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Residency training programs to support residents working in First Nations, Inuit, and Métis communities

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Abstract

Background To gain culturally appropriate awareness of First Nations, Inuit and/or Métis Health, research suggests that programs focus on sending more trainees to First Nations, Inuit and/or Métis communities Working within this context provides experiences and knowledge that build upon classroom education and support trainees' acquisition of skills to engage in culturally safe healthcare provision. This study examines residents' and faculty members' perceptions of how residency training programs can optimize First Nations, Inuit and/or Métis health training and support residents in gaining the knowledge, skills, and experiences for working in and with First Nations, Inuit and/or Métis communities.

Methods A qualitative approach was used, guided by a relational lens for collecting data and a constructivist grounded theory for data interpretation. Theoretical sampling was used to recruit 35 participants from three main study sites across two western Canadian provinces. Recruitment, data collection, and analysis using constructivist grounded theory occurred concurrently to ensure appropriate depth of exploration.

Results Our data analysis revealed five themes: Five themes were generated: Complexity of voluntourism as a concept; Diversity of knowledge representation required for developing curriculum; Effective models of care for First Nations, Inuit and/or Métis health; Essential traits that residents should have for working in First Nations, Inuit and/or Métis communities; and Building relationships and trust by engaging the community.

Conclusions First Nations, Inuit and/or Métis Health should be prioritized within Canadian postgraduate medical education. Equipping trainees to provide holistic care, immersing in and learning from First Nations, Inuit and/or Métis communities is essential for developing the next generation of clinicians and preceptors. We present educational recommendations for residency programs to optimize First Nations, Inuit and/or Métis health educational experiences and provide residents with skills to provide effective and culturally safe care.

Keywords First Nations, Inuit and/or Métis Curriculum, Postgraduate Education, Grounded theory

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Background

In June 2015, the Truth, and Reconciliation Commission of Canada (TRC) [1] released 94 calls to action. Within the 94 calls, First Nations, Inuit and/or Métis health is addressed specifically in calls 18 to 24. The TRC calls upon medical schools and residency programs to recognize specific needs for competent care delivery to First Nations, Inuit and/or Métis peoples and to address hidden influences that may be encountered in teaching and learning in medicine. In addition, in 2021, the United Nations Declaration on the Rights of First Nations, Inuit and/or Métis Peoples provided a framework for promoting reconciliation and healing for First Nations, Inuit and/or Métis people based on mutual understanding and respect [2]. This is crucial for promoting equitable healthcare practices, restorative anti-racism, and improving interactions with diverse First Nations, Inuit and/or Métis communities and people [3]. The consensus vision from the First Nations, Inuit and/or Métis Health Committee at the Royal College in 2019 was to design inclusive health care, free of prejudice and where each First Nations, Inuit and/or Métis person is appreciated and recognized as an individual rather than a stereotype. Hoping that they will be exposed to the premium level of health care and that stakeholders have the knowledge to recognize that colonial structures and systems have caused the existing health inequities in the medical and educational system [4].

Existing research suggests that teaching about equal access to healthcare for First Nations, Inuit and/or Métis communities people will promote awareness and appreciation for the traumas First Nations, Inuit and/or Métis patients have faced and continue to face [3, 5]. Similarly, to gain culturally appropriate awareness of First Nations, Inuit and /or Métis communities and people, research suggests that training programs should focus on sending more trainees and health professionals to First Nations, Inuit and/or Métis communities [5].Additionally, a recent review revealed that postgraduate medical education programs should focus on increasing community driven partnerships by building relationships and open dialogue between residents and First Nations, Inuit and/or Métis educators, community Elders, and knowledge keepers [6]. Ideally, working within this context will provide experiences and knowledge that build upon education in the classrooms and Western clinical contexts and support trainees to acquire the skills and knowledge required to engage in culturally safe health care provision [5, 7]. However, programs may not be equipped to operationalize recommendations for reconciliation and decolonization as they work to include First Nations, Inuit and/or Métis voices and people in the process, let alone transform structures to include First Nations, Inuit and/or Métis health practices and knowledge systems through deep engagement with I First Nations, Inuit and/or Métis people [8]. Furthermore, preparation of a resident to work with First Nations, Inuit and /or Métis communities is often lacking. The objective of this study is to understand residents' and faculty members' perceptions of how residency training programs can optimize First Nations, Inuit and/or Métis health training and support residents in gaining the knowledge, skills, and experiences for working in and with First Nations, Inuit and/or Métis communities.

Statement of reflexivity

Our research team consisted of individuals from different backgrounds, making our research inclusive and focused. (MR) is a woman and visible minority scholar. (JN) is a learner and from a visible minority background. (WC) is a First Nations Scholar from Northern Manitoba with Swedish/Anglo and Inuit ancestry. (IJ) is a learner from a visible minority background. (JF) Pediatrics residency program director with a commitment to improving EDI in PGME. (MC) leader and was involved in numerous EDI initiatives for learners and HPEs. (MB) clinical lecturer and Domain Lead, Health Equity. (PR) Scholar and member of the Métis Nation of Alberta. (MM) is a Métis surgeon. (SF) is a woman, committed to improving EDI and teaching and learning in medicine.

Method

Study design

Constructivist grounded theory [9] guided by relational lenses [10] was used in this study. Relational approaches emphasize relationships as core aspects of individuals' everyday interactions. The Cree term wâhkôhtowin encompasses relationships with all things and is an essential element of First Nations, Inuit and/or Métis ways of knowing and living [10]. This desensitizing concept of relationship building is often undermined in non-First Nations, Inuit, and Métis approaches to research. Hence, incorporating relational lenses was vital as it ensured that the First Nations, Inuit and/or Métis points of view were well represented in the study [11]. In keeping with this perspective, an advisory council of Elders and knowledge keepers who provided guidance and feedback at all stages of the project was engaged. Constructivist grounded theory allowed for the investigation of complex, multifaceted human experiential phenomena, offering a rich understanding of the perceptions and perceived outcomes to achieve conceptual clarity. This design permitted saturation and allowed for the accommodation of diverse perspectives around First Nations, Inuit and/or Métis health education.

Recruitment

Theoretical sampling was used to recruit participants from the three main study sites (University of Alberta, University of Calgary, and University of Manitoba. A total of 35 participants (residents and faculty members) were recruited. This number was based on theoretical saturation, a point during data collection when no new information was emerging [12]. Residents were recruited through an information letter distributed by e-mail via their postgraduate medical education (postgraduate medical education) office and/or by their program director at each of the institutions. Faculty members were recruited by an email invitation from the research team and Informed consent to participate was obtained from all the participants in the study. Ethics approval was received from the University of Alberta (Pro00117423) and Trainee Research Access Committee (TRAC) [TRACMRSF20220510], University of Calgary (Pro00117423 / pSite-22–0011), and University of Manitoba (Ethics #: H2022:110).

Data collection

We collected our data using a semi-structured interview via the online platform Zoom or telephone, based on participant preference. Interviews were conducted from February 2022 to June 2023. The interviews were 45–60 min long with a mean length of 40 min. A baseline interview guide was developed in consultation with our advisory council of Elders, outlining perceived skills and knowledge required for working in First Nations, Inuit and/or Métis communities. The guide consisted of the following questions: Please explain what residency programs could do to make residency training in First Nations, Inuit and/or Métis communities a better experience for residents. How should we increase community involvement? And why? In keeping with conversational methods in First Nations research suggested by Kovach, we did not limit ourselves to the interview guide as our focus was on the participants' conversations and further spontaneous probes were asked as the interviews progressed [13]. Please see the supplementary file for the full interview guide.

Data analyses

Anonymized verbatim transcripts were transcribed by a professional transcription company (Rev.com). Data collection and analyses were iterative with an ongoing process of integrated and concurrent recruitment, data collection and analysis. Data analysis was guided by the relational lens. Using this theory allowed us to work alongside our advisory council of Elders who directed us throughout the data analysis. Saturation of categories was determined through a search for repeated instances of categories, increased elaboration of identified categories, ongoing data review, and subsequent recruitment and data collection, as needed. Transcripts were analyzed by identifying, categorizing, and describing common perceptions found throughout the data (i.e., breaking data into discrete segments that reflect meanings). Common patterns were labelled and assembled into broad saturated categories through constant comparison. Throughout our data analysis, we conducted multiple meetings with our Advisory Council of Elders to discuss our themes and categories and they were also part of the naming/ labelling of the themes. We verified interpretations using the following strategies (a) regular meetings to discuss emergent findings with our research team and Elders; b) practicing reflexivity and (c) upholding principles of qualitative rigor to assure methodological credibility, transferability, dependability, confirmability, authenticity, and fit [14].

Results

Participants

Nineteen residents and sixteen faculty members were recruited, of which 13 participants were from the main study site, 14 were from the second site, and 8 were from the third site. Study participants were recruited from a wide range of disciplines and subspecialties in medicine (Table 1). Five themes were generated: (1) Complexity of voluntourism as a concept; (2) Diversity of knowledge representation required for developing curriculum; (3) Effective models of care for First Nations, Inuit and/or Métis health; (4) Essential traits that residents should have for working in First Nations, Inuit and/or Métis communities; and (5) Building relationships and trust by engaging the community. Each main theme included several sub-themes.

Theme 1: complexity of voluntourism as a concept

Voluntourism is a form of travel that is short-term and involves volunteer work or care provision at the destination to help others [15]. Based on our findings, participants felt that trainees visiting First Nations, Inuit and/or Métis communities in rural settings may be classified as voluntourism. Participants described how First Nations, Inuit and/or Métis community rotations allow learners to explore their interests and hone their skills and this may lead to more physicians within these communities. However, medical voluntourism may not always be beneficial. Study participants described scenarios where a trip that starts as an adventure, a challenge, and with good intentions might become a unilateral relationship with little to no benefit to the people of the community. Thus, voluntourism is a complex concept and the role it plays in First

Table 1 Study Characteristics

Demographic Characteristic	Number of Participants (*n* = 35)
Self-reported Gender	
Female	*n* = 26
Male	*n* = 8
Other	*n* = 1
Self-reported Indigenous Identity	
Yes	*n* = 6
No	*n* = 29
Study Site	
Site #1	*n* = 13
Site #2	*n* = 14
Site #3	*n* = 8
Type of Participation	
Residents	*n* = 19
Faculty	*n* = 16
Stage of Training at Time of Study Interview	
Post-graduate training year 1(PGY1)	*n* = 2
Post-graduate training year 2(PGY2)	*n* = 4
Post-graduate training year 3(PGY3)	*n* = 5
Post-graduate training year 4(PGY4)	*n* = 5
Post-graduate training year 5(PGY5)	*n* = 3
Years of Teaching	
1–10	*n* = 8
11–20	*n* = 6
21–30	*n* = 1
31–40	*n* = 1
Disciplines	
Pediatrics	*n* = 11
Surgery	*n* = 2
Family Medicine	*n* = 18
Dermatology	*n* = 1
Internal Medicine	*n* = 1
Emergency Medicine	*n* = 1
Psychiatry	*n* = 1

Nations, Inuit and/or Métis communities and postgraduate medical education should continue to be explored. Two sub themes (Table 2) were generated related to voluntourism and its complexities as a concept:

Concerns of voluntourism

Several participants voiced concerns about rotations being seen as "sight-seeing tours" rather than a learning opportunity. They worried about residents going to communities for "fun" or an "adventure" where they take part in an experience but give little back to the community (and may potentially harm the community). To reduce this risk, participants suggested focusing on the motivation of the residents—ensuring that they are invested in the rotation and well prepared to focus on what they can share with the community with less focus on what they will gain from the community.

Voluntourism as a double-edged sword

Participants described voluntourism as "a double-edged sword" with both favourable and unfavourable consequences. First Nations, Inuit and/or Métis community placements can be excellent learning opportunities, but they come with significant responsibilities and potential risks if not approached with the right attitude and preparation. Participants expressed concern about balancing learning and healthcare provision and the potential negative impacts if care is not delivered in a culturally appropriate manner.

Theme 2: diversity of knowledge representation required for developing curriculum

Many participants identified key individuals who should be involved when developing the First Nations, Inuit and/or Métis curriculum. All our participants supported the notion that the curriculum should have contributions from different healthcare providers and community representatives, to incorporate a variety of experiences and knowledge into the curriculum. One sub theme (Table 3) that emerged was related to defining the needs of stakeholders and the community.

Incorporating community driven needs and perspectives from different stakeholders

Many emphasized that curriculum development should focus on what specific communities need, which would best be explained by community members themselves. Priority must be given to individuals from the community for defining elements within the curriculum and to healthcare providers at many levels (including learners, practicing physicians, and allied healthcare workers) with experience working in First Nations, Inuit and/or Métis communities. Scholars and academic physicians with experience working in rural communities should offer advice on curricular elements, and methods to implement as well as teach the curriculum within the guidelines of accreditation standards.

Theme 3: effective models of care for First Nations, Inuit and/or Métis health

When we asked about training and models of care, our participants felt that a supportive model with more time to collaborate and reach a mutual understanding of healthcare needs was optimal. This model would allow residents to have the time to not only communicate but more importantly to develop relationships.

Table 2 Theme 1, Complexity of voluntourism as a concept

No	Sub-themes	Exemplar quotations
1	Concerns with voluntourism	"It always worries me to say things like this because I worry about a voyeurism component and I think they need to be really careful about that, that it's not just them coming to watch and look and see it. It's about trying to get to know the community in a really respectful way." [Interview #2] "I do worry about; you don't want it to be a tour; sight-seeing. Because residents will sound like, "Wow! I was really surprised by how run down the houses were, and boarded up, and the bad state of the house, blah, blah, blah. But sometimes the way they talk about it, the residents with me, it's like, "You know what I mean? "Go home and say, "Wow! I did such great work, but did I?" You're not giving anything back to the community at all. Nothing. Unless you keep on going back and build something, like build a relationship, you're not giving anything back to them. So, it's a tricky thing. They call it voluntourism. And we could be accused of doing voluntourism if we don't do this properly."They [community] don't want it to be tourism. I think you need to first get the permission of the local community, "We have learners coming in. Is it okay if we drive around?" You don't need permission, honestly. Anyone one can drive around. When you're in the community, you don't need the permission. But I think we should. We can't be like, "We're bringing a learner so we can show them the conditions you live in." So, you need that." [Interview #12] "My perspective is that people sign up for these things because it will be fun or an adventure for them as an individual like, "Oh, it'll be such great experience. I'll go, I'll take and then I won't bring back…" It's a unilateral relationship which means there is no relationship. The person is just taking an experience away, and so I do not agree with medical travel or medical tourism in this way where people are just going to communities for their own experiences. I think there needs to be an invested interest where people want to learn from communities. And even me, I questioned if I should go because I'd already done so many experiences like that and I was like, "What am I really bringing?" But we need to be… That's where that ethics piece comes in. It's like, "What are my motivations? What do I have to bring? What is my end goal? How do I not just go and take and leave these communities?" I think that in the pre-departure or in the education PGME curriculum that should be emphasized, intentions. What are your intentions? Even if they're pure and they're good, let's dig into that a little bit more because you need to be honest with what you want out of this." [Interview #27] "They want to arrive and visit a foreign place and a foreign people and save them. So this is another very real context that sometimes we experience. Sometimes people's intentions are misplaced, right? They really embody this white saviorism and this whole volunteerism context that you see in that regard. And other times, they're simply medically interested. So they're not even interested in the people themselves. They're just like, "This is really cool. I get to do stuff that I wouldn't be able to do if I was in an urban environment."And then they know subconsciously that they are not held to the same level of accountability in these places because people are disempowered and wouldn't be able to fight back if they made mistakes or if they overstepped their scope of practice." [Interview #34]

Table 2 (continued)

No	Sub-themes	Exemplar quotations
2	Voluntourism a double-edged sword	"I think it very much, and this is where it comes to, we can do real damage to communities even though we go in with the best intentions of delivering medicine and improving health outcomes, we can have the best intentions, but we can actually have a really, really negative impact. I think that's a danger. We see it internationally all the time. I don't see why that can't be happening within our borders." [Interview #29] "It's like you're going to elevate your own status of how great you are, or how empathetic and how kind you are. You did all these amazing things for these other people. Yeah, I don't know how to screen out that situation. It's such a complicated question of… I would want people to have the opportunities in training to actually go and see how other patients they see and how the families will live. But I feel like it's so hard to do it without knowing that someone won't exploit that experience." [Interview #35] "I think medical tourism or volunteerism, as a whole, is a very complex issue that I've wrestled with in the past, because I started out with global development stuff, but definitely with a volunteerism thing that turned into more. But that's how it started. And I've done a medical elective in rural Uganda. And in both of those I'm not providing much help abroad, but it does give me my foot in the door for the person who's willing to be critically thinking and is willing to act on things, like you said, the people are willing to go back to the communities and stuff. But it gives them that introduction to that culture and that environment. So it's kind of a double-edged sword. You don't want that medical tourism, but people do need to have the exposure to see if they are willing to work in those environments." [Interview #28]

These were viewed as significant skills that were lacking when providing care to First Nations, Inuit and/or Métis patients.

The two critical elements (Table 4) impacting models of care are described in two sub themes:

Fee for service as an incompatible physician remuneration approach to First Nations, Inuit and/or Métis health

There were many drawbacks described with the fee for service model. Participants described how the billing structures frequently reward quick patient visits, and conversely, there are financial penalties when time is spent developing relationships or delving into complex patient issues. When less time is spent, learners do not gain an appreciation of the impact of contextual knowledge when providing care for their patients. This was felt to be especially detrimental with patients who often, based on cultural preferences, start by sharing their stories and forming a bond with their physician instead of having their medical issues dealt with immediately.

Patient centered approaches to First Nations, Inuit and/or Métis Health

Participants described this as understanding their patient's context and tailoring care to the patient's environment is an important skill that residents need to help patients reach optimal health outcomes. Understanding and learning about their patient's backgrounds helps the residents to provide better care – collaborating to create management plans that are more likely to be successful. In addition to spending time and learning about a patient's context during the visit, travel to First Nations, Inuit and/or Métis communities helps residents see the circumstances and resources that patients in these communities have and need.

Theme 4: essential traits that residents should have for working in First Nations, Inuit and/or Métis communities

Participants described several traits that learners should have when working with First Nations, Inuit and/or Métis communities. These traits are not meant to be an exhaustive list but rather building blocks to creating a

Table 3 Theme 2, Diversity of knowledge representation for developing curriculum

No	Sub-themes	Exemplar quotations
1	Community driven involvement and perspectives from different stakeholders	"If you could get people from both sides, as in residents, people from the PGME office. But I would say especially, we need to get people from the community involved because I think we understand what we would like to do, but what the community really needs is a different story." [Interview #29] "I think we have a lot of people that would have good insight. For example, the social workers would be good partners in developing something like this, because they get to interact with physicians and residents and allied health professionals, and they're interacting with families at the clinical level." [Interview #18] "I think you need somebody from all levels. You need junior mid-range and senior learners because they each have a different perspective on what they're learning and how to learn. You need the medical mentors involved. You need leaders from the Indigenous communities involved. I think really it must be quite broad and you must have as much Indigenous representation at all levels as possible. What I think is important and maybe different from what a junior resident thinks are important, then certainly going to be probably different than what an Indigenous elder might think is important. How do you bring all those viewpoints together, right?" [Interview #21] "I think most important is Indigenous, not just physicians but Indigenous community members. So Indigenous patients who have interacted with the healthcare system. Really any that maybe would volunteer their time and ideas. So that would be the most important I think is having that voice. But then I feel mindful of it can't be just the Indigenous people doing the work and creating the curriculum and involving in the planning and the teaching because it's not right either. And so there must be a balance with a give and take I think where white settler physicians are also involved and included, but that everybody has an equal voice or perhaps even that the Indigenous group has a heavier weight to their ideas with the rest of us being the workhorses a little bit." [Interview #20] "But overall, I think inviting the surrounding Indigenous communities that you would be working in and asking them, basically, "What do you want learners to know? And what experiences you want learners to have before going into your communities?", and then basically letting them run with the ball for what it should be." [Interview #28]

solid relationship between the community and the residents. Although these traits were described under the context of learner it is important to point out that these traits should be embodied by all who work within First Nations, Inuit and/or Métis communities and strive to be excellent health practitioners. Three sub themes (Table 5) were generated:

Being open minded and having a willingness to learn

Participants suggest that having an open mind with a non-judgmental attitude was very important when visiting and providing care in First Nations, Inuit and/or Métis communities. Those who are inflexible, unwilling to learn, or unwilling to consider new perspectives were viewed as less desirable candidates for working in communities.

Having humility

Participants regarded humility as an essential trait. Learning about the community and its needs, distinct cultures, traditions, and histories; respecting customs and values; and being aware of power dynamics can help individuals create a safe healthcare environment.

Being a good listener

Lastly, being a good listener was another trait that was deemed essential. Being able to listen to preceptors, the community, and the patients will have a positive impact on the learner's experience and allow the community members to feel respected and heard.

Theme 5: building relationships and trust by engaging the community

Many participants highlighted the significance of building relationships and trust with the community, with patients and with the preceptor as valuable for both the residents and the First Nations, Inuit and/or Métis community members. Three important relationships are portrayed (Table 6) in the sub themes:

Table 4 Theme 3, Effective model of care for First Nations, Inuit and/or Métis health

No	Sub-themes	Exemplar quotations
1	Fee for service as an incompatible physician remuneration approach to First Nations, Inuit and/or Métis health	"There is also the style of medicine that we are training people to participate in, [which] is often a slower, take time, uncover, discover, work together sort of approach because it takes more time. It is financially disincentivized by a fee-for-service model. So, the way to make the most money in a fee-for-service model is to see the greatest number of patients for a shorter period. And that's not a model of care that meshes well with new graduates. The other piece is, is that's also not a model of care that meshes well in the Indigenous context for patients or for communities because it leads to overprescribing and a lack of opportunity to uncover, discover, and create alignment, and to ensure that there's concordance in a plan between a practitioner and the patient." [Interview #4] "Tell me your story.", I get a very beautiful answer. Versus if you ask a white person tell me your story, they kind of look at you, "What? I don't know how to answer that question. What does that mean?" And then the story often is like, "Well I've had this problem with my skin." It becomes a medical story as opposed to the story of the person. And that's really what I love about that clinic is that how open and how vulnerable they can share their stories. And the struggles. Not so much the skin problems really, is more just being with the people." [Interview #20] "We stick with the fee-for-service. We have smaller, shorter appointment times, we can see more patients, great. But it does make me wonder, are we delivering effective care to these patients? Are we generating good outcomes? Are they going to come back with the same issue in two weeks? Are we going to cause more problems that in the end we're seeing these patients six times for 15 min when really if we had one 30-min appointment or one 45-min appointment, we could have gotten to the root of this and been more efficient. Does the fee for service work for anyone, really? Maybe, maybe not. But I think we must be particularly attentive to it in these contexts because it is going to take us more time because these are patients that we need to build a better relationship with. Maybe we need to spend a little more time in terms of communicating and making sure everyone's on the same page and making decisions." [Interview #29]

Table 4 (continued)

No	Sub-themes	Exemplar quotations
2	Patient centered approaches to First Nations, Inuit and/or Métis health	"But I think every day I learned something unique, whether it was about the drug plan or whether things about the culture, ways about interacting, maybe developing rapport with my patients, just understanding how difficult it is to… For instance, obtaining food or drinking water. It just allowed me to understand better. Also, the living conditions, because oftentimes, one or two times I had to go with my preceptor to the patient's house and see what it's like to live there and what are available resources to the community. So, I think it just allowed me to have a better understanding of… I guess, the social determinants of health and their impact on Indigenous communities' health. But just like visiting people, seeing how they live? Where they live? What does it look like?" [Interview #9] "Really, have it be patient-centered, family-centered and trying to understand better their viewpoint and their world view and how we can collaborate and work together because we can each benefit from it, right? It has to be… I think the students are better at it, maybe they're younger generation, but being much more collaborative that way." [Interview #21] "And you can't provide good care if you don't understand the context of people in those communities. Often even the suggestions that specialists provide in the city, for some people, even dietary changes and activity, a lot of the time people on the reserve can't implement that. There's no indoor running gym, for example, that people can move around in the winter. There's not much access to healthy food if you don't have money. And a lot of people don't." [Interview #25]

Table 5 Theme 4, Essential traits that residents should have for working in First Nations, Inuit and/or Métis communities

No	Sub-themes	Exemplar quotations
1	Being open minded and having a willingness to learn	"I think just almost preparing people to go into it with a very open mind and be ready for anything. Because I think that's one thing that is not necessarily unique to practicing in indigenous communities, but you just never know what's going to walk in the door. So going there with a very open non-judgmental receptive attitude, I think can serve you well. Because it's easy to go to those communities and be very judgemental." [Interview #14] "If you are a particularly close-minded person or inflexible or unwilling to consider new perspectives, then you're probably not the best candidate for working in an area that is nuanced and does require cultural safety." [Interview #30]
2	Having humility	"And I think approaching things with huge humility and having that ingrained in their approach to when they are coming into a community is really, important. And I don't think that has been taught strongly enough in terms of my previous training, I think things are getting better. I think there is a shift towards some of that being introduced and I think seeing the students coming up now, there is a little bit more of that awareness. But I think having those kinds of backgrounds in place is vital to not cause further harm when students and medical providers are interacting with those communities." [Interview #2] "I think the main thing is humility and realizing that you don't know anything, and you want to learn from your patient experiences, you want to learn from your patient. I think that is crucial in terms of how you can develop, but I think it is just the communication skill that you would have… That you develop when interacting with patients in general." [Interview #9]
3	Being a good listener	"Because I can also spend the time and listen to them, just listen to the issues they're having." [Interview #8] "You must understand that, even if a person lives within a certain culture, they still have their own thoughts and perspectives, and they're not going to agree with everything of the broader culture. It is about listening to each person and each family, but being aware of what their likely perspectives are going to be for some things." [Interview #13]

Table 6 Theme 5, Build relationships and trust by engaging the community

No	Sub-themes	Exemplar quotations
1	Relationship building with the community	"So, I think it's a bit of an understanding of that too because you hear about doctors going into communities and this fly in fly out where they don't really develop a good relationship with the patients." [Interview #22] "So, if somebody is … so you're passionate, you're there, you want to build relationships, you want to get invited out to the things, you just must ask. You don't sit back and wait for things to happen to you. If you want to be involved in the ceremony, you say, "Hey, I'm really interested. Can I come?" "Yes, of course, you can come. Here's a vehicle, go find it, or I'll drop you off, or they'll come pick you up." "Hey, I want to go fishing. Yeah, okay, somebody is moose hunting," and they go, okay. You just must ask. So that would be … that's one thing that somebody can do to build those relationships, to get to know people because you're going to get to know people a lot better outside of your clinic room, your office room, than you are in the office room." [Interview #23] "I think what I've seen work well is that when people are going to the same community multiple times to provide care, they start just developing relationships with the people who work in the health centers or work in the communities. So, I think those tend to happen a bit more organically like spending time with them, sharing meals with them at the health center, having more informal downtime, or even trying to do teaching sessions or discussion sessions, meeting with people who live locally." [Interview #35]
2	Relationship building with the patients within the community	"We found that the patients of that facility did not want to interact with the residents. The caregivers in that facility were not trusting of the residents because it's such a short time [that the resident was not able to establish long term relationships with the patients]. [Due to which] the residents didn't feel that it was a good experience either weren't able to do anything." [Interview #6] "There are some patients I see where the first time they come for a meet-and-greet, we might talk about fishing and sports most of the time. I'm not going to just really push the interview to try to gather every little piece of medical information that I can, because I've noticed that half the time when I did that, when I first started out, no one was coming back." [Interview #11] "You must be exposing yourself to the community events and understanding where that person is coming from. So, asking a lot of the questions that we don't normally ask our non-indigenous counterparts. For example, about family, community, spirituality, those things are important to indigenous people and will help to better understand them and better serve them." [Interview #16]
3	Relationship building between the preceptors and learners	"They know these doctors care and they're there. So, if they bring a learner, I don't think they'd be offended. But I think you need the trust and the buy-in from the community. And then why are you bringing the learners? You're bringing the learners so we can teach them better medicine. But also, hopefully this means that future learners will work there. That's the whole point. You would have to be paired up with a preceptor who has a trust of the community and has been there. So, people like…." [Interview #12] "So I think you need to have a supervisor, who understands their situation, is able to give you that kind of cultural background knowledge and how medicine's done in the Indigenous community, before you are even kind of allowed to interact in kind of a doctor/patient scenario, because you don't want to bring biases and you don't want to bring how medicine's done in the hospitals to an Indigenous community, where it might not be welcome. It's not kind of something where we're there to figure things out. We should be there with a high level of knowledge before we even get going." [Interview #28] "I think having the mentor with you attending, having a physician who goes to that community regularly, be there with you to both be a mentor and to help ask questions to and help guide you both before and then during the process I think is important." [Interview #32]

Relationship building with the community

Participants described building relationships with the community by interacting and spending time with community members outside of the clinic, attending community events such as smudging ceremonies and being a part of a sharing circle with community members. Physicians who only visit and stay in communities when they need to treat patients lose the opportunity to spend time with the community and gain their trust. Taking the time to actively engage with the community and to build relationships enriches the experience for both parties.

Relationship building with the patients within the community

This was described by the participants as getting to know patients on a personal level by asking questions about other aspects of their lives, such as their family, community, and spirituality. Partaking in community activities and taking the time to build a long-term relationship with the patient is essential to building trust with the community members. Additionally, engaging with patients can help residents understand the context of the patients they treat and therefore, serve their needs better.

Relationship building between the preceptors and the learners

Many participants reported the benefit of having a supervisor who shares their experiences before they start working in a community. This can increase a resident's knowledge about the community and help the resident to address unconscious biases. In addition, having a mentor within a community during their rotation can help guide the residents in developing cross-cultural communications, facilitate building relationships with the community, form connections with patients, and promote self-reflection.

Discussion

We found themes related to two potential sides of voluntourism, where these placements can be valuable learning opportunities, but come with significant responsibilities and potential risks; several models of care optimal for First Nations, Inuit and/or Métis health provision, highlighting community- and patient-centred care and outlining reasons why a fee-for-service compensation model is less desirable in First Nations, Inuit and/or Métis communities; several learner traits essential to working in these communities, including open-mindedness, willingness to learn, and humility; the significance of community engagement, including time spent building relationships with the community, patients, and preceptors.

Voluntourism is a complex phenomenon as reported by our study participants. This concept is often used in the context of global health. However, it is important to highlight some important distinctions between voluntourism in the First Nations, Inuit and/or Métis communities' context versus voluntourism in a global health context. Voluntourism in the context of global health is more likely to be short-term and infrequent [16] while in the case of First Nations, Inuit and/or Métis communities, because these health professionals are responsible for providing care in a colonial nation state to First Nations, Inuit "and/ or" Métis patients, the frequency increases and it is longer term in nature. The complexity of the phenomenon of voluntourism in this context is also evident in the current literature, suggesting that while voluntourism may provide health professionals with an opportunity to gain unique experiences in First Nations, Inuit and/or Métis communities, their presence might also be damaging to a community [16]. Some scholars believe that voluntourism only serves in the interest and benefit of those who are individually involved in it and there is no direct benefit to the community that is being 'served' [17]. Our participants saw the benefit of voluntourism and suggested ways to mitigate some of the risks. This included adopting a service mindset where health professionals collaborate with First Nations, Inuit and/or Métis communities to identify issues and find solutions [18]. Additionally, engaging in guided reflexivity should be encouraged [15]. Furthermore, based on the data we collected from our study participants, and the discussion with our advisory council of Elders, we recommend that the residents engage in pre-departure training, frequent rotation debriefing, end-of-rotation reflections, and community feedback. This should also include teaching about cultural safety and community members being involved in their evaluation. Such pre-departure training requires a mentor, ideally a community member or someone who has had long-term exposure as well as work experience in First Nations, Inuit and/or Métis communities where the learners are completing their rotations. We envision that if a resident would like to participate in a First Nations, Inuit and/or Métis communities' experience/rotation, they would be placed in the affiliated First Nations, Inuit and/or Métis communities, allowing for local experience and expertise to support their preparation. Before they leave for their rotation, the residents should be required to meet with their mentor and discuss what it means to be travelling into the community, teaching about cultural safety and how their presence in that community may have unforeseen consequences. We also suggest having a documentary or recording of "a day in the life" of a local community member. Asynchronous virtual methods of sharing community experiences could help to provide insight into local First Nations, and/or Métis community contexts [5]. Finally, end-of-rotation guided reflections should give residents time to reflect on their experiences in the community. In this phase. The learner should be evaluated by community members in addition to their medical teacher. It is vital to note that not all First Nations, Inuit and/or Métis communities are homogeneous, and programs developing such initiatives must be sensitive and cognisant of diversity among First Nations, Inuit and/or Métis communities. We do not claim that the recommendation is transferable to all First Nations, Inuit and/or Métis communities; hence, postgraduate medical education programs should be aware of and collaborate with their respective communities to ensure their needs are met.

Perspectives related to optimizing and decolonizing (a continuous process, which includes bringing about Indigenous land and life through the sharing of knowledge and mutual understanding [19]) First Nations, Inuit and/or Métis health and experiences by actively involving the First Nations, Inuit and/or Métis communities and partners' perspectives were deemed valuable.

These findings were comparable to existing literature focusing on postgraduate medical education curriculum development both in the Canadian context [6] and internationally [20]. Previous studies have also shown that supporting residents to gain the skills and knowledge they need for working in a First Nations, Inuit and/or Métis communities required relationship building and knowledge representation as significant for First Nations, Inuit and/or Métis health curricula development [21]. Furthermore, embracing collaborative approaches and taking part in community engagement helps build trust, reciprocal connections [22, 23], and a safe environment for learners and First Nations, Inuit and/or Métis patients [24]. Hence, we recommend having community liaisons, preferably community members, who will help the postgraduate programs build relationships with the community and share information. Their priorities would include community engagement, building relationships within the community, guiding residents by showing them around the community, introducing residents to the community Elders, knowledge keepers, and patients and creating opportunities for residents to take part in community events that share cultural practices such as smudging.

Creating opportunities to learn from First Nations, Inuit and/or Métis peers during rotations like talking circles/peer-to-peer circles where residents have an opportunity to reflect, deliberate and have thoughtful discussions, can increase understanding, and help residents feel supported. Our finding agrees with existing literature which suggests that incorporating inclusive techniques in teaching First Nations, Inuit and/or Métis curricula increased their comfort in care delivery and decreased judgmental attitudes towards First Nations, Inuit and/or Métis patients [25, 26]. These teaching techniques also increase awareness of the unique medical needs and ultimately contribute to a workforce that is competent in providing care to patients [27]. Despite these findings, a current environmental scan conducted by the Royal College of Physicians and Surgeons of Canada in 2021 showed that even though an interest was expressed in promoting First Nations, Inuit and/or Métis initiatives, there were institutions that did not deem First Nations, Inuit and/or Métis curriculum as their priority [28]. Sanson-Fisher et al., indicated that it is not just the responsibility of the individual healthcare providers to deliver appropriate and sensitive care to promote cultural safety. Their educational programs have a responsibility to ensure that there is a foundational First Nations, Inuit and/or Métis health curriculum with specific training experiences for those spending time in communities [29].

Strengths and limitations

This study addressed existing research focused on ways to support and equip trainees to work with First Nations, Inuit and/or Métis communities including a focus on ways to optimize health training in postgraduate medical education. The methods used in this study were in-depth and comprehensive, and data was collected from three sites across two western Canadian provinces which greatly augments the trustworthiness of our study outcomes. However, despite a comprehensive and robust study design and data collection, it is critical to recognize that our study has its limitations. It is significant to highlight that due to the diversity of First Nations, Inuit and/or Métis cultures, our findings will not be transferable to every program or discipline in health professions education involved in developing educational content related to First Nations, Inuit and /or Métis health. Our study focused on trainees spending time in First Nations, Inuit and/or Métis communities, and runs the risk, as Henderson and colleagues (2023) noted of making this seem like a special interest topic when First Nations, Inuit and/or Métis health is an essential foundational area of all postgraduate education [30]. Colonization and epistemic racism have contributed to disproportionately more white voices in healthcare and leadership represented here. Most of our study participants identified themselves as females who may have a different perception of how to better prepare resident learners for working in First Nations, Inuit and/or Métis communities. The female voice may be well represented however gender diverse and non-binary perspectives were not.

Conclusion

First Nations, Inuit and/or Métis health should be prioritized within Canadian postgraduate medical education [3, 31]. How we authentically equip trainees to provide holistic care, immersing in and learning from First Nations, Inuit and/or Métis communities is essential, for both First Nations, Inuit and/or Métis health as well as developing the next generations of clinicians and preceptors. We present educational recommendations from the perspective of residents and faculty members for residency programs to optimize First Nations, Inuit and/or Métis health educational experiences and provide residents with skills to provide effective and culturally safe care.

Supplementary Information

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Supplementary Material 1.

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Authors' contributions
The study was conceived by MR and SF. MR WC, MB, MM, MKC and PR conducted participant recruitment. MR and JN conducted all the interviews. MR, JN, JF, IJ, and SF analyzed the data. All the authors contributed to the interpretation, and manuscript preparation, reviewed the manuscript critically, and gave final approval of the version to be published. Agreed to be accountable for all aspects of the work. All the authors contributed to the interpretation, and manuscript preparation, reviewed the manuscript critically, and gave final approval of the version to be published. Agreed to be accountable for all aspects of the work.

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Data availability
The datasets used and/or analysed during the current study are available from the corresponding author upon reasonable request.

Declarations

Ethics approval and consent to participate
Ethics approval was received from the University of Alberta (Pro00117423) and Trainee Research Access Committee (TRAC) [TRACMRSF20220510], University of Calgary (Pro00117423 / pSite-22–0011), and University of Manitoba (Ethics #: H2022:110). Informed consent to participate was obtained from all of the participants in the study.

Consent for publication
All authors have consented to the publication of this manuscript.

Competing interests
The authors declare no competing interests.

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