Aboriginal and Torres Strait Islander Health Practitioner student perspectives on an interprofessional education program

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Introduction

The Remote Health Experience is run by three Northern Territory (NT) partner institutions – Flinders University Northern Territory, Charles Darwin University (CDU) and Batchelor Institute of Indigenous Tertiary Education. It is a three-day, On Country, interprofessional education program that simulates a real-life remote health context in Katherine, NT. Participants are final year Nursing, Pharmacy, Aboriginal and Torres Strait Islander Health Practitioner, and first year Doctor of Medicine students.

The team from Flinders, CDU and Batchelor developed and implemented the Remote Health Experience to assist in achieving the challenging goal of delivering meaningful interprofessional education in a Northern Territorian context. Interprofessional education aims to prepare future health professionals for effective collaboration in practice (Deutchman 2012; Mfopu et al. 2014; Halaas et al. 2007), yet there is currently only limited evidence of successful programs.

This case study focuses on Aboriginal and Torres Strait Islander Health Practitioner students' perspectives, gathered via a post-event evaluation, of the Remote Health Experience program. The evaluation aimed to determine if and how the interprofessional aspects of the program influenced the students' practice and aspirations.

Aims and Objectives

The aim of the Remote Health Experience is to teach students to become confident in a remote, cross-cultural, interprofessional primary health care context and to become clinical partners rather than clinical leaders.

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The Remote Health Experience program objectives are aligned with those of the Centre for Remote Health, which aims:

- To promote interprofessional learning for remote contexts – the context is an inseparable work and living environment characterised by unique cultural, linguistic, social, economic, geographical and climatic conditions.
- To enhance remote applications to practice – the practice at the Centre for Remote Health is interprofessional, with profession-specific skills, knowledge, and attributes required for competent, confident and accountable remote and Indigenous health practice within the primary health care framework.

The post-event evaluation discussed in this case study aimed to:

- explore Aboriginal and Torres Strait Islander Health Practitioner students' perspectives on interprofessional teaching and learning at the Remote Health Experience;
- understand some of the challenges and successes the Aboriginal and Torres Strait Islander Health Practitioner students may have in an interprofessional education delivery model;
- determine if interprofessional learning may influence changes of practice and aspirations among Aboriginal and Torres Strait Islander Health Practitioner students;
- add to the body of knowledge for interprofessional education with a focus on remote practice; and
- provide a basis of understanding about what can lead to improved remote interprofessional education.

Approach

With the assistance of local remote practitioners and faculty educators from the three NT partner institutions, locally relevant content was developed and implemented in 2011 and consolidated over the following years. The content focused on remote health issues, Aboriginal health status, and remote interprofessional practice in resource-poor environments. These issues were constructed into seven simulated scenarios in which Medicine, Nursing, Pharmacy and Aboriginal and Torres Strait Islander Health Practitioner students learn interprofessional practice and increase their confidence in managing these sometimes challenging situations.

All Aboriginal and Torres Strait Islander Health Practitioner students are employed at a health clinic while they undertake their studies, and come together for two blocks of one-week long teaching per year. One of these blocks includes the Remote Health Experience in Katherine. Understanding the challenges and successes of an interprofessional education delivery model for these students is the focus of this case study.

Aboriginal Health Services from Katherine provide the appropriate logistical support and context for this learning experience. The activities are designed to support work in small interprofessional groups, reflecting real practice settings through the seven scenarios. The Remote Health Experience was designed to address and blend each of the four discipline's learning objectives and is part of each discipline's curriculum. Blending four different health professional program course objectives,

for similar but distinct rural and remote health topics, presents itself as a challenging prospect. Students are mixed randomly in interdisciplinary groups in which they remain for the three days. This interdisciplinary structure simulates the real professional remote context for the students. It is also applied to the teaching and facilitating teams, in which Aboriginal and Torres Strait Islander Health Practitioners from remote clinics teach next to faculty members from Darwin or Adelaide.

While the Rural Interprofessional Program Education Retreat implemented in Tasmania in 2006 and 2007 (Whelan, Spencer & Rooney 2008) was used as an early model for the development of this program, it differs in four major ways:

- The inclusion of Aboriginal and Torres Strait Islander Health Practitioner students and graduates in the Remote Health Experience program, some of whom are local people living and working in remote Aboriginal health services in the Katherine region, adding a cross-cultural dimension to the program.
- The program is delivered at a remote campus thereby embedding the environment into the learning content.
- The number of stations varies in the two programs, with the Remote Health Experience having a seven-station circuit simulating different real-life clinical needs for remote practice.
- The final point of difference is that the Remote Health Experience has become an ongoing program managed by the three partner universities over the last four years.

The program was designed with an integrated evaluation process for which ethics approval was granted over four years (HREC-MSHR/NT, 2011–1515). This embedded evaluation was used as a continuous quality improvement method, with anonymous and voluntary surveying tools given to all participants (students and facilitators) after each workstation, and at the end of the whole Remote Health Experience program. This evaluation informed the development process of the program but did not explore the impact that an interprofessional program may have on students' perceptions of other health disciplines when working together. Nor did it provide information on their perspective of effective teamwork.

To address the above, a voluntary post-event evaluation (guided questionnaire) was initiated in 2013 for all Aboriginal and Torres Strait Islander Health Practitioners who participated in the Remote Health Experience in 2011 and 2012. The evaluation sought to discover the impact of the event on students, with the aim of demonstrating how interprofessional teaching can influence changes in student practice and aspirations. Only Aboriginal and Torres Strait Islander Health Practitioner students were asked to participate in the evaluation at this stage, as they were the only participants already working at the time. The remaining students will be asked to take part in a second stage evaluation following their graduation. As such, the results presented in this case study are from the Aboriginal and Torres Strait Islander Health Practitioner students only.

A qualitative approach underpinned the evaluation, using guided questions designed to explore students' personal experiences. This style of information gathering was chosen by the team following a discussion with the Aboriginal and Torres Strait Islander Health Practitioner course lecturers, as an appropriate and sensitive way of engaging with the group (AIATSIS 2013; Gladman 2012). It was the first time in the evaluation of the Remote Health Experience that personal feedback from the Aboriginal and Torres Strait Islander Health Practitioner students had been

sought. The approach resonated better and was more meaningful for the students than the self-reported surveys used for the earlier process evaluation.

A questionnaire was designed using open- and closed-ended questions to elicit qualitative data only (excluding Likert scale questions). Seven questions were included that explored the perceived benefit of interprofessional education to oneself and to one's practice; the effectiveness of teamwork; and 'what works well' and 'what does not work so well' for encouraging student learning. The questionnaire was kept deliberately short with clear and concise questions. Participation was anonymous and voluntary, and consent was sought from all participants.

The final sample size was 10 students – those who completed the evaluation prior to presentation of the data at the Leaders in Indigenous Medical Education (LIME) Connection in August 2013.

Students provided a total of 45 answers/comments via the questionnaire. The team performed a triangulated content analysis to data treatment and it was analysed by Social Representation Theory, which is concerned with the relationship between knowledge and practice (or action). Social representation defines what possible responses to certain events within a particular context are seen to be reasonable by different communities. Therefore, it allows for the co-existence of competing and contradictory forms of knowledge in one and the same community, culture and individual (Sammut & Gaskell 2010; El Sayed et al. 2011).

The next exploratory step was to understand the impact this training had on the students and determine any change of perceptions when practising in the workplace (Gladman 2012).

Results

According to the set of results, the Aboriginal and Torres Strait Islander Health Practitioner students found that this interprofessional education event helped to reduce their own assumptions that the other health professionals were 'better' (more skilled, more confident) than them. The data also contains the strong message that all participants were students learning together at the same time, and that doctors and nurses had one day been students just like themselves. One student (idS4) reported that:

> *Learning alongside doctor, nurse and pharmacy students gives you added confidence in yourself and a sense of pride.*

This increased self–confidence and self-esteem appears to be connected to the realisation that all participants in the Remote Health Experience are students, and that every professional started his or her journey as a student. Two students reported that they 'did not think of doctors being students' (idS2,7) and this has changed their perspectives at the workplace. They reported being 'less scared by doctors' (idS2,7,8).

Three major themes emerged from the dataset:

1. Knowledge, skills, self-esteem and peer support were self-reported as improved after the program. Students recognised their advanced clinical skills when practising at the stations and mentioned the value of peer support when learning in the interprofessional education design.

2. Students reported increased confidence and this is being seen as an important part of the interprofessional team learning approach.
3. Interprofessional relationships improved; students all noted that they felt more part of a health team as they saw the other health workers as students who had to learn as well, and not only as health professionals who know everything. This also includes appreciation and respect for other health professional roles:

   Great to see so many [representatives] from the various health professions and the urban, regional and rural practitioners as well; also very important to have a great cross-cultural mix of staff and advisors (idS3).

Eight of the students (80%) found the program beneficial and would recommend it to other students. Two did not answer this question.

One student reported a personal positive event after the Remote Health Experience:

> *I have met this trainee doctor before at Remote Health Experience and we connected easier due to having been through the Katherine experience together. We have a shared history. This can be a good… example for the students to develop and maintain strong interprofessional relationships and respects during their health careers* (idS10).

Eight Aboriginal and Torres Strait Islander Health Practitioner (80%) students reported that breaking into the other discipline groups was challenging.

There was an overall agreement that '…the whole interprofessional, holistic health professional interaction during the day' (idS1,4,8,9) was valuable and beneficial. If offered the opportunity, all respondents said they would attend again.

Discussion

Successes

One of the aims of the project was to get an understanding of the challenges and successes experienced by the Aboriginal and Torres Strait Islander Health Practitioner students in the interprofessional education setting. Honest feedback was given through the new evaluation method (Gladman 2012). Evaluation formats and resulting responses in this context have been highlighted as an area for future studies.

The Aboriginal and Torres Strait Islander Health Practitioner students reported that 'training with other health professional sectors has the effect of breaking down barriers' (idS7); '... we must always strive to break down the barriers between sectors. Barriers reflect unprofessional attitudes and restrained practice and cause problems for clients seeking health care' (idS5).

Students reported positive experiences after completing the Remote Health Experience, including:

> *I really improved myself in the clinic… a doctor couldn't understand an old lady who wanted medication… [because] she was talking in her language. The doctor came and asked for my help. So that was the good thing that came out of this experience for me* (idS3).

The collaborative role modelling of the three academic institutions coming together with the local Aboriginal health services in Katherine to deliver an interprofessional event was also perceived as part of the success for the event. This contributed to the students' feeling of 'being comfortable in this environment' (idS2,4,7). A secondary outcome of the program was that the Aboriginal and Torres Strait Islander Health Practitioner students stated that '…meeting the other students of the course was great' (idS8). The students do not get many opportunities to meet and undertake activities in an interprofessional context and this also contributed to group bonding and an enhanced sense and value of peer support.

Some of the Katherine-based students have returned in following years (one in 2014, three in 2015) as practising registered Aboriginal and Torres Strait Islander Health Practitioners, to facilitate and teach the future cohort of students attending the event and to pass on their knowledge and experience.

These Aboriginal and Torres Strait Islander Health Practitioner students have demonstrated partnership skills in engaging with the other students and presenting to the larger group as part of their assessment. Their feedback shows that as a group they have understood the importance of an interprofessional team working together in remote settings, and are becoming confident clinical partners in a context relevant to their future practice.

Challenges

For faculty members involved, one of the main challenges was to teach the realities of remote practice outside the classroom; to teach students to become confident in a primary health care, cross-cultural context; and to become clinical partners rather than clinical leaders. The main gap which needed addressing was the dearth of information concerning the impact that interprofessional teaching may have on these students' future practice and the learning opportunities that an interprofessional education method provides (WHO 2010).

The eight Aboriginal and Torres Strait Islander Health Practitioner students who reported that breaking into the other discipline groups was challenging are mature students working at health centres. Some of them also have family and/or community responsibilities, which along with their age could affect their relationships with other students, who are often much younger and from diverse personal and professional backgrounds.

Students also often found the oral presentation to the whole group – 80 people represented by 56 students from four health disciplines and 24 varied faculty staff and facilitators – confronting and difficult. However, they also reported that the presentation provided a great opportunity to show themselves as health professionals undertaking complex and multiple roles as part of the health care team at remote health centres. This presentation assisted in breaking the disciplinary silos and fostering student engagement when forming their interprofessional work groups.

Many students (60%) reported that the language used was 'too complex, too medically orientated or not explained in sufficiently simple words'.

One of the recognised major limitations to this paper is the small number of respondents. This is due to the low enrolment numbers of Aboriginal and Torres Strait Islander Health Practitioners in 2011 and 2012, and to workplace constraints where student absence made contact difficult or

impossible. Faculty members agreed that this type of evaluation needs to be repeated over time to gather more robust evidence. An on-site visit and an evaluation by the student's workplace supervisor, following the Rural Health Experience, could also substantially add to the information gathered from the self-reported evaluation.

Conclusion

The Remote Health Experience simulates the core of the health team in remote settings. This simulated environment has offered a learning platform that is conducive to cross-cultural teamwork; highlights the importance of relationships in health care delivery; and focuses on teaching students to become more confident clinical partners.

This post-event impact evaluation of the Remote Health Experience 2011 and 2012 highlighted that teaching and learning in interprofessional teams provides multiple benefits to Aboriginal and Torres Strait Islander Health Practitioner students (WHO 2010). It also showed that, overall, those students undertaking the Remote Health Experience program found it to be beneficial to their learning, aspirations and current practice. In addition, it has provided evidence for the transformative experiences of interprofessional relationships for this group of students who work and study at the same time. It illustrates that there is benefit in outside classroom experiences that foster these relationships – findings that correlate with those of Gladman (2012).

Furthermore, the Remote Health Experience has added value to the didactic learning of the Aboriginal and Torres Strait Islander Health Practitioner students, via an On Country activity that accurately simulates clinical situations.

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