1. OVERVIEW
As per the decision of the Association of Faculties of Medicine of Canada, in 2010 the Faculty of Medicine at McGill University recommended the introduction of a new Indigenous Health Curriculum under the leadership of Ann C Macaulay, Professor of Family Medicine and Director of Participatory Research at McGill. The ongoing development of the curriculum is under the stewardship of the Indigenous Health Curriculum Committee and in accordance with the materials developed by the Indigenous Physicians Association of Canada in partnership with the Association of Faculties of Medicine of Canada.

"Medical education at McGill is based on a set of fundamental premises. First, that the basic sciences and scientific methodology are fundamental pillars of medical knowledge. Second, that a physician fulfills two roles in service to the patient: that of a professional and that of a healer. This is referred to as physicianship."

- Indigenous Students & Medical Education at McGill University brochure; also see www.mcgill.ca/medadmissions

This report provides a background and summary of the activities of the McGill Indigenous Health Curriculum from September, 2010 to April, 2011. The Indigenous Health Curriculum Committee will resume meetings in September 2011 for the 2011-2012 academic year.

2. BACKGROUND
Critical Reflection Tool – In April 2010 the Indigenous Physicians Association of Canada (IPAC) and the Association of Faculties of Medicine of Canada (AFMC) published the First Nations, Inuit, Métis Health Core Competencies Critical Reflection Tool as part of the IPAC-AFMC Curriculum Implementation Toolkit for Undergraduate Medical Education. The Toolkit was developed through a broad consultation process and designed to facilitate the goal of culturally safe healthcare services for Canada’s Indigenous Peoples. The Critical Reflection Tool is one of three resources developed to support this work. http://www.limenetwork.net.au/files/lime/Interactive_CRT_FINAL.pdf

On June 22, 2010, an Indigenous Health Curriculum Summit was held with representatives from both McGill University and Indigenous Communities at the Trottier Building. The one day meeting included small working groups that reviewed key questions from the Critical Reflection Toolkit, and asked for recommendations to guide
the new Indigenous Health Curriculum Committee (IHC). This participatory process set the tone for developing and implementing a McGill Health Curriculum for the 2010-2011 academic year. Subsequently, a McGill Indigenous Health Curriculum Committee was assembled to meet five times in 2010-2011:

**McGill Indigenous Health Curriculum Committee 2010-2011**

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
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<tbody>
<tr>
<td>Adrienne Boon</td>
<td>3&quot; year McGill medical student</td>
</tr>
<tr>
<td>Alex McComber</td>
<td>Community Member, Mohawk Nation Kahnawake, Project Coordinator, Indigenous Physicians Association of Canada</td>
</tr>
<tr>
<td>Alexander Nataros</td>
<td>Medical student, McGill</td>
</tr>
<tr>
<td>Andrew Biteen</td>
<td>Replacing Charmaine Lyn, Medical School Admissions Office, McGill</td>
</tr>
<tr>
<td>Ann Macaulay</td>
<td>CM MD FCFP, Professor of Family Medicine, Director of PRAM</td>
</tr>
<tr>
<td>Charmaine Lyn (mat. leave)</td>
<td>Director of Admissions, McGill</td>
</tr>
<tr>
<td>Cynthia Perlman</td>
<td>Professor and member of admissions committee for OT/PT McGill</td>
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<tr>
<td>Dan David</td>
<td>Community Member, Mohawk Nation Kaneshtake</td>
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<tr>
<td>Dennis Nicholas</td>
<td>Community Member, Mohawk Nation Kaneshtake/Kahawake</td>
</tr>
<tr>
<td>Gregory Brass</td>
<td>PhD Candidate, Anthropology, McGill, Anishnawbeg (Saulteaux)</td>
</tr>
<tr>
<td>Kakwiranoron Cook</td>
<td>Community Outreach Coordinator &amp; Career Advisor, McGill First Peoples’ House (Mohawk/Lakota - Kahnawake)</td>
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<tr>
<td>Kathy Skye</td>
<td>Community Member, Mohawk Nation Kahwage/Kaneshtake</td>
</tr>
<tr>
<td>Kent Saylor</td>
<td>Paediatrician, Montreal Children’s Hospital, Community Member Kahawake</td>
</tr>
<tr>
<td>Lindsey Sikora</td>
<td>McGill Life Sciences Library</td>
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<tr>
<td>Lucy Manchester</td>
<td>Medical Student</td>
</tr>
<tr>
<td>Mary Ellen Macdonald</td>
<td>Assistant Professor, Faculty of Dentistry, McGill</td>
</tr>
<tr>
<td>Michael Doxtater</td>
<td>Associate Professor, Integrated Studies in Education, McGill, Mohawk</td>
</tr>
<tr>
<td>Michael Loft</td>
<td>McGill Indigenous Access, McGill School of Social Work (Mohawk from Kahawake)</td>
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<tr>
<td>Morgan Phillips</td>
<td>Community Member, Mohawk Nation Kahwage; Community Researcher Network for Aboriginal Mental Health Research, IHC Assistant</td>
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<tr>
<td>Paige Isaac</td>
<td>Coordinator, McGill First Peoples’ House (Mi’kmaq Nation)</td>
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<tr>
<td>Rola Helou</td>
<td>Health consultant in Kaneshtake</td>
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<tr>
<td>Saleem Razack</td>
<td>Assistant Dean of Admissions, Faculty of Medicine, McGill</td>
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<tr>
<td>Stanley Voltant</td>
<td>Physician, Université de Montreal (Innu)</td>
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<tr>
<td>Stéphane Dandeneau</td>
<td>Assistant Professor, UQUAM, Department of Psychology Métis</td>
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<td>Tamara Glavinovic</td>
<td>Medical student</td>
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<tr>
<td>Terri Normandin</td>
<td>Native Women’s Shelter of Montreal (Mohawk Nation)</td>
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<tr>
<td>Yves Sioui</td>
<td>First Nations and Inuit Faculties of medicine program Coordinator, FNQLHSSC (Huron Nation)</td>
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<tr>
<td>Zoé Thomas</td>
<td>Medical Student, McGill</td>
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A vision statement was soon drafted by the IHC:

**Vision Statement:**

*The vision of the interdisciplinary McGill Indigenous Health Curriculum Committee is culturally safe health care for Indigenous patients and communities, and the support of Indigenous knowledge systems through a collaborative, comprehensive curriculum for McGill students and trainees in the health professions.*
The McGill Indigenous Health Curriculum Committee made up of Indigenous community members, McGill faculty, medical students, and other health professionals, worked together throughout the 2010-2011 academic year to implement recommendations set forth at the June 2010 summit. The committee met at the Department of Family Medicine (517 Pine Avenue) in September, October and December of 2010 and February and May of 2011. Minutes were recorded and distributed to all committee members. Recommendations were based on responses from the Indigenous Health Curriculum Summit to: 1) build relationships with Indigenous communities; 2) develop core competencies for building an Indigenous Health Curriculum; and 3) develop culturally-specific pedagogy for an Indigenous Health Curriculum.

It was felt by the IHC that an accompanying mission statement would provide a more concise explanation of the objectives of the health curriculum and was added to the vision statement.

Mission Statement:

*Our mission is to guide the McGill Indigenous Health Curriculum to foster the development of the knowledge and skills needed to promote culturally safe care for Indigenous patients through collaborative, hands-on teaching. The goal of the McGill Indigenous Health Curriculum is to provide students and trainees with an understanding of Indigenous worldviews and philosophies, including the history of colonization, traditional knowledge, holistic approaches to healing, and social determinants of health.*

3. **OPPORTUNITIES PROVIDED BY FACULTY OF MEDICINE** (Dr. Joyce Pickering): See Appendix E.

   a. **1st year:** Two-hour lecture in Physicianship 1 - Dr Kent Saylor (Mohawk pediatrician from Montreal Children’s Hospital and consultant to communities of the Cree Health Board and Kahnawake). The objectives were to introduce students to the overall issues of Indigenous peoples in Canada (history includes pre-contact statistics, treaties, acts of Parliament, residential schools) and current health statistics (with a focus on the pediatric population), interpreted through the social determinants of health. This presentation is based on Dr Saylor’s work in developing background materials for the Indigenous section of the Canadian Pediatric Society.

   b. **2nd year:** Two hours in Introduction to Clinical Medicine: The objectives were to increase knowledge about i) the Cree communities, where many students go for their electives, and ii) type 2 diabetes which has a very high prevalence in Indigenous populations and also now seen in some of the Indigenous children. The presenters were a combination of family physicians (Drs. Dannenbaum and Macaulay) and Indigenous experts Sol Awashish who works in health promotion for the Cree Health Board and is a residential school survivor and Dawn Montour Lazare who is a nurse/certified diabetes educator from Kahnawake. The presentations and discussions included Cree history, the personal and multigenerational impact of residential schools, how these
stressors impact those patients diagnosed with diabetes and recommendations for providing culturally safe care of those with type 2 diabetes. For the third session of 60 students both Sol and David were unable to present due to family/scheduling problems. They were replaced by Ruth Loft from Kahnawake who talked about her personal experiences of being taken into residential school aged 6 – for 7 years, and Dawn presenting the realities of living with diabetes in northern communities i.e. high prices of food, leaving the community for dialysis, etc.

c. 3rd year: Indigenous case study – to be developed in partnership with IPAC for 2011-2012.

d. 4th year: (10 students) Indigenous Elective for Physicianship 4 (see syllabus-Appendix A and evaluations). The objectives were to offer an elective where students had the opportunity to learn more about Indigenous history, health and challenges, met a variety of Indigenous people including First Nations and Métis and visit Montreal Indigenous organizations and the community of Kahnawake. A website was developed for students (see Appendix B).

4. OTHER

a) **Interdisciplinary Field Course in Kahnawake – Aboriginal Field Studies IDFC 380 (Summer 2011) – 3 credits**: This 3-week intensive course (2 weeks McGill, 1 week Kahnawake Mohawk Territory) provides an opportunity for Social Work, Law, Medicine and Anthropology students to learn about Indigenous cultures and worldviews, with particular emphasis on linkages to students’ practice areas. Attention given to effects of Canadian policies on contemporary Aboriginal society (Instructors Nicole Ives, Michael Loft, Kirsten J. Anker).

Due to scheduling issues, this year no medical students are available for this elective. Dr. Macaulay is working with the Faculty of Medicine to explore if this elective could be combined with an elective in family medicine in 2012.

b) **Reading list**: from this 4th year elective have been made available to the McGill University Aboriginal Affairs Working Group.

c) **Medical school curriculum currently under revision**: under the leadership of Dr. Anne Andermann, who also has an appointment with the Cree Health Board, to include increased public health, social determinants of health and Indigenous Health.

d) **Outreach initiatives**: Through the Towards Health program, the faculty has engaged in outreach initiatives at elementary and high schools in Aboriginal communities and we have invited students from communities around Quebec to programs put on at McGill.
e) **Aboriginal Health Interest Group**: Lucy Manchester and other members of the medical student Aboriginal Health Interest Group have organized:
   i) Lecture series through the year,
   ii) Pre-departure training for students before they leave for clerkships in Aboriginal Communities.

5. **FUTURE:**
   - The IHC will resume meetings for the 2011-2012 academic year beginning in September and will meet four times throughout the school year.
   - We will again try to find Inuit representation on the committee and to include more Inuit context in next year’s curricula.

6. **APPENDIX**
   b. WIKI website – contact/background information, reading materials
   c. Physicianship 4 schedule (February 17 – March 10, 2011)
   d. Evaluation of group leader (Dr. Ann Macaulay)
   e. McGill MDCM Curriculum Schema (class 2013)
APPENDIX A

INDIGENOUS ELECTIVE – PHYSICIANSHIP 4

ANN C MACAULAY CM MD FCFP
Professor of Family Medicine
Director Participatory Research at McGill
ann.macaulay@mcgill.ca

This new elective will use a holistic approach to introduce students to issues in Indigenous Health in Canada. The goal is to help students develop an understanding of the history of Indigenous peoples and how colonization and the social determinants of health impact overall health and illness. The elective will foster the recognition of students’ own values, increase decolonizing knowledge, cultural awareness and skills to help students to provide culturally safe care to future Indigenous patients.

The first two sessions on Indigenous history and residential schools will be given by Aboriginal health professionals. This will be followed by visits and interactive sessions with front line workers, community members and health professionals in Montreal based Indigenous organizations and visits to the community directed health organisations in the neighbouring Mohawk community of Kahnawake.

Limited to 15 students
A reading list will be provided

Evaluation

1. Attendance at all sessions (10%)
2. Interactive discussions indicating knowledge gained from reading list (20%)
3. Daily journaling (30% of final grade)

Students are required to maintain a journal throughout the course, documenting their thoughts, questions and feelings after each session. This journal will also be of assistance in writing the final paper. The journal will be turned in with the final paper and returned to the student after the instructors’ evaluation of the final paper. Detailed guidelines will be distributed.

Questions to be explored in the journaling include all the points below. (Not all will apply to all sessions). Please link them to how they will contribute to your practice of offering cultural safety to your patients:

1. What was your greatest learning experience today? Discuss and provide examples.
2. What was the most challenging part of today? Discuss and provide examples.
3. What did you learn that will help you to provide culturally safe patient care?

4. Final written paper (50% of final grade)

A final 4 - 6 page paper should focus on a topic chosen by the student-based on an Indigenous patient presenting with a medical/psychosocial complaint that you have experienced in the past or one developed by yourself. This can be an adult or a child living in Montreal or currently based in Montreal for medical care. In choosing your topic, students should incorporate the information learned during the course, draw upon the readings and personal research, integrate a personal reflection based on journal entries and consider potential Indigenous organisations to help in the overall care of this patient and their family.
Students will be required to provide evidence in the text of the paper (with appropriate references) that they have delved deeply into the research and practice/policy literature on this topic and how their knowledge will contribute to their future practice of offering cultural safety to their Indigenous patients, families and communities. Extensive use of the current research and practice/policy literature on the issue should be present (minimum 3 article references from scholarly sources). Literature sources should be cited within the text of the paper and included on a separate page.
APPENDIX B

INDIGENOUS HEALTH CURRICULUM READING MATERIALS

WIKI WEBSITE

http://mcgillindigenoushealth.pbworks.com/w/page/36087642/Syllabus

1. Contact information (Lindsey Sikora, Library Liaison, McGill Life Sciences Library)
2. Background information
3. Mandatory readings
4. Additional, optional readings

mcgillindigenoushealth: Contact information

For suggestions to pages on this Wiki, or comments for changes, please contact:

Lindsey Sikora
Liaison Librarian
Life Sciences Library
McGill Medical Library, 3rd floor,
3655 Promenade Sir William Osler
Montreal, Quebec, Canada
H3G 1Y6

Telephone: (514) 398-4475, local 09844
lindsey.sikora@mcgill.ca
Mcgillindigenoushealth: Background information

Mission Statement
The objective of the McGill Indigenous Health Curriculum is to integrate issues in Indigenous health into the McGill Medical School. The goal is to help students develop an understanding of Indigenous worldview and philosophies, including the history of colonization, traditional knowledge, holistic approaches to healing, and social determinants of health. Guided by the interdisciplinary Indigenous Health Curriculum Advisory Committee, the curriculum will support collaborative, hands-on teaching, and foster the development of the knowledge and skills needed to promote culturally safe care for Indigenous patients.

Background readings
Indian Act (Retrieved February 14th, 2011)

Royal Commission Report on Aboriginal Peoples (Retrieved February 14th, 2011)

Discussion Paper Series in Aboriginal Health: Legal Issues No. 1 - Aboriginal Health: A Constitutional Rights Analysis
Discussion paper series in aboriginal health: Legal Issues No. 1.pdf

Discussion Paper Series in Aboriginal Health: Legal Issues No. 2 - First Nations, Métis and Inuit Health Care: The Crown’s Fiduciary Obligation
Discussion paper series in aboriginal health: Legal Issues No. 2.pdf

Discussion Paper Series in Aboriginal Health: Legal Issues No. 3 - The International Right to Health for Indigenous Peoples in Canada
Discussion paper series in aboriginal health: Legal Issues No. 3.pdf

Discussion Paper Series in Aboriginal Health: Legal Issues No. 4 - First Nations, Métis, and Inuit Women’s Health
Discussion paper series in aboriginal health: Legal Issues No. 4.pdf


Websites
National Aboriginal Health Organization (NAHO)
http://www.naho.ca/english/

Métis National Council
http://www.metisnation.ca/

Inuit Tapiriit Kanatami (ITK)
http://www.itk.ca/

Assembly of First Nations - Assemblée des Premières Nations
mcgillindigenoushealth: Mandatory Readings

Reading List for McGill Indigenous Health Elective

*Please note: You MUST be connected to the McGill VPN to have access to some of the articles.

**Thursday, February 17, 2011**


**Tuesday, February 22, 2011**


*Photocopied first chapter will be handed out during the first session*

- 2009_HealingTraditions_C1.pdf
- 2009_Healing_Chanp13_KirmayerFletcherWatt.pdf
- 2011_CP_Resilience.pdf


**Tuesday, March 1, 2011**


**Thursday, March 3, 2011**


Welcome to the McGill Indigenous Health Resources Wiki

Indigenous Elective for Physicianship 4

This new elective will use a holistic approach to introduce students to issues in Indigenous Health in Canada. The goal is to help students develop an understanding of the history of Indigenous peoples and how colonization and the social determinants of health impact overall health and illness. The elective will foster the recognition of students' own values, increase decolonizing knowledge, cultural awareness and skills to help students to provide culturally safe care to future Indigenous patients.

The first two sessions on Indigenous history and residential schools will be given by Aboriginal health professionals. This will be followed by visits and interactive sessions with front line workers, community members and health professionals in Montreal based Indigenous organizations and visits to the community directed health organisations in the neighbouring Mohawk community of Kahnawake.

Syllabus
Background information
Mandatory Readings
Additional/Optional Readings
Physicianship Schedule
Contact Information
APPENDIX C

4TH YEAR PHYSICIANSHIP SCHEDULE (FINAL)
(Room 238 McIntyre Medical Building, 3655 Promenade Sir William Osler)

1. Thursday, February 17, 2011 (9-12am)
   - Dr. Kent Saylor, Aboriginal Health: An Introduction/history/social determinants

2. Tuesday, February 22, 2011 (9-12am)
   - Michael and Ruth Loft, Residential Schools in Canada and Intergenerational trauma (with film)

3. Thursday, February 24, 2011 (9-12am) (at 4333 Cote Ste Catherine Rd – Institute of Community and Family Psychiatry/Culture & Mental Health Research Unit)
   - Dr. Laurence Kirmayer, Mental Health of Indigenous Peoples of Canada

4. Tuesday, March 1, 2011 (9-12am) (at Native Women’s Shelter of Montreal)
   - Terri Normandin and NWSM team (Nakuset, Sedalia Fazio, Michael Standup)

5. Thursday, March 3, 2011 (at Native Friendship Centre of Montreal)
   - 9-10:30am: Brett Pinneau and NFCM Team (Alan Harrington, Keren Tang, Sarika Beauchamp)
   - 10:30am-12noon: Michael Doxtater and Gregory Brass, Forgotten Warriors – Indigenous War Veterans of WWII (with film)

6. Tuesday, March 8, 2011 (9-12noon)
   - Stéphane Dandeneau, Métis Health in Canada

7. Thursday, March 10, 2011 (9-12noon) (trip to Kahnawake)
   - 9am-10:15am: Kateri Memorial Hospital Center Team (Luke McGregor, Calvin Jacobs)
   - 10:30am-12noon: Kahnawake Schools Diabetes Prevention Project (Judi Jacobs, Elaine Delaronde, Ann Macaulay, Morgan Phillips)
7 Respondents

Please rate the CONTENT of the elective sessions on the following:

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Please rate the DISCUSSION LEADER on the following:

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Responses to Questions

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Ability to Facilitate Discussion

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Mean scores are calculated using the McGill standard 5-point scale.

How would you rate the elective overall?

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Comments:

- Very good elective. Should be part of regular curriculum. Truly inspiring, enriching. Will change the way I practice. Gave me an amazing insight in aboriginal culture. I developed into a better person during this elective.
- Wonderful new elective, invaluable for any future physician / healthcare provider in Canada, but especially so for those with an interest in Aboriginal health.
- Amount of readings were re-adjusted and was much more reasonable consequently. Overall, a really wonderful elective on a very important topic. Being able to go on outings really increased the scope of the course (Native Women's Shelter, Friendship Centre, Kahnawake). THANK YOU!
- Very interesting topics. Outings very useful. Many readings were redundant, however.
- Very interesting. Field trips were great. Too much reading and work compared to other electives. Some readings were repetitive.
- Too many (re: the readings)
APPENDIX E

McGill MDCM Curriculum Schema (class 2013)

### Basis of Medicine (BOM)

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<td>Molecules, Cells &amp; Tissues (4 wks)</td>
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<td>Life Cycle (3 wks)</td>
<td>Endocrinology, Metabolism &amp; Nutrition (7 wks)</td>
<td>Musculoskeletal &amp; Blood (4 wks)</td>
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<td>Host Defense &amp; Host Parasite (6 wks)</td>
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**Physicianship-1** Will include one Aboriginal session of 2 hours

**Physician Apprenticeship 1**

### Introduction to Clinical Medicine (ICM)

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<td>Pathobiology, Treatment &amp; Prevention of Disease (14 wks)</td>
<td>Physician-2b* ICS EBM (4 wks)</td>
<td>Introduction to Internal Medicine, Intro to Pediatrics (7 wks)</td>
<td>Introduction to Surgery, Anesthesia, Ophthalmology (7 wks)</td>
<td>Introduction to Oncology, Neurology, Radiology, Dermatology, Psychiatry Family Medicine with one 2-3 hour Aboriginal Health session for each of the three student groups (7 wks)</td>
<td>Vacation (4 wks)</td>
<td>Intro Clerk (1wk )</td>
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**Physician Apprenticeship 2**

### Core Clerkship sequencing will vary for each student- this is an example

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**Physicianship-3** Add Aboriginal based on- line case study
### Senior Clerkship

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**Physician Apprenticeship 4**

- *PHP 2b – Physicianship 2b waiting for approval*
- *Core Clerkships may be completed in 12 different sequences; one representative sequence is depicted*
- **Senior Clerkships may be completed in 7 different sequences, one representative sequence is depicted**
1. **APPENDIX**

McGill Indigenous Health Elective (INDS 420) 2011 – STUDENT JOURNALS

February 17 (Kent Saylor)

- Today we were given an introduction by Dr. Kent Saylor to the history of the Indigenous population, and their current health issues. Being of Mohawk origin himself, and being in the company of people coming from Kahnawake, it was interesting to gather their perspective on the history of their nations and the current misconceptions/stereotypes they continuously strive to dispel. Morgan’s input was certainly appreciated in advocating the resilience of the aboriginal population, and that current data consistently emphasizing the negative aspects of their conditions is not always conducive to their rebuilding of culture and self from colonialism. Additionally Dr. Saylor’s emphasis on maintaining a culturally-sensitive practice was instilled in the group, as he noted an experience when a patient of his, a small boy who had been born prematurely was delayed in his milestones, and although he would benefit from staying in a structured academic setting to help his skills foster, this conflicted with his family’s way of life of living in the bushes. As a result, Dr. Saylor did not force his suggestion upon the family, and in fact demonstrated the utmost respect for their culture. Thus far I am highly looking forward to this course, as an aspiring psychiatrist with an interest in transcultural issues, this certainly appeals to me in understanding the sociocultural determinants faced by the First Nations, Inuits and Metis, and how they interplay with health, and ways in which we can resolve these issues.

- Today’s session provided me with a solid background on why the health of Aboriginal people is different than non-Aboriginal people. In all people, health is intricately linked with social issues, however with Aboriginal people, the history of the people has a more profound effect on the health of people today than in non-Aboriginal people. This session also provided a great background on several Aboriginal definitions and history. Many of these issues are things I learned in an Aboriginal woman’s studies course I took in university, however it was great to have a refresher course on these issues. I think the thing that surprised me the most of today’s session, was some of the statistics we were given. Most noticeably was the large number of Aboriginal children that are taken into foster care compared with the rest of the Canadian population. To me, that number was a clear indicator of how far we are from equalizing the health of Aboriginal people and providing them with as fair a chance of leaving a healthy life and acquiring an education.

- After this session, I was walking with 2 acquaintances, one Canadian, one German. I told them I had just been in this great session about indiginous health given by a Mohawk physician. Their response confused me. The German said: “Was he drunk and high?” The Canadian laughed. I was very irritated and responded that every Mohawk at the session was either a graduate student, a PhD or a physician. The German said: “I didn't know there were any that were educated. I thought they were all drunk all the time and unemployed” The Canadian said “I used to live next to a reserve. They are mostly drunk all the time. There's a reason why the stereotype exists.” This demonstrated 2 things to me:

1) The racism that aboriginals experience is very real, very direct and simultaneously based on ignorance. My experience of First Nations culture is so different, that what they said struck me as very bizarre, even though I have been exposed to the high prevalence of substance abuse far more directly than they have.

2) It was very encouraging to meet a Mohawk physician. When I was in Mistissini, several healthcare workers emphasized the need for first nations physicians and regretted that they didn’t know of even one Cree physician. They were very concerned about the education of their youth – no one had graduated from high school in 3 years. Kent Saylor and his Mohawk colleagues prove that progress is possible. Things can get better and they are getting better.

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1 Please note that permission to include testimonials/journal entries was obtained from all medical students.
3) The resilience of the First peoples is remarkable.

- Though I have heard the depressing statistics about health discrepancies between aboriginals and the general population numerous times in the past, what I was glad to learn in this session was the notion that we should concentrate on the positive and not just on the negative. For example, when looking at how many students graduate from high school, we should be happy that there are an increasing number of students graduating – i.e. look at the “glass half-full instead of half-empty”.

Also interesting was the results of the discussion of the Chandler and Lalonde study that showed that aboriginal communities with relatively low suicide rate had increased attempts at re-establishing culture; control over health issues, police and fire departments; control over education; returned self-government; and at least an attempt at land claims. The study showed that standard “western” solutions to prevent suicide, such as setting up hotlines, providing psychiatric therapy and medication, were not as useful. This discussion reminded me that I need to be humble about my abilities as a physician in helping native people – what they do for themselves will likely have a bigger impact than what I can provide.

- The information conveyed by Dr. Saylor today were largely points that I had encountered before, either in the Global Health course in second year or through my own experience up in Chisasibi. This did not, however, diminish the lecture’s impact. Once more, I was reminded of how much inequality exists between Indigenous communities and other Canadian communities. Just as many cultural and ethical issues imbue the health care of Indigenous peoples in Canada as for the provision of health care in developing countries, and yet due to the geographical location of the former within Canada, these issues tend to be forgotten or ignored. I feel very privileged to have been able to experience to some extent what being Cree means during my month in Chisasibi, and am looking forward to learning more about Indigenous health both within the major cities and in more remote communities. It is still shocking to realize that the last residential school closed in 1996, and that my ancestors believed that they had the right to demolish thousands of lives in the name of self-interest. However, as Morgan and Dr. Saylor stressed, one must not forget the resilience of Indigenous peoples, and focus on what we as health professionals can do to foster that resilience.

- I am super excited to explore different indigenous people and their view points. Some of what we discussed today – the decreased eye contact in some people groups, the way grandparents are often included in the decision making process, and the way adolescents often defer to their parents in a medical setting explains many of the phenomena I saw in Mistissini.

- **What was your greatest learning experience today? Discuss and provide examples.**
  
  Basic background about the different groups (Métis, Inuit and First Nations) and how they have been affected by the multigenerational trauma created by political decisions will serve invaluably to give context to the rest of the course. Other important learning points which I believe will help me to deliver culturally appropriate care and contextualize further learning included the introduction to the holistic view of health, including equal focus on the spiritual and emotional as the physical and mental aspects of health and the considerations language (as a symbol of self-determination). Perhaps language is the feature of self-determination to which I most easily relate as I find myself to be the generation in which both the languages of my heritage have been lost (paternal: Yiddish & Hebrew, and maternal: Icelandic). As I try to find my cultural identity, I often wish for these language skills.

- **What was the most challenging part of today? Discuss and provide examples.**
  
  The most challenging part of the class today was realizing how little I knew about the history of Aboriginal peoples in Canada. Though I have been educated in Canada from preschool through university and have had various government mandated history classes, I do not feel that I have been taught enough about Canada’s Aboriginal communities and the political decisions that have largely
shaped the social context in which they live today. Though I thought that because I had worked in Chisasibi last year, I was aware of some of the health issues faced by the Cree, I now realize that I did not fully understand the cultural, political and social aspects that impact on their health.

- What did you learn that will help you to provide culturally safe patient care?

One of the most interesting things that Dr. Saylor mentioned for delivering culturally sensitive care was about the differences in non-verbal communication. It is important to keep these differences in mind when interacting with Aboriginal patients. He mentioned that culturally there is less eye contact, that teenagers often differ to their parents to speak for them and that the opinions of grandparents are of utmost importance in making medical decisions. These subtle differences, if not known could be misinterpreted and ultimately impact on patient care.

- Being new to this topic, I found this lecture very informative and was a good starting point to introduce issues, concepts and terminology/definitions that will be discussed in this course. I’ve been aware of the health disparities between aboriginals and non-aboriginals but never really took a look at the “numbers” and I was really struck by them; some of the stats seemed consistent with populations in developing nations but they were in fact Canadian. I appreciated how Dr. Saylor emphasised that we often group all aboriginals together but there are important significant differences (cultural and socioeconomic) amongst different communities. 10% of aboriginal children are in foster care. To better understand why today there is such a discrepancy between aboriginal and non aboriginal people’s health status, one must consider the historical, geographical and social contexts, pre and post-colonization. Western medicine concentrates on the physical and mental health whereas the aboriginal medicine wheel gives equal importance to physical, mental, emotional and spiritual well being.

- The epidemiological data presented by Dr. Kent Taylor is striking, more than I expected. The aboriginal population health status is comparable to third world countries. Health disparities are directly related to social, cultural and political inequities. The problems are entrenched in the history of colonization. It must be clear that there is no genetic or aboriginal trait that can explain these disparities.

- The numbers are striking – something must be done: Suicide, injuries, substance abuse all occur in huge proportion.

- I realized that the government has just started to address the problem. It started with the Oka crisis.

- There is hope, the aboriginal population is resilient, and the healing will start as they rebuild their nation, their culture, their language and spirituality.

February 22 (Michael/Ruth Loft)

- Today we had the pleasure of meeting Michael and Ruth Loft, and discuss the ramifications on indigenous society from the implementation of residential schools in Canada, as we also listened to poignant accounts of the cultural genocide that took place. By watching the video “Healing the Hurts”, a documentary on the Four World Development Project that focused on group therapy sessions for people who continue to struggle with such painful memories and the effect of cultural sterilization on their current selves. The residential schools have certainly instilled them with fear by bullying and intimidation, all the while robbing these children of not only their culture, but of self-esteem and expression of love. Michael Loft even noted that children of parents who themselves are residential school survivors are more likely to commit suicide than the survivors themselves. He reasoned that it was due to survivors having had at least their first five years of warm, loving parenting prior to boarding school, whereas children coming from families already deeply affected by the oppression they’ve undergone will most likely suffer from the intergenerational trauma (ie: manifested in lack of expression of love towards their children). In addition, past generations have passed onto offsprings their internalized sense of cultural self-hate, as Residential School training had engrained them with
the notion that “talking Indian meant pain” (strapping/beating), and that being Indian was akin to a mortal sin or an inherent flaw, as evidenced by the sterilization process the survivors in the film spoke of. Michael Loft even noted how his father, himself a survivor of such a system and having lost knowledge of his language/culture, would grow angry whenever his wife would converse in Mohawk. What was especially poignant was the personal account of Ruth Loft, as she passed around a photo of her 4 year old granddaughter, and emphasized that she was her granddaughter’s age when she was torn away from her family and forced into this “prison/institution”. We were especially moved as she recalled how commonplace the beatings were to these young children, how her siblings had become practically strangers to her, and how her nights would be filled with the voices of young girls praying for their parents to rescue them. The “stoic Indian” or the “whiny Indians” stereotypes are only fueled by the cultural self-hate and shame these survivors and their offsprings had endured during this cultural genocide. In the end, Michael and Ruth emphasized the resilience of the survivors either direct or intergenerational trauma, as they continue to not only engage in the self-healing process and expand their understanding of the situation, but they are striving to foster awareness of such past hideous atrocities and understanding of the disparities facing Aboriginal communities today.

- Today’s session was very moving and emotionally challenging. Watching the film “healing the hurt” was difficult as we witnessed people going through cathartic therapy to express the pain they continue to embody after being in the residential school system. I found hearing the personal story of a residential school survivor the most moving. It was so clear in every word she said how much the trauma she experienced in the residential school system is still with her today and I felt honored that she was willing to share her experiences with us. I also thought it was a very interesting comparison to hear the story of someone who grew up with a residential school survivor as a parent. It showed how the trauma was just as real and alive for the child of a survivor as it was for the survivor herself. This really demonstrated the inter-generational effect that the residential school system has had on the Aboriginal people and why it continues to impact their culture, identity and relationships today.

- I knew little about the residential school system before this session. I had heard it discussed multiple times in Mistissini and in literature and in the media, but I can’t say I knew very much. I know a few more details now, but my knowledge is still poor. Meeting a survivor and watching the video really reinforce how real and current the impact of this schooling system is. I think this is more valuable than the numbers themselves. I am now motivated to read a lot more about these schools. One of the things I noticed in Mistissini was the unusual combination of recently acquired material wealth in the context of a very troubled social fabric – high suicide rates, prevalent abuse and violence, substance use and family problems. It was a strange juxtaposition. Now I am convinced that 150 years of intentional social destruction through the residential schools has something to do this.

- Super depressing. I felt like crying when I left. The shame, the guilt, the feelings of no self-worth bled from the screen into the room. I felt sick at the account of the woman who had been forcibly sterilized by our people. Most potent was the story and the tears of the real survivor. I was impressed by her strength and ability to look to the future after that kind of experience. I left the small group afraid. Although Britain had proposed the residential school system as a solution to the “Indian problem” and the Canadian government had taken intentional measures to erase their culture, I am aware that those who had decided to be teachers and supervisors for the schools had for the most part had good intentions, at least initially. Many of the native people had pointed this out, and seemed equally confused with the disparity between the intentions and their actual effects on the children. I was also aware that the regimentation and institutionalization, including the separation of genders and the types of punishment employed which created such deep scars on the aboriginal soul, were part of the British system for bringing up children well-accepted in that era – roughly comparable to the upbringing of my British grandmother in an English orphanage and my own grandfather in a East Indian boarding school. This made me terrified that somethings we may be doing today, well-accepted “healthy”
changes we may be implementing, may in the next generation be looked back upon as deeply
disturbing and harmful.

- I think the greatest learning experience was also the most challenging part of today’s class. To witness
the amount of suffering that Ruth Maloney Loft had as she spoke about her experiences in residential
schools from being separated from her family to the feelings of loneliness and abandonment echoed
from the film “Healing the Hurts” really resonated with the group. As we saw each other throughout
the rest of the day, we acknowledged how the experiences had affected us. Perhaps to fully understand
the impact of oppression one needs to see the consequent suffering first-hand. Though it cannot be
easy, I hope Ruth continues to tell her story to educate others and to spread the message so that we can,
as she concluded, trust in the future.

While I worked in Chisasibi, when patients seemed overwhelmingly calm in alarming situations or
insensible and occasionally indifferent, I was told they were stoic – meaning “free from passion,
unmoved by joy or grief, and submit without complaint to unavoidable necessity”. (http://dictionary.reference.com/browse/stoic.)
Today, I learned how this is a stereotype. I believe this
will help me deliver more culturally sensitive care because I am learning to understand the context in
which their “stoicism” has evolved. Through the oppression and domination applied by the residential
school system, the eradication of culture, the dissolution of families and the taking of territory, passion
and emotion were eradicated. As I try to offer my patients medical care, my image (a Caucasian
Canadian) represents the harbinger of disease and cultural annihilation. I hope to learn ways to discuss
the effects of the injustices to Aboriginal peoples with my Aboriginal patients to better understand
their health and deliver more appropriate care.

- The residential school experience is something that I have only become aware of as a young adult; as
far as I can remember, nothing of this was taught in Quebec or Canadian history courses in high
school. The video that we saw was difficult to watch, both because the quality of the sound was poor,
but also because it felt somewhat intrusive to be witnessing people’s emotional distress. I also felt
uncomfortable because despite my young age, as a white Canadian whose family ancestor was in
government, I felt complicit. How would I be able to deal with someone if they came to be and opened
up about the effect the residential schools have had on them? I can’t imagine that any Aboriginal
person would choose me as the person to turn to given my ethnicity, but I may be the best option
available to them. As Mike Loft said, I assume I would just ride it out, and now that I have listened to
Ruth’s experiences in residential school, I have a better basis for understanding the situation. Will I
ever completely understand the impact of this cultural genocide on Aboriginals? It’s unlikely, since
like the Holocaust or Rwanda I did not live through it, and my mind revolts at anyone treating other
human beings in such a way. But hopefully I will be able to put aside my own misgivings about the
situation, and simply be a human being.

- This was an extremely difficult but essential session to attend. I felt embarrassed by ignorance
regarding residential schools. All my history classes had completely whitewashed this part of Canadian
history; I had been taught about atrocities that had occurred in other countries but not about the
atrocities that had occurred (and to some degree continue to occur) in our own “backyard”.

- Even with the limited exposure I have had to aboriginal cultures, I have always admired their beautiful
artwork, stories and their relationship with nature and its elements. So to hear that the church
disregarded all this beauty and robbed so many indigenous children of their culture was devastating.
Moreover being brought up in a traditional Italian family, my cultural background is very important to
me and I know I draw a lot on this in many situations so I can’t even imagine what so many
aboriginals have gone through being ripped away from their cultural identity. In the film that was
shown one of the parts that struck me was the intro where many of the individuals didn’t know how to
identify themselves.
• Mike and Ruth Loft were extremely effective speakers. I felt so privileged to have them explain their history to us. They explained how even though residential schools are no longer present their effects are far from over- they have traumatized multiple generations of aboriginals. The Lofts explained how this trauma has been “passed on” thorough generations very effectively.

• Although I left this session feeling awful/helpless, something Mike said did kind of make me feel a little better; the goal of the session hadn’t been to make us feel bad or undo what had been done but they just wanted us to start understanding/to be aware of the reality that aboriginals are living with.

• The pain of the residential school experience is still readily palpable, affecting not only the lives of direct survivors but also those of children and grand-children of residential school survivors as a result of multigenerational trauma. - Upon returning to the community after residential school, many children were alienated from their own family and culture. They felt disconnected from others, but also from their spiritually and heritage. The had lost their sense of self and identity.

• Residential school = Ultimate effort of colonization and assimilation. Lifelong and inter-generational impact on aboriginal community. There is a phenomenon of internalization that has occurred by which a colonized group begins to judge itself by the standard of the colonizing society, swallowing externally imposed negative valuations. The movie is poignant, and as opposed to many students, I think I could relate to this movie for 2 reasons. I went to school with many aboriginal students in Mont-Laurier and I am a French Canadian. Of course, nothing is comparable to the ``cultural genocide that took place towards the “savages” as they used to call them. However, the French community of Quebec has had its load of difficulties. Even though my culture and sense of self identity is still preserved, we are still threatened by assimilation and our lack of self-esteem/confidence and our self destructive personality persist. As a result, the movie made me feel anxious, sad, frustrated. At one point, I wish I could have hit a punching bag as hard a possible like in the movie.

February 24, 2011 (Dr. Laurence Kirmayer)

• Today we were given the opportunity to listen to Dr. Lawrence Kirmayer discuss the sociocultural determinants of indigenous people, and how they interplay with mental health. It was striking as to how there was no single category or defined definition of mental health, however such illnesses were provided cultural explanations (ie: a man with strong delusion of being pursued by 3 white men was perceived as having had “heavy thoughts”, that would dissipate after proper intervention, yet rather than approaching this case as a prodrome to schizophrenia, he is instead returned to the community and deemed to have been cured indefinitely).

• We were able to address the risk factors contributing to the high suicide rate in this particular population, ranging from instability of self due to internalization of colonialism resulting in poor coping strategies, exposure to family/friend history of suicide thus creating a powerful process of suicide clusters within the community, and finally the lack of continuity (in both personal and cultural) thus rendering these people increasingly vulnerable to taking their own lives, as they are unable to see themselves in the future. We also explored the common adolescent predicament of high solvent abuse rate, due to the exposure to the suffering of past generations (who themselves turn to substance abuse as a coping mechanism for their internal discords) and lack of engaging activities within the community. An interesting question did arise on the facilitation between approaching patients with western medicine all the while maintaining mindfulness of their cultural backgrounds. It was emphasized not to stick to a rigid algorithm/approach, yet that we should strive to approach the patient as an individual, and certainly not belittle them, as with any patient.

• This session was very interesting and informative. The themes from the previous sessions continued, showing how the effects of colonization have continued to impact the Aboriginal people today. What I found most interesting about this session was the relationship that Aboriginal people have with mental illness and their ideas about the roots of mental illness being linked to spirits and demons. I really enjoyed our discussion about how these beliefs affect the way in which we as western medical
providers can enter Aboriginal communities and recommend treatments. One of my personal goals for this course is to develop better strategies in working with Aboriginal people and learn how to treat and educate without imposing western beliefs and furthering the cultural assimilation of colonization.

- Very interesting and insightful talk. Demonstrated how much about aboriginal health is poorly understood while showing that research can lead to concrete answers and ideas for intervention. The work on “self government” or cultural continuity is very interesting and somehow makes a lot of sense. The Cree health board appeared (to me at least) to work quite well. They were pretty organized and made services fairly easily accessible in Mistissini at least. I can't help thinking that for communities further away from Montreal (like the Inuit, Cree etc.) geography and isolation play a major role in many of the existing health problems. There is a major economic problem facing many of these communities: If they are to participate in the modern Canadian or global economy, what resource/service/product will they sell? Wood? There is almost no wood in Inuit territory. Seal meat? Soap stone carvings? Some of this problem has been addressed by the James Bay agreement and this is quite apparent in Mistissini. They roads are clean, straight and new. Brand new cars and boats abound. But will public health indicators in these areas ever match the national average without the development of local “industry” of some sort?

- In Montreal, as an immigrant, as an Anglophone, as a non-Christian, I don’t consider myself part of the dominant society. When treating patients from cultural minorities in Montreal, I like to believe that I have a certain connection to them as a fellow member of a minority community. This session made me realize that to a native person (and likely to many of the aforementioned patients in Montreal), I do in fact represent the dominant society – as a white male from the city, or least as a physician and in a role of authority. I hope this will encourage me to redouble my efforts in making patients comfortable with me and creating a relationship of mutual trust and respect.

- Today I was struck by the complex network of beliefs used by the Inuit to explain mental illness well illustrated by the web-like diagram and accompanying explanations put up by Dr. Kirmayer. He was describing the very pan-human habit of how we pull together contradictory ideas gathered from a plethora of sources to explain the unknown. In examining my own thinking processes I was able to related very directly to this confusing diagram and found it interesting that we who consider ourselves so logically trained still have to admit that deep down inside we hold fragmented and illogical world views. Male death by suicide rates are always higher than female rates but I was intrigued by the explanation offered by one of the reading that this is due to gender disparities in the shift of roles with the movement from a tribal and land-based society to a sedentary hierarchical society. The idea in essence what that what it means to be a successful male has changed more dramatically that what it means to be a ’good’ or successful female. Therefore men have greater sense of powerlessness and worthlessness and ultimately, have undergone a greater loss of identity.

- I appreciated the reading Traditional Anishinabe Healing in a Clinical Setting. I do not remember considering if my patients were also using traditional medicine when working with Aboriginal populations, though I often included asking non-native patients if they were taking supplements or seeking alternative treatments. I hope to learn how to ask about traditional healing practices in an appropriate way and if my patients are interested in seeking such care to integrate it with western medicine. It is a good reminder to ask about complimentary treatments when seeing any patient. Learning what cultural safety actually means was important. I had assumed that it was synonymous with delivering culturally sensitive care. After Dr. Kirmayer’s talk I understand that it is very different. Cultural safety goes beyond just providing culturally competent care (aka having cultural knowledge) and recognizes that there is power disparity in the interaction that can impede communication and tries to empower those who have been historically oppressed.
• I found today’s session very interesting, and very different from Tuesday’s. This was much less emotional and much more academic. Although the point of focus was Aboriginal mental health, and the numbers, especially around suicide attempts and deaths, are shocking, we were looking at the problem from a broad epidemiological perspective. It was a sharp contrast to Ruth’s personal story during the previous session. One aspect that struck me while preparing for the session was the way in which even the way research is conducted has to be considered when you are engaging with a culture different from your own. These are things that hadn’t occurred to me, but as I wish to practice medicine in close relationship with Aboriginal peoples, and will likely be engaged in some sort of research regarding issues of Aboriginal health, it’s important to realize that considering culture should pervade every aspect of my practice, not just when I have a patient in front of me. I will strive to remember this as I move forward in my career.

• During this session we discussed how indigenous peoples interpret/understand mental health issues and how important it is to understand and respect their views in order to effectively build a relationship and communicate with these communities. We also discussed how indices of empowerment were associated with decreased suicide attempts. It was interesting to about Dr. Kirmayer experience working with inuits: how he approached getting involved with the community and how he learned to understand their perspective on mental health. Although aboriginal people all share colonization as part of their history and culture, each community was impacted in a unique way. Therefore, one should not limit his or herself to the label of aboriginal ancestry when trying to understand the context of a patient’s mental health problem, but rather should recognize and explore community diversity as well as the patients relationship with his/her specific environment. Cultural safety takes the concepts of cultural competency and humility one step further in emphasizing the recognition of the power differential that exist between the patient and the health care provider. Etiologies of the power imbalance are many - from the effects of overt dominance of white culture during colonization to current racial discrimination maintained by societal ignorance and government policies.

• Very good session. Cultural safety, cultural competence and most importantly, cultural humility must be incorporated in any type of medical practice. It is crucial, especially as a family doctor to be aware of different culture. Our western society definition of health is not the absolute truth. Personal history vs collective history. It is important to integrate and take into account shared background and its impact of personal history and vice versa. Many aboriginal cultures appear sociocentric and ecocentric in that the self is defined in relation to nature and the well being of the family, band or community. The health of the aboriginal community appears to be linked to the sense of local control and cultural continuity.

March 1, 2011 (Terri Normandin et al)
• Visit to the Native women’s shelter was certainly an enlightening experience. We met with Terry Noumadin who was more than enthusiastic in helping us familiarize ourselves with the purpose of the shelter and the numerous resources and services they provide. A tour was given of the facility, and we were given lectures by traditional healers who provided their own insight on the interaction between the body, mind and spirit and their individual approach to the healing of the person as a whole. It was truly a privilege to have had visited the site and I was ever the more grateful for Terry and everyone else’s hospitality.

• Today’s session was the most meaningful to me thus far. The session was very well organized to show us the many aspects of care that are offered through the women’s shelter. I was very impressed by how nice the facilities were. I found the experience very uplifting and inspiring to continue to try and work on community projects like the shelter. I also found the talk by the elders very interesting. I find I tend to be a skeptic of alternative medicine and although the session did not change all my beliefs about the
importance of western medicine, I found it helped me realize the importance of traditional Aboriginal medicine to their culture and how to have more respect for its purpose in our western medical system.

- Great session. I understood so much more about traditional healing than I did before. The medicines and treatments have much deeper, spiritual significance than western medicines. We view medication in a very detached, mechanical way. Traditional healing seems to be as much about the meaning of using the medicine, who administers it and how it is taken as it is about the medicaction itself. I'd like to do a sweat. I can see how traditional healers and elders for a pivotal social structure and support in the first nations communities. The loss of these practices through colonization probably contributes to the high prevalence social problems. It's great that these practices are making a comeback.

- The most interesting part of this session was our discussion with Mike Standup and Sedalia Fazio. One of the first things Sedalia said was that she has not seen a “western” doctor in decades. She said this with a sense of pride. I was taken aback by this, because how are we supposed to improve the health of native people (keeping in mind all those sobering statistics from the first session) if they refuse to visit doctors? I suppose that a lot of people, from any culture, would rather not bother with things like blood pressure control and mammograms. It is a challenge to convince anyone of the benefits of preventative medicine, and this challenge is even more difficult among native people, who may have an instinct of distrust of “western” doctors due to past injustices. The rest of Sedalia’s discussion regarding mainstream medicine was more tempered, and Mike’s view of his role as a traditional healer was also more comforting. The discussion emphasized the fact that traditional and mainstream medicine should not be viewed as “either/or” but as complimentary, each with its own strengths and weaknesses.

- What an amazing place to have in Montreal! A staff physician and I had sent a Cree woman with whom I had had multiple encounters to this shelter from Mistissini almost a year ago and I never thought I would have the privilege to see the workers down the line, the one who would make the REAL difference in this woman’s life. I only wish there were more across the country and in the more northern regions. Perhaps a good location for a second similar woman’s shelter would be Chisasibi which would easily provide for the Cree and Inuit women in or closer to their native communities where they might also find the support of friends and family. Mike Standup also drove home two other points that will stick with me on my journey to becoming a healer myself – the power and healing of touching a patient, and the fact that we are all human. In fact the recognition of the humanity in each person is what I believe will solve the current racism and misunderstanding between aboriginal and non-aboriginal people more than any other single factor.

- I cannot remember ever visiting any sort of shelter before and I think in itself it was a very unique experience to be able to see a shelter and what it is like. I found it very interesting that most of the staff working at the shelter were of Aboriginal descent who had been brought up in Montreal. It struck me that they were trying to reconnect to their roots in some way. As they were so open to understanding and incorporating the different customs, I felt they were a good example of cultural safety. I think it would also have been very interesting to interact with some of the patrons of the shelter, though I realize that many of them may not have been interested in that. Being able to meet traditional healer Mike Standup and elder Sedalia Fazio was amazing. In a clinical context, I have never had the opportunity to meet with or discuss the spiritual side of health with any spiritual leader. I think this is such an important service to be able to offer our patients and to meet with them was a privilege.

- Today we visited the Native Women’s Shelter. My only other exposure to a shelter was in Toronto, where as part of an Inner City Health elective I worked at Seaton House, a men’s shelter. The two places could not be more different – one was large, smelled of alcohol and urine, and overall was quite dirty; in contrast the Native Women’s shelter was immaculately clean, with homey private rooms. I
was very impressed with the facilities. However, what I learned the most about today was from the two elders who spoke of their practice of medicine and healing. Although I am generally sceptical of non-Western medical practices, what was impressed upon me was the notion of healing the “inside” to help people feel better. This notion is discussed even in Western medicine in the difference between healing and curing, but what I understood from the Elders’ discussion was that everyone could benefit from this. I would be very interested to try a sweat lodge, and experience what for so many people is healing. It also opened my eyes to the fact that people like Mike Standup are available for any Aboriginal patients who are interested in his services, and that he could come into the hospital for those who are unable to go to him.

- Important for physicians to know about different services available to our patients. We can’t take everything on ourselves so it’s important to know about places where our patients can go for help. Reinforced importance of having a holistic approach to medicine. Introduced to the obstacles aboriginal women have in even accessing our healthcare system – loss of medicare cards, language issues etc...Meeting with the traditional healers was great. Allowed us to gain an understanding of the services they offer and how they are complementary and not antagonistic to western medicine.

- No matter the motivation behind leaving their home and community to come to a big city, it must not be evident for most aboriginal woman (or man) how to navigate around Montreal and its culture. Seeking medical care can become a huge challenge because of differences in language and customs. For example, it is not necessarily because a patient is disorganized or disinterested that he/she does not answer a question directly. Healing comes from within. Provided a safe and welcoming environment, aboriginal people are more than happy to teach and share their traditions and culture. Regarding how medicine is practice nowadays, there is no «us» versus «them» but rather this hope that one day we can bring together western medicine and traditional healing philosophies.

- Traditional health is a revelation to me. I knew it exists, but it seems so real, profound and deeply rooted in aboriginal culture. I wish I could incorporate some of it in my practice. I am so glad that I was exposed to it. I would like to do sweat lodge. There are many similarities between traditional healing and cognitive behavioural therapy. However, the spirituality has a more important role, and traditional healing is more holistic.

**March 3, 2011 (Native Friendship Centre)**

- Today’s session included a visit to the Native Friendship centre, where we met with their volunteers and coordinators. We were also shown a film “Forgotten Warriors – Indigenous war veterans of WWII”, showcasing the unresolved historical grief from colonization, which was magnified especially during the second world war where many aboriginal people volunteered to serve their country. It was emphasized that aboriginal people didn’t particularly fight for imperialism or territorial issues or some form of allegiance to the queen, however they felt obliged to fight for their country, feeling that they had ever more the right to do so than other citizens. Unfortunately we learned as to the many injustices they faced, either by having been recruited for suicide missions, or having their status as natives revoked upon returning home, and their land sold while they were gone as a result. It was especially moving to hear one of the veterans exclaim his shock, when thinking that he was going to receive some type of honour or recognition for his service abroad, only to receive a notice that he had “broken the law” and his status as an Indian was thereby lost. One veteran in the film recalled as to how his self esteem was drastically affected afterwards, and the only way to forget such pains would be to substance use. We also met with a traditional healer at the centre, who was kind enough to bring samples of the medicine utilized in his culture. He also indicated as to how the Indigenous population have become resilient in taking ownership of the intergenerational trauma by engaging in such self-healing practices, such as sweatlodges (where the belief was to sweat or physically purge out such
negativities in order to correct one’s inner self). It was also interesting to listen to volunteers and the activities they engage in with the aboriginal community in Montreal.

- Today’s session was interesting to me as it taught me new things about Aboriginal and Canadian history. I was unaware that so many Aboriginal soldiers went overseas and fought in World War 2. It was upsetting to hear about yet another injustice that was done to Aboriginal people in our history and how many of them were denied land and status upon return to Canada. This was one of the first issues that I did not know about prior to taking this course and further strengthens my understanding of the many mistreatments that were done and continue to be done to Aboriginal people and their effect on Aboriginal life and society today.

- Panindianism – in the city, nations and communities are sharing/borrowing culture from each other very efficiently, but there do remain differences between peoples, especially between the Inuit and the First Nations. Nevertheless, there seems to be some community spirit, probably centered around the common experience of colonization and racism. I’d like to come back to the center and visit again. The friendship center seems to hover between a drop-in center for aboriginal people on the streets of Montreal and a cultural center for the broader indigenous community.

- I found the discussion of native soldiers and veterans very interesting – a part of history I had never learned. I was surprised at the level of Canadian patriotism among natives, exemplified by one of the veterans in the film who said “this is my country, if anyone should go to war, it’s the Indians.” The concept of intergenerational trauma mentioned in previous session was discussed again. At the risk of over-simplification, it reminded me of my own family and community’s struggle to come to terms with the Holocaust. A large part of the “success” of Jewish people in dealing with that atrocity was through educating the community’s young generation as well as the general population about that history. Education is necessary to understand a community’s current state, and to prevent future occurrences of such discrimination. I think that the aboriginal community is in the process of doing that now.

- I was super fascinated by the traditional medicines that one of the Friendship center workers shared with us. It may seem like a trivial thing, but for me this was the highlight of the experience. I was also interested to learn that the medicinal value to native people comprises more than just the plant itself, and that somehow there is healing in seeking the plant in the wilderness, being thankful to Creator, and feeling one with nature ect. I would have like to ask, although I had not figured out how to ask it in a politically correct manner, if there are any ongoing clinical studies of any of these plants involving native community members. Although I am aware that this is a hotly controversial topic, this is being done in Mistissini and a Cree community nurse who is married to a Cree medicine man are heavily involved in the project which thus far has seemed to help community members with diabetes and the community at large.

- I think seeing Greg, who seems so academic in other discussions about the subject, experience such severe emotions speaking about his father and his upbringing was a very grounding experience. It really illustrated how much suffering has gone through the generations and how resilient someone like Greg and his family are in the face of adversity. Prior to this morning, I did not even consider that Aboriginal peoples fought in the world wars for Canada. As some people in the video intimated, my first thought would have been “why would you want to fight for a country that has done its best to ruin you at every turn?” However, as was illustrated in the film, the land takes precedence for many Aboriginal people. The whole situation - going off to fight, being put in the most dangerous places, coming back to have their land sold out from under them for other war veterans – is so revolting, and yet hardly surprising given the rest of Canada’s history of interactions with Aboriginal peoples. This proved to be yet another example of the Whites’ legacy of trauma inflicted upon those who were here before us. As Dr. Macaulay stated, “it just goes on, and on, and on.”
• Watching the movie and hearing Greg speak brought up a lot of the same feels and questions I had after meeting the Lofts. Issues aboriginal patients have/are dealing with. Another great organization to know about to help in treating aboriginal patients. It’s important to know about these organizations to help communicate with this underserved population; they provide a link to the community and help facilitate trust building.

• While watching the movie «Forgotten Warriors», I was most struck by the portrayal of the native men and women during the war and after returning home. While overseas, these individuals lived liked any other soldier: they experienced fear while in the cold and wet trenches, displayed courage and a fighting spirit on the fields, had families and loved one home praying for their safe return. However, once back in Canada, they were not treated like decorated heroes but instead lost their status and lost their land. As it was so well described in the movies, they had gone to fight fascist oppression in Europe only to return home to be themselves oppressed. This is an obvious example of institutional discrimination that has contributed to the perpetuation of the colonization spirit. In order to effectively help with the healing process, we must meet our patients half way, respecting their knowledge, beliefs and culture.

• Nice visit of the Native Friendship Centre of Montreal. The movie was excellent. Another example of the pervasive effect of colonization, political ignorance and neglect and technical control of aboriginal populations. Shame on the federal government. It is non-sense to me.

March 8, 2011 (Stéphane Dandeneau)

• Today Mr. Stéphane Dandeneau was gracious enough to speak with us on his experiences of being of Metis origin. He discussed the history of his people, the harsh discrimination inflicted upon them and the sense of identity crisis they initially experienced. Fortunately he emphasized the resilience of his population, as younger generations have taken the initiative to restore and propagate pride in their heritage. Coming from a mixed background of Korean, Japanese and Anglo-Canadian myself, I felt an understanding of the unique culture that Mr. Dandeneau was brought up in, where there wasn’t a strict delineation of the languages and customs but a melting pot of them. The video he then showed played a nice contrast on the growing resurgence in pride of the younger Metis generation, and the ramifications of the prejudice experienced by the old. A young reporter for APTN in the documentary who herself was of Metis origin was determined to have her grandmother admit her heritage, as we go through the process of self-discovery and healing for both the reporter and her grandmother. The session on Metis health was very interesting. What I found the most interesting was to learn a little bit more about what it means to be Metis. I felt like I was getting bogged down by the semantics of the word, but I found it confusing why some people who have not identified with their Metis roots for generations can be called Metis and get their Metis card, while others with mixed Indigenous roots can not. I understand the concept of why this is so and how the Metis are a distinct culture, however this still seemed slightly confusing to me. This further highlighted for me how complicated Aboriginal issues can be and how the current generation is left with the task of sorting out their roots and figuring out who they are and where they came from.

• The Franco-Metis seem to have dual culture identities: French-Canadian and also Metis. I understand much better the answer to “who is Metis?”: Being Metis seems to come with a constant searching and exploration of cultural identity. This is slightly familiar to me – I have 3 passports and multiple cultures. My cultures are however all European in origin, so it’s much less confusing. German, English and Quebecois culture are all closer together than Francophone, First Nations and Metis cultures appear to be.

• “Metis history” in high school consisted of not more than 4-5 points – Metis homeland map, intermarriage of francophone voyagers and native women with subsequent community development, the rise of Louis Riel and the concomitant crushing of the francophone people and the Metis. The
history told from a very French Canadian perspective – the francophone voyagers were understanding and valued the aboriginal people while the English were painted with a very black brush. It was eye opening to hear the Metis history from their own perspective, to see how distinct their culture is from their partial francophone roots, and to learn that their were also Metis populations all over Canada, including some Scottish ancestry communities in Labrador.

- Stéphane Dandeneau is such a good example of resilience. I think he tells a very clear story and really left us with a positive outlook for the future. It was a refreshing lecture. Also, having a lecture to address Métis health is important since there are many significant differences in this diverse group. I like how the Métis were considered in some ways mediators due to their cultural understanding of both parties. A friend once asked me “aren’t you mixed up, having two religions and two cultural heritages?” Honestly, I’ve never felt that way. If anything I think it is a wonderful advantage because it enables you to see things from different perspectives. Like Stéphane explained, it’s the marrying of two parts into a new unique identity of its own. I consider it a real advantage to have been brought up celebrating lighting menorah candles next to the Christmas tree and trying to figure out how to eat Easter hot-cross buns on Passover. The more I understand of each culture, the more I find similarities between the two. As I find similarities, I am also curious about other cultures and think this curiosity lets you remain flexible and open-minded.

- Today I learned about the Metis, about whom I knew almost nothing. I found it difficult to appreciate the distinction between métis, being of “mixed” heritage, and Metis. I also found myself having trouble appreciating the differences between Metis and French Canadians who try to keep the Voyageur culture alive. I think perhaps this is because the video that was shown during class seemed to emphasize the francophone aspect of Metis. Maybe if I had seen a video about people who still spoke a mixture of Cree-Ojibway language I would not have had as much trouble distinguishing groups. Regardless, I will now be aware of my own assumptions and try to put them aside when dealing with people who identify as Metis.

- Never knew anything on métis culture so it was interesting to learn about it and see the similarities and differences from first nations. Didn’t really learn much of métis health though however I do see how this is difficult given the lack of research in this area and the heterogeneity of this population.

- Discrimination and prejudice endured by Métis people was somewhat proportional to how much of their aboriginal heritage was displayed. Physical characteristics could not be as easily hidden as language or traditional activities and therefore was used by Non-natives, First nations and other Métis as a reason to further segregate individuals from the rest of society. The difficulty in establishing and accepting one’s own identity as an aboriginal person has been a central theme over the past weeks. The movie Mémère Métisse demonstrated this in a clear way. Because being Métis was at one point considered synonymous with «savage, ignorant and drunk», the Métis people, in order to protect themselves, had to reject their identity to succeed in a white world. For the Métis, reconnecting with their indigenousness proves to be a even bigger challenge given that their is such homogeneity in how they express their culture. In order to practice cultural safety, a good question to ask would be «where are you from?», keeping in mind that independent of common geographical location, there is not a single, standard aboriginal culture applicable to all indigenous people.

- The métis culture is very different. It seems that they faced many injustices and adversities, but they were perhaps more equipped to deal with it. They were subjected to less discrimination; they could more easily fit in the non-aboriginal world. These days, they represent a very good example of
resilience, their culture is flourishing, they advocate for themselves and they accept their origins. The
metis are somewhat similar to the nationalist French Quebecers.

March 10, 2011 (trip to Kahnawake, Kateri Memorial Hospital Centre and Kahnawake Schools
Diabetes Prevention Project

Today we went on the much anticipated trip to Kahnawake, where we were given a tour of the Kateri
Memorial Hospital Centre and Kahnawake Schools Diabetes Prevention Project. We were introduced
to the facilities and their staff, the history of the infrastructure, Dr. MaCaulay’s strong involvement
with the group, and the role of the hospital in the community. With the Kahnawake Schools Diabetes
Prevention Project, there was a strong emphasis on appealing to the younger generations to dispel the
notion that Diabetes was an inevitability within their families and communities, and to take an active
stance in combating such a disease, either by running, or engaging in traditional activities such as
hunting and fishing. We had discussed the positive effects of such interventions on the community, all
the while truly gaining a sense of pride from the Mohawk populations for their resilience in the face of
colonization.

I found the trip to Kahnawake quite inspiring. I have lived in Montreal for the majority of my life yet
had never seen the community or the Kateri hospital. I had created a vision in my head of a very
impoverished town and a hospital that was falling down, but I found their hospital nicer than many in
downtown Montreal. Not only was it nice to see that the community is doing better than I expected, I
also found it taught me a lesson in forming unfounded judgments. Clearly, the community is
continuing to prosper and has many events and programs in place. This was just another example for
me of how this course opened up my eyes to some of the realities of Aboriginal health in Montreal.

Well organized hospital!  Participatory research is a great idea. I could never quite get over the feeling
that anthropologists study cultures like insects in a bottle. All research is important, but I can
understand how communities would get irritated by outsiders coming in, observing things and then
going off to write who knows what about them. This is a perfect solution to this problem, that has all
courts of benefits: better research, locals getting involved in research and then higher education,
initiatives being homegrown and therefore better adapted to the environment and so on. It's disappointing
that health advocacy programs have not been more effective, but things are up, running and they have
a life of their own. This is the most important thing. Hopefully funding will continue to come through.

This was my first trip to Kahnawake. I was surprised at how close the community is to downtown, and
yet it is quite different from any other of the city’s suburbs. My first impression of the community was
unfortunately not a positive one – for all that we were on our way to the hospital and the diabetes
prevention center, the first thing I saw on the road to the town center was the cigarette stores.
Nonetheless, the hospital was nice, looked like any other community hospital and illustrated how
traditional and mainstream medicine can co-exist. The discussion about the diabetes prevention
program was humbling. As is the general rule with many public health initiatives, it takes years of hard
work to change entrenched behaviour. Yet public campaigns about the hazards of smoking have been
successful in improving behaviour in just a few generations, so the diabetes prevention program, and
my own future one-on-one discussions with my patients about healthy living, are unlikely to be lost
causes.

The first week of the course we read the paper Colonialism and State Dependency by Dr Alfred in the
Journal of Aboriginal Health, Nov 2009, which as a whole was one of my favorite readings for the
course. At the time I was more-a-less in agreement with the idea expressed in the article that:

“It is evident to anyone who has experience living
or working within First Nations communities that
conventional approaches to health promotion and
community development are not showing strong signs
However the diabetes health initiative has proved everyone wrong. Health promotion projects can and are effective IF they are carried out in a true partnership with the community. Rather than being dreamed up at academic or governmental institutions, and forced on the the people, this project has shown how medical personal can listen to the elders concerns and walk hand in hand with the community down the road to better health. What a empowering experience for both parties when this actually happens!

Compared to Chisasibi (the only First Nations community in which I have spent some time), I found the prevailing atmosphere in Kahnawake to be more uplifting. I am not sure if this is because we were only speaking to those people who were very actively involved in the well-being of the community or if it is because the community itself is different in some way. Perhaps because of the participatory research and the associated sense of empowerment has changed the framework of the community somehow. It would have been interesting to talk to other members of the community, not directly involved in KSDPP. I also think speaking with some of the children would have been very interesting to see what their opinions were on the issue of healthy food in schools.

The community felt like such an ideal practice setting. Though I’m not sure I could live in a smaller rural community (having been brought up in the city), I love the concept of what family medicine is in those settings – of being a real “omnipracticien”. Being able to do this in a community that seemed so proud and involved in bringing about change in their health would be inspiring.

Finally, being able to take part in this course was a true learning experience, from a thorough historical perspective of multigenerational trauma to understanding what cultural safety really is and from talking to traditional healers and elders to seeing the strength of resiliency. Aboriginal Health is such an important topic for anyone who is planning to practice in Canada and we learn so little about it in the curriculum (at least during my four years, as I know they have since changed some aspects of the program to try to incorporate more Aboriginal Health teaching). The visits (Native Women’s Shelter, the Native Friendship Center and Kahnawake) and meeting so many different lecturers, both in the medical profession (Dr. Kent Saylor and Dr. Kirmayer) and from the community (Residential School survivor Ruth Maloney Loft and her husband Micheal Loft, Terri Normandin, traditional healer Mike Standup and elder Sedalia Fazio, Micheal Doxtater, Stephane Dandeneau and others), really broadened the scope of the course – there is so much more learning when you leave the classroom and interact with other professionals and members of the community.

The visit to Kahnawake reminded me of my time up in Chisasibi simply because the hospitals are similar. Otherwise, Kahnawake is quite different. Although touring the hospital was instructive insofar as I was able to appreciate the specific efforts of the community to incorporate Mohawk traditions and culture into the hospital, I thought the time spent at the Diabetes centre was invaluable. It was nice to see how a community concretely tackles one of its major problems in a way that embraces Native culture. I will try to follow up on the progress of Kahnawake’s diabetes prevention project from BC and see how it would be possible to incorporate some of their ideas into other aspects of Aboriginal health.

Great way to end the course! I feel it was good example of the resilience Morgan emphasized at the end of many of our session; this community was taking charge of their own health by promoting community initiatives that emphasized their cultural traditions. It was also interesting to learn that they sharing their knowledge/experience with other communities to see how the program could be adapted for them. It was very interesting to learn about the traditional foods and to see that these foods were being reintegrated into the community and that the hospital was reintroducing/amalgamating
traditional and mainstream medicine. I was also very impressed by the capacity-building that was being encouraged in this community because of these health programs.

- There exist a will to revitalize aboriginal culture especially in the medical field. Transmission of knowledge of traditional medicine being a part of it, but also working to incorporate it in a concrete way into the future of the community, for example in the development plans of the extension of Kateri memorial hospital. The elders of the community wanting prevention strategies to specifically target the youth is suggestive of great hope and optimism in future generations. Encouraging bettering of health is only one of the ways to engage and empower community members. It is only with better self esteem and sense of self, that there can be healing.

- Great visit. The best part was certainly the diabetes prevention project. In my opinion, this is the “emblem” and “gold standard” of community medicine. It must be very rewarding to have such an impact on a whole community. Targeting the younger generation is key, not only because they are the future, but also because kids and teenager, believe it or not, have a tremendous influence on their parents. By targeting the children, we can hope that it will impact on older generations. This visit gave me great ideas that I wish I could implement in the community where I will work. Thank you very much for this elective