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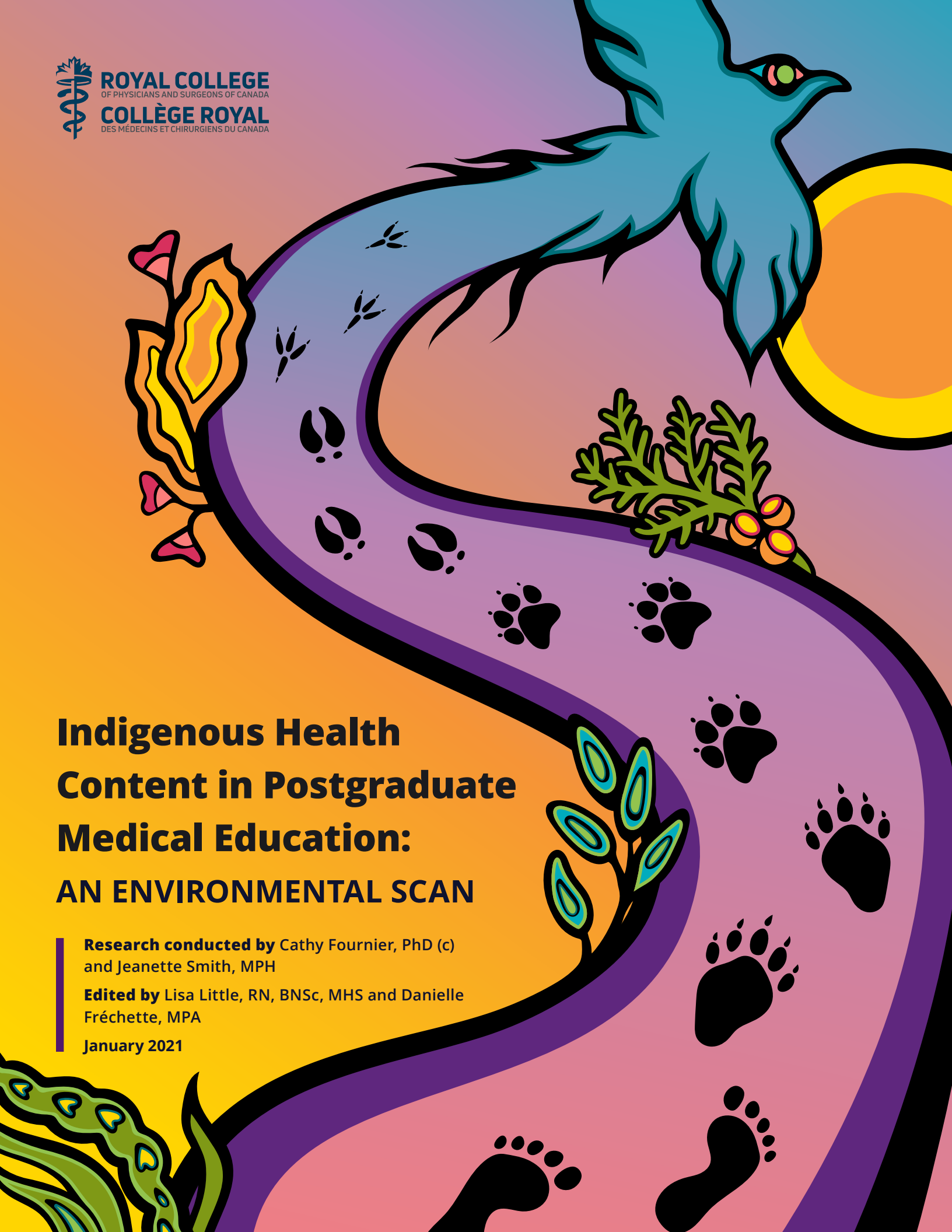

Indigenous Health Content in Postgraduate Medical Education:

AN ENVIRONMENTAL SCAN

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Executive Summary

In an effort to promote health equity for Indigenous Peoples in Canada, on October 26, 2017, the governing Council of the Royal College of Physician and Surgeons of Canada (Royal College) approved the recommendation from the Indigenous Health Committee (IHC) that Indigenous health become a mandatory component of postgraduate medical education (PGME), including curriculum, assessment and accreditation. An Indigenous-led Health Specialty in PGME Steering Committee has been established to lead and support implementation of the decision. To inform the work of the committee, and other stakeholders in medical education as needed, an environmental scan was commissioned to provide an overview of the current "state of readiness" of the 17 faculties of medicine (FoM) in Canada to integrate Indigenous health in PGME curriculum and programming. In the spirit of self-determination, Indigenous consultants were retained to carry out this work.

The PGME programs were initially assessed through web-based searches conducted between July and December 2019 for existing curriculum, assessments, accreditation and initiatives, followed by consultations conducted through key informant interviews. Associate deans from the 17 PGME programs in Canada were contacted by email to request their participation in an interview. Fifty-five additional contacts from PGME programs in Canada were emailed invitations to participate in supplemental interviews. These contacts included senior executives, Indigenous student advisors, faculty, program directors and coordinators, and curriculum leads. In total, interview data was collected from 15 of the 17 FoM represented by PGME associate deans (nine verbal interviews and six written responses) and 12 supplementary interviews.

While Indigenous health related curriculum and initiatives at the PGME level was considered to have high importance, a lack of resources, community relationships and dialogue were commonly reported. The Truth and Reconciliation Commission (TRC) Calls to Action has created a catalyst for the development of content and programming currently available at many universities, but direction and additional understanding of culturally inclusive and reciprocating practices to uphold social accountability were reported as necessary areas of development.

The quantity of content, as well as indications of social responsibility and accountability, were influenced by multiple factors such as available resources (human and financial), geographic location and quantity of visible Indigenous

Peoples in the general population. For example, the University of Manitoba in Winnipeg and the Northern Ontario School of Medicine (located in North Bay and Sudbury) are in geographic regions with a relatively high Indigenous population and close vicinity to rural and remote First Peoples communities, which resulted in the most extensive Indigenous health curriculum, programming and initiatives. There was also evidence of an increased amount of involvement and relationship building with Indigenous communities to develop initiatives and content in these regions. Conversely, in other regions where the interviewees reported a low visible Indigenous population and proximity to Indigenous reserves, there was relatively much less curriculum content, programming and dialogue to build relationships with Indigenous Peoples and communities.

Another noteworthy observation was found in relation to the universities offering French as a first language in PGME training, primarily in Quebec. Despite the proximity to First Nations communities, the least amount of Indigenous health programming or initiatives were observed at these universities. Although there was recognition of the importance of developing Indigenous health initiatives and education, it was not deemed to be the highest priority at present. The French language school respondents stated that many of the Indigenous communities in the region did not speak French, resulting in a higher likelihood of Indigenous Peoples in the region seeking English language hospitals in Montreal.

A thematic analysis was conducted on the qualitative data derived from the web search and key informant interviews. Themes arising from the analysis include: relationships with Indigenous communities; social accountability; TRC as a driver for Indigenous health and programming change; informal learning; human resources; financial resources; mandatory training and accreditation; structural constraints; social responsibility and self-determination; cultural safety training; inclusion and reciprocity; learning environment for Indigenous students; and admissions.

The findings of this environmental scan represent a snapshot in time. Unfortunately, the COVID-19 pandemic delayed the release of this report. It is recognized that this is a constantly changing environment with PGME programs frequently modifying and evolving their Indigenous health related curriculum. The Royal College plans to update this scan in the future.

Introduction

In an effort to promote health equity for Indigenous Peoples in Canada, the governing Council of the Royal College of Physician and Surgeons of Canada (Royal College) approved on October 26, 2017 the recommendation from the Indigenous Health Committee (IHC) that Indigenous health become a mandatory component of postgraduate medical education (PGME), including curriculum, assessment and accreditation. An Indigenous Health Specialty in PGME Steering Committee has been established to direct and support implementation of the decision.

This environmental scan was commissioned by the Indigenous Health Specialty in PGME Steering Committee to provide an overview of the "state of readiness" of the 17 faculties of medicine (FoM) to implement the Royal College's decision to integrate Indigenous health in their PGME programs. In the spirit of self-determination, Indigenous consultants were retained to carry out this work. The Steering Committee would like to thank Cathy Fournier, PhD (c) and Jeanette Smith, MPH for their research.

Methodology

Web-based information

An internet search was conducted July and December 2019 to gather data from the 17 Canadian PGME publicly accessible websites (N=17) in support of interview data. The internet scans consisted of two sets of keyword strings, including but not limited to PGME and Indigenous, and Boolean logic forming combinations of search strings targeted to individual universities. PGME websites hosted by each university were also examined, searching for information pertaining to both formal and informal programs associated with residency rotations with specializations specific to Indigenous health, Indigenous communities, Indigenous education and rural, remote or underserved populations that may have exposure to Indigenous populations. Keywords were used to lead a more thorough examination of each PGME website by using the site-based search bar and navigating site links.

An inventory of web-based Indigenous educational resources was created as documentation of these searches and categorized by each university, the program researched, initiatives highlighted on the website, formal and informal advertised programs, medical education levels revealed through structured searches and any related material offered on the website.

Interviews

Initial contact with the 17 faculties of medicine was made by the Royal College staff. The consultant sent a follow-up email immediately afterward. Additional follow-up email inquiries (a maximum of three attempts) were issued over a span of six to eight weeks. The three French universities were contacted and followed up with by Royal College staff. The interviews took place over the phone, or if preferred by participants, responses to the interview questions were submitted via email. Information collection was not an iterative process but rather more unidimensional when participants corresponded through written form. However, in cases where it was deemed important or for points of clarification, the respondent was emailed for more information.

Structured interviews were conducted by the consultant and permission was requested to record the interviews which were later transcribed verbatim (and validated). A set of interview questions were created with consultation and approval by the Steering Committee. The questions were centered on five main themes:

1. Indigenous health education and cultural safety,
2. Relationships with Indigenous Peoples and communities,
3. Learning environment,
4. Admissions, and
5. Looking forward, barriers and facilitators to Indigenous health education.

(See Appendix A for complete interview guide)

A total of 27 Interviews from 15 universities were conducted and serve as the source of data for analysis:

- PGME associate, assistant, vice deans or other senior management, N=15: 17 sites contacted and 15 interviews completed (nine phone interviews; six written responses) resulting in an 88% response rate.
- Other university employees who were identified as involved to varying degrees in Indigenous health education, N=12; 12 responses out of 55 invitations for supplementary interviews resulting in a 22% response rate.
- Written responses were received from two of the three French universities.

(See Appendix B for list of key informant interviewees and Appendix C for a list of supplemental interviewees)

Findings

Results from the web-based search

The extensive amount of time required to find evidence of Indigenous health education during the public web-based search was a common occurrence. The university websites appeared to prioritize the promotion of innovation, equipment, or specific methods of learning above health equity or Indigenous health to promote their programs to potential trainees. Sixty five per cent (11/17) of the schools had either direct links, easily accessible Indigenous health program information, or advertised health equity initiatives reaching beyond the undergraduate medical education level. The web-based navigation of the specific PGME sites at each university revealed the most common place to find Indigenous health-related content was through informal education, which was most often mentioned in the family medicine rotations, or through the undergraduate level of medical education. There was one school that clearly indicated a program offering pre-med preparation for Indigenous students. In addition, two of the 17 schools did not have evidence of any Indigenous health education on their website or through broad web searches.

The extent of Indigenous health education accessible on public domains varied from involvement with surrounding Indigenous communities, offering specializations and courses addressing equity and social determinants of health, to an absence of any accessible information pertaining to Indigenous populations. Five of the 17 (29%) schools that offer PGME programs mention ongoing dialogue or social responsibility with dialogue between the university and local Indigenous communities, Elders in Residence, or Indigenous leadership when creating Indigenous programs and initiatives. There was limited mention of the availability of Elders and or Indigenous leaders in PGME, while at the same time many mentions of the need to develop social accountability. The search revealed

- vacancies in positions related to Indigenous staff and faculty advisors,
- once occupied, but now vacant, positions related to Indigenous initiatives,
- Indigenous programs put on hiatus,
- Indigenous programming at the very beginning stage of discussion, and
- limited information available on web sites.

A lack of social accountability was evidenced with only five of the 17 (29%) schools mentioning or showing accountability measures for dialogue and engagement with communities, Elder involvement and leadership roles.

Approximately 14 of the 17 (82%) schools showed evidence of informal programs through tutoring and residency rotations that are specialized to serve Indigenous communities, or in rural areas that could provide exposure to Indigenous community members. Thirty-five per cent (six) of the school websites indicated the presence of admissions initiatives to support Indigenous students. Of note, much of the information accessible on websites in terms of available Indigenous student supports was not verified through interviews to ascertain ongoing accuracy.

There was evidence at most sites that Indigenous health education and more broadly Indigenous studies are of high importance at many of the universities. Six (35%) of the universities mentioned directly on the websites that initiatives were either based on the Association of Faculties of Medicine of Canada Joint Commitment to Action on Indigenous Health, or the Truth and Reconciliation Commission (TRC) Calls to Action. The six schools addressing admission barriers and using tool kits provided to meet commitments to the TRC Calls to Action also offered a significant amount of information about Indigenous health initiatives offered at their university. The remaining 65% did not mention how the policies or programs were formed. Overall there was a strong sense from the websites and even more so from the interviews that the TRC Calls to Action is a major a driver to include or increase Indigenous health content and cultural safety training in PGME. Part of the reason for this could be due to the TRC Calls to Action being a major factor in the availability and sustainability of funding for increasing Indigenous health content across the board as many universities have answered the TRC Calls to Action as part of their university wide strategic plan. [1]

[1] For example, "Northern Ontario School of Medicine's Response to the Truth and Reconciliation Commission's Calls to Action"; and "Answering the Call Wecheehetowin Final Report of the Steering Committee for the University of Toronto Response to the Truth and Reconciliation Commission of Canada"

Interview themes

RELATIONSHIPS WITH INDIGENOUS COMMUNITIES

There was a clear awareness of the need for more relationship building with Indigenous communities from each respondent. Some universities have begun relationship building, with six of the 15 schools having reported at least one ongoing partnership. This was reflected through testimonial inclusion of Indigenous involvement during planning stages of Indigenous education and training, provided evidence of reciprocity, transparency, social accountability and indications of humility being expressed by means of ongoing collaboration. The lack of sustainable, ongoing relationships was apparent and many interview respondents talked about the need for more education on power, privilege, varying worldviews and increased initiatives promoting the awareness of historical factors influencing Indigenous relations with settlers. Further understanding of Indigenous health needs was raised with a focus on not just biological factors but also social dynamics of health in order to engage with Indigenous Peoples/communities from a position of humility and respect for cultural differences, differing worldviews and life experiences. Interactions with Indigenous populations are occurring often enough to be noted, but there was limited indication of social responsibility, transparency or reciprocity needed to build meaningful relationships that are based on trust and mutual needs being taken into account.

Geographic location, such as the proximity to Indigenous communities and the visible local population level of Indigenous Peoples, was evidenced through the interviews as having significant impact on the quantity and quality of Indigenous related programming and rotations, as well as the extent of engagement with Indigenous communities. The PGME programs that saw themselves as being geographically close to First Peoples communities or having a large visible Indigenous population in the region reported more Indigenous programming and rotations, as well as increased community engagement, Indigenous student support and Indigenous collaboration when planning and creating programming. They also reported more cultural safety training for staff, faculty and trainees. However, relationship building with Indigenous communities in proximity to the universities is still in the pre-planning or planning stages at more than half (8/15) of the universities. The sites that perceived themselves as having a low visible Indigenous population in the region or having no First Peoples reserves close by reported less Indigenous health related education and programming.

LACK OF UNDERSTANDING OF INDIGENOUS CULTURE

Every respondent stated that increased communication with local Indigenous communities and better understanding of "Indigenous culture" is required before moving forward with humility and respect for knowledge beyond the western educational system. Indigenous culture was sometimes spoken about as if it was homogeneous, which highlights the need for further education about the diversity of Indigenous Peoples/communities/cultures in Canada. There was limited expressed awareness of the diversity of Indigenous Peoples, nations and experiences in Canada. This presents a risk that local expression of culture could be oppressed, and lumped into one homogeneous Indigenous culture and identity, which may make relationship building more difficult.

There were also noted inconsistencies among the universities regarding the best practices for teaching Indigenous health education. Some universities were considering uniform Indigenous training or including Indigenous health under the umbrella of global health, while others spoke about the need to see culturally diverse and relevant content that is appropriate for each particular region, demonstrating respect for the lands where the universities are located.

During the interviews non-Indigenous people and allies were reported as often hesitant to be involved in Indigenous health programming and initiatives because of lack of expertise, not wanting to do the wrong thing, or being afraid of offending Indigenous Peoples.

SOCIAL ACCOUNTABILITY

As defined by the World Health Organization, social accountability refers to the medical schools' obligation to direct their education, research and service activities towards addressing the priority health concerns of the community, region and/or nation they have a mandate to serve, and thus the need to improve the welfare of marginalized populations while protecting patient rights. There was a reported general sense of good will, awareness and general understanding of health inequities related to the impact of colonization and Canada's history in relation to Indigenous Peoples, as well as the importance of improving Indigenous health education and cultural safety.

TRUTH AND RECONCILIATION COMMISSION OF CANADA'S CALLS TO ACTION AS DRIVER FOR INDIGENOUS HEALTH PROGRAMMING AND CHANGE

During the interviews, it was very apparent that the TRC Calls to Action are a predominant factor driving increased Indigenous health programming and cultural safety training at most of the PGME sites. There was a definite sense from most respondents of wanting to do the right thing in relation to the TRC, and to make sure programs were at least on some level responding to the Calls to Action. Many of the strategic plans related to Indigenous health content in development are a direct result of the TRC Calls to Action being adopted at the university as a whole. However, it was noted that at the sites where the TRC Calls to Action was reported as being the predominant catalyst for change, there appeared to be concurrent focus on providing medical care to communities but little expressed consideration of principles of self-determination for the local communities.

INFORMAL LEARNING

Many respondents stated that potential Indigenous health learning opportunities happen on an informal basis, typically on the spot in a clinical encounter. In addition, many of the respondents expressed concern that these potential learning moments are often missed due to a lack of knowledgeable or experienced preceptors to provide culturally sensitive guidance, either during or after the encounter. This leads to ad hoc learning, as well a reported frustration for trainees, which may in turn affect their sense of comfort with subsequent encounters with Indigenous patients.

HUMAN RESOURCES

The lack of human resources, specifically Indigenous Peoples working at the university, and in the PGME program in particular, was a dominant theme in all of the interviews. Multiple sites stated that they did not have the human resources to do justice to developing Indigenous curriculum and programming, or to build relationships with Indigenous communities. Building relationships with community takes time and human resources. It was often reported that there might be one Indigenous lead in the Department of Medicine, or in the Faculty of Arts and Sciences as a whole, and this person was also often described as being over-burdened as they are asked to be involved in every Indigenous related program, event or initiative.

The common issue of the reliance on one or at most two Indigenous faculty to lead "all things Indigenous" in PGME creates a heavy load which may be problematic on many levels:

- Firstly, placing the burden of the work on one or two faculty also comes with the risk of essentializing one Indigenous person as the expert on all Indigenous health matters and programming, while also increasing the workload of faculty and/or trainees in an already high-pressure workplace, such as medicine.
- Secondly, consulting or involving one or possibly two Indigenous faculty member staff in the Indigenous health programming and training of residents is not equivalent to community outreach or relationship building with local community members, as they may not be from or even familiar with the local Indigenous community where residents will be providing care.

To illustrate, many respondents stated that they had consulted with Indigenous Peoples in program development, yet it was also often revealed that this consultation was with the one Indigenous person on faculty or staff rather than the larger local communities. It is important to reiterate however that this may be related to the lack of financial resources and/or support from the university to hire more Indigenous Peoples or to create new positions for Indigenous community liaison.

FINANCIAL RESOURCES

Sustainable funding was stated as being a challenge for five of the 14 universities. This was often reported as being a barrier for students and faculty to complete cultural safety training, as well as a barrier to hiring Indigenous leadership or knowledge keepers specifically for PGME. Financial resources were also reported as needed to have adequate human resources to build relationships with Indigenous communities.

MANDATORY TRAINING AND ACCREDITATION

The key informants' recommendations were notably divided when considering whether cultural safety training should be mandatory or whether there should be more formal accreditation standards related to Indigenous health education. The concerns being that making training and accreditation mandatory has the risk of trainees, faculty and staff regarding the training as a box to tick off. This would lead to it becoming more of a mechanical learning requirement that may circumscribe more meaningful learning and initiative building. The same concern was raised about formal accreditation standards. Those in favour thought that making training

mandatory and having formal accreditation standards ensures a baseline of knowledge that is important. They felt that for Indigenous health to be taken seriously it must be officially mandated by the Royal College.

STRUCTURAL CONSTRAINTS

The structure of medical training was indicated as being restrictive to the development of inclusive, comprehensive and respectful Indigenous health related content and initiatives. A number of respondents talked about the need to look at some of the structural constraints before moving forward to incorporate more Indigenous health education and Indigenous knowledges into PGME. This was highlighted as a concern for some respondents due to the fragmented nature of western medicine and education that may be in contrast to many Indigenous epistemologies and ontologies, which tend to be holistic, relational and nonlinear. The rigid time-table structure for residents to follow, during rotations with restrictive time allowances when providing care for patients, was cited as a challenge.

Further, with the programs becoming predominantly competency-based, designed to benefit western-based sciences using a linear curriculum and structure, there are complex challenges in trying to include and protect intellectual property while teaching Indigenous knowledges. Indigenous knowledges tend to be relationally based and may be difficult to maintain their inherent integrity if merely made to fit within the current curriculum structure.

Many respondents expressed serious concerns about finding time to engage with Indigenous communities with inclusive, sustainable, self-determining practices and implementing Indigenous health education into an already full curriculum. There were also concerns about residents or doctors having enough time to address needs of reciprocity and dialogue when treating patients due to strict guidelines when working with patients as a resident, as this is not built into the structure of the training. This is also related to structural constraints of PGME.

Other reported barriers to incorporating Indigenous health education and training into the curriculum included stigma and lack of understanding about local Indigenous culture as well as a lack of access to Indigenous communities or relationships to share knowledge. The latter was the reported dominant obstacle to inclusive and reciprocated education with eight of the 15 or 53% of the universities indicating this as a barrier.

The political and economic structure of the university was also noted as a barrier when advocating for the implementation of initiatives supporting Indigenous health education due to the length of time involved in processes to move initiatives forward to make policy and procedural change.

SOCIAL RESPONSIBILITY AND SELF-DETERMINATION

Social responsibility and self-determination ask us to shift from settler worldviews and colonial practices to a ground up of patient-centred perspective. When searching websites, there were some schools citing support; however, there was limited evidence of this taking place from the interviews. Transparency, reciprocity and relationship building were areas of weakness for the majority of the medical schools. Many of the schools reported having some rotations on reserves or serving Indigenous populations, yet many were very inconsistent (occurring irregularly due to logistics of travel and PGME structure) or very short rotations, providing care for one week and then leaving the site. This demonstrates a need for building social responsibility and creating space for Indigenous communities to practise self-determination and implement measures to ensure respect for worldviews and to base programming/rotations on the needs of the community and not just the PGME program requirements.

Without social responsibility, available partnerships might negatively impact potential ongoing collaboration with communities for developing safe and inclusive Indigenous health education based on need. Based on the interviews, it seems that teaching about what self-determination means, what it entails and how it might be enacted are important things to consider moving forward.

CULTURAL SAFETY TRAINING

During the interviews, recommendations were made by a few respondents for Indigenous health education to begin by first teaching self-reflection, learning to think critically about and unpack privilege, as well as completing anti-racist training. Cultural safety education and training is either not yet in the planning stages or being planned at nearly half (six) of the 15 PGME programs who responded to interviews. Many reported that cultural safety training is the bare minimum for a foundation for trainees, faculty and staff. However, the feasibility of implementing and tracking who has completed the cultural training was reported as a barrier. Seven of the universities have programs or training in place and one has completed the implementation but is still working on improving the relevancy of the content. Three of the 15 universities interviewed mentioned San'yas cultural safety training

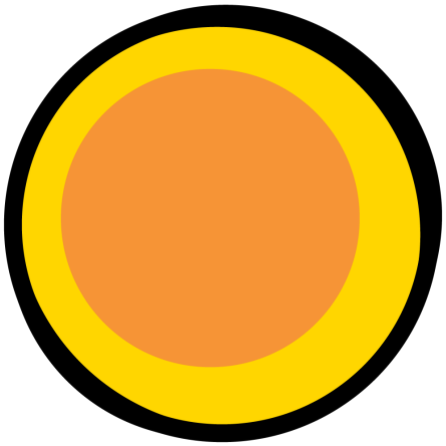
being accessed; however financial and timing barriers due to the cohort approach to training were indicated as challenges in the feasibility of the training.

LEARNING ENVIRONMENT FOR INDIGENOUS LEARNERS

Seven of the 15 universities are in the process of offering some form of supports for Indigenous populations (including residents); however, the other half of PGME programs either have no concrete plans or are still in the planning stages of creating safe spaces for Indigenous leaners and community members. The majority of the university sites stated that the university as a whole had some informal Indigenous learner support in place, which ranged from an Indigenous student centre and access to Elders to available referrals outside of the university, should learners need support.

ADMISSIONS

None of the key informants reported their sites having specific spots allocated for Indigenous students at the PGME level. However, many have allocated seats at the undergraduate medical education (UGME) level and these students all go through the same Canadian Resident Matching Service (CaRMS) matching process. Respondents stated that there is currently no Indigenous-specific focus or seat allocation during the CaRMS placement process. Many stated that this should not be an issue as the placement is merit based. One site stated they have programming with rigorous entry requirements within their remote family medicine rotation that prioritizes Indigenous residents. Another site reported they have two remote rotations that privileges residents from rural areas, including First Nations and Inuit communities. Another site privileges students from low socio-economic backgrounds in their UGME program.



Limitations of the environmental scan

The information in this report is limited by the data gathered from the respondents who sometimes acknowledged having limited knowledge and understanding about Indigenous health-,related programming and initiatives at the PGME level given the number of PGME specialties and programs. Associate deans were sometimes uncertain about the informal content taught in each of the specialties. Further, within a time frame of the four months available for interview participation, responses were not received from every invitation. This resulted in data gaps. In some instances, despite sending an interview request and numerous other attempts to connect, the interviews were often limited to one person per PGME site. For the web-based searches, search strings were often limiting as well, as many searches lead to information that primarily focused on admissions for undergraduate programs intended to reduce barriers and provide support for Indigenous applicants.

Furthermore, Indigenous communities were not consulted during any part of the environmental scan as the focus was on providing a current state of readiness of PGME programs from the perspective of the PGME program.

Finally, the results of this scan represent a snapshot in time. It is recognized that this is a constantly changing environment and further Indigenous health curriculum changes may have been initiated since its completion. Unfortunately, the COVID-19 pandemic delayed the release of this report.

Disclosure

The consultant and the research assistant involved in this environmental scan have affiliations with four of the 17 universities researched, which may have influenced the ability to navigate websites and access supplemental information more efficiently than unfamiliar websites. Additional assistance was required for French translation when conducting interviews. The research consultant has mixed ancestry (Metis, Mi'Kmaq, French and Scottish), and the research assistant has a worldview formed through combining Ojibway and settler teachings.

Appendix A: Interview guide

1. INDIGENOUS HEALTH EDUCATION AND CULTURAL SAFETY

Please tell me about Indigenous health education within your residency training programs. If necessary, the following interview prompts will be used:

a. Have you developed or are you using any specific programs or resources that target Indigenous health cultural safety in medical residents? **Are there any courses, standards or guidelines for PGME curriculum, residency training, assessment, accreditation or any other programs related to Indigenous Peoples health/history education?**

b. Is Indigenous health / cultural safety a formal learning objective within any of your training programs?

c. Are Indigenous People involved as teachers in your residency training programs?

d. Are any specialties and/or programs taking notable steps in the area of Indigenous health education?

e. **Are there any courses, standards or guidelines for PGME curriculum, residency training, assessment, accreditation or any other programs related to Indigenous Peoples health/history education?**

2. RELATIONSHIPS WITH INDIGENOUS PEOPLES AND COMMUNITIES

Please tell me how Indigenous Peoples are involved in the co-development of your PGME programs and how Indigenous communities are part of residents' learning experiences. If necessary, the following interview prompts will be used:

a. Have you partnered with Indigenous Peoples to assess and co-develop PGME cultural safety programs and resources at your university? **If so, please tell me how that worked.**

b. Does the current PGME program include resident rotations in Indigenous communities or in communities that **serve local Indigenous populations?**

3. LEARNING ENVIRONMENT

Please tell me how Indigenous residents and faculty are supported within your PGME learning environments. **If necessary, the following interview prompts will be used:**

a. Have you developed and instituted support programs, resources and policies that are specifically geared toward Indigenous residents and faculty? For example, have you established Indigenous safe spaces, offices, traditional healing services, etc.? Does your university formally recognize Indigenous cultural **holidays and celebrations**?

b. Do you offer continuing professional development programs or resources that enrich the cultural safety **competencies of non-Indigenous educators and administrators?**

4. ADMISSIONS

Please tell me how your PGME entry processes support Indigenous candidates. If necessary, the following interview prompts will be used:

a. Do you have allocated spots for Indigenous residents?

b. Do your program descriptions describe the programs and resources that are available to Indigenous residents?

c. Do you have specific selection criteria related to Indigeneity?

5. LOOKING FORWARD

Please tell me what you think PGME needs to do to increase residents' knowledge of Indigenous health and instill **greater cultural safety in medical practice. If necessary, the following interview prompts will be used:**

a. Are there specific knowledge deficits that need to be addressed?

b. Do we need to focus on specific clinical and professional skills?

c. What do you see as the main barriers and enablers to enriching PGME in the area of Indigenous health and cultural safety? (structural and otherwise)

Appendix B: Key informant interviewees

Faculty of Medicine	Name	Title
University of Alberta	Ramona Kearney (written)	Associate Dean, Postgraduate Medical Education
University of British Colombia	Ravi Sidhu (phone interview)	Associate Dean, Postgraduate Medical Education
University of Calgary	Lisa Welikovitch (written)	Associate Dean, Postgraduate Medical Education
Dalhousie University	Andrew Warren (phone interview)	Associate Dean, Postgraduate Medical Education
University of Manitoba	Clifford Yaffe (phone interview)	Associate Dean, Postgraduate Medical Education
McGill University	Fernanda Claudio (written)	Academic Associate, Curriculum Design & Alignment
McMaster University	Parveen Wasi (phone interview)	Associate Dean, Postgraduate Medical Education
Memorial University	Sohaib Al-Asaaed (phone interview)	Associate Dean, Postgraduate Medical Education
Université de Montréal	François Girard (written)	Vice-doyen, études médicales postdoctorales
Northern Ontario School of Medicine	Thomas Crichton (not available) Jennifer Fawcett (phone interview)	Interim Associate Dean, PGME; Assistant Dean - Family Medicine Senior Director Postgraduate Medical Education and Health Sciences
University of Ottawa	Lorne Wiesenfeld (phone interview)	Vice Dean, Postgraduate Medical Education
Queen's University	G. Ross Walker (phone interview)	Associate Dean, Postgraduate Medical Education
Université de Sherbrooke	Matthieu Touchette (written)	Vice Dean, Postgraduate Medical Education
University of Toronto	Glen Bandiera (written)	Associate Dean, Postgraduate Medical Education
Western University	Christopher Watling (phone interview)	Associate Dean, Postgraduate Medical Education

Appendix C: Supplemental Interviewees

1. Dalhousie University	Role
Lisa Sutherland	Director, Office of Resident Affairs
Michele Graveline	Indigenous Student Advisor
Joe MacEachern	Indigenous Health Program Manager Faculty of Medicine, Global Health Office
Amy Bombay	Associate Professor School of Nursing
Margot Latimer	Professor, Indigenous Health Chair in Nursing School of Nursing
Michelle Williams	Director of Indigenous, Blacks and Mi'Kmaq initiative
Elder Geri Musqua-LeBlanc	Coordinator of Elders in Residence
2. University of British Colombia	**Role**
James Andrews	Indigenous Student Initiatives Manager Faculty of Medicine (provided information about Family Medicine cultural safety training)
3. McGill University	**Role**
Saleem Razack	Assistant Dean of Admissions, Equity & Diversity Faculty of Medicine
Kent Saylor	Director of Indigenous Health Professions
4. McMaster University	**Role**
Sarah Kinzie	Postgraduate Program Director for Family Medicine
Amy Latour	Indigenous MD and faculty
5. Memorial University of Newfoundland	**Role**
Russell Dawe	Program Director Family Medicine Residency Program
Lisa Grant	Program Coordinator Strategic external liaison
Carolyn Sturge-Sparkes	Coordinator for the Aboriginal Health Initiative in the Faculty of Medicine
6. University of Ottawa	**Role**
Darlene Kitty	Director Indigenous Program, Undergraduate Medical Education
Melissa Forgie	Vice-Dean, Undergraduate Medical Education

7. University of Toronto	Role
Anna Banerji	Faculty Lead Post-MD, Indigenous & Refugee Health
Risa Freeman	Vice-Chair, Education and Scholarship
Stuart Murdoch	Director, Postgraduate Program
Jeff Golisky	Rural Residency Program Director
Nadia Incardona	Rural Northern Initiative Coordinator
Fadia Bravo	Rural Northern Initiative Administrator
Rochelle Allen	Indigenous Peoples UME Program Coordinator
Dr. Giovanna Sirianni	PGY3/Enhanced Skills Program Director
8. Northern Ontario School of Medicine (NOSM)	**Role**
Jennifer Fawcett	Senior Director, Postgraduate Medical Education NOSM at Lakehead University
Cathy Duchesne	PGME Core Curriculum and Events Lead NOSM at Laurentian University
Joseph Michalik	Program Coordinator Family Medicine, NOSM at Lakehead Rural Northern Ontario, Remote First Nations streams and PGY3 FM Remote First Nations
9. Queen's University	**Role**
Laura McEwan	Four Directions Indigenous Student Centre
Laura Maracle	Indigenous Cultural Safety Coordinator, Four Directions Student Centre
Vanessa McCourt	Indigenous Advisor
Denise Jones	Program Coordinator, Postgraduate Medical Education
Cortney Clark	Indigenous Access and Recruitment Coordinator Faculty of Health Sciences
David Taylor	Program Director, Core Internal Medicine Program Associate Professor
Mike Green	Director of Family Medicine
10. University of Alberta	**Role**
Tibetha Kemble	Director, Indigenous Health
Jill Konkin	Associate Dean, Department of Family Medicine, Faculty of Medicine and Dentistry
David McKennitt	Division of Community Engagement

	Faculty of Medicine and Dentistry
11. University of Manitoba	**Role**
Alexandra Ilnyckyj	Director, PGME Core Curriculum Chair, PGME Educational Development Committee (PGME-EDC)
Joel Kettner	Associate Professor, Faculty of Health Sciences
Catherine Cooke	Associate Dean, First Nations, Métis and Inuit Health
Karla Lavoie	Assistant to Vice Dean, Indigenous Health Integration
Marcia Anderson	Vice-Dean, Indigenous Health
Brain Postl	Dean, Max Rady College of Medicine; Dean, Rady Faculty of Health Sciences & Vice-Provost, Health Sciences
12. University of Saskatchewan	**Role**
Joanna Winichuk	Aboriginal Health Committee
Heidi Brown	Staff, Family Medicine (Rural) - Prince Albert
Lisa Eisan	Staff, Family Medicine (Rural) - Moose Jaw
Sheralyn Norton	Director, Family Medicine
13. Western University	**Role**
Adrean Angles	Indigenous Liaison
14. University of Calgary	**Role**
Lynden (Lindsay) Crowshoe	Director, Indigenous Health Dialogue
Rita Henderson	Co-chair, Indigenous Health Dialogue
Renée Huntley	Coordinator, Indigenous Health Program
15. Université Laval	**Role**
Marie Gervais	Professeure titulaire au Département de médecine sociale et préventive
16. Université de Montréal	**Role**
Nathalie Caire Fon	Director, Department of Family Medicine and Emergency Medicine
17. Université de Sherbrooke	**Role**
Brigitte Quintal	Faculty of Medicine and Health Sciences, Director of Development

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