

Friends with benefits: Should Indigenous medical educators involve the Indigenous community in Indigenous medical education?

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Introduction

The Māori Indigenous Health Institute (MIHI), University of Otago, Christchurch, has used the teaching method of Indigenous simulated patients to enhance its Indigenous health curriculum for the past eight years. This involves engaging Indigenous community members to participate as Indigenous simulated patients. Indigenous simulated patients are used throughout the Advanced Learning in Medicine clinical years (Years Four to Five) as part of small workshop tutorials and Objective Structured Clinical Examination (OSCE) assessments.

The role of Indigenous simulated patients within the University of Otago, Christchurch, curriculum is to provide medical students the opportunity to hone their application of the Hui process (a model of Māori patient engagement) (Lacey et al. 2011) and the Meihana Model (a clinical history-taking model) (Pitama et al. 2007) to a clinical scenario involving a Māori patient. Indigenous simulated patients are also utilised within the OSCE components of the fifth-year Hauora Māori vertical module.

A curriculum audit was conducted by staff at MIHI using a case study design to explore six Indigenous community members' experiences as simulated patients. The aim was to identify possible enablers of and barriers to the Indigenous community being involved in Indigenous medical education.

Why was this project initiated?

This project was initiated to understand the complexities of being involved in Indigenous medical education as community stakeholders.

Aims and objectives

The purpose of this study was to:

1. Ascertain the benefits of participation by Indigenous community members.
2. Ascertain the risk/burden carried by Indigenous community members because they had participated as simulated patients.

Approach to achieve aims and objectives

Six Indigenous simulated patients were selected and interviewed using a purposive sampling method. All six participants had been involved with the program for at least five years and were aged between twenty-five and sixty-five. Participants were interviewed using a semi-structured interview schedule. These interviews were transcribed and coded using inductive analysis.

Once the interview data was coded and then categorised, challenges and benefits, as described by the Indigenous simulated patients, were identified. The following sections outline the challenges and benefits as identified by the Indigenous simulated patients, as well as the actions that have been implemented by MIHI/medical educators as a result of this research.

Challenges

Two key challenges were present throughout the development of the program. First, the reality of the burden of disease on whānau (extended family) meant that even though the simulated patients knew the scenario was not 'real', there would often be aspects of the scenario that related to their own or whānau experiences. To counter this, all simulated patients are now provided with the scenarios in advance, and can provide feedback to the medical educators prior to the session.

Additionally, the challenge of standardisation of simulated patient responses to students needed to be addressed. Simulated patients often found it challenging to refrain from supporting students (as is often culturally appropriate), especially in assessment situations. To counter this, simulated patients are now provided with training and briefing by the medical education team regarding assessment and the need to standardise responses.

Successes

As a result of their participation in the program, all simulated patients experienced increased awareness of Indigenous health rights. This increased awareness has led to all simulated patients, at one time or another, advocating for the health of their whānau. One participant stated that they now expect a certain level of care:

I am a consumer and you need to deliver me and my whānau an excellent service.

Following the sessions, simulated patients are now provided the opportunity for feedback and support, which may include further information on health rights.

The simulated patients described the experience of supporting student clinicians who are learning to work competently with Māori patients and whānau as a benefit. All simulated patients reported feeling that they were working positively towards supporting the students' competencies in regards to Māori health care. In order to further improve the curriculum, those simulated patients working in the hospitals are now able to provide feedback to the Indigenous medical educators.

The program also increased students' awareness of the Indigenous health support workers within the hospital environment and medical teams. Hospital staff, who took an active interest in supporting students on the wards where possible, were provided with training to be simulated patients by MIHI staff.

Additionally, The University of Auckland has adapted this model for use in its School of Medicine.

What are the impacts?

As a response to the findings, the way in which clinical scenarios are written for Indigenous simulated patient sessions has been adapted to take into account the heavy burden of disease on Indigenous communities. As this research has demonstrated, it is highly likely that the Indigenous people involved as simulated patients have had personal and/or whānau experiences of the diseases that are commonly explored in the scenarios (for example, cardiovascular disease) and this needs to be acknowledged.

This finding has ultimately led to the inclusion of clear introductory sessions for all simulated patients, no matter how experienced they are, that run through the scenarios prior to student contact in order to identify any content that may resonate with their real-life experiences.

The study also identified that being involved in the curriculum meant that as an Indigenous medical education unit we need to provide adequate space and opportunity for the community to feedback to us about personal and whānau experiences, and provide clinical support where appropriate. The identification of barriers to involvement for the Indigenous community has led to MIHI developing a more robust training and feedback process that ensures accountability to our community members.

How has the project developed Indigenous leadership?

The most common enabler identified by all of the Indigenous simulated patients was the increase in awareness and knowledge about their own and their whānau health rights, and an awareness of the level of quality care that they should be receiving from health professionals. This serves to strengthen awareness of Indigenous patient health rights and hold the health environment to account for Indigenous inequities.

Results of this qualitative audit of Indigenous simulated patient experiences were presented by Māori staff from MIHI at LIME Connection IV, 2011, in Auckland, Aotearoa/New Zealand, as well as at the Association for Medical Education in Europe conference, 2012, in Lyon, France.

What's next? Project sustainability

The next stage is to conduct a larger research project to further explore the experiences of the Indigenous community as simulated patients. This will include a systematic literature review of the experiences of simulated patients in medical education to further inform the practice of utilising Indigenous simulated patients. This initial audit has demonstrated that involving the Indigenous community as simulated patients to assist in the delivery of Indigenous medical education is beneficial for all stakeholders.

Utilising Indigenous simulated patients within medical education provides not only an opportunity for students to learn, but also for educators and community to develop a greater understanding of each other. This understanding allows for a community-accountable approach to medical education. This accountability is paramount within Indigenous medical education.

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References

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