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Introduction:

Population health studies report that Aboriginal peoples (a term which includes Canada's First Nations, Inuit and Metis peoples) continue to have poorer health and shorter life expectancies when compared to the Canadian population as a whole[1][2]. New research has indicated that Aboriginal peoples are also less likely to seek medical attention from urban health care services due to feeling "judged, ignored, stereotyped, racialized and minimized"[3].

Across Canada, efforts are being made to improve health care delivery and address the health inequities of Aboriginal peoples. These efforts are meant to create health care environments "free of racism and stereotypes, where Aboriginal people are treated with empathy, dignity and respect"[4]. For instance, urban health centres in numerous provinces have created "Aboriginal patient navigators" to help reconcile relationships between Aboriginal patients and western health care providers[5]. In British Columbia, the Provincial Health Services Authority launched an online module called the "Indigenous Cultural Competency Training Program", which is the first province-wide mandatory cultural training program for health authorities. The importance of such initiatives is highlighted in a recent report by the Truth and Reconciliation Commission report about the experiences of Aboriginal students in residential schools[6]. The report specifically calls upon health care institutions to train their providers in cultural safety and to teach them about how the traumatic residential school experiences have engendered significant personal and social costs for the survivors.

Since 1972, over 2000 students from Southern Ontario participated in electives in Northwestern Ontario through the Northwestern Ontario Medical Programme[7]. Trainees continue to travel to Canadian rural areas for a "Third World" experience but may not have

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prior knowledge about the social and cultural circumstances of the communities. Frequently, communities accommodating trainees have significant populations of Aboriginal peoples.

In keeping with the World Health Organisation's report on "social accountability", medical schools are encouraged to focus educational and research initiatives on the specific health needs of the communities they serve[8]. Physicians, residents or medical students travelling to Northern communities, whether for a short or long period of time, owe a duty to the community which encompasses pre-requisite education. Similarly, the Indigenous Physicians Association of Canada (IPAC) and the Royal College of Physicians and Surgeons of Canada (RCPSC) have recognised that education is essential to improving care to Canada's Aboriginal peoples, both in Northern communities and in urban environments. In 2009, the IPAC-RCPSC Advisory Committee developed a core training module to help residents and physicians understand the "social, political, linguistic, economic and spiritual realm" of First Nation, Inuit and Metis patients[9]. Despite these initiatives, no nationwide mandate currently exists requiring health care providers or medical trainees to complete education on cultural competency.

This research was aimed at exploring the northern perspective towards trainees traveling to these regions without adequate education. The objectives of the study were to learn from the inhabitants of a rural Canadian community, including the Aboriginal population, what medical students and residents need to know/learn/experience to be adequately educated to travel there as part of their medical training and/or subsequent practice.

Methods:

Setting:

Our research was conducted in Kenora, a town of 15 348 people in Northwestern Ontario near the Manitoba border. There is a large Aboriginal population, with 2365 (15.4%)

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inhabitants reporting "Aboriginal identity", (defined as either Metis, Inuit, North American Indian Status or Non-Status First Nation) making it the largest concentration of Aboriginal inhabitants of all Ontario towns[10]. Kenora is surrounded by 13 Aboriginal reservations including Rat Portage, Shoal Lake, and Ochiichagwe'Babigo'Ining Ojibway Nation. Medical students and residents have been traveling to Kenora through the Northwestern Ontario Medical Program (NOMP), since 1972. This program was a collaborative effort between Thunder Bay and McMaster University to recruit and maintain doctors in Northwestern rural and remote communities[11]. The longstanding history of trainees coming from Southern Ontario and the significant Aboriginal population made Kenora an ideal location for our research.

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Study Design and Sampling:

Historically, research conducted within Aboriginal communities often did not directly involve their input or reflect their values or beliefs[12]. Results from projects conducted in these areas, in turn, may not have benefitted the people, causing Aboriginal peoples to view research within their communities with apprehension[13][14]. To ensure our research was collaborative with the Kenora community, a research agreement was drafted between a local Aboriginal Health Care Access Centre (Waasegiizhig Nanaandawe'iyewigamig, or WNHAC) and the primary research team (see Appendix 1). The document specified commitments regarding "collective community participation and decision making, sharing of benefits and review"[15]. These concepts are in keeping with the primary principles of research with Aboriginal communities including mutual responsibilities in project design, data collection and management all the way to ownership, access and possession of data. Ethics approval was obtained from the University of Toronto Research Ethics Board.

With the help of the core collaborator group and WNHAC, a preliminary purposive sample was created for initial interviews. Eligible participants included, but were not limited

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to, health care workers and community members who had previously interacted with medical students or residents from Southern Ontario medical schools including the University of Toronto. Interviews were set up to allow preliminary analysis of results, to allow interative adjustment to the interview script and study sample. Subsequent interviewees were chosen both through purposive sampling and through snowball sampling ("sampling participants found by asking current participants in a study to recommend others whose experiences would be relevant to the study")[16].

Data Collection and Analysis:

Interviews were conducted semi-structured by the primary investigator. An interview guide was created in collaboration with the primary research team and members of a core collaborator group, including representative from WNHAC (see Appendix 2). Interviews were recorded and anonomysed onto a digital recording device, then later transcribed verbatim by the primary investigator. Constant concurrent comparative analysis allowed theoretic coding of the data within a critical constructivist framework based on decolonizing Indigenous research methodology[17]. Themes were refined through discussion among the authors who represented Indigenous and non-Indigenous critical perspectives as well as life experiences in both Northern and Southern Ontario. Purposive sampling was used to address gaps identified in the initial data. The results reviewed with representatives from WNHAC prior to submission, as outlined in the "Possession section" of the research agreement.

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Results:

In total, 17 semi-structured interviews were conducted between February and March 2014. Interviewees consisted of community members and health care employees who self-identified as either Aboriginals or non-Aboriginals

Southern Trainees in Northern Ontario:

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Of the 17 interview subjects, 13 of them had previous experience with medical students or residents from either Southern Ontario medical schools or the Northern Ontario School of Medicine (NOSM). NOSM was established in 2005 with a mandate to train doctors to serve Northern Ontario's urban and remove communities. NOSM is the only Canadian medical school to have developed a core curriculum in Aboriginal health which includes a four week Aboriginal cultural immersion placement in year 1[18].

Some interviewees commented specifically on negative interactions between the Southern Ontario trainees and members of the Kenora community, all during interactions with the Aboriginal population. Some Southern trainees were found to lack a basic understanding of the geographical barriers for Aboriginals to access health care, resulting in poor compliance to treatment plans. Interviewees with direct interactions with Southern Ontario trainees also commented on their lack of knowledge surrounding important historical events. Another health care professional recalled a Southern trainee making racist comments during their rotation.

> "I just remember one in particular because we were sharing some of the stuff about residential schools and roles of the elders, stuff like that. He was Canadian, and had no idea, had never heard of this 60s scoop or anything like that. So that was really shocking to me." INTERVIEW 10

> "Almost always there was very little knowledge in the group. And that's one of the reasons we had the content that we did. Because we realized that you don't get this in your health care training program." INTERVIEW 10

> "The only time they've seen a reserve is Six Nations. So they see these very high end, organized, beautiful places and that's their experience of what a First Nations reserve is like ... So they don't understand what reserves in the rest of Canada are like. They

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don't have a good appreciation of residential schools or the Third World living conditions that exist right within our community." INTERVIEW 13

"I've had a couple individuals from Toronto come down ... I think they were frustrated ... Without taking into account their patients can't afford to go to Kenora, or they can't afford time off work or the day that it takes with the medical van. That sort of judgment came across and it wasn't appreciated by the population." INTERVIEW 15

Many of the health care employees interviewed commented on the difference between NOSM and Southern Ontario trainees. The interviewees observed that NOSM students had superior baseline knowledge on the historical, political and geographical issues affecting rural communities.

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"You know since NOSM University has been around they are way more prepared than the other universities. I think they have a community component to their curriculum." INTERVIEW 1

"I do know just through a friend that did the Northern Ontario School of medicine that they receive a lot of education on the First Nation culture. And she did feel prepared for those conversations." INTERVIEW 4

"Are the northern students that much more aware? I would say they are, but they still have a lot to learn ... in their first three months they are out already on their first northern placement. It's not necessarily a clinical one, it's an immersion in the culture and they are sent to different First Nations communities for four weeks. So their awareness and knowledge really develops very early in the program. As far as living conditions, social economic conditions, health challenges." INTERVIEW 10

"There's five NOSM students right now, some of them are from the north ... I think they have a better appreciation and understanding of the demographic in the region

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than someone coming from Toronto who have never maybe been on a reserve ... I think a lot of the students we have right now from NOSM have a pretty good appreciation of the social deprivation that exists in some of these far north communities ... So I think there is a difference, I think for some of our students that we had from the Toronto area, aren't familiar with the North." INTERVIEW 11

Determinants of Health Affecting the Aboriginal Community:

Access to Health Care:

There was a unanimous consensus that poor access to health care is a significant determinant of health among the Aboriginal population, especially those residing on reserves outside the city of Kenora. While some communities have clinics or health centers, many interviewees felt they were understaffed and/or inadequately equipped to perform the simple services such as X-Rays, blood work or ECG's, commonly performed in hospital. Without the skills or equipment, patients on reserves must find other ways to obtain care, often delaying diagnosis and/or treatment.

"Yes there are clinics in the community. Some of them have everything and some of them have nothing. So we have to bring our own stuff like pap lights and blood pressure cuffs." INTERVIEW 1

"No we don't have ECGs, there's no testing done here. We're more of a health center than a medical center. The only professions that are here are the nurses and the nurse practitioner." INTERVIEW 5

"I'm waiting for an answer to see when we're going to get our new healthcare facility. This one is very small we're overcrowded we don't have a lot of places to put storage. We don't have anywhere to put medical files." INTERVIEW 5

"They have nurses. There are two of them that live there Monday through Friday. But there's no one there on the weekends. They do have access to first response services,

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there's a team of trained individuals for first response. But they are over utilized and they get burnt out. So there's a high turnover." INTERVIEW 15

The importance of having clinics located on the reserve becomes evident when you consider some of these communities are hundreds of kilometers from the nearest hospital. During the winter months, many of the roads are inaccessible and community members may not have access to a vehicle.

"It's getting into work early, loading up all our supplies and traveling through all kinds of treacherous conditions of the road. It's traveling an hour to two hours and maybe spending four hours in the community and then coming back." INTERVIEW 1

"Some communities have nursing stations that have home care services or have medical drivers that can get people to town... but if a student doesn't realize that someone might not be able to get to town because it's over an hour away and it's $100 and they can't afford to get into town." INTERVIEW 11

"It's 110 km north of Kenora so it takes just over an hour to drive. Sometimes the road's out, which always makes it exciting ... It's a regular road but several areas along the road they have washouts because of water and culverts are not maintained ... And often they have to close it for repairs, so you can travel through it. They only open it up to let people through for one hour a day, so it really limits the travel to the community. INTERVIEW 15

On the other hand, some of the interviewees commented on an overall improvement in access to health care with the development of roads, the helicopter service operating out of the hospital, and physicians traveling to reserves.

"Probably the access to the hospital is easier now than it was 40 years ago because of roads and because of the helicopter. The helicopter brings a lot of people from the reserves." INTERVIEW 3

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"A lot of the family doctors have adopted a First Nations community. So they are receiving care at that level to." INTERVIEW 4

"The outreach of physicians going to the communities has had a world of change." INTERVIEW 16

Residential School Influence:

Each of the 17 interviewees commented on the pervasive effect that residential schools continue to have on the local Aboriginal community.

"There are a lot of negative impacts that happened from the residential school and that goes into each generation." INTERVIEW 7

"The history, of colonization and residential schools how that has affected our population here ... people don't understand, they don't make the connection that your ER patient today, how it affected their family and their mothers their grandparents or themselves." INTERVIEW 8

"I think it had a profound impact on the native community. That finally something was acknowledged about what we did to the Native people. As heartbreaking as it was it needs to be told." INTERVIEW 12

"Generations of disruption, that nobody knows how to raise kids, survive as a family, survive without intoxicants which help you forget about all the other stuff that you don't want to remember." INTERVIEW 13

"So we are trying to deal with the residential school and those impacts. We try to have sharing circles and I think we need to work on that awareness. The healing has to happen from their own hearts." INTERVIEW 14

"I expected to see the legacy of the residential schools and that would all be starting to fade and we'd be seeing a light but it's no different now than it was 20 years ago. In fact in some cases it's worse." INTERVIEW 16

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Patient and Provider Specific Factors Affecting Delivery of Care:

Provider Specific Characteristics:

Every interviewee offered perspective on the characteristics of health care employees that facilitate culturally safe care. Being respectful, empathetic and a good listener were consistently emphasized.

> "I think if you're dealing with somebody who has some degree of empathy, and patients, and a little bit of understanding, I mean you don't need anything more than that." INTERVIEW 3

> "Being respectful and kind. I think that of many different cultures, so if you're being respectful to an individual and asking them how can I help you, I think that can be perceived too as appropriate cultural care." INTERVIEW 4

> "When I have students with me I really remind them to have good listening skills. This sometimes means a lot of time and not talking. I do believe that you can then deliver quicker healthcare in the longer term because you can understand the patient and you're probably going to get better compliance. " INTERVIEW 10

> "White healthcare people have not walked in the same types of shoes. We are so quick to talk and to give information and instructions and recommendations and with the First Nations population, you have to be a good listener and give time for someone to tell their story." INTERVIEW 10

> "Learn how to listen to the stories that the elders have to share. Sometimes the stories are pretty long but being able to really listen to them and take the little seeds are pearls of wisdom and if you learn how to do that you're going to benefit an awful lot. And you're going to find the time you're in that First Nation community a lot better a lot easier." INTERVIEW 17

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In addition to being a good listener, interviewees emphasized good communication skills as essential to facilitating meaningful relationships with patients. Interviewees described being direct and using simple language as effective strategies for communication.

> "On a more macro level it's ensuring that there's really good communication in a manner that is received and then confirming that information has been received. So that might be making sure there is information available in Ojibway or Cree that there's translators available." INTERVIEW 16

Patient Specific Factors:

Interviewees commented that some Aboriginals mistrust the Western health care system, or prefer to use traditional medicines. This mistrust is an obvious obstacle in developing comprehensive patient care plans, and in creating meaningful patient-provider relationships.

> "We do have part of our community that's at the far end and they are very untrusting. The grandfather got a flu shot and the next day he died. So they really thought that it was the flu shot that killed him. And I think to this day it's really hard to break that barrier." INTERVIEW 5

The interviewees who were health care employees for the most part were accepting of traditional medicines and their unique role in the overall health of the Aboriginal community. However, they suggested using traditional medications with caution in combination with other pharmaceuticals.

> "I don't stop people having it. I think that sweats help because of the psychological component. I think Indian medicines help again for the psychological component. If you need an antibiotic, like if they have a rip roaring impetigo or cellulitis I say you can use your Indian medicine but will give ours as well. So you can overlap it. See I

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will do a deal, you can carry on with your Indian medicine and I'll give you some white man stuff." INTERVIEW 9

"And I'm fine with people using native medicine; they need to be careful about interactions because there are some very powerful roots and herbs." INTERVIEW 13

"I think from a mental health perspective, the sweats and the sage smoking is very therapeutic. It is a negotiation with those patients to come to some sort of common ground to say okay, I'm okay with you using your traditional medicine but I think it's in your best health issue to also consider using this medicine." INTERVIEW 15

Finally, some interviewees explored fundamental cultural differences that may strain relationships between health care provider and patient.

"It's understanding the very different attitude just towards parenting, towards social intervention, the concept of noninterference which is totally at odds with our jobs ... Western medicine is based on a concept of direct interference and the First Nations approach is noninterference and it applies to parenting and it applies to healthcare and applies to justice." INTERVIEW 16

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New Curriculum for Education of Southern Ontario Trainees:

All of the 17 interviewees felt that a pre-departure curriculum would be beneficial.

"It would be good for them to be prepared so that when they come they are aware of the stressors in the community ... And what did it stem from." INTERVIEW 4

"You could probably do an introductory type session; go over the pertinent social problems. Maybe some of the social dynamic issues about negotiating with patients and that you will are not going to get everything on your optimal care list. And what's available, the cost of transportation, what's involved time-wise. Because in Toronto everything's there. And the expectation when they go elsewhere is that it should be there." INTERVIEW 15

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"I think it's a really good idea to go over that before you come because then when you have that first patient in your office who has multiple co-morbidities, you have an understanding of where they're coming from ... So certainly a historical perspective would make it a little easier." INTERVIEW 16

"Knowing a little bit about the geography, some of the history of the community, of the First Nations people. Certainly with the First Nations people an understanding of the Indian Act, the residential schools and the impact that it had over the generations." INTERVIEW 17

Interviewees also identified the need to instruct trainees on some of the nuances surrounding effective communication with the Aboriginal population within the curriculum.

"An appreciation for how to communicate, knowing that not looking people in the eye is not rude, if people don't look at you it's not that they're ignoring you. INTERVIEW 13

"Some cultural interactions, like how to interact with the First Nations people ... they don't make eye contact, they often make a number of gestures. If you could make an effort to make or to learn a few words in their local language goes a long way to develop more rapport." INTERVIEW 15

"The nonverbal aspects, the eye contact ... don't make it direct until they feel more comfortable with you." INTERVIEW 17

In addition to a pre-departure curriculum, the interviewees suggested an immersive experience to teach trainees about the complexities of Northern Ontario. This experience could include spending time in an Aboriginal community, having story-telling sessions with native Elders, or participating in traditional ceremonies.

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"I think if they attend a sweat lodge ceremony and learn the rationale behind it why to do it. You will gain a better perception of what the cultures and beliefs are." INTERVIEW 6

"I think every doctor that comes out should have some training in a First Nations community." INTERVIEW 7

"We have had some storytelling from elders ... that is the most profound understanding that you can get." INTERVIEW 8

"We have lots of students that want to go on Third World placements, and we say not to put down our region but you can get a Third World experience in Northern Ontario." INTERVIEW 10

"I think that maybe they can be given some resources or something in advance to help orient themselves. But I think it's really successfully done as an immersion approach when you're here, and you can learn and integrate and apply all of the same time, simultaneously." INTERVIEW 10

"There's nothing that will overtake hands-on experiential learning. But if everybody had a half day or a day of immersive learning certainly people do a lot of, bring a lot of culture stuff into their teachings. INTERVIEW 13

"I think spending time on a First Nations community is probably the best way to really understand and appreciate the challenges and the healthcare challenges." INTERVIEW 16

Some of the interviewees discussed the concept of mentorship (having a preceptor to help with the educational and practical aspects of a placement) as beneficial for students and residents coming to Northern Ontario for the first time.

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"Say if you're going to work for someone like WHNAC, you know the people there are really awesome. They don't need to, but they'll bring you with them and they will introduce you, introductions are made a kind of ease you into it." INTERVIEW 5

"When people come and go for short term, it's the best when they go with the physicians because the physicians are really community involved ... But we are their gateway to the community for the students and residents." INTERVIEW 13

Discussion:

Many publications exist regarding medical elective tourism in the global setting, but there is no current literature focusing on what education is needed for medical students and residents prior to traveling to Northern Ontario. Using a collaborative methodology, we were able to gain the perspective of a Northern Ontario community about what elements should be incorporated into a pre-departure curriculum for Southern Ontario trainees wishing to travel there on elective.

The interviewees who had worked previously with Southern Ontario trainees felt they were inadequately educated about Northern politics, society and history. All interviewees felt that a pre-departure curriculum would be beneficial to mitigate deficiencies in knowledge. The agreed unanimously about the content, that it should include information on the political, historical, and social determinants of health affecting the Aboriginal populations in Northern Ontario. They also felt education on historical events like the Indian Act is important to understanding the current health structure, and how services in care delivery are organized for the Aboriginal population. Incorporating didactic sessions with an integrative immersive approach while in Northern Ontario was felt to be a more effective way for students to understand the area and to collaborate more successfully with the Aboriginal community. The importance of good mentorship during the placement, and education to improve

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communication were also identified. As a result, the trainees will feel more prepared, deliver appropriate, culturally competent care and have an overall better educational experience.

A major determinant of health affecting the Aboriginal community in Kenora includes unreliable access to health care for remote reserves, which has previously been described in the literature by the National Collaborating Centre for Aboriginal Health[19]. Interviewees discussed efforts made to improve health care access, including doctors/nurses traveling to reserves and the helicopter service available for emergency transportation of patients to the hospital. Another determinant discussed by the interviewees included the pervasive effect of local residential schools. Kenora was home to three residential schools, the last one closing in 1969[20]. Most of the Aboriginal community would have had family members who attended these schools. To this day, the historical implications of these schools continue to resonate within the community. The concept of historical trauma in one generation influencing subsequent generations has been described in the literature[21]. Survivors of the Canadian Residential School experienced trauma in the form of physical, mental and sexual abuse, as well as separation from their families. Not surprisingly, evidence has found that children of residential school attendees have higher rates of substance abuse and depressive symptoms[22][23]. Therefore, the history of Canadian residential schools should be part of a curriculum describing the current health issues of Aboriginal peoples in Northern Ontario.

Another theme uncovered from the interview scripts included patient and provider specific factors influencing culturally safe care to the Aboriginal population. The interviewees emphasized respect, patience and understanding as important provider characteristics. The themes brought up by the interviewees are in keeping with IPAC and the RCPSC "core competencies" published in 2009. The "Communicator" section suggests that "reciprocity, equality, trust, respect, honesty and empathy" are required during interactions with the Aboriginal community, as with all patients[24]. Additionally, some interviewees

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discussed the principle of "non-interference" as a fundamental backbone of Aboriginal culture and its impact on patient-provider relationships. Non-interference is a concept described by Rupert Ross in his book "Dancing with a Ghost" which encapsulates the importance of allowing individuals to make their own mistakes, and not to interfere with the behaviors of others[25]. This principle conflicts with the patriarchal aspects of Western health care, where doctors are supposed to interject and guide patients towards good health care decisions. Understanding cultural differences such as this can help doctors and health care employees understand why resistance may exist, and how to collaborate more effectively.

The research was limited to one of many towns in the vast expanse of Northern Ontario. Each town/city in Northern Ontario undeniably encompasses its own set of values and nuances as does every Aboriginal community. The opinion of what should be incorporated within a curriculum was based on the perspectives of health care employees and community members, but did not include trainees. Strengths of the research included the use of a collaborative methodology, with community representatives as active research team members in project design and execution. A research agreement was created between the primary researchers and a local health care access centre (WNHAC) to ensure collaboration in regards to ownership, access and possession of all data obtained during the research. Our methodology (including the use of a research agreement) can be used as a template for future research conducted in Aboriginal or other communities in which a community based research initiative is needed. This study also provides an example for non-Aboriginal researchers about how to partner with Aboriginal communities in a meaningful way to bring about transformative change. Such partnerships and allegiances are a critical step towards reconciliation and towards moving forward with reciprocal respect to improve the care of Aboriginal peoples in Canada.

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In summary, the interviewees agreed that pre-departure education on the social, political and historical aspects of Northern Ontario was needed. As outlined by IPAC and the RCPSC, eduction on providing culturally competent care is essential for health care employees who work with the Aboriginal community, whether in urban or rural environments. This concept has been reiterated with the recent publication of the "Truth and Reconciliation Report"[26]. In the executive summary under the health section, the commission calls upon medical schools to create Aboriginal health curriculum including the history of residential schools, and the government to enforce nation-wide cultural competency education for all health care employees. Educational efforts such as these will ensure culturally safe care is being provided to Canadian's Aboriginal population and as a result, the health inequities in this population may start to improve.

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Appendix A: Research Agreement for the project:

Northern Perspectives of medical elective tourism: Creating a curriculum for medical students and residents traveling to Northern communities

Research, Data, Statistics, and Publication Agreement Between

Waasegiizhig Nanaandawe'iyewigamig (WNHAC)

and

the Primary Investigators of this research project, including the Core Collaborator Group

Purpose of Agreement:

This research agreement will ensure the project *"Northern Perspectives of medical elective tourism: creating a curriculum for medical students and residents traveling to Northern communities"* is respectful to the cultures, languages, knowledge, and values of the Aboriginal Community in Kenora as represented by the **WNHAC**. This agreement respects that the Aboriginal community has a right to self-determined data management and governance. The agreement acknowledges the desire of Dr. Sarah Coke to conduct collaborative research by involving community representatives as active research team members in all aspects of this project.

Agreement Principals:

- Maintaining mutual respect and accountability between the parties
- Recognize the complementary and distinct expertise, responsibilities, mandates, and accountability structures of each party
- Ensure the highest standards of research ethics, including the acknowledgement of **WNHAC** specific principles of self-determined data management
- Respect the individual and collective privacy rights of **WNHAC** staff
- Recognize the value and potential of research that is scientifically and culturally validated

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Ownership:

- The principle investigators acknowledge that the **WNHAC** is the rightful custodian of all data collected *from Aboriginal clients*
- *Both parties respect that the individual interviewee (including Aboriginal interviewees) is the rightful owner of all data collected through the interview process*

Collaboration:

- The **WNHAC** agrees to undertake the research roles, responsibilities and activities described as part of the collaborative research methods
- The principle investigator agrees to the inclusion of project team representatives from the **WNHAC** as co-investigators

Access:

- The principle investigator will be required to protect the data from unauthorized use and act as stewards on behalf of the rightful owner, *the Aboriginal person*
- The **WNHAC** has provided prior consent to Dr. Sarah Coke to maintain a copy of the data generated by this project in accordance with the study protocol reviewed and approved by the Research Ethics Board for the purpose of qualitative research

Possession:

- The principle investigators will provide the **WNHAC** the opportunity for review of any research reports before the submission of reports for publication
- The representatives from the **WNHAC**, upon their review, will be co-investigators on any and all publications, reports, documents, or other material and or presentations from which this data is utilized

This agreement will be signed by both parties in person when the primary investigator is in Kenora. Copies collectively bearing the signatures of all parties shall constitute the fully executed agreement.

Signature: (Anita Cameron, Executive Director WNHAC)

Signature: __________ (Sarah Coke, primary investigator)

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Interview Guide:

We gathered data for this project using semi-structured interviews. In the table below we have listed the research areas addressed along with examples of questions.

Research Areas:	Examples of Interview Questions:
What is the experience of community members in terms of interacting with medical students or residents from Southern Ontario	1) Tell me about your experience with health care in Kenora
	2) Have you encountered students or residents traveling from Southern Ontario?
	3) What was your experience/interaction like with these students/residents?
Do medical elective tourists historically provide culturally safe care to the community	1) In your experience, were residents/students adequately prepared to serve the community's needs?
	2) Did they appreciate the diversity within the community?
	3) Are you aware of any negative experiences between students/residents coming from Southern Ontario and the community?
What should be incorporated into a formal curriculum for medical elective tourists wishing to travel to Kenora or other similar communities	1) What are the essential qualities of Kenora that people from Southern Ontario should appreciate prior to coming?
	2) Are there are books/articles they should read that would help them to understand the community?

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