean, Northern Ontario School of Medicine

May Toulouse, Senior Program Officer, First Nations and Inuit Health Branch, Health Canada

Stanley Vollant, MD, FRCSSC, Director, Aboriginal Program, University of Ottawa, IPAC Board Member

Shirley Williams, Elder, Ojibway Bird Clan, Odawa First Nations and Professor Emeritus, Trent University

Erin Wolski, Health Policy Analyst, Congress of Aboriginal Peoples

**CONTRIBUTORS AND SUPPORTING ORGANIZATIONS**

Aboriginal Nurses Association of Canada (ANAC)

Rosalyn Howard, facilitator, Director of Learning & Development Services & Howard Consulting and Training

Health Canada – First Nations and Inuit Health Branch

Le Collège des médecins du Québec (CMQ)

The Association of Faculties of Medicine of Canada (AFMC)

The College of Family Physicians of Canada (CFPC)

The Congress of Aboriginal Peoples (CAP)

The Indigenous Physicians Association of Canada (IPAC)

The National Aboriginal Health Organization (NAHO)

The Northern Ontario School of Medicine (NOSM)

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Introduction

In 2005, the Council of the Royal College of Physicians and Surgeons of Canada (RCPSC) set the following goal (3.4) for the Strategic Directions:

“*To work toward improving the health status of Aboriginal Canadians*”.

In pursuit of that objective, the Royal College of Physicians and Surgeons of Canada entered into a contribution agreement with Health Canada–First Nations and Inuit Health Branch (FNIHB) which supported the establishment of the *Advisory Committee on Improving the Health of First Nations, Inuit and Métis Peoples Through Enhancements to Postgraduate and Continuing Medical Educational Programming.*

This Advisory Committee was comprised of experts in Indigenous health and wellness, Indigenous education and culture as well as postgraduate deans, faculty and medical educators from several Canadian medical schools. The primary objectives of the Advisory Committee were as follows:

1. To assure a common understanding of the needs of Canada’s Indigenous populations
2. To identify and acknowledge barriers and opportunities for curriculum development and implementation
3. To identify existing resources and best practices which will inform the development of curriculum for postgraduate and continuing medical education which is based on cultural competency and an understanding of the context of cultural safety.

Through participation on the IPAC-AFMC Aboriginal Health Task Group, The Royal College, led by Dr. Deborah Danoff, Director of Education, participated in the development of cultural competencies specific to First Nations, Inuit and Métis populations. Initially developed for undergraduate medical education, the *IPAC-AFMC First Nations, Inuit, Métis Health Core Competencies* were modeled on the *CanMEDS 2005 Physician Competency Framework*, which was developed by the Royal College.

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Subsequently, the Royal College seeking then to extend these cultural competencies beyond medical school and across the continuum of medical education into residency training and continuing medical education, developed similar competencies applicable and appropriate for Postgraduate and Continuing Medical Education.

The intent of the FN/IM Core Competencies is to provide postgraduate educators with broad thematic domains around First Nations, Inuit and Métis (FN/I/M) health knowledge, skills and attitudes upon which appropriate curriculum can be developed.

As part of the plan for integrating the FN/I/M Health Core Competencies into PGME and CME programs, IPAC and the RCPSC have entered into a partnership agreement for the development of educational modules in select disciplines.

The Royal College and the Indigenous Physicians Association of Canada encourages program directors and medical educators to engage with their local First Nations, Inuit and Métis communities, healthcare workers and leaders in order to develop and promote respectful working environments, share knowledge, learn from each other and collaborate to create better physicians and healthier communities.

Terminology

We use the term Indigenous to refer to “communities, peoples and nations…which, having a historical continuity with pre-invasion and pre-colonial societies that developed on their territories, consider themselves distinct from other sectors of the societies now prevailing on those territories, or part of them.

They form, at present, non-dominant sectors of society and are determined to preserve, develop and transmit to future generations their ancestral territories, and their ethnic identity, as a basis of their continued existence as peoples, in accordance with their own cultural patterns, social institutions and legal system.”

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

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

As the First Peoples of Canada, these communities are diverse in their languages, beliefs, histories and health practices. And while varied languages, histories and health practices may also be true of cultural groups who have immigrated to Canada, FN/I/M peoples are not a cultural group to Canada, but rather distinct constitutionally recognized peoples with Aboriginal and treaty rights. A brief overview of some of the persistent health disparities between FN/I/M peoples and the overall Canadian population further highlights the urgent need to prioritize the health and well being of these communities in medical school curriculum.

- The life expectancy of First Nations peoples was estimated at 68.9 years for males and 76.6 years for females, reflecting differences of 7.4 and 5.2 respectively, from the Canadian population’s life expectancies.
- Preventable deaths due to circulatory diseases (23% of all deaths) and injury (22% of all deaths) account for a staggering near 50% of all deaths.
- For First Nations ages 1 to 44, the most common cause of death was injury and poisoning. The primary cause of death for children less than 10 years was classified as unintentional (accidents).
- Suicide rates for Aboriginal youth range from 5-7 times higher than the national average. Inuit males are at the most risk with rates 20 times higher for completed suicide amongst ages 15-24 years old, as compared to the rest of Québec. Suicide is one of the greatest causes of injury related deaths of Aboriginal peoples in Canada.
- Infectious diseases continue to drive current disparities with the rates of pertussis (2.2 times higher), rubella (7 times higher), tuberculosis (6 times higher) and shigellosis (2.1 times higher) than the overall Canadian population for the year 2000.
- The potential years of life lost from injury alone was more than all other causes of death and was almost 3.5 times that of the general Canadian population.

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

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

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

FN/I/M patients are often faced with physicians who might not recognize, acknowledge and address some of the barriers they face to improving their health.

When physicians are trained and supported, they are better able to bridge barriers such as language, social challenges, and institutional racism and to recognize and develop the necessary advocacy skills to work collaboratively with these clients, their communities and other members of interdisciplinary teams in achieving better health outcomes.

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

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

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Successful implementation of the First Nations, Inuit and Métis Health Core Competencies will require all medical educators to have a working knowledge and definition of cultural safety.

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

The concept of cultural safety has its origins with the Maori People of Aotearoa (New Zealand). Cultural safety takes us beyond:

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

While these three approaches have contributed to our understanding of the need to attend to a patient’s culture, there are real limitations and concerns associated with each of them. Recently, the problems associated with cultural competence have been highlighted and include:

- the reduction of culture to technical skills for which clinicians can be trained to develop expertise;
- a series of “do’s and don’ts” that define how to treat a patient of a given cultural and or ethnic background;
- the idea that cultural communities exist as isolated societies with shared, homogenous cultural meanings; and,
- the fact that cultural factors are not always central to medical care.

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

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

**A central tenet of cultural safety is that it is the patient who defines what “safe service” means to them.**

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

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

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

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

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The following Core Competencies for CME were developed by the Advisory Committee on Improving the Health of First Nations, Inuit and Métis Populations Through Enhancements to Postgraduate and Continuing Medical Education Programs.

First Nations, Inuit and Métis Health

Core Competencies for Continuing Medical Education
1. Medical Expert

Key Competency

*Physicians will demonstrate the knowledge, skills and behaviours necessary to providing compassionate, culturally safe, relationship-centred care for First Nations, Inuit and Métis patients, their families or communities. Physicians will apply lifelong learning skills to enhance areas of professional competence especially as it relates to cultural competence.*

Enabling Competencies (Objectives)

Physicians are able to...

1.1 Demonstrate awareness of the connection between historical and current government practices towards First Nations, Inuit and Métis peoples (including, but not limited to: colonization, residential schools, treaties, bills and land claims), and the intergenerational health outcomes that have resulted.

1.2 Employ critical analysis skills in evaluating the delivery of health care services to First Nations, Inuit and Métis peoples, the historical basis for the system, and how various treaties, bills and land claims have influenced health care delivery.

1.3 Demonstrate an understanding of the cultural diversity of First Nations, Inuit and Métis peoples that results in a variety of perspectives, attitudes, beliefs and behaviours. Describe three examples of this cultural diversity.

1.4 Demonstrate an understanding of the impact and correlation of the various medical, social and spiritual determinants of health and well-being on First Nations, Inuit and Métis peoples.

1.5 Demonstrate an awareness of the context of patient referrals, especially as it relates to patients travelling unaccompanied from remote locations, and engage in effective consultation with health care professionals in the patients’ home community to establish and ensure appropriate support systems and follow-up for sustained culturally appropriate care.

1.6 Identify and describe the range of healing and wellness practices (traditional and non-traditional) present in local First Nations, Inuit and/or Métis communities.
2. **Communicator**

*Key Competency*

*Physicians will demonstrate effective and culturally safe communication with First Nations, Inuit and Métis patients, their families and peers.*

**Enabling Competencies (Objectives)**

Physicians are able to....

2.1 Provide culturally safe care to First Nations, Inuit and Métis patients.

2.2 Establish positive therapeutic relationships with First Nations, Inuit and Métis patients and their families. Effective and culturally safe communication encourages reciprocity, equality, trust, respect, honesty and empathy.

2.3 Deliver information to First Nations, Inuit and Métis patients and their families regarding tests, reports, protocols and diagnoses and treatment plans in a way that is understandable, respectful and encourages participation in decision-making.
3. **Collaborator**

Key Competency

*Physicians will use effective collaboration with both Aboriginal and non-Aboriginal health care professionals in the provision of effective health care for First Nations, Inuit and Métis patients/populations.*

Enabling Competencies (Objectives)

Physicians are able to.....

3.1 Effectively assess, plan, provide and integrate care for different First Nations, Inuit and Métis patients/populations appropriate to the patients’ environment/locale (e.g. urban, reserve, Northern).

3.2 Understand the role of Aboriginal healers and health care professionals/workers/healers working in First Nations, Inuit, and Métis communities and foster a supportive working environment for these professionals among other health care professionals.

3.3 Appropriately enquire whether a First Nations, Inuit or Métis patient is taking traditional herbs or medicines to treat their ailment and integrate that knowledge into their care.

3.4 Utilize community-based research, initiatives and resources (i.e. suicide prevention centres, parenting resource centres, Chiefs and Councils) which are available for creating collaborative approaches to improving Aboriginal health and well-being.
4. Manager

**Key Competency**

*Physicians will be able to develop and implement approaches to optimizing the health of First Nations, Inuit and Métis communities through a just allocation of health care resources, balancing effectiveness, efficiency and access, employing evidence-based and Indigenous best practices.*

**Enabling Competencies (Objectives)**

Physicians are able to.....

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

4.2 Identify and engage key First Nations, Inuit and/or Métis community contacts, resources and support structures in the provision of effective health care for First Nations, Inuit and Métis patients.

4.3 Understand the complexity of providing health care in context to jurisdictional areas and local health service models.

4.4 Research and implement successful approaches to improve the health of First Nations, Inuit and Métis peoples, either locally or nationally.

4.5 Exhibit diligence in understanding measurements of outcomes and interpret statistical data as it relates to overall improvements in population health for First Nations, Inuit and Métis populations.

4.6 Understand and identify discrimination as it occurs in allocating medical resources or treatments which impact the inequalities in medical care at the population level.
5. **Health Advocate**

*Key Competency*

*Physicians will be able to identify the key determinants of health of First Nations, Inuit and Métis populations relevant to the specialty and use this knowledge to promote the health of individual First Nations, Inuit or Métis patients and their communities.*

**Enabling Competencies (Objectives)**

Physicians are able to.....

5.1 Demonstrate an understanding of the inequity of access to health care/health information for First Nations, Inuit and Métis peoples and factors such as discrimination and racism and assimilation that contribute to it.

5.2 Take appropriate measures to redress the inequity of access to health care/health information with First Nations, Inuit, and Métis patients/populations.

5.3 Demonstrate an understanding of the impact of government policies on the healthcare of First Nations, Inuit and Métis communities.

5.4 Demonstrate the ability to engage collaboratively in culturally appropriate strategies which identify local First Nations, Inuit or Métis health issues and which focus on developing health promotion/disease prevention campaigns in partnership with First Nations, Inuit and/or Métis communities.
6. Scholar

Key Competency

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

Enabling Competencies (Objectives)

Physicians are able to....

6.1 Utilize appropriate and effective strategies of working with First Nations, Inuit, and Métis populations to identify health issues and needs.

6.2 Effectively share and promote population health strategies and health information with First Nations, Inuit, and Métis patients/populations.

6.3 Exhibit respectful ways of acquiring information (in a transparent manner) about First Nations, Inuit, and Métis populations which involves communities as partners.

6.4 Critically assess the strengths and limitations of available data used as key indicators of Canadian Aboriginal health and recognize the rights of First Nations, Inuit and Métis communities related to self-determination of research agendas and processes.

6.5 Acknowledge and appreciate knowledge, scholarship and healing practices.

6.6 Acknowledge traditional indicators of health and wellness in First Nation, Inuit and Métis communities.
7. Professional

Key Competency

Physicians will demonstrate a commitment to the improvement of First Nations, Inuit and Métis health by increasing personal and professional awareness and insights of First Nations, Inuit and Métis culture and health practice.

Enabling Competencies (Objectives)

Physicians are able to....

7.1 Identify, acknowledge and analyse one’s own cultural values or considered emotional response to the many histories and contemporary environment of First Nations, Inuit and Métis peoples and offer opinions respectfully.

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

7.3 Acknowledge and practice reciprocity and exchange with First Nations, Inuit and Métis communities and engage in opportunities to give back to communities in return for contributing to the physicians’ continuing professional development and learning.

7.4 Exhibit authentic, supportive and inclusive behaviour in all exchanges with First Nations, Inuit and Métis individuals and communities.

7.5 Implement an environmental scan to determine all community and health resources available to First Nations, Inuit and Métis patients and/or communities.