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| Title | Northern perspectives on medical elective tourism: a qualitative study on creating a curriculum for medical students and residents traveling to Northern communities |
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| **Reviewer 1** | Pricivel Carrera |
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| General comments (author response in bold) | Thank you for the opportunity to review the manuscript "Northern perspectives on medical elective tourism: creating a curriculum for medical students and residents traveling to northern communities". I found it to be informative in terms of the unique circumstances and unmet needs of Aboriginal peoples, on the one hand, and the role of medical training in providing effective healthcare to all members of society, on the other hand. Whereas a multi-pronged approach is imperative to improve the access to and increase the acceptability of health services to Aboriginal peoples, better patient-doctor communication and patient-centeredness are critical, imperatives. Unfortunately, the manuscript suffers from several limitations which weigh it down.<br><br>1. To start off the statement of the research objective is imprecise if not inelegant. As stated in page 3, lines 36-39, to "(explore) the northern perspective towards trainees traveling to these regions without adequate education" suggests that those sent to Aboriginal communities have not undergone any or requisite formal training necessary to do their placement. Yet, the Northwestern Ontario Medical Program (NOMP), has served since 1972 as a bridge between medical students and residents between Southern Ontario and Kenora, as stated in page 4, lines 10-21. The stated objective in the body of the manuscript, meanwhile, differs from that stated in the abstract which was "to identify elements of appropriate pre-departure curricula for (these) medical trainees".<br><br>As I went through the manuscript, I was left wondering whether the goal of the research was to compare the training of students and residents from the NOMP and the Northern Ontario School of Medicine (NOSM) since the results section mentions the experience of (13) interview subjects with medical students and residents from "either Southern Ontario medical schools or the NOSM" as stated in page 6, lines 3-10. But if that were the case, the comparison is not consistent and the examples of interview questions in the interview guide (page 26) not indicative of this. It did not help that the section "residential school influence" in page 10, lines 12-57 and its discussion in page 17, lines 7-42, are seemingly indirectly relevant to the subject on hand. The paper needs to be more consistent and clear about the central theme.<br><br>2. Meanwhile, the use of the concept "third world", as mentioned in page 2, line 54, in the context of development economics is passé. The old concepts of the "third world" and "first world" no longer apply in the new multipolar global economy and for several years now have been replaced by new approaches that take into account the interests of developing and less developed countries (The Economist, 2010; Nielsen, 2011). By the same token, patient poor compliance as mentioned in page 6 lines 25-26, has been replaced by patient adherence in recognition of the important role of the patient in his/her own care and movement towards shared decision-making and patient-centered health systems (Bridges, Loukanova and Carrera, 2008).<br><br>3. Whereas the authors state that "many publications exist regarding medical elective tourism" in the global setting" in page 16 lines 18-19, no reference was offered/mentioned. Interestingly, a PubMed search of "medical elective tourism" does not return any study while a google search for the phrase/concept returns only five hits, of which three refer to the research presented in conferences. Granted that "medical elective tourism" is related to "medical tourism" the practice of moving within the same health system might not qualify (as an aspect of medical) tourism in conjunction with a medical elective (Runnels and Carrera, 2012). Nonetheless, a case can be made where the motivations of medical students and residents are presented for engaging in training and temporary practice in Aboriginal communities. For this, there needs to be an elaboration of the features of the NOMP and NOSM particularly with regards to the socio-cultural orientation/awareness/training provided to participants.<br><br>4. In consideration of the qualitative nature of the research, additional details about the interviews including but not limited to duration (i.e. minimum, maximum, average), participants (male/female, age), role of other members of the research team (in data collection and analysis), piloting of the questionnaire are needed. The additional information are crucial for understanding the rigorousness of gathering and analyzing qualitative data, including attention to reliability and triangulation (Patton, 1999). The authors may want to refer to the Consolidated criteria for reporting qualitative research |

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| | (Tong, Sainsbury and Craig, 2007) or Standards for reporting qualitative research (O'Brien et al., 2014) to ensure the quality of reporting their research.<br><br>5. In consideration of word count constraints and the nature of CMAJ, the authors might consider presenting the quotations in boxes/tables and be more selective of quotations presented. As mentioned earlier, there are aspects covered in the paper which do not seem to be significantly relevant to the central theme.<br><br>6. As a final note, there are, among others, grammatical errors in pages 15, lines 5-6 and 29-30; 16, lines 38-39; 19, lines 7-8. Hopefully, these observations will help the authors improve the paper to make it sound and well-written in the end.<br><br>The cultural dimension of access is an important but overlooked dimension of access, which is no less important (Fortney, et al., 2011). In this regard, better understanding of the subject matter and evaluation of identified means of dealing with it are crucial for us to continuously improve the delivery of health services to all and not just sections of the population. I laud the work of the authors on the topic and their potential contribution to the limited evidence base, thus far, and look forward to further research on the various dimensions of access to healthcare both from Canada but also other parts of the world given the international reach of the CMAJ.<br><br>References:<br>1. Bridges J, Loukanova S, Carrera P. Empowerment and health care. In International Encyclopedia of Public Health 2008, K. Heggenhougen and S. Quah (Eds.), pp.17-28. San Diego, USA: Academic Press.<br>2. Fortney JC, Burgess JF Jr, Bosworth HB, Booth BM, Kaboli PJ. A re-conceptualization of access for 21st century healthcare. J Gen Intern Med. 2011 Nov;26 Suppl 2:639-47.<br>3. The Economist. Rethinking the third world: seeing the world differently, 10 June 2010. Accessed in http://www.economist.com/node/16329442 on 21 September 2015.<br>4. Nielsen L. Classifications of countries based on their level of development: how it is done and how it could be done. IMF Working Paper, 2011. WP/11/31. International Monetary Fund.<br>5. O'Brien BC, Harris IB, Beckman TJ, Reed DA, Cook DA. Standards for reporting qualitative research: a synthesis of recommendations. Acad Med. 2014 Sep;89(9):1245-51.<br>6. Patton MQ. Enhancing the quality and credibility of qualitative analysis. Health Serv Res. 1999 Dec;34(5 Pt 2):1189-208.<br>7. Runnels V, Carrera PM. Why do patients engage in medical tourism? Maturitas. 2012 Dec;73(4):300-4.<br>8. Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. Int J Qual Health Care. 2007 Dec;19(6):349-57. |
| **Reviewer 2** | Donald Juzwishin |
| Institution | Alberta Health Services, Health Technology Assessment & Innovation, Research, Innovation and Analytics |
| General comments (author response in bold) | This is a relevant, timely and important topic to be addressed within the Canadian health care system. The theoretical underpinnings of qualitative method lead to interviews which identified findings that highlighted the shortcomings of contemporary practice and proposed responses that would improve physician and aboriginal people's interactions. Recommendations for a pre departure curricula are proposed. To strengthen their case the authors might have made suggestions as to how and what policy changes would be necessary to accommodate the introduction of such a curriculum. |