Essential Elements for Advancing Cultural Humility through a Community-Based Physical Therapy Practicum in a Métis Community

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ABSTRACT

Purpose: This article reveals MPT practicum participant perceptions of the impact that a community-based practicum in a Métis community had on their learning in the area of cultural humility and cultural safety. **Method:** The impact of this community-based practicum intervention in a Métis community on MPT student education was explored using phenomenological descriptive methodology, with data gathered via exit interviews conducted on completion of the community-based practicum. Concepts of cultural humility and safety from the literature, along with themes emerging from practicum participant interviews, informed the analysis and theme development. **Results:** Participants' experiences were categorized into three themes: (1) realizing Métis community strengths; (2) learning from experiences and shaping future practice; and (3) prioritizing relationships. Findings support that participants demonstrated the practice of cultural humility as a result of engaging in the community-based practicum. **Conclusions:** Our results highlight the importance of (1) community engagement, (2) community-informed practicum design based on strong relationships, (3) a backbone of reflective practice, and (4) a base of community and student readiness to support practicum success. These essential elements support a cultural humility approach to implementing MPT practicums in Indigenous communities, as well as a practice in reconciliation.

Key Words: cultural competence; experiential learning; Indigenous health; preceptorship; qualitative research.

RÉSUMÉ

Objectif : le présent article révèle les perceptions d'étudiants à la maîtrise en physiothérapie sur les retombées d'un stage en communauté métisse dans leur apprentissage de l'humilité culturelle et de la sécurité culturelle. **Méthodologie :** les chercheurs ont exploré les retombées de ce stage en communauté métisse sur la formation d'étudiants à la maîtrise en physiothérapie au moyen d'une méthodologie phénoménologique descriptive et ont récolté leurs données lors d'entrevues à la fin du stage. Ils ont appuyé leur analyse et leurs thèmes sur les concepts d'humilité culturelle et de sécurité culturelle tirés des publications scientifiques ainsi que sur les sujets découlant des entrevues avec les participants. **Résultats :** Les chercheurs ont regroupé les expériences des participants en trois thèmes : 1) comprendre les forces de la communauté métisse, 2) apprendre des expériences, modéliser les futures pratiques et 3) prioriser les relations. Les résultats confirment que les participants ont adopté des pratiques d'humilité culturelle après leur stage communautaire. **Conclusion :** les résultats démontrent l'importance a) de l'engagement communautaire, b) d'un stage communautaire axé sur de solides relations, c) d'une structure de pratique réflexive et d) d'une certaine préparation de l'étudiant et de la communauté pour soutenir la réussite du stage. Ces éléments essentiels corroborent l'approche d'humilité culturelle pour instaurer des stages d'étudiants à la maîtrise dans les communautés autochtones, de même qu'une pratique de réconciliation.

Racism and discrimination are rooted in Canada's history of colonization, and they are prevalent in its health care system. This situation makes it difficult for Indigenous peoples to access appropriate, timely, respectful, culturally responsive, and safe care.^{1,2} They often have fear and trepidation when accessing health care as a result of the experience of residential schools, systemic racism, and other traumatic impacts of colonization.³ In Saskatchewan, approximately 15.6% of the population currently

identifies as Aboriginal, the second highest proportion among all the provinces.⁴ Researchers expect that by 2036 the proportion of Aboriginal peoples living in Saskatchewan will increase to 22.7%.⁵ To provide culturally safe and responsive care to this growing demographic, physical therapists require enhanced training and preparation that will develop their cultural safety skills.

The Aboriginal population in Canada is made up of three distinct groups – First Nations, Inuit, and Métis, as

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Contributors: All authors designed the study; or collected, analyzed, or interpreted the data; and drafted or critically revised the article and approved the final draft.

Competing Interests: None declared.

Physiotherapy Canada 2019; 71(2):146–157; doi:10.3138/ptc.2017-94.e

recognized in the *Constitution Act of Canada*⁶ – and *Aboriginal* is the term used by Statistics Canada and the Truth and Reconciliation Commission of Canada. *Indigenous* is a general term that refers to Indigenous peoples around the world and is broader than the constitutional and legal definitions of *Aboriginal*. In this article, we use both terms, and we use *Métis* and *First Nations* to refer to these two individual population groups.

Cultural safety in health care is achieved when clients perceive that the care that health care professionals provide is equitable, respectful, inclusive, responsive, and supportive of their individual needs.⁷ A culturally safe health environment acknowledges the diverse historical, economic, and social environments that affect health outcomes among Indigenous populations,^{8,9} but it also requires health care practitioners to be adequately educated in providing services that respect this diversity.⁸ To achieve cultural safety, health practitioners need to integrate a cultural humility approach into their professional practice. *Cultural humility* is defined as “a lifelong commitment to self-evaluation and self-critique” to “redress power imbalances in client-practitioner relationships.”¹⁰(p. 123) It requires health care professionals to suspend their assumptions about an individual that are based purely on generalizations about their culture, and look inward to examine where these generalizations and assumptions come from.¹¹

In practising cultural humility, practitioners from the dominant culture can build on their awareness of their own worldviews and engage in a lifelong process of honest self-evaluation and self-reflection to examine what role they can play in mitigating racism, discrimination, and health inequities.¹² Research suggests that diverse teaching and learning strategies beyond the classroom are important to support the development of cultural humility among health care professional students, particularly when working with Indigenous peoples.^{13–16} Explicit steps must therefore be taken in physical therapy training programmes to support students in developing cultural humility skills.

The School of Rehabilitation Science at the University of Saskatchewan trains approximately 40 physical therapists per year, and it has been taking steps to increase the diversity of its student population.¹⁷ For example, the Education Equity Program has been in place since 1996. Six seats of the 40, or 15%, are designated for Indigenous students; this number represents their proportion of the population of Saskatchewan. However, our students are still predominantly white and middle class. They are less likely to be exposed to, or be aware of, diverse perspectives on health and wellness outside the dominant Western values and systems of thought (also known as the “Western paradigm”).¹⁸

Similarly, the department’s faculty and staff are non-Indigenous; thus, their professional development in cul-

tural safety and humility needs to also be adequately supported so that they can apply it in the classroom and school. Diverse teaching approaches must be integrated throughout the curriculum to support the development of cultural humility skills; this will ensure that Master of Physical Therapy (MPT) students are adequately prepared to work with diverse Indigenous and other ethnic populations and to develop culturally safe environments in their future practice.

Clinical practicums and experiential learning approaches are highly valued in physical therapy professional programmes and curricula because they enable physical therapy students to apply their classroom learning in real-world, clinical situations.¹⁹ Building on these strengths, we designed a community-based practicum, in partnership with a Métis community, that was guided and informed by Métis community priorities, and we integrated a backbone of reflective practice and both student and community readiness. These unique elements, we believed, were critical to supporting the students’ professional development in the areas of cultural humility and cultural safety while they learned in a Métis community context.

Our goal was to study whether expanding the clinic beyond the classroom and into a Métis community would make the students more aware of their own identities and worldviews, how they may be different from those in that community, and how they shape their stereotypes and misperceptions of peoples from other cultures. We believed that this learning would affect the quality of care that students provided in their future practice.

We expected that the students taking part in this Métis community-based practicum – actively participating in community events, interacting with community members, and critically reflecting on their conversations and experiences – would have a rich learning experience. This article reveals their perceptions of the impact of this practicum on their learning in the area of cultural humility and cultural safety.

METHODS

Research team

Our research team consisted of two faculty members (SO and SA), two Métis community members (LD, TJR), and five first-year MPT students (JN, JP, LS, MS, KS). Both faculty members are non-Indigenous and Western-trained, and they have experience in community-engaged Indigenous health research, participatory action research, physical therapy, medical anthropology, intervention research, and mixed-methods approaches to research and evaluation. Both Métis community members live and work in the community of Île-à-la-Crosse, Saskatchewan; speak English, Michif, and Cree; and are

deeply rooted in their culture and the importance of passing on cultural teachings to the next generation. The four of us work collaboratively to honour and privilege the Métis worldview in all elements of research and practice. However, we acknowledge that there are strong power differentials that exist between the academic and the community research team members, and we attempt to make Métis perspectives and worldview more visible.

The student researchers were non-Indigenous, and none were participating in the practicum at the time of this study.

Study design

This study was part of a student-team research project, which was a requirement of the MPT programme. We (SO, SA, LD, and TJR) designed it as an intervention research project, whereby the practicum intervention used a community-engaged approach and incorporated several distinct but related factors that we believed were critical to its success. The student researchers were supported in ensuring that community members who had helped design and implement the practicum were engaged at all levels of the research project, thus integrating Métis perspectives and worldview throughout. We integrated four elements that we thought were essential for the participants to develop a culturally humble approach to physical therapy practice: (1) community engagement with the practicum community, (2) a student practicum built on strong relationships with community and informed by community, (3) a backbone of reflective practice, and (4) a base of community and student readiness. We also built in the time to appropriately prepare the practicum participants to ensure that they would honour and respect the Métis community's priorities.

Five students self-selected to participate in the study as researchers so that they could learn about Indigenous health and qualitative health research, and they were supervised by the primary author (SO). They were not involved in designing or implementing the intervention, but they participated in developing the research questions and methodology and conducting data collection and analysis. The research questions were as follows: What are MPT practicum participant experiences engaging in a community-based practicum in a Métis community and how does this type of practicum support the development of cultural humility? The impact of this intervention on MPT student education was explored using phenomenologically descriptive methodology, with data gathered in exit interviews conducted after the practicum was finished.²⁰

Ethics approval was obtained for all project activities from the University of Saskatchewan Behavioural Research Ethics Board (Beh-15-81). Community practices and protocols were followed, guided by the community research

team members (LD and TJR), thus ensuring that community ethical practices were integrated and respected.

Participants

All students in the MPT programme at the University of Saskatchewan, regardless of what year they are in, are made aware of the Métis community-based practicum by the programme's clinical coordinator. Those who are interested in participating in the practicum clearly identify themselves to the clinical coordinator. To date, six students have participated in the practicum: four final-year students on a 6-week placement and two middle-year students on a 4-week placement. We refer to these students as *practicum participants*.

The practicum participants either engaged completely outside a health-based facility – that is, fully in the community – or engaged in a hybrid community-clinical placement (depending on whether a clinical physical therapist was available in the community). Those participating in a community-clinical placement spent approximately 2 days per week in a health facility (on a conventional placement) and the other 3 days participating in community activities. None of the participants were Indigenous or had previously visited Île-à-la-Crosse. They were interviewed for this study at the end of their placement.

Community

The community of Île-à-la-Crosse is the second oldest community in Saskatchewan. It is located 520 kilometres northwest of Saskatoon and is situated on the west side of Lac Île-à-la-Crosse, on the southern peninsula.^{4,21} The community was established in 1776 as an outpost for fur traders. French Canadian, English, and Scottish traders settled in this region and developed intimate and long-lasting relationships with local First Nations women, creating the Métis population and community.²² The population of Île-à-la-Crosse in 2016 was 1,295: 26% (345) aged 0–14 years, 47% (610) aged 15–49 years, and 26% (345) aged older than 50 years.²³ A small proportion of the population speaks Cree (7%), Dene (2%), and Michif (7%), whereas the large majority speaks English (97%).²³ A full 95% of the population identifies as Aboriginal, of whom 18% identify as First Nations and 77% identify as Métis.^{22,23}

Île-à-la-Crosse is a welcoming and open community, one that has developed strong relationships with many departments and colleges at the University of Saskatchewan through research partnerships and educational opportunities. Physical therapists have also been keenly welcomed and are respected in the community.

Our partnership with the community

Two of the authors (SO and SA) have well-established relationships with members of the Métis community, which they have cultivated for the past 5 years. These

relationships have been strengthened through research and collaboration. For example, these authors are carrying out two major research projects with seniors and youth in the community. Research goals were developed collaboratively with community partners and focus on health promotion across the life span. It is in the context of these research projects, the associated research agreements, and, most important, the relationships in the community that the idea of the community practicum was created.

We wish to point out that the idea of engaging MPT students in a clinical practicum in this community was born from dialogue initiated with community partners. They showed a keen interest in supporting the students in their learning and were instrumental in creating space for this to occur. Although the practicum is certainly of value to the students, the safety, health, and desires and needs of the community were paramount.

Preparing for the departure

The practicum participants were prepared in diverse ways for this northern community-based placement. In the first year of their physical therapy programme, they engaged in classroom learning, delivered primarily through the mandatory Professional Practice 2 course as part of their general MPT programme. A portion of this course focuses on Indigenous health. Learning was layered throughout this course so that students gained knowledge about the history of colonization in Canada and its impact on health and health care today; racism in the health care system; and how their own personal experience, perspective, and awareness of these issues can affect their clinical practice. The participants received in-class content on cultural competence,^{1,12} cultural humility,^{12,16,24} and cultural safety.¹² They completed readings on historical and contemporary Indigenous health care issues, were exposed to Indigenous health-related podcasts and videos, participated in inter-professional problem-based learning modules (titled *First Nations Culture, Health and Healing*), and heard from First Nations and Métis Elder guest lecturers.

Near the end of the course, the participants explored their awareness of Indigenous culture and their perspectives on and biases toward Indigenous health through reflective practice assignments and an in-class sharing circle. A Community Health Workshop in the core neighbourhood of Saskatoon, Saskatchewan, and a Racism in the Health System assignment were delivered to the final-year students, providing additional background on the social determinants of health and racism in the health system.

All practicum participants received a 6-hour pre-departure orientation outlining their roles, our expectations of them, ethical considerations, methodology, and the importance of respecting the pre-existing relationship

with the community and respecting the community in general. Emphasis was placed on their commitment to building relationships in the community and incorporating the four Rs (respect, reciprocity, relevance, and responsibility)²⁵ into their practice. (The 4 Rs, originally described by Kirkness and Barnhardt, provide a framework for understanding and engaging in Aboriginal research and practice ethics from an Aboriginal point of view.) As practicum participants in our larger programme of research, their travel and accommodation costs were subsidised by our research grants.

The practicum

The practicum participants were embedded in the research projects, described earlier, as a starting point for engaging in the community. Broadly speaking, they were tasked with building rapport and relationships with community members while engaging in community events and, when appropriate, collaboratively designing and piloting mini health-promoting interventions. (Community events such as coffee houses, game nights, radio shows, bingo nights, talent shows, Michif festivals, crafting, school events, school and community recreational activities, aquafit, singing, and jigging were often planned and facilitated by community partners.) The participants were given a community-based practicum orientation manual, which included suggestions about whom they might speak to in the community to kick-start relationship building and generate community-driven ideas for health promotion activities.

The two Métis authors (LD and TJR) live in the community, and they guided the participants in their initial activities. They introduced them to key individuals who were already organizing health-promoting initiatives in the community. The participants could then build on these activities, or they could support the design and implementation of new health-promoting activities, guided by the community.

One activity that was effective in reaching the broad community promoted relationship building and community engagement: speaking on the local radio station. Participants were invited to explain who they were and what they were doing in the community. Hosting a weekly radio show became a key activity; it enabled the participants to share health-promoting messages, garner input from community members, and advertise the health-promoting initiatives they had set up. In fact, one pair of participants initiated an aquafit programme at the request of a community member who contacted them after hearing them on the radio. The concept of reciprocity and giving back to the community by piloting mini health-promoting interventions was an expectation of the community practicums.

The participants refined their reflective practice skills, which are introduced in the first year of the MPT

programme and developed throughout the programme. They were instructed to write about their experiences each day, including their feelings and observations about these experiences, and submit them to their supervisor (SO) each week. SO reviewed these reflections, gave the students written and oral feedback, and asked questions for the students to consider. Critical reflection informed the participants' professional development, critical thinking, reflexivity, and learning, and it supported an inner exploration of their identity and any preconceived assumptions they may have held.

The reflective practice component of this practicum is critical for developing cultural humility and was thus an essential element in its design. Weekly telephone meetings between students and their supervisor were held, and students could request a meeting as often as needed. Meetings created space to discuss issues, clarify expectations, answer questions, and give overall support. Students were encouraged to develop action plans in response to the supervisor's feedback to stimulate deeper thinking. LD and TJR engaged with the participants personally every day and supported them in their community engagement activities.

Data collection

The experiences of the practicum participants were captured in in-depth, semi-structured exit interviews that took place at the end of the practicum. The interviews lasted 45–60 minutes; they were conducted by the five student researchers (JN, JP, LS, MS, KS) and supervised by SO. Each participant was interviewed by one student researcher; this approach gave all student researchers the opportunity to conduct at least one interview and to engage in the different aspects of qualitative research.

Before conducting the interviews, an information letter was emailed to the practicum participants, and we obtained written or verbal consent. The interviews were conducted in person or by telephone, as requested by the participants, and they were audio recorded; participants were given the opportunity to review their transcribed interview. The interview guide (see the Appendix) consisted of open-ended questions focused on exploring the participants' experiences, including their perspectives on the development of their cultural humility and cultural safety, as well as their learning about Métis perspectives and ways of knowing and living. The exit interviews were intended to capture the key learning elements from the practicum experience and the reflective practice component of the practicum intervention. Practicum participants received a small honorarium for their participation.

Data analysis

Thematic analysis was driven by a combined a priori and open coding strategy.²⁶ The concepts of cultural humility and safety were drawn from the literature, and along with the themes that emerged from the interviews,

they informed the thematic analysis. This approach facilitated a link among the community-based practicum experiences, the literature, and the projected impacts on future practice among the participants, while allowing for unanticipated observations to emerge. The thematic analysis was carried out iteratively by JN, JP, LS, MS, KS, and SO.

A preliminary categorization process was conducted using the strategy of detailed reading, selecting revealing statements, and identifying representative sentences that revealed the meaning of the text. After individual analysis, common patterns and themes were identified through iterative discussion, and final themes were agreed on by consensus. The list of final themes was brought back to the larger research team for review. Data analysis was not completed until LD and TJR had read and approved the themes. Member checking established rigour in the study, ensuring the credibility, dependability, and confirmability of the data.²⁷

RESULTS

The reflections of the practicum participants on their experiences in the northern Saskatchewan Métis community highlighted areas of learning that supported the development of cultural humility, and they were categorized into three main themes: (1) realizing Métis community strengths, (2) learning from experiences and shaping future practice, and (3) prioritizing relationships.

Realizing Métis community strengths

The enhanced knowledge gained by the participants about the structure and strengths of Métis community practices centred on the passing of knowledge from Elders to others. The community network and the support that the individuals give their families and friends was identified as a strength. One participant noted, "There's lots of people who've been [living] there forever (for generations), and they're just a wealth of knowledge. . . . They have so much information, and historical information, especially if you connect with the Elders."

Observations such as this suggest that the participants explored in depth the social structures that exist in this Métis community and recognized the strengths of the intergenerational interactions and how they support health among community members, even though they are different from the participants' own experiences and community context. Such observations may also suggest that the participants recognized their lack of knowledge of Métis culture and the value of spending time with Elders to learn more about what it means to be Métis in this community. This recognition of not knowing everything about a topic – in this case, Métis culture – is a practice in humility.¹⁰

The participants acknowledged the strong relationships and supports in the family structures, and the community,

as important strengths that they had not been fully aware of before attending the practicum. For example, two participants said, “The importance of community, like the role of the family and then extended family. . . . There’s just a sense of community for health,” and “Community definitely is structured to support one another . . . that was an interesting health-related aspect that I learned while being there.” Another participant reported, “It really gave me a good insight into how, I think, Métis communities work and support each other . . . where the grandparents are responsible for child care.”

These comments indicate that family and kinship structures in the community were observed by participants to be different than what they had initially expected to see and offer insight into the valuable role that Elders play in teaching younger generations. They also reveal the diverse demands placed on the time of a Métis older adult and Elder, demands that create potential barriers to engaging in their own health care. These comments are examples of how new learning about the strong interconnections between family members, and the importance of family, can support MPT practicum participants in future treatment planning when working with Indigenous populations.

Initial preconceived assumptions held by many participants, such as negative stereotypes of the way of life of Métis community members, were identified as misguided, leaving participants to reflect on their personal biases and assumptions. For example, one participant stated, “There was a lot of preconceived notions I had that were debunked,” and another said,

I think it’s just kind of breaking down those barriers ‘cause you just hear all the negative stereotypes. And actually living there and meeting the people first-hand and meeting the leaders of the community and . . . in terms of assets that they have . . . it just changes your perception of it.

This inner exploration of personal assumptions and biases among the participants is one of the first stages in developing cultural humility. The participants’ experiences gave them an opportunity to suspend any assumptions they had held about Métis peoples and to view the community and community members from a new and different perspective than before their practicum. These new-found perceptions will inform the practicum participants’ future practice in cultural humility.

The participants also noted the opportunity they had to spend time learning about the Métis way of life, including the challenges of living in a northern, rural community. They noted the resilience and resourcefulness that the community members have developed. As one participant noted,

The Northern Saskatchewan that I experienced was nothing short of fantastic, beautiful, amazing, and the people were welcoming once they got used to us being

there. . . . And people are really open to sharing their lives and their stories once they welcome you into their lives. There’s a richness there, there’s a culture there . . . amazing things to learn from the people.

These observations support the transformation in thinking from preconceived, negative notions of Métis people and communities to the understanding of strong and resilient Métis people with tremendous capacity for resourcefulness.

Learning from experiences and shaping future practice

Layering student observations and experiences with the demographics and literature on the social determinants of health (all of which were part of the preparation for departure) suggests that the practicum participants were starting to consider how the social determinants of health can have a negative effect on health outcomes among Métis people. This is captured in the following quote:

You start to see the other obstacles that Indigenous communities face in terms of food security, or meal planning, and how that’s going to tie into nutrition and growth, obesity, and chronic disease management. You’re like, “Well, I can’t even get a tomato.” Or when you get there and you see poverty . . . and you have somebody who’s coming to you, but you actually can’t help them because they need another service provider that’s not there, or they don’t have the family support, . . . or they’ve got a priority that’s beyond my understanding. . . . You know that those things all exist, but until you’re actually there, you don’t have any concept.

Although the practicum participants explicitly shared their experiences and observations of the social structures and interplay of the social determinants of health in the community, they did not explicitly talk about concepts of power and privilege in their exit interviews. Perhaps some of these ideas were implicit in their realization of what community members must overcome to be well and healthy, or perhaps the participants need repeated exposure and critical reflection to recognize these concepts and reflect on them in their dialogue.

The participants indicated that being in a northern Métis community, where they were immersed for the whole of their practicum and could not “escape” to their home, their friends, or their comfort zone, was important for their learning. One participant noted, “Just being immersed up there . . . you see the good, and you see the bad. You can’t drive home every weekend to see your friends . . . and experiencing the kind of difficulties too” – suggesting that the participants had to confront challenges that they were unfamiliar with.

Increased awareness was built among the participants about how the social determinants of health affect the community, how the unique Métis culture supports

health in the community, and how important it is to apply these concepts to professional practice. One participant reflected that “something you wouldn’t necessarily get anywhere else is seeing the . . . full social determinants of health, global view of an individual as well as of a community.” Another participant realized that

[you have the opportunity to see] the physical environment and . . . [the] food options or [the] job options and things. So you can see all of those encompassing aspects that are largely part of the social determinants of health. You can physically see them . . . it’s apparent, it’s obvious, it’s there.

These comments indicate that although the practicum participants learned about the social determinants of health in preparing for their departure, experiencing and learning about the diverse social determinants first-hand had a strong impact on their learning.

As the participants observed the diverse social determinants at play in the community, they talked about their discomfort with terminology such as *cultural competency*, which centres on the development of awareness, knowledge, and skills and implies that practitioners can reach a testable endpoint and sense of completion of a task.¹² For example, one practicum participant said, “I was like, yeah, I’m culturally competent. . . . I can define the *Indian Act*, great. Then you go up north and see what the *Indian Act* actually means.” Although this participant felt culturally competent before engaging in this practicum, this quote suggests the realization of a need for ongoing learning, reflection and action, all of which are encompassed in the term *cultural humility*.¹⁰ This suggests an increased likelihood that the participants will honour a commitment to life-long learning and self-reflection when working with Indigenous populations and, thus, may be more likely to create culturally safe health environments in their future practice.

The practicum participants repeatedly indicated the important impact of their experiences on the development of their professional practice skills and their future practice. For example, one participant indicated, “I feel like it was a very valuable opportunity in terms of being able to immerse myself in Indigenous culture. And being able to take that forward into my professional career”; another reflected that “without having this experience, planning for discharge for Aboriginal patients going back to their Indigenous communities . . . would be 100% completely different.” These comments suggest that the participants were starting to practice cultural humility because they were emphasizing the importance of learning from the community members, who are experts in their lived experience,¹² in shaping future practice. It is clear that the participants examined current professional practices in relation to their experiential learning in a

Métis context, thus informing their plans for setting up their future physical therapy practice.

Prioritizing relationships

The practicum participants began to realize that basic human communication and relationship building were the basis of any and all interactions in the Métis community, as an important way to seek out, and learn from, the community members themselves. The participants were required to plan their daily activities on the basis of conversations, teachings, and events that were community driven, thus building relationships with community members without the potential imposition of Western-based institutional structures or hierarchies. One participant came to realize that

when you’re . . . part of somebody’s day to day, they feel like they can approach you and ask you questions because you understand. You’ve seen it, so you know what they’re living with or what their life looks like. . . . So people begin to trust you, and I think that’s the biggest thing.

Relationship building and sharing common experiences in a community were valued and linked to creating trust with the community members.

The participants also acknowledged the deep-rooted relationships that exist in the community and families:

We would meet an Elder, and then you meet their niece, and then you meet their child, and then you meet their brother-in-law, and then you meet, . . . so you get a wide scope of a person’s [family life], not only parental heritage but also their children.

These comments indicate that the participants observed the value that the Métis community members place on relationships. The participants talked about how relationships built outside a practitioner–client relationship, and at a more human and community level, were also valuable to their professional development – for example, “I don’t think my [practice of] cultural competence was enhanced through my clinical practice . . . as much as it was through my after-hours stuff, like going to community barbeques or going to high school volleyball games.”

Several participants described their discomfort with the freedom of developing their own daily schedule. One noted, “We basically designed every day that we were up there. . . . We didn’t have a day plan at all; we had to make it ourselves . . . that probably was a little bit of an obstacle.” The participants experienced first-hand that things were done very differently in the Métis community than in their familiar, Western, urban clinical context. They became more comfortable toward the end of the practicum as they became more familiar with the community and its members and were more engaged in

community activities. Other participants talked about the importance of putting themselves out there, leaving their comfort zone, to maximize their opportunity for meeting people, building relationships, and learning how to practise in a more culturally humble way. A sample comment was,

That's one thing that we've tried to do . . . is be out in the community, putting on different kind of clinics, being out to community suppers, putting together different kinds of clubs and getting out and meeting people that way.

Participating in this unique, community-based practicum stretched the participants' comfort level, nudging them into situations that they would not encounter in classroom or clinical settings. This discomfort may be what is needed to create opportunities for transformative learning and exploring cultural humility.

DISCUSSION

With this project, we set out to reveal whether a community-based practicum in the Métis community of Ile-à-la-Crosse would enable the participants to develop cultural humility and recognize the need to enhance culturally safe approaches to care in their future physical therapy practice when working with Indigenous individuals. Building on deep-rooted community relationships, designing the placements with active community engagement, and intertwining the participants' experience with reflective practice ensured a rich, "in the community" placement. Not only did our data reveal that the participants' perspectives of the Métis people, including their general health and wellness, were enhanced, we also observed that applying a cultural humility frame to the design of the community-based practicum led to transformational learning, engagement in reconciliation, and a response consistent with developing cultural humility among the participants.^{28,29}

In Canada, a need exists to augment the training of MPT students to develop cultural humility skills as one way to actively address the racism and discrimination that is prevalent in the health care system.¹ Cultural humility requires individuals to critically reflect on how their own perspectives may differ from those of others and to examine their role in the social structures and power relations that perpetuate health inequity.^{10,12} Through a process of reflection and self-critique, the participants began to practise cultural humility by acknowledging their preconceived ideas of Métis communities and members. As the participants engaged with community members, they began to acquire new knowledge about themselves and about Métis culture, health and wellness practices, and worldview. It became clear that a community-based practicum in a Métis community, built on a strong partnership with the community, could create the context in which physical therapy students could

apply a cultural humility approach. Practising cultural humility in health care is an important first step to informing and enhancing culturally safe health environments that support Indigenous peoples.

An important outcome of this study was the successful transformational learning experienced by the participants. *Transformative learning* has been defined as "learning that transforms problematic frames of reference," such as assumptions, expectations, beliefs, mindsets and/or worldviews.^{30(p. 58)} (Mezirow suggested that critical reflection on an individual's assumptions and beliefs is an important element of transformational learning, followed by consciously reasoning and implementing plans to develop new ways of defining the world.³⁰) As the participants in this study developed respectful relationships with community members and became aware of the strengths of Métis community, culture, health, and wellness, many of their initial assumptions and beliefs about Métis people were brought into question. Several participants who initially admitted having negative stereotypes about the way of life and worldview of Métis community living later acknowledged that these stereotypes were misguided.

Reflecting on the dichotomy between the participants' preconceived ideas and what they experienced allowed them to view the community from a very different, strengths-based perspective. This change in perspective alone provides evidence that the participants were developing a culturally humble practice.^{7,12} They could see the value in the roles of diverse community members in the health of family members and friends and the importance of community and "relationality." These are all strong foundations of the Métis worldview and lived experience, and they gave the participants a different perspective than what they were familiar with or expecting.

Not only did the participants critically reflect on their pre-existing, problematic negative stereotypes, many also indicated their keen interest in applying their new understanding to their personal and professional growth. The experiences described in their exit interviews, such as those noted earlier, revealed that they could safely critique their own worldview and lived experience and identify how these could perpetuate preconceived or misguided generalizations about Métis peoples (or Indigenous peoples as a whole). This critical reflection is a defining element of practising with cultural humility.^{10,12}

The changes in thinking and perceptions that participants identified, followed by plans to implement and apply their learning to their future professional practice, provides evidence that transformational learning took place during these practicums. We believe that this transformational learning is directly linked to the development of cultural humility and cultural safety and that it was supported by the four essential elements of the design of the community-based practicum: (1) community

engagement with the practicum participants, (2) a student practicum built on strong relationships with community and informed by community, (3) a backbone of reflective practice, and (4) a base of community and student readiness. We suggest that if any one of these elements is missing, then transformational learning, and the stage for developing cultural humility, may not occur.

Community engagement

The design and implementation of the Métis community-based practicum were supported and enhanced by our deep-rooted relationships with Métis community members. Indigenous health education content must be delivered in ways that respect Indigenous worldview and practice. Educators and physical therapists must be careful when implementing an Indigenous health curriculum and content to prevent any further harm to Indigenous peoples and their communities. A recent editorial in this journal highlighted the need to acknowledge that physical therapists have a responsibility to collaborate in addressing unmet needs among populations around the world, including Indigenous peoples in Canada, but we must do so in ways that do not perpetuate colonial practices and power imbalances, which could continue to perpetuate inequity.¹⁵ In this study, we collaborated with our Métis community partners to deliberately create a safe educational space that honoured Métis knowledge, beliefs, values, and practices.

Community-informed student practicum

The practicum was designed with enough flexibility to allow the community members to drive most of the participants' experiences. We respected Métis community perspectives and ensured that the Métis voice, knowledge, and worldview emerged and directed participants' activities, health promoting interventions and experiences. This, in turn, naturally led participants to apply the four Rs of respect, reciprocity, relevance, and responsibility while engaging with the community.²⁵

Backbone of reflective practice

The participants' reflective practice was an essential part of their transformational learning experience. They engaged in individual daily reflections but also deconstructed their reflections through regular feedback and weekly conversations with SO. The consistent written and oral feedback that the participants received was a necessary part of their reflective practice because it allowed them to be honest about their own beliefs and assumptions and created a safe space for them to not only acknowledge any negative stereotypes but also create an action plan to address them. This has been described as a first step in practising "allyship" with Indigenous community members.^{31,32} Again, we believe that if any component of the reflective practice approach as described in

this study is missing, the opportunity for transformational learning may be lost.

Community and student readiness

This final element is, we believe, critical for nurturing transformational learning and the development of cultural humility among participants. Community readiness, defined by the willingness of Métis community members to host the participants and guide them in implementing community-driven health-promoting interventions, was required for the success of this project.

Student readiness was also essential to ensure that respectful and trusting relationships were maintained between the participants and community members. Student readiness was developed through the diverse pre-departure activities and through the self-selection process used for recruiting participants. MPT students who self-selected to participate already demonstrated a keen interest in learning more about cultural humility through experiential learning in partnership with Métis community members. Ensuring a high level of community and student readiness was essential to maintaining the safety, priorities, values, and wishes of the community.

An interesting finding was that as participants took part in this unique practicum, some described their initial discomfort and frustration with being in an unfamiliar environment and in an unstructured learning situation. They were not able to easily walk away from these feelings or experiences and were forced to recognize that they felt uncomfortable. This discomfort was foreseen in the practicum design and has been found to be a critical component of personal transformation.³⁰ The participants were given support, in a safe and respectful way, to problem-solve their experiences through the reflective practice and conversational elements of the practicum and at the same time maintain their relationships with community members. This sense of safety, for both participants and community members, was made possible by the essential community and student readiness elements of the practicum design and by applying the four Rs.

The participants' discomfort was also a result of being new to a community and being a minority in a new community. This, too, is a tremendously valuable experience for trainees because they realized what it might feel like to not fully understand the environment in which they are living, giving them a glimpse into what some Indigenous people may feel for much of their lives in the Western-based systems trainees navigate every day. This discomfort led to lasting change in the students' learning and professional development.

A timely outcome of these community-based practicum is that they support reconciliation. As the nation is involved in critical dialogue about how everyone can respond to the Truth and Reconciliation Commission of

Canada's final report, we find that the participants' experiences are aligned with several of the health-specific calls to action.²⁹ Medical, nursing, and physical therapy schools have been called on to help health care students and trainees develop enhanced cultural competence and cultural humility, thereby addressing the problem of cultural safety in the health system.²⁹ Realizing the strengths of the Métis community and valuing relationship building with its members are steps in practising reconciliation.

This study had several limitations. First, the results were based only on the exit interviews for the first six participants who had completed the practicum at the time the project was undertaken. Further research is required to more fully capture the impact of this type of community-based practicum on the development of cultural humility and safety among MPT students. Second, the fact that students self-selected to participate in these practicums could be considered a limitation because they are already identifying and prioritizing Indigenous health as a topic of interest; however, we believe that it is a strength because we identified student readiness as an essential element for the success of this type of placement. Finally, the length of time that participants lived in the community (4 and 6 weeks) might not be long enough to develop trusting and deeper rooted relationships in a Métis community; although more time may strengthen the participants' transformational learning, this is not always possible within the MPT programming and curriculum. Thus, providing MPT students with numerous and diverse exposures within Indigenous health contexts should be a curricular consideration for MPT programmes.

CONCLUSION

These Métis community-based practicums demonstrated essential elements that support a cultural humility approach to MPT professional development and the practice of reconciliation by MPT students. Our results highlight the success of (a) community engagement with the practicum participants, (b) a student practicum built on strong relationships with community and informed by community, (c) a backbone of reflective practice, and (d) a base of community and student readiness. Moreover, the results suggest that these key elements set the stage for supporting MPT students in developing cultural humility skills. Graduating culturally humble physical therapy practitioners is one step in decolonizing Canada's health care system and creating a more accessible and culturally safe health care environment for Indigenous peoples.

KEY MESSAGES

What is already known on this topic

Indigenous populations in Canada often do not experience culturally safe interactions with health care profes-

sionals and the health care system in general. Addressing inequitable health outcomes among Indigenous populations requires physical therapy student practitioners to engage in enhanced training in cultural humility. Professional physical therapy programmes place a strong value on clinical placements because they give students an opportunity for rich experiential learning that will enhance their clinical and professional practice skills.

What this study adds

This study is the first of its kind to explore student practicums in a Métis community. It revealed the value of giving MPT students the opportunity to develop cultural humility through experiential learning practicums in this environment. The design of the practicum included four essential elements that were shown to be successful in supporting development of cultural humility among MPT students and that should be considered when developing practicums in partnership with Indigenous communities. It also suggests that such practicums are one step that Canadian MPT students and physical therapy schools can take in practising reconciliation.

REFERENCES

1. Leyland A, Smylie J, Cole M, et al. Health and health care implications of systemic racism on indigenous peoples in Canada. Mississauga: Indigenous Health Working Group of the College of Family Physicians of Canada and Indigenous Physicians Association of Canada; 2016.
2. Sasakamoose J, Bellegarde T, Sutherland W, et al. Miyo-pimatisiwin developing indigenous Cultural Responsiveness Theory (CRT): Improving indigenous health and wellbeing. *Int Indig Policy J*. 2017;8 (4). <https://doi.org/10.18584/iipj.2017.8.4.1>.
3. Allan B, Smylie J. First Peoples, second class treatment: the role of racism in the health and well-being of Indigenous peoples in Canada. Toronto: Wellesley Institute; 2015.
4. Statistics Canada. Aboriginal peoples in Canada: First Nations people, Metis and Inuit [Internet]. Ottawa: Statistics Canada [cited 2018 Apr 25]. Available from: <http://www12.statcan.gc.ca/nhs-enm/2011/as-sa/99-011-x/99-011-x2011001-eng.pdf>.
5. Morency J, Caron-Malenfant E, Coilmobe S, et al. Projections of the Aboriginal population and households in Canada, 2011 to 2036 [Internet]. Ottawa: Statistics Canada; 2015 [cited 2019 Jan 4]. Available from: <https://www150.statcan.gc.ca/n1/pub/91-552-x/91-552-x2015001-eng.htm>
6. *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11.
7. Jull JE, Giles AR. Health equity, Aboriginal peoples and occupational therapy. *Can J Occup Ther*. 2012;79(2):70–6. <https://doi.org/10.2182/cjot.2012.79.2.2>. Medline:29507771
8. Gerlach AJ. A critical reflection on the concept of cultural safety. *Can J Occup Ther*. 2012;79(3):151–8. <https://doi.org/10.2182/cjot.2012.79.3.4>.
9. Doane G, Varcoe C. The hard spots in family nursing: relational practice as connecting across differences. In: Varcoe GDC, editor. *Family nursing as relational inquiry: developing health-promoting practice*. Philadelphia: Lippincott Williams & Wilkins; 2005. p. 289–331.
10. Tervalon M, Murray-Garcia J. Cultural humility versus cultural competence: a critical distinction in defining physician training outcomes in multicultural education. *J Health Care Poor*

- Underserved. 1998;9(2):117–25. <https://doi.org/10.1353/hpu.2010.0233>. Medline:10073197
11. Moncho C. Cultural humility, part 1 – what is “cultural humility”? 2013 [cited 2018 Apr 25]. In: The social work practitioner [Internet]. Available from: <https://thesocialworkpractitioner.com/2013/08/19/cultural-humility-part-i-what-is-cultural-humility/>.
  12. Beagan BL. Approaches to culture and diversity: a critical synthesis of occupational therapy literature. *Can J Occup Ther*. 2015;82(5):272–82. <https://doi.org/10.1177/0008417414567530>. Medline: 26590226
  13. Hayward LM, Li L. Promoting and assessing cultural competence, professional identity, and advocacy in Doctor of Physical Therapy (DPT) degree students within a community of practice. *J Phys Ther Educ*. 2014;28(1):23–36.
  14. Health Council of Canada. Canada’s most vulnerable: improving health care for First Nations, Inuit, and Métis seniors. Toronto: Health Council of Canada; 2013.
  15. Aboriginal Health Initiative Committee. Health professionals working with First Nations, Inuit, and Métis consensus guideline. *J Obstet Gynaecol Can*. 2013;35(6 Suppl 2):S1–S52. Medline:23870781.
  16. Cleaver SR, Carvajal JK, Sheppard PS. Cultural humility: a way of thinking to inform practice globally. *Physiother Can*. 2016;68(1):1–4. <https://doi.org/10.3138/ptc.68.1.GEE>. Medline:27504041
  17. Proctor P, Oosman S. Physical therapy students embracing indigenous health curriculum in Saskatchewan. In: *Physiotherapy practice*, Vol. 5, 8. Ottawa: Canadian Physiotherapy Association; 2015.
  18. Smith L. Decolonizing methodologies: research and Indigenous peoples. New York: Zed Books; 1999.
  19. Wishart LHE, Swinamer J, Miller C. Entry-to-practice physiotherapy curriculum: content guidelines for Canadian University programs. Canadian Council of Physiotherapy University Programs; 2009.
  20. Mayan MJ. Chapter 3: method. In: Mayan MJ, editor. *Essentials of qualitative inquiry*. Walnut Creek, CA: Left Coast Press Inc.; 2009. p. 34–56.
  21. Oosman S, Abonyi S, Jeffery B, et al. Healthy aging in place: environmental scan. Ile-a-la-Crosse, SK: University of Regina and University of Saskatchewan, Saskatchewan Population Health & Evaluation Research Unit; 2013.
  22. MacDougall B. Wahkootowin: family and cultural identity in Northern Saskatchewan Metis communities. *Canadian Historical Review*. 2006;87(3):431. <https://doi.org/10.1353/can.2006.0082>.
  23. Statistics Canada [homepage on the Internet]. Ottawa: Statistics Canada; c2017 [cited 2019 Jan 4]. Census profile, 2016 census: Île-à-la-Crosse, Northern village [Census subdivision], Saskatchewan and Saskatchewan [Province]. Available from: <https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/prof/details/page.cfm?Lang=E&Geo1=CSD&Code1=4718067&Geo2=PR&Code2=47&Data=-Count&SearchText=Ile-a-la-Crosse&SearchType=Begins&SearchPR=01&B1=All&GeoLevel=PR&GeoCode=4718067&TABID=1>
  24. King J. Cultural evolution: a case cultural humility [Internet]. Ottawa: Canadian Physiotherapy Association; 2014 [cited 2017 Nov 29]. Available from: <https://physiotherapy.ca/cultural-evolution-case-cultural-humility>.
  25. Kirkness V, Barnhardt R. First Nations and higher education: the four R’s – respect, relevance, reciprocity, responsibility. *J Am Indian Educ*. 1991;30(3):9–16.
  26. Fereday J, Muir-Cochrane E. Demonstrating rigor using thematic analysis: a hybrid approach of inductive and deductive coding and theme development. *Int J Qual Methods*. 2006;5(1):80–92. <https://doi.org/10.1177/160940690600500107>.
  27. Mayan MJ. *Essentials of qualitative inquiry*. Walnut Creek, CA: Left Coast Press; 2016.
  28. Gasparelli K, Crowley H, Fricke M, et al. Mobilizing reconciliation: implications of the Truth and Reconciliation Commission report for physiotherapy in Canada. *Physiother Can*. 2016;68(3):211–15. <https://dx.doi.org/10.3138/ptc.68.3.GEE>. Medline:27909369
  29. Canada Truth and Reconciliation Commission. Truth and reconciliation commission of Canada: calls to action. Winnipeg: The Commission; 2015.
  30. Mezirow J. Transformative learning as discourse. *J Trans Educ*. 2003;1(1):58–63. <https://doi.org/10.1177/1541344603252172>.
  31. Hojjati A, Beavis ASW, Kassam A, et al. Educational content related to postcolonialism and Indigenous health inequities recommended for all rehabilitation students in Canada: a qualitative study. *Disabil Rehabil*. 2017;1–11. <https://doi.org/10.1080/09638288.2017.1381185>.
  32. Bishop A. *Becoming an ally: breaking the cycle of oppression in people*. 2nd ed. London: Zed Books; 2002.

APPENDIX: INTERVIEW GUIDE

SEMI-STRUCTURED INTERVIEW QUESTIONS FOR PRACTICUM PARTICIPANTS

1. Tell us about your experiences in your community-based practicum in a Métis community.
2. How did your research placement in the community support your clinical and professional practice development?
3. What aspects of your placement influenced your knowledge of Indigenous health? And influenced your cultural humility and safety skill development?
  - a. Tell me/us something new that you learned on placement in the community that you didn't feel you understood/were exposed to prior to going on placement.
4. Has your perspective of Indigenous health changed since your time in the community-based practicum in a Métis community?
5. If you had to do this practicum again, what (if anything) would you change? And would you recommend this type of experience to other MPT students? If not, why not? And if so, why?
6. What would have made this experience better?
7. What do you think the role of physical therapy is in providing culturally safe health care to Northern communities and Indigenous peoples?
8. Do you have anything else you would like to share with us?