Primary Research

Educating Medical Students’ “Hearts and Minds”: A Humanities-Informed Cultural Immersion Program in Indigenous Experiential Community Learning

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ABSTRACT

Well-documented disparities in health status persist between Indigenous and non-Indigenous people in Canada. Medical schools have a responsibility to address underlying causes of these inequities, in part by developing future physicians’ cultural humility and their capacities in cultural safety by increasing critical anti-racism knowledge and understandings about First Nations, Inuit, and Métis Peoples. Undergraduate medical education relies heavily on, among other pedagogies, experiential learning. Moreover, a growing body of research is evidencing the value of applying humanities-informed approaches to medical education in order to produce “better doctors” (i.e., physicians who are more empathetic, compassionate, and attuned to wholistic orientations to patient wellness). The combined impact of these two approaches (experiential learning and humanities-informed pedagogies) on medical students’ development of cultural humility and capacities in cultural safety with Indigenous Peoples is unknown. This paper describes how the First Nations Community Education Program—an innovative humanities-informed Indigenous cultural immersion program—was developed and implemented as a collaborative project of the Northern Medical Program (itself the result of a partnership between the University of British Columbia’s Faculty of Medicine and the University of Northern British Columbia), the First Nations Health Authority, and Northern Health. The paper also documents impacts of the program and provides a resource for other medical education programs considering similar initiatives focused on cultural humility or the Truth and Reconciliation Commission’s Calls to Action.

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Introduction and Background

I want to bump against you and feel the rush of contact and ask important questions and offer compelling answers, so that together we might learn to live beneath the surface, where the current bears us forward deeper into the great ocean of shared experience.

Richard Wagamese, 2016, p. 83

This paper is authored by a multidisciplinary team of Indigenous and settler/non-Indigenous scholars and researchers. The project at the heart of this paper, the First Nations Community Education Program (FNCEP), unfolds in British Columbia, Canada, and is carried out through an ongoing partnership between the First Nations Health Authority (FNHA), the Northern Health Authority (NH), and the Northern Medical Program (itself a collaboration of the University of British Columbia [UBC] and the University of Northern British Columbia). Recognizing the paramount importance of this partnership leads us to three important and introductory observations. First, many of us are deeply anchored in urgent conversations about the violence of white supremacy and anti-Indigenous racism in the health care system (see for instance Aldred et al., 2020; Greenwood et al., 2018a). We take seriously, relatedly and secondly, the risks of re-entrenching non-Indigenous settler (especially white) “innocence”

through now well-established problematics of assuming that, rather than addressing colonial oppression enacted by settlers, settlers can instead go gaze upon Indigenous Peoples¹ and communities and naïvely learn to appreciate Indigenous ways of knowing and being without accompanying critical anti-racist learning (Razack, 1998). With this squarely in mind, however, it must (thirdly) be noted that the FNCEP arose as a direct response to an Indigenous-headed health authority (FNHA) requesting that more medical trainees come into communities. The project was envisioned as a means of Indigenous communities unsettling deficit stereotypes too often held by non-Indigenous peoples in Canada about Indigenous Peoples, families, and communities. The project was also envisioned as a way of potentially recruiting physicians into Indigenous communities. Finally, those with the FNHA who dreamed the project into being believed that hosting medical students in communities had the potential to transform hearts and minds of future physicians, which would go a long way to address the systemic racism faced by First Nations people in northern, rural, and remote geographies. All involved in the partnership behind the project entered the work with the hope of addressing some of the vast and persistent disparities in health status and outcomes between Indigenous and non-Indigenous people in Canada (Greenwood, 2019; Greenwood et al., 2018a, 2018b; Greenwood & de Leeuw, 2012).

Compared with non-Indigenous Canadians, First Nations, Inuit, and Métis Peoples and communities bear disproportionate burdens of chronic illness (Crowshoe et al., 2018; Gracey & King, 2009; Halseth, 2019) and infectious diseases (Clark et al., 2002; Gallant et al., 2017; Inuit Tapiriit Kanatami, 2013; Odulaja & Halseth, 2018). Some Indigenous communities also experience higher rates of mental illness (e.g., trauma-related disorders) and indicators of mental illness (e.g., suicide-related behaviours) than non-Indigenous populations (Atkinson, 2017; Nelson & Wilson, 2017; Tourand et al., 2016). In British Columbia's rural areas, Indigenous people represent 30.3% of the population (Statistics Canada, 2016), thus underscoring the critical need for medical practice in these remote (mostly northern) geographies to be supported with training opportunities in Indigenous cultural capacity so that health service provision can be culturally appropriate and culturally safe.

A persistent failure to recognize or understand Indigenous Peoples' lived realities and the unique determinants of Indigenous health have produced health care systems and clinical settings that First Nations, Inuit, and Métis broadly perceive and experience as unresponsive, discriminatory, unsafe, and racist (Allan & Smylie, 2015; Turpel-Lafond, 2020). Social determinants of health frameworks are well-established ways to understand health inequities, including the realization that anti-Indigenous bias by health care professionals and in health care environments can impede Indigenous Peoples' health outcomes (Allan & Smylie, 2015; Greenwood & de Leeuw, 2012; Marmot, 2015). These perceptions and experiences exacerbate

¹ The term "Indigenous" is used throughout to refer to the original inhabitants of Canada and their descendants, including First Nations, Inuit, and Métis Peoples as defined by Section 35 of the Canadian Constitution of 1982. Wherever possible, this paper cites specific Indigenous groups.

disparities, including poor health outcomes (e.g., Goodman et al., 2017; National Collaborating Centre for Indigenous Health, 2011).

Following the Truth and Reconciliation Commission's (TRC) Calls to Action (2015)—and specifically those (18–24) focused on health—came increased public awareness about the divide in health status between Indigenous and non-Indigenous people in Canada. In response, action in health care contexts has begun to change at structural, systemic, and service delivery levels (Greenwood, 2019). For example, faculties of medicine have mobilized resources to develop Indigenous-focused health curricula that respond to Call 23 (all levels of government must increase the number of Indigenous professionals working in health care, ensure retention of Indigenous health care providers, and provide cultural competency training for all health care professionals) and Call 24 (medical and nursing schools must require all trainees to complete a course in Indigenous health issues, including skills training in intercultural competency and anti-Indigenous racism training) (TRC, 2015). Leading up to and after the TRC, curriculum interventions supporting the development of knowledge, skills, and capacities in relation to Indigenous Peoples' health increased across Canada (Jacklin et al., 2014; Robinson et al., 2017). Since 2012, for example, family medicine residents have been undergoing mandatory training in Indigenous health (Robinson et al., 2017; Tannenbaum et al., 2013). Other policy documents reaffirm commitments to increase curriculum related to Indigenous Peoples' health and to actively support the well-being of Indigenous patients, families, and communities. These documents include the *Indigenous Health Values and Principles Statement* (Royal College of Physicians and Surgeons of Canada [RCPSC], 2013) and the Indigenous Physicians Association of Canada (IPAC) and RCPSC's curriculum framework (IPAC-RCPSC, 2009).

Theoretical Framings: Experiential Learning, Critical Self-Reflectivity, and Humanities-Informed Ways of Teaching and Learning

While approaches to medical education in Canada vary, three interlocking modes have the direct potential to transform medical students' understandings of Indigenous Peoples and themselves by fostering greater cultural humility and safety. These modes are experiential learning, critical self-reflectivity, and humanities-informed ways of teaching and learning.

Experiential learning (EL) is a multi-step “process whereby people individually and ... with others, engage in direct encounter and then purposefully reflect upon, validate, transform, give personal meaning to and seek to integrate their different ways of knowing” (McGill & Weil, 1989, as cited in Maudsley & Strivens, 2000, p. 538). In EL, learning is socio-culturally constructed; in this learning model, learners are appointed to, for example, internships (Adams, 2018). Experiences and observations are followed by reflection, conceptualization, and experimentation, all of which can lead to transformative learning (Adams, 2018; Gibbs, 1988, as cited in Stanton & Grant, 1999; Kolb, 1984, as cited in Maudsley & Strivens, 2000). Cultural immersion is emerging across Canada as an effective, evidence-based means to promote development in medical or allied health care trainees. Cultural immersion is based on the principle that engaging with another individual's or collective's cultures and practices facilitates

learning about oneself and the host community (Carpenter et al., 2011, as cited in Smith et al., 2015; Crampton et al., 2003). In Canada, medical schools now integrate Indigenous cultural immersion placements into the undergraduate curriculum (Jacklin et al., 2014; Jong, 2011), which has increased trainees' capacities for improving Indigenous cultural safety, cultural awareness, and sensitivity (Thackrah et al., 2017). In a qualitative synthesis of nine peer-reviewed articles on health profession students' cultural immersion experiences, researchers found evidence of learner growth across cognitive, affective, and perceptual (i.e., increased awareness of poverty, discrimination, inequity, etc.) domains (Brock et al., 2019).

Critical self-reflectivity is a less quantifiable outcome of community placements and cultural immersion through which learners can: strengthen and reaffirm their commitments to optimizing Indigenous Peoples' health; destabilize normative roles and activities that place learners in the role of "expert"; and externalize their ideas and experiences in order to critically appraise them. Reflective processes can take a variety of forms, including creative ones (e.g., drawing, journaling, free-writing). This can feel burdensome to some health learners but, in total, participants in this project did not spend more than 15 hours on reflective practices. Through these practices, learners critically assess biases and privilege, grapple with uncertainty, and work through impactful events (e.g., Shannonhouse et al., 2015). Combining reflective practice with cultural immersion might thus be understood as creating spaces of productive self-challenge. As health care learners are removed from familiar routinized places and expectations for professional medical performativity, they are being prompted to question unknown or unacknowledged biases and privileges. While combining self-reflection with cultural immersion is not well-established in the medical education literature, reflective practices more broadly are a reasonably well-established component of medical and health education (Hall et al., 2012).

Reflective practices interface with the third approach to medical education: humanities-informed pedagogies, or "health humanities" (Crawford et al., 2010). Medical-health sciences research, education, and practice have long histories of engaging arts and humanities (Bleakley, 2015; de Leeuw et al., 2014; de Leeuw et al., 2017; Kidd & Connor, 2008; Kumagai, 2017; Kumagai & Wear, 2014; Mangione et al., 2018); these involve creative (e.g., storytelling), artistic (e.g., drama, film), and self-reflective (e.g., journaling) practices to broaden health learners' emotional landscapes and worldview (de Leeuw et al., 2014). Health humanities are increasingly represented in the undergraduate medical curriculum as a means of improving patient care by enhancing future physicians' observational and communication skills, critical self-reflection, empathy, and related clinical skills (Bleakley & Marshall, 2013; Kumagai, 2017). They represent another "way of knowing" in the medical curriculum, offering much to inform activities that are at the heart of clinical practice: working collaboratively; listening and hearing; understanding patients' deeper concerns; and democratizing the culture of medicine and the clinical encounter (Chiavaroli, 2017). Another important function of health humanities is their ability to disrupt assumptions, beliefs, biases, and attitudes: health humanities nudge learners to experience other ways of knowing, living, and learning—and compel learners to critically reflect on their new encounters (Kumagai, 2017; Kumagai & Wear, 2014). While it would be a

disservice to lump the vital importance of Elders' knowledge into the relatively limited purview of "humanities learnings," some programs at UBC have seen great success from having an Elder on staff, particularly when and because Elders often teach and guide through storywork.

Although health humanities-informed methods are well-established and acclaimed, and while many trainees express positive orientations to learning through and with them, some critics question their overall relevance (Bleakley, 2015; Chiavaroli, 2017; Kidd & Connor, 2008). Furthermore, while there is much anecdotal evidence about the importance of health humanities in educating future physicians, there is almost no literature examining the efficacy of *combining* experiential cultural immersion activities, critical self-reflection practices, and humanities-informed learning opportunities for medical students. Moreover, no studies to date have examined the efficacy of combining these methods with a specific aim of increasing Indigenous cultural capacities in medical or allied health care trainees. This research begins to fill that gap, which we argue is especially important given the globally increased demand to develop novel pedagogical modes for health learners that emphasize the cruciality of cultural humility and safety, particularly with regard to Indigenous Peoples and communities. In this study, we explored whether and how medical students' perspectives, orientations, knowledge, and attitudes toward rural, remote, and northern First Nations people and communities were impacted or changed as a function of participation in an experiential, humanities-informed Indigenous cultural immersion program. Students were specifically immersed in First Nations (reserve) communities, so our analysis is limited to transformations in understandings about First Nations. There is likely applicability to Indigenous Peoples more broadly, but that requires further study. Based on thematic analysis of learners' self-reflections, this study evaluated the outcomes of the First Nations Community Education Program, an innovative and unique initiative of the University of British Columbia's (UBC) MD undergraduate program.

Methodology

The highest point of knowing is not knowing. Herein lies the paradox of learning from experience.

Brew, 1993, as cited in Maudsley & Strivens, 2000, p. 538

Program Description

In 2013, the University of Northern British Columbia's Northern Medical Program (NMP; delivered in partnership with UBC's Faculty of Medicine), the FNHA (Northern Region), and the Northern Health collaboratively developed a pilot project offering a unique opportunity for early undergraduate medical students in the NMP to visit northern (Canadian), rural, and remote First Nations communities. The project was piloted in 2012 and 2014 (five students participated), and an official inaugural cohort participated in the FNCEP in 2015. Yearly program implementation has occurred thereafter. To date, 48 students have enrolled through yearly cohorts. The number of students placed is based on program demand and host community availability.

The broad objectives of the FNCEP are to:

- enhance the understandings of future medical professionals about health and wellness in northern First Nations communities;
- encourage bilateral learnings between medical-health learners and northern First Nations communities;
- build competencies in health by grounding medical students in safer and more sensitized and empathetic understandings about northern First Nations people and communities;
- increase social accountability and responsibility of future medical professionals toward northern First Nations communities; and
- lay the groundwork for students to consider working in First Nations communities in their future practice.

The specific goals of the FNCEP are to:

- foster opportunities for medical students to learn in a deep, experiential, and place-based way about northern First Nations people and communities;
- provide opportunities for medical students to understand northern and rural First Nations people and communities from a strengths-based perspective; and
- enhance medical students' social accountability and responsibility competencies, including cultural sensitivities and capacities toward northern First Nations people and communities.

Students arrive, in pairs or small groups, in northern First Nation host communities that have volunteered to participate through agreements with the FNHA. Well-established, direct relationships between the FNHA and First Nations communities facilitate FNHA health directors' travel to, and in-person conversations with, northern, rural, and remote First Nations communities to negotiate the timing, frequency, and duration of students' visits. Based on the strength of established relationships, some First Nations communities have provided an "open invitation" to host medical students in the context of the program. Students spend two to four nights with a host family, mainly participating with host families and communities in spontaneous activities that are not related to medicine and health (e.g., visiting hosts' friends and family; attending community events). The intention of this unstructured experience is to disrupt any context allowing a predisposition toward "expert status" vis-à-vis First Nations communities, instead offering a more equalized opportunity for relationship-building through empathetic, engaged interactions. Students are specifically asked not to prepare for their visits, and they are particularly discouraged from developing strategies to help or teach community members. To ensure they are primed to meaningfully and effectively engage with host communities, learners are advised on the FNCEP objectives and course requirements, including submissions of arts-based critical reflections, before their departure.

The FNCEP is publicized through the Flexible Enhanced Learning (FLEX) course, which was introduced as part of UBC's Faculty of Medicine's renewed undergraduate curriculum. In FLEX, during Years 1, 2, and 4, students complete a series of opportunities involving different

scholarly activities in self-selected areas of interest in academic or community settings. All medical students in UBC's Faculty of Medicine complete a mandatory Indigenous cultural safety course (UBC 23 24 Indigenous Cultural Safety). Undergraduate medical students from all distributed sites of the UBC Faculty of Medicine are eligible to participate in the FNCEP.

Between 2015 and 2019 (inclusive), 48 students undertook Indigenous cultural immersion placements across 12 northern, rural, and remote First Nations communities. Year-over-year enrollment in the program increased as follows: 6, 8, 12, 10, and 12 students completed the program in 2015, 2016, 2017, 2018, and 2019, respectively. Partnering communities included Takla Lake (Takla Lake First Nation), Hagwilget Village (Hagwilget First Nation), Moberley Lake (West Moberly First Nation), Burns Lake (Carrier Sekani First Nations), New Aiyansh (Nisga'a First Nations), Old Masset (Haida First Nation), Kispiox Valley (Gitksan First Nations), Hartley Bay (Gitga'at First Nation), Lower Post (Kaska First Nation), Moricetown (Wet'suwet'en First Nations), Fort St. John (Treaty 8 Territory First Nations), and Terrace and Kitimat (including Kitsumkalum, Kitselas, and Haisla First Nations). Each student provided arts-based, narrative reflections at pre-, mid- ("in situ"), and post-program, for a total of 148 data points inclusive of text- and arts-based reflections. Time for this project was opened through a block away from standard academic curriculum.

Methods

Data comprising FNCEP students' arts-based, humanities-informed critical reflections were collected with multi-institutional ethics board approval (i.e., harmonized review by University of Northern British Columbia, UBC, and Northern Health research ethics boards [REBs]) based on secured community partnership agreements anchored in research sharing and ownership arrangements. Community feedback/expectations consistently guided updates to study processes, which were incorporated into amended study protocols and reviewed annually by the REBs noted above. Students were guided in undertaking a three-part reflective process (detailed below). Their reflections informed program assessment, impacts of cultural immersion, and quality improvement. Moreover, they were used to analyze the efficacy of reflective practice. Students could choose the format of their arts-based reflections (e.g., writing prose or poetry; making videos; painting). Data thus consisted of a variety of multimedia formats.

Reflective Process

Prior to their departure to the host communities, students completed a short orientation about learning with and within northern First Nations communities, with instructions for reflecting on the questions: "What comes to my mind when I think of First Nations communities (the people who live there, what it might feel like to live there, what it looks like in my imagination, where I think it is, what the health status is there, etc.), and how am I feeling about visiting a community next week?" During their community placements, students were instructed to undertake at least one reflective activity (e.g., photography, drawing, creative writing) that addressed the broad question: "What am I feeling now that I am here?" A week after their community visits, students were tasked with completing a final critical self-reflection in which

they broadly considered the questions: “How has my perception about First Nations communities changed through this program, and what have I learned that I envision taking with me throughout my career as a medical professional?”

Data Analysis

Two of the authors (SDL and RL) entered into deep, iterative engagement with the data, looking for emerging concepts and themes that they refined over multiple rereadings. Analysis unfolded along an “unscripted” approach (described elsewhere: see de Leeuw et al., 2017). One of the goals was to arrive at an understanding of learners’ preconceptions, imaginings, and orientations toward First Nations communities and people, as well as learners’ in situ observations. Another was to determine whether positive shifts in orientation and cultural capacities had developed toward Indigenous Peoples and communities as a function of program participation.

Findings and Discussion

When assessing and analyzing learners’ experiences of the FNCEP, including its perceived impacts from pre- to post-program, three major findings or themes emerged from the data. First, the majority of learners’ reflections revealed transformative learning *had* occurred; their previously held perspectives about northern First Nations had been overturned, resulting in more positive orientations and increased cultural sensitivities to First Nations communities. Second, and conversely, some pre-existing stereotypes were confirmed or even reinforced during and following the program. Third, regardless of whether attitudes had shifted, all learners demonstrated serious, meaningful, and committed engagement with the formal assignments through their production of critical reflections (see Appendices).

Analyses revealed that individual learners’ reflections generally unfolded along a “typical” pathway from pre- to post-program by (a) showing expressions of naïveté prior to arrival in First Nations communities; (b) demonstrating transformative learnings emerging from experiences; and (c) articulating ways in which prior attitudes, perspectives, and orientations had undergone transformative shifts as a function of program participation. For instance, many learners’ pre-immersion reflections demonstrated their significant lack of familiarity with Indigenous communities, realities, and cultures. One participant wrote:

First, I must acknowledge that I have so much to learn, so little experience, and cannot even possibly begin to understand the extent of what colonial influence has done to devastate First Nations people. ... I just need to start from square one.

Another participant admitted, “I do find myself feeling a bit self-conscious going into a First Nations community though ... due to my lack of knowledge or experience with First Nations community and culture,” while another confessed to “going in with a lot of biases and preconceived notions about what this trip [may be] like.” Other learners were forthright about their inexperience causing them to feel afraid. One remarked:

My outsider status embodies my feelings about visiting a First Nations community next week. ... I am fearful that I will not be accepted or that I will do something culturally unacceptable or shameful due to my preconceived ideas or lack of knowledge.

Another noted:

Although I cannot picture the people or housing or events that are part of the community I am travelling to, I do have a pre-conceived image of the community based solely on its rural location. ... I imagine that it will be difficult to access certain products [and services] whether they are for health or not.

These student reflections confirm that, despite the existence of opportunities for medical students to be educated about Indigenous Peoples, health, and communities, there remains for many future physicians considerable fear about northern First Nations in British Columbia, stemming from the unknown.

The learners' in situ reflections demonstrated that they were gaining new awareness of the cultural and geographic diversities across First Nations communities through experiential, relationship-based learning from Indigenous community knowledge holders. Many learners felt their interest in engaging in further career-informing culturally immersive experiences being piqued. One student noted:

[I see now] how different each First Nation is, which is something I didn't really appreciate before. We always just talk about Aboriginal people as a whole and not necessarily the differences in the various nations or bands or areas. So I think it was a good reminder of how diverse the population is and will remind me not to assume things based on limited experiences.

Another student reported they had “learned a lot about the community and that’s been great—there are a lot of really amazing things happening here with education and programming. This is something that really surprised me.”

A student expressed how the community learning and being in place generated critical self-reflectivity:

Going into this immersion program ... I expected long distances from community to the next bigger town ... what I did not expect was to be uncomfortable. ... [A] conversation with my host in community was my first chance to critically reflect on my feelings and biases [about religion], and ultimately challenge them.

Another student reflected on desires to link the experiential learning to future clinical practice, making such observations as,

This project has sparked a greater interest in me to learn about First Nations people and culture, to hear more stories, and try to understand how I can help First Nations people

as a doctor. ... I believe this experience will relate to my medical practice as it has helped deepen my cultural humility. ... Through this experience I was also able to reflect upon the way that I view First Nations people and culture, and understand why I have certain views, as well as address unhelpful biases.

A different learner expressed surprise about the feelings they experienced in First Nations communities, suggesting that, prior to being in situ, they felt apprehension and fear about First Nations:

I have been surprised by how welcome I have felt. ... I think that part of my surprise at being welcomed so openly comes from my knowledge of residential schools and colonial history ... I think it is important to ... welcome conversations about colonization and how it has affected this person, this community, this culture.

This surprise extended to understandings about overall access to health in northern First Nations:

I have learned and gain[ed] such an appreciation for [community members]. ... as far as the health care is concerned we have had the privilege of learning a bit of how the system is set up. ... I have been very surprised by how many [community members] have to go elsewhere to seek better medical care ... it has been an eye opening experience.

The majority of students' in situ reflections were anchored in feelings of destabilization and transformation. These were generated by living in First Nations communities. The challenges to their preconceived notions about First Nations people and the resulting metamorphoses underscore how much future medical professionals have to learn about Indigenous Peoples and communities. One student perfectly captured this sentiment:

When I got into medical school, and we had a few lectures and modules on Indigenous cultural awareness and competence, I was always uncomfortable when presenters would introduce themselves using their cultural identity as a "settler." I now recognize that my view was biased and culturally unaware ... I now can see that ... my worldview is very self-centered. My understanding is beginning to change ... I believe this experience will relate to my medical practice as it has helped deepen my cultural humility. I am learning to step out of my own self-centered worldview and listen to the stories of the people around me.

After they returned from community placements, students documented that they valued their experiences and unique learning opportunities, which they observed had facilitated transformations in orientations toward First Nations people and communities. Learners' critical, arts-based narratives demonstrated that their cultural capacities, social accountabilities, perspective taking and empathy, and understandings of health determinants for northern, rural,

and remote Indigenous Peoples and communities had been enhanced (see Appendix B). These outcomes align with program objectives. One learner noted:

My time in [community] opened my eyes to the complexity of providing health care to individuals living in remote First Nations communities in northern BC. I am so much more aware of the way in which historical and current politics influence the local landscape. If we want to help support the health of communities, we need to listen very closely to what it is that communities need.

Another student observed: “So can I say that my perception of First Nations communities changed over this program? Yes, they have taken a large step in my mind to positivity.” Another learner explained:

Spending time in the community really hammered home just what kind of an injustice has happened, and continues to happen, to so many [I]ndigenous communities. The enormity of that injustice is overwhelming, and I feel the draw to throw myself against it in what little ways I could. In that way, I could see how rewarding it would be to work directly in Indigenous health.

Another student also reflected on how they had been challenged and transformed:

Following my visit to a First Nations community, I feel as though my perspective on First Nations life and culture has changed in some notable ways. My mental image of a “typical” First Nations community is more dynamic ... gaining a true understanding of the culture, mindset, and lifestyle of First Nations people is an ongoing process and will require many visits and the building of many relationships. ... I have come to appreciate the wholistic approach that many First Nations people take towards health and medicine, especially with regards to mental and public health.

Given the program was expressly geared at overturning biases anchored in the unknown and addressing misunderstandings about Indigenous communities, it was notable that another student observed:

I feel that the most important piece of knowledge I left with is that it is hard ... to overcome the stigmatization and racism that [Indigenous Peoples] are faced with. It is hard to live in communities that have been attacked physically and emotionally by other cultures for generations. It is hard to live far away from resources that could make lives healthier and happier. ... but [Indigenous Peoples] are resilient.

This sentiment was mirrored by a number of participants’ observations. For example:

After visiting this community, I now have a much different image of what a First Nations community looks like. ... I experienced a rich and resilient culture that was deeply rooted

in history and territory ... it was a privilege to experience it in this way ... we were invited to share their experiences and traditions, so I experienced the meaning of every activity for myself. It was totally moving and personally transformative to be a part of it.

With these documented transformations in mind, some reflections revealed that, contrary to the goals and objectives of the program, some participants' preconceived ideas regarding First Nations communities, cultures, and realities did not change or were even reinforced. For example, one student noted, "Many of the stereotypes I had heard about beforehand have unfortunately been confirmed so far." Another learner wrote, "So far, the stereotypes I was trying to shed light on and transform, have more so been strengthened and confirmed." Additionally, some students remained neutral in their reflections. One noted, "I am trying to determine if my perceptions about [F]irst [N]ations communities [in general] has changed. Overall, no. But my ideas of [host community] ha[ve] been developed. Everyone, everywhere are different people, with their own versions of normal life." One student's observation emblemizes other students' expressions of either their neutrality about their experience or their awareness that their biases had not shifted:

I [participated] because I wanted exposure to [I]ndigenous life on reserves. I knew the stereotypes and I was hoping that this community would break those. I can't say that it did entirely. But I think I saw how they came to be and the importance of looking pas[t] the stereotype to the individual.

All results of the FNCEP are provided back to Northern Health and the First Nations Health Authority (Northern Region), who co-own all results. Students also presented at the FNHA-organized Northern First Nations Health Gala, where they shared experiences of the program with community members, Chiefs, leaders, and FNHA executive and staff.

Conclusions and Moving Forward

Ongoing concerted efforts toward reconciliation and closing health gaps between Indigenous and non-Indigenous people will require physicians and allied health professionals who are ready, willing, and equipped to enter into collaborative, respectful, trusting, and responsive practice and relationships with Indigenous Peoples and communities (e.g., Greenwood et al., 2018a; Richardson & Murphy, 2018). Having an understanding of the determinants of Indigenous Peoples' health, of bias awareness, and of the necessity of lifelong learning is essential to these endeavours. But understanding does not need to come through didactic or abstracted educational and learning means. Future health care providers and professionals must understand reconciliation with their hearts and their minds. Experiential and immersive education, alongside humanities-informed critical self-reflection, might be a pedagogically innovative way to successfully transform learners of today for clinical practices of tomorrow. In addition to these approaches, more upstream strategies directly addressing systemic

racism in health care, including making Indigenous cultural competencies requisite in medical school admissions processes, may be a future avenue for consideration.

This paper documented the efficacy of the FNCEP in building cultural safety and increasing socio-cultural fluencies about rural and northern First Nations peoples and communities. Our findings suggest experiential, humanities-informed Indigenous cultural immersion is an effective, learner-centred, embodied pedagogical approach that is in dialogue with the literature on experiential learning (e.g., Maudsley & Strivens, 2000). Although our findings were mixed—reinforced stereotypes and transformative learning were revealed alongside each other—the program had clear impacts on students’ learning and professional development. Insights into future physicians’ imaginaries were also revealed.

Somewhat surprisingly, some students’ pre-departure reflections revealed uncertainties about what they might encounter in First Nations communities despite having completed in-depth, self-directed Indigenous cultural safety training. This was sometimes the case even for students who experienced positive transformations and shifts. This suggests that medical students may not be entering clerkship years adequately trained in Indigenous cultural capacities. Robust evidence suggests experiential learning, with opportunity for critical self-reflection, can help health care professionals overcome cultural naïveté and build CanMEDS competencies¹, including those associated with social accountability and responsibility in health care professionals (Dharamsi et al., 2010).

We recognize that more work is required to fully understand the potentials of immersed experiential and humanities-informed reflective learning. For example, further research is required to understand the ways in which these types of educational experiences impact future physicians’ practice, including but not limited to decisions to specialize in Indigenous health. Still, there are some early lessons that might be applied to other institutions and programs considering how to transform future medical professionals. First, it is imperative to work in relationship and partnership with Indigenous communities, organizations, families, and leaders. This takes time and resourcing, neither of which should ever be less than generous. We need authentic, trust-based relationships, anchored in hearts and minds, in order to change the world of tomorrow. The First Nations Community Education Program is a tiny step. We know there is much work to be done. All great journeys, however, start with such small steps. With small steps, we are hopefully moving toward health care systems that honour, value, and celebrate Indigenous Peoples, communities, and ways of knowing and being.

¹ CanMEDS is a framework for improving patient care by enhancing physician training. Developed by the Royal College of Physicians and Surgeons of Canada (the broadest oversight body of physicians in Canada) in the 1990s, its main purpose is to define the necessary competencies for all areas of medical practice and provide a comprehensive foundation for medical education and practice in Canada. See <https://www.royalcollege.ca/rcsite/canmeds/about-canmeds-e>

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Appendix A

Sample Pre-Program Reflection

In this picture (and arrangement!) I was trying to capture my hopes/feelings about going on this trip. [I] believe that to be a good doctor, I must also understand—or at least try my best to understand—the context of other people’s lives. I need to understand why a treatment might not be in line with someone’s beliefs ... that someone uncompliant to their medication could be saving their money to feed children at home.

Appendix B

Sample Mid- and Post-Program Reflections

This reflection is a documentation of our journey. The experience of an incredible culture, wonderful tradition, food from the land. ... [Our host] helped us carve our own “yelliss sticks” for eating soap berry ice cream.

[My experiences were] certainly not what I expected when coming to a First Nations reserve ... but why did I think this? Is it wrong or is this ... [an] atypical lifestyle on a First Nations reserve? ... It may not be representative of many other First Nations reserves but it certainly helped to abolish any pre-existing stereotypes I may have had.