



THE LIMENETWORK
Leaders in Indigenous Medical Education

LIME GOOD PRACTICE CASE STUDIES

VOLUME FIVE
2019







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Definition: In this document, we use the term 'Indigenous' to refer to the Aboriginal and Torres Strait Islander peoples of Australia and Māori in Aotearoa/ New Zealand. The terms 'Aboriginal', 'Aboriginal and Torres Strait Islander peoples' and 'Indigenous' are used interchangeably with reference to the Australian context. The term 'Māori' and 'Indigenous' are used interchangeably with reference to the Aotearoa/New Zealand context.

FOREWORD

It is essential that medical students and doctors understand the social, cultural and political context of Indigenous peoples' lived experiences, and practise with cultural safety when working with Indigenous people. The knowledge, attributes and skills to work competently and respectfully with Aboriginal and Torres Strait Islander peoples and Māori are needed by all doctors working in Australia and Aotearoa/ New Zealand.

Medical Deans Australia and New Zealand is committed to improving Indigenous health outcomes by working to recruit, support, retain and graduate Indigenous medical students, and promoting best practice in the teaching of Indigenous health in medical education.

The LIME Good Practice Case Studies make an important contribution to these goals.

This fifth in the series highlights work in Indigenous health education occurring across a number of medical schools, including activities focused on community engagement, learning on Country, student beliefs about health and inequalities, and the effects of constructively aligning curricula in our medical schools.

These LIME Good Practice Case Studies shine a light on the innovative and effective work that's being done across our two countries. They share ideas, stories and successes, and aim to stimulate different thinking about how we can all contribute to improved equity of health outcomes and opportunities for Indigenous peoples. They also encourage action – from all of us.

I congratulate all those who contributed to this latest publication, and the LIME Network and its members for their leadership, collaborative approach, and unflagging commitment to working for the improvement of effective and sustainable Indigenous health and education outcomes.



Professor Ian Symonds

President, Medical Deans Australia and New Zealand

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- Dr Elana Curtis (The University of Auckland)
- Ms Odette Mazel (LIME Network)
- Dr Scott McCoombe (Deakin University)
- Professor David Paul (The University of Notre Dame University, Fremantle)
- Ms Caitlin Ryan (LIME Network).

This publication is an important outcome of the LIME Network and we express our appreciation to the members of the LIME Network Reference Group for their leadership and ongoing commitment to the program.

INTRODUCTION

This fifth edition of the *LIME Good Practice Case Studies* showcases some of the papers that were first presented at LIME Connection VII in Melbourne, Australia in 2017.

The theme of the Connection – ‘The Future of Indigenous Health Education: Leadership, Collaboration, Curriculum’ – encouraged strengths-based presentations that captured new initiatives, shared evidence-based practices and sparked visions for the future. Importantly, as is supported at each LIME Connection conference, presenters also discussed the challenges and critiqued current practices, and shared in robust discussion on leadership, curriculum innovation and collaboration in Indigenous health and health professional education.

The papers included in this volume provide a snapshot of the breadth and depth of the presentations from LIME Connection VII. They include reflections on:

- Community engagement
- Indigenous health teaching and learning
- Curriculum development and research.

The papers in Volume Five build on the those included in Volume One (2012), Two (2013), Three (2015) and Four (2017) to highlight programs of work that are being conducted across Australia, Aotearoa/New Zealand and further afield. The translation of these presentations into papers for publication is part of the LIME Network’s ongoing commitment to advancing the discipline of Indigenous health education and to developing a body of work that builds the evidence base for informing good practice approaches in the field.

ABOUT THE **LIME NETWORK**

The **Leaders in Indigenous Medical Education (LIME) Network** is a program of Medical Deans Australia and New Zealand. It receives funding from the Australian Government Department of Health, and is hosted by the Faculty of Medicine, Dentistry and Health Sciences at the University of Melbourne.

The **LIME Network** is a dynamic initiative dedicated to ensuring the quality and effectiveness of the teaching and learning of Indigenous health in medical education, as well as promoting best practice in the recruitment and graduation of Indigenous medical students. This is achieved by establishing a bi-national presence that encourages and supports collaboration within and between medical schools in Australia and Aotearoa/New Zealand, and through building linkages with the community and other health science sectors.

The LIME Network promotes the primacy of Indigenous leadership and knowledge. Its achievements to date include the following:

- The facilitation of bi-annual **Reference Group** meetings to provide the opportunity for those working in Indigenous health within medical schools to collaborate, share information, provide feedback and peer network
- The biennial **LIME Connection** conference to provide a forum for knowledge exchange and dissemination, and the conference's **LIMELight Awards** to celebrate successes in the field
- The **Indigenous Medical Student and Community Bursary Scheme** providing the opportunity for networking and peer support at LIME Connection
- Publication of the tri-annual **LIME Network Newsletter** promoting best practice and sharing successes in the field
- Maintaining the **LIME Network Website** housing information on LIME Network projects, relevant resources, and other news and events
- Building the evidence base of the efficacy of Indigenous health curriculum development and implementation, as well as Indigenous student recruitment and support to graduation initiatives through publications such as the **Good Practice Case Studies**
- Developing and implementing internal **review tools** to support medical schools and Specialist Medical Colleges to reflect and evaluate their performance

- Supporting Indigenous secondary school and mature age students to understand the pathways to studying medicine through the online **Indigenous Pathways into Medicine Resource** and **Indigenous Pathways into Medicine Videos**
- Strengthening capacity and sharing knowledge among network membership through **Slice of LIME Seminars** and **professional development workshops**
- Developing a **Peer Support Statement and Strategy** that operates across universities
- Building linkages across health disciplines and with medical colleges through **networking and information sharing**
- Supporting collaboration between medical schools and their local Indigenous Community Controlled Health Organisations through the facilitation of **Regional Meetings**.

Background

The LIME Network began as an informal collaboration between Indigenous and non-Indigenous medical educators, doctors and students concerned with improving the teaching and learning of Indigenous health in medical education, and the recruitment of Indigenous medical students. This group convened at forums such as the Indigenous Medical Conferences in Salamander Bay, New South Wales in 1997; the Australian Indigenous Doctors' Association gatherings since the formation of the association in 1998; and the Committee of Deans of Australian Medical Schools' (CDAMS) working groups and workshops since 1999.

In 2003, the CDAMS Indigenous Health Curriculum Development Project was funded by the (now defunct) Office of Aboriginal and Torres Strait Islander Health, in the (then) Australian Government Department of Health and Ageing, and an audit of existing Indigenous health content in medical curricula undertaken. The findings of the audit were used to inform the development of the *CDAMS Indigenous Health Curriculum Framework*¹ to provide medical schools with a set of guidelines for developing and delivering Indigenous health content in core medical education. Importantly, following its publication in 2004, it became the only curriculum framework to be endorsed by all medical schools in Australia and Aotearoa/ New Zealand, and in 2006 was incorporated into the Australian Medical Council standards for medical school accreditation.

1 G. Phillips 2004, *CDAMS Indigenous Health Curriculum Framework*, VicHealth Koori Health Research and Community Development Unit, The University of Melbourne, Melbourne.

ABOUT THE LIME NETWORK

The growing network of medical educators from Australia and Aotearoa/New Zealand, many of whom contributed to the CDAMS Indigenous Health Curriculum Development Project, came together at the inaugural LIME Connection in Fremantle, Western Australia in 2005. An outcome of the conference was the formal establishment of the LIME Network.

In 2008, the Australian Government Department of Health and Ageing agreed to fund the LIME Network as a program of Medical Deans Australia and New Zealand. Funding for the Network continues through the Australian Government Department of Health.

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LIME GOOD PRACTICE CASE STUDIES

CURRICULUM DEVELOPMENT AND RESEARCH

Constructively aligned curricula, culturally safe clinicians... and world peace!

Dr Rhys Jones, Te Kupenga Hauora Māori, Faculty of Medical and Health Sciences, The University of Auckland, Aotearoa/New Zealand

As educators working in Indigenous health professional education, we are strongly motivated by the stark inequities in health between Indigenous and non-Indigenous populations (Anderson et al. 2016). With our role of educating current and future health professionals, we are acutely aware of the ways in which cultural incompetence has contributed to unacceptably poor Indigenous health outcomes.

Reducing health inequities is an integral and important aim of health professional education programs and institutions (Sanson-Fisher, Williams & Outram 2008). How far does this responsibility extend and what does this aim entail?

This paper argues that health professional educators and institutions have a role, and one that extends well beyond formal curricula, in advancing cultural safety among health professionals. However, to unlock the potential of medical education to improve Indigenous health outcomes, we must promote learners' development as agents of change. There must also be a broader agenda of transformation – in institutions, in the health professions, in our health care systems and in wider society.

As we strive for constructively aligned Indigenous health curricula that seek to cultivate culturally safe clinicians, we also need to keep in mind the bigger picture. Perhaps 'world peace' is a little too ambitious – but our work has to be underpinned by an emancipatory goal. This relates to the elimination of health inequities, necessitating an agenda of decolonisation that centralises Indigenous rights.

Determinants of health inequities – How much is amenable to the influence of medical education?

Inequities in health between Indigenous and non-Indigenous populations have a complex and multifactorial causation. They have been established, and are perpetuated, through differential access to the social determinants of health and to high-quality health care (Reid & Robson 2007). These inequitable distributions of health determinants are driven by systemic racism that is underpinned by colonisation (Paradies 2016; Sherwood 2013).

LIME GOOD PRACTICE CASE STUDIES

How much of this is within medical education's realm of influence? I argue that there is a legitimate role to play in all areas, including addressing social, political, environmental and economic factors, but that medical education clearly has a central role in contributing to equity in health care. This is largely because, in comparison to broader social determinants, health system factors are more amenable to direct influence by medical professionals who can effect change as part of their clinical and health leadership roles.

The determinants of health care inequities can be broadly conceptualised in three categories: health system factors, health professional factors, and patient or population factors (Smedley, Stith & Nelson 2003). Medical and health professional education has traditionally focused on the second category by seeking to improve clinical engagement between health professionals and Indigenous peoples with a view to improving clinical outcomes.

This is, of course, important as medical education must address those health professional factors (e.g. clinician bias) that contribute to health care inequities and poorer health care outcomes for Indigenous people. However, medical education also has a significant role to play in addressing the health system and patient/population factors that lead to these inequitable health outcomes.

Health professionals must have more than just the requisite knowledge and skills to work effectively with Indigenous people in clinical settings; they also need to be able to engage with communities, health organisations and across sectors. If they are to make a genuine difference, they must have the knowledge and skills to work within institutions, structures and systems in ways that can influence the political, social, economic and environmental determinants of inequity (Hixon et al. 2013).

There are also broader implications for our institutions, which must become agents of change (Murray et al. 2012). This requires internal change to address structures and processes that limit Indigenous development, as well as external action to promote transformation within health systems and in the wider society (Fay 2017; Chin et al. 2018).

What does this 'big picture' agenda mean for our work in Indigenous health education? This paper explores the implications for pedagogical development, Indigenous workforce development and advocacy for health equity.

The curriculum

As Indigenous health educators we are often accustomed to working at the curriculum level, focusing on learning outcomes such as the knowledge, attitudes and behaviours necessary to work effectively with Indigenous patients. This is clearly important as health professional characteristics contribute to the complex processes that culminate in health care inequities (van Ryn et al. 2011). Addressing these factors in medical education can both enhance the quality of clinical interactions and improve clinical decision-making, which in turn improve health care outcomes for Indigenous patients. However, if we focus on graduating culturally safe clinicians in isolation of addressing the systems in which they are educated, trained and ultimately practice, we may improve patient experience at an individual level but fail to effect systemic change.

Seeking to develop culturally safe students and clinicians is problematic when their education, training and practice occur in a culturally unsafe system. Approaches to address this range from educational initiatives centred on developing critical thinking among students to interventions aimed at modifying system factors. Where should Indigenous health educators be directing our efforts?

At one level, working to change the educational curriculum and institution should be a critical part of our efforts. Medical education has long been complicit in reinforcing racist discourse about Indigenous peoples and perpetuating health inequities (Ly & Crowshoe 2015). There is also evidence that educators generally feel poorly prepared to support learners in developing Indigenous health competencies (Jones, Poole et al. 2013). Recognising the influence of this hidden curriculum and lack of cultural competence in Indigenous health education is essential for lasting systemic change (Ewen, Mazel & Knoche 2012).

Medical education institutions must, therefore, work towards building capacity for quality teaching, learning and assessment in Indigenous health throughout the curriculum (Phillips 2004). Experience at the University of Auckland has identified the assessment of Indigenous health learning outcomes by clinical supervisors as an important opportunity for building capacity in this area. On most clinical attachments students are assessed in the Hauora Māori (Māori Health) Domain, an area that clinical teachers find challenging (Jones, Henning et al. 2013). To support them, we have invested in professional development and educational resources in a variety of settings so they can more effectively engage in Indigenous health teaching, learning and assessment.

In addition, medical education institutions must ensure that their systems and policies are consistent in addressing, legitimising and valuing Indigenous health and equity. However, given that a significant amount of health professional education occurs in contexts outside their direct influence, medical education institutions must also advocate for building and mandating cultural safety in partnering health care organisations and the wider health sector.

Indigenous health workforce development

As with curriculum development, our work in developing the Indigenous health workforce must be grounded in an emancipatory framework. It cannot simply be about recruiting, supporting and graduating more Indigenous doctors, nurses and other health professionals. There needs to be a broader vision under which this stream of work is situated, and a clear articulation of how Indigenous health workforce development contributes to that vision (Phillips 2004; Mackean et al. 2007; Curtis, Reid & Jones 2014).

Often, the rationale given for increasing the number of Indigenous doctors is that it will allow Indigenous patients to have a greater chance of seeing a doctor who is also Indigenous. There is some indication that many Māori prefer being treated by Māori doctors (Jansen, Bacal & Crengle 2008), and ethnic differences between patients and health professionals have been associated with shorter consultations and less participatory communication styles (Cooper et al. 2006). However, the findings from research internationally in this area are inconsistent. A review of studies examining the effect of patient–provider race concordance on minority patients' health found inconclusive evidence of positive health outcomes (Meghani et al. 2009).

A more representative workforce can contribute to 're-presenting' Indigenous peoples in health professional education. Rather than being portrayed solely as the recipients of care, Indigenous people can also be identified as providers of care, and as experts and leaders in the health sector (Curtis, Reid & Jones 2014). There are also likely to be important effects on the informal curriculum in health professional education, such as mitigating discrimination and increasing the accessibility of Indigenous role models (Paul, Ewen & Jones 2014).

We must not assume, however, that these positive impacts will occur automatically as a result of increasing the number of Indigenous health professionals. Systemic change will also require advancing Indigenous leadership at all levels and having an explicit orientation towards decolonisation and Indigenous self-determination throughout the medical curriculum and institutions (Curtis, Reid & Jones 2014). Indigenous health workforce development must be conceptualised within this broader agenda of transformation.

Decolonisation is about challenging the role of our institutions in the ongoing colonisation of Indigenous peoples, and making them responsive to Indigenous goals of self-determination and wellbeing (Mihesuah & Wilson 2004). It is intrinsically linked with a process of reclaiming Indigenous epistemologies and knowledges, and reasserting self-determination (Smith 2012). In this context it involves dismantling institutional structures and systems that enable racist processes and outcomes, and centring Indigenous ways of knowing and doing.

Advocacy for health equity and Indigenous rights

It has long been recognised that health professionals have a legitimate role in influencing the social, economic and political determinants of health (Mackenbach 2009). The New Zealand Medical Association notes that doctors' roles include advocating for improved population health and health equity, and a commitment to the Treaty of Waitangi (NZMA 2011). Similarly, the Australian Medical Association claims that doctors have a role in advocating for their patients and communities, particularly those who are disenfranchised (AMA 2011).

Medical education curricula must, therefore, seek to achieve learning outcomes related to social and political advocacy for health equity and Indigenous rights. In support of this goal, it is critical that educators and institutions 'walk the talk' as agents of change. This requires medical education providers to engage clinical teachers who are also advocates, and to value advocacy to the same degree as other professional attributes (Luft 2017). In addition, institutions should accept the role of societal critic and conscience by taking action to address the social, political, environmental and economic determinants of Indigenous health.

Conclusion

There is a need for decolonisation at multiple levels, including in the curriculum, throughout the institution and across our broader systems and structures. These spaces vary in their amenability to the influence of medical education, but it is important that Indigenous health educators are engaged in all of them.

Decolonising health professional education must involve not just the Indigenous health curriculum, but also addressing the formal, informal and hidden curricula across educational programs. This will require the alignment of all elements in the institutional curriculum (Murray-Garcia & Garcia 2008). The Indigenous health curriculum must include a critical analysis of colonisation and racism, and seek learning outcomes that are decolonising and anti-racist. We must also examine the wider curriculum with a view to eliminating racism and reinforcing Indigenous health learning outcomes in all educational contexts.

Indigenous health workforce development must be situated within a similarly broad vision. Improving the representativeness of the workforce is important, but such endeavours must be accompanied by more ambitious goals that seek the advancement of Indigenous leadership with a view to decolonisation and Indigenous sovereignty.

Indigenous health education cannot simply be about ensuring that health professionals are culturally safe in clinical interactions with Indigenous patients and families. It must also be about developing learners as agents of change, and ensuring that our institutions are agents of change at both the health system and societal levels. These transformative outcomes cannot occur without transforming medical education institutions themselves.

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INDIGENOUS HEALTH TEACHING AND LEARNING

Beliefs about Māori health and inequalities: Findings from a cross-sectional study of final year medical students in Aotearoa/New Zealand

Dr Donna Cormack and Dr Ricci Harris, The University of Auckland, Dr James Stanley, University of Otago Wellington, Dr Rhys Jones, The University of Auckland, Dr Cameron Lacey, University of Otago Christchurch, and Dr Elana Curtis, The University of Auckland, Aotearoa/New Zealand

Introduction

Historically, there has been only limited examination of the role of health providers in (re)producing the long-standing and stark health inequities between Māori and non-Indigenous peoples in Aotearoa/New Zealand (Harris et al. 2016). However, research to assess how racism operates via provider racial/ethnic bias to influence health has increased in recent years (Hall et al. 2015; Maina et al. 2017; Paradies, Truong & Priest 2013; Smedley, Stith & Nelson 2003). Racial/ethnic bias is part of the broader system of racism in colonial societies that involves beliefs about groups that have been socially constructed as 'racial' or 'ethnic', structured power relations reflected in racialised hierarchies, and racially discriminatory actions (Garner 2010). Generalised beliefs about Māori patients, Māori health and causes of ethnic health inequities are manifestations of societal racism that can be expressed in overt, as well as in implicit, automatically activated ways (van Ryn et al. 2011).

A small, critical body of literature explores health provider beliefs and recurring narratives about Māori patients and Māori health in Aotearoa/New Zealand including persistent discourses of Māori (non-)compliance (Johnstone & Read 2000; Penney, Moewaka Barnes & McCreanor 2011; McCreanor & Nairn 2002). In explaining Māori health and inequities, health providers also draw on narratives of purported biological predisposition, delays in accessing care, Māori identity or cultural factors, environmental determinants including socioeconomic status and, to a lesser extent, colonisation (Johnstone & Read 2000; Penney, Moewaka Barnes & McCreanor 2011; McCreanor & Nairn 2002).

Stereotypes and generalised beliefs about Indigenous patients and Indigenous health have also been documented elsewhere, including in Australia (e.g. Ewen et al. 2015), Canada (e.g. Ly & Crowshoe 2015; Tang & Browne 2008) and the United States (e.g. Bean et al. 2014), among a range of health workforce groups,

including medical students and doctors. Consistent with literature from Aotearoa/New Zealand, these generalised assumptions include recurring discourses of 'non-compliance' and 'deviance' (such as addiction), and narratives of egalitarianism whereby health providers talk about treating everyone the same (Browne 2005; Ly & Crowshoe 2015; Tang & Browne 2008). Egalitarian discourses have been linked to 'colour-blind' approaches to ethnic health inequities and Indigenous health (Browne 2005). More broadly, negative beliefs and stereotypes about Indigenous peoples are endemic in settings outside of health in Aotearoa/New Zealand (Nairn et al. 2006) and in many other nations (Browne 2005; Ly & Crowshoe 2015).

Medical students will, therefore, be exposed to narratives about Indigenous patients, Indigenous health and ethnic health inequities within and outside of medical education (Ly & Crowshoe 2015). These representations are likely to influence student assumptions about Indigenous patients, with potential impacts on clinical encounters (van Ryn et al. 2011). However, little is known about Aotearoa/New Zealand medical students' beliefs about Māori health either at the beginning or at the completion of their medical education. This paper examines the patterning of beliefs about Māori health and health inequities among final year medical students, as part of a wider Bias and Decision-Making in Medicine (BDMM) study assessing medical student racial/ethnic bias and associations with clinical decision-making (Harris et al. 2018).

Method / approach

BDMM was a voluntary, anonymous web-based study with final year medical students in Aotearoa/New Zealand. Undertaken as part of a broader international collaborative project entitled 'Educating for Equity', the study aimed to explore how racial/ethnic bias among medical students in Aotearoa/New Zealand was patterned, and whether or not it was associated with clinical decision-making. Details on the full study development and piloting is published elsewhere (Harris et al. 2016; Harris et al. 2018). In brief, data were collected via an online questionnaire in November 2014 and February 2015 with two cohorts of final year students at the two medical schools in Aotearoa/New Zealand – the Universities of Auckland and Otago. Ethics approval was received from the University of Auckland Human Ethics Committee (Reference 011693), and ratified by the University of Otago Ethics Committee.

All final year medical students at the two medical schools (n=888) were sent an email invitation by an administrator with a link to the Qualtrics™ online questionnaire. Overall, 302 (34%) students participated in the study across the two waves. Students who took part were broadly similar in age, gender and ethnicity to the total cohort of final year medical students in 2014 and 2015.

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The study included modules assessing responses to chronic disease vignettes, implicit and explicit racial/ethnic biases, and demographic questions. As part of the assessment of explicit racial/ethnic biases, the authors developed eight statements to assess generalised assumptions and beliefs about Māori health and health inequalities (Harris et al. 2016) (see Table 1). The statements were introduced with the lead-in text:

Major inequalities in health exist between Māori and NZ European in New Zealand. Please indicate how much you AGREE or DISAGREE with the following statements about Māori health and ethnic inequalities.

Participants were asked to indicate their response to each statement on a seven-point Likert scale from '1. Strongly disagree' to '7. Strongly agree'.

Statistical analysis was undertaken using R 3.1.2 to calculate frequencies and means of responses for each statement, with 95 per cent Confidence Intervals reported for the means. Further details on participant profiles and results of other modules are published elsewhere (Harris et al. 2016; Harris et al. 2018).

Results / outcomes

Overall, 233 of the 302 students who took part in the study completed the explicit racial/ethnic bias module, which included the eight belief statements. Mean levels of agreement were highest for the statements that drew on social determinants or structural factors as explanations for Māori health and health inequity. The highest level of agreement was with the statement about socioeconomic position as an explanation for poorer health for Māori relative to New Zealand Europeans, with 85 per cent of respondents indicating some level of agreement (mean = 5.5) (see Table 1). Most respondents also indicated at least some agreement that ethnic bias among health providers was an explanation for inequities in quality of care for Māori (73%), and that racism in society (63%) and inequitable delivery of health care (65%) were also explanations for poorer Māori health outcomes. Respondents agreed to some extent with statements more focused on patient behaviour, with 60 per cent of students agreeing that delays in seeking health care were an explanation for Māori health status, and about half (53%) indicating some agreement that Māori health was worse because of individual lifestyle factors.

Mean scores were lowest (indicating lower average agreement) for the statements relating to genetics as an explanation for chronic disease prevalence among Māori, and to Māori preferences for care as a reason for health care inequities. However, around one-quarter (26%) of all respondents agreed to some extent with genetic predisposition as an explanation.

Table 1 Frequencies of responses to belief statements about Māori health and inequalities, with means and 95% CIs

Statement	Strongly disagree				Strongly disagree				Mean (95% CI)
	1	2	3	4	5	6	7		
The higher prevalence of chronic disease among Māori is because they are genetically predisposed.	65 (28)	59 (25)	22 (9)	25 (11)	50 (21)	10 (4)	2 (1)	2.9 (2.7, 3.1)	
Māori have worse health than NZ Europeans because of individual behaviours such as smoking and diet.	15 (6)	28 (12)	30 (13)	35 (15)	67 (29)	43 (18)	15 (6)	4.3 (4.1, 4.5)	
Māori have worse health than NZ Europeans because of lower socioeconomic position.	7 (3)	4 (2)	9 (4)	14 (6)	52 (22)	98 (42)	49 (21)	5.5 (5.4, 5.7)	
Māori have worse health than NZ Europeans because of racism in New Zealand.	11 (5)	22 (9)	16 (7)	36 (15)	91 (39)	42 (18)	15 (6)	4.6 (4.4, 4.7)	
Māori have worse health than NZ Europeans because they do not seek care early enough.	8 (3)	17 (7)	22 (9)	48 (21)	88 (38)	41 (18)	9 (4)	4.5 (4.3, 4.7)	
Ethnic bias by health providers leads to poorer quality of care for Māori.	3 (1)	10 (4)	24 (10)	27 (12)	72 (31)	65 (28)	32 (14)	5.1 (4.9, 5.2)	
If Māori patients receive less care than NZ European patients it is most likely due to Māori preferences for care.	44 (19)	76 (33)	50 (21)	43 (18)	14 (6)	5 (2)	1 (0)	2.7 (2.5, 2.9)	
Māori have worse health than NZ European because the health system does not deliver equitable care to Māori.	8 (3)	14 (6)	26 (11)	33 (14)	60 (26)	42 (18)	50 (21)	4.9 (4.7, 5.1)	

Discussion

Encouragingly, medical students indicated highest levels of agreement with statements focused on social and structural determinants of health as explanations for current Māori health outcomes and ethnic health inequities between Māori and New Zealand Europeans. This finding aligns with available evidence and is a key focus of Indigenous health curricula (Jones et al. 2010). Beliefs about late presentation and lifestyle factors were not as strongly endorsed, although most students still agreed with these statements to some degree. These explanations are less aligned with ethnic inequities research or Indigenous health content, but have previously been identified among health professionals in Aotearoa/New Zealand (Penney, Moewaka Barnes & McCreanor 2011; McCreanor & Nairn 2002).

Agreement was lowest for the statements about genetic predisposition and patient preference. There is only limited support for these as explanations for chronic disease inequities between socially defined population groups. Genetic explanations for ethnic population health inequities are problematic and potentially stigmatising (Yudell et al. 2016), and may reaffirm discredited biological notions of 'race'/ethnicity with potential flow-on effects for clinical interactions and medical care. Genetic narratives have been previously identified among health providers in Aotearoa/New Zealand (Johnstone & Read 2000; McCreanor & Nairn 2002), and internationally (Tang & Browne 2008). Our finding that about a quarter of final year medical students agreed at least somewhat with the genetics statement suggests the persistence of this narrative, and reinforces the need for medical education to engage more effectively and critically in this space, a need that has been described as 'acute' in the medical curriculum (Braun & Saunders 2017).

Our study provides useful information about the current patterning of beliefs about Māori health and inequities among a group of final year medical students, and the extent to which these beliefs are reflective of the literature and research in the field. Understanding the prevalence of stereotypical or generalised assumptions about Māori patients – such as those relating to patient preferences, late presentation and genetic predisposition – is important as these stereotypes can have impacts on medical interactions both by influencing provider behaviour and communication, and potentially through the activation of stereotype threat (van Ryn et al. 2011). Stereotype threat has been described as happening '... when cues in the environment make negative stereotypes associated with an individual's group status salient, triggering physiological and psychological processes that have detrimental consequences for behaviour' (Burgess et al. 2010:s169). The activation of stereotype threat can influence the quality of medical interactions, levels of satisfaction and trust, and future health care encounters (Burgess et al. 2010).

It is likely that medical students are exposed to a range of stereotypes and generalised assumptions about Indigenous patients in their everyday lives, through exposure to racialised discourses in broader society and through their medical education. Within this study, we were not able to assess whether or not medical student beliefs differed from those held by the general public, or whether their beliefs about Māori health and inequities changed over the course of medical education. This is an area where future research is needed to help us better understand the role of medical education in (re)producing or disrupting beliefs about Māori health and Māori patients.

Our study had a relatively low response rate and was only conducted with final year medical students, which impacts on the generalisability of the findings. Future research should also consider the patterning of agreement with these statements among other health professional student groups and health providers.

Conclusion

Medical student beliefs about Māori patients in particular, and Māori more generally, are likely to be influenced by discourses outside of the medical school. Thus, medical education can contribute to addressing the ways in which racism may impact on Indigenous health and maintain health inequity through racialised beliefs among health providers, including those about genetic predisposition (Braun & Saunders 2017). In recent years, medical school curricula have advanced teaching approaches to Māori and Indigenous health inequities that focus more on the role of social determinants and health provider bias (Jones et al. 2010).

Our findings reinforce the importance of the broader medical curricula focusing on explanations for Māori health inequities that are supported by the literature. They also suggest the need to highlight the role of the 'hidden' curriculum in promoting explanations that contrast with formal Indigenous health content (Ewen, Mazel & Knoche 2012).

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INDIGENOUS HEALTH TEACHING AND LEARNING

Change starts from within us

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Introduction

Aboriginal and Torres Strait Islander concepts of social and emotional wellbeing have long informed national policy and medical practice guidelines (NATSILMH 2018). However, little attention has been given as to how public health educators can best instil in multidisciplinary groups of professionals an understanding of, and the skills to apply, such concepts. According to Delany and others, transformative approaches that stimulate an examination of different perspectives and values are required (Delany et al. 2016; NHMRC 2018).

This case study describes the application of such an approach through embedding Stage One of the Family Well Being (FWB) program in the 13-week postgraduate 'Aboriginal Health and Wellbeing Across the Lifespan' (Lifespan) course delivered by the School of Public Health and Community Medicine at UNSW Sydney each year between 2011 and 2015. It explores students' responses to FWB as a transformative learning tool, and its role in 'changing the lens' through which students viewed Aboriginal social and emotional wellbeing.

The Lifespan course was developed by Muru Marri, the School's dedicated Aboriginal health unit, to address a need identified during strategic planning involving Aboriginal Elders, critical friends and leaders in the field. It was also designed to be a core course in the School's postgraduate specialisation stream in Aboriginal Health and Wellbeing launched in 2012 (Jackson Pulver et al. 2013). Informal student feedback on an existing course, which focused on Aboriginal public health, demonstrated the value of curricula that encouraged critical reflection among students, which gave them a sense of empowerment through a better understanding of themselves and their potential role in promoting Aboriginal health and social and emotional wellbeing (Muru Marri 2015:22).

To implement and test this feedback, members of the unit sought to identify existing programs that could provide a framework for reflective practice that supported the empowerment aims of the specialisation stream, which was to be delivered within an action research framework. The FWB program was identified by author Haswell, who had previously participated in and co-facilitated this well-researched Aboriginal empowerment and leadership program (Haswell et al. 2013; McKendrick et al. 2013; 61-66).

Aboriginal educators developed the FWB program in the early 1990s. It has been implemented across many health, educational and community settings to promote healing and leadership development, including as an adapted short course for postgraduate students (McCalman et al. 2012). Research on FWB in First Peoples' contexts has attributed its effectiveness to an 'emphasis on holism, encompassing physical, emotional, mental and spiritual aspects of life and wellbeing; and the respect for Indigenous cultural and spiritual identity' (Tsey et al. cited in Haswell et al. 2013:86). Commencing with a recognition of one's own strengths and values (inner qualities), FWB aims 'to empower participants by helping them acquire greater understanding and skills to gain control over their lives' in order to effect broader change (Haswell et al. 2013:86).

Laliberté and colleagues have described empowerment as both:

a theoretical model for understanding the process and outcome of efforts to exert control over decisions that affect one's life, and a value orientation providing an approach to working with the community to achieve social justice (2012:29, emphasis added).

As a social action process such multilevel empowerment promotes mastery and control at personal, family, community and societal levels, improved quality of life and social justice (Tsey et al. 2010; Tol et al. 2015).

This Aboriginal-informed theory of empowerment resonated well with the authors' collective experiences of oppression, empowerment, healing and recovery (Jackson Pulver, Haswell & Fitzpatrick 2011). It highlights the importance of people's lived experiences of empowerment as a way to become more respectful and appreciative of another's inner qualities, and to gain insight into how to engage with others in empowering ways, especially in the context of Aboriginal health. Using FWB's key mechanisms, which include creating safe spaces, encouraging personal exploration and expression, and reflective dialogue, we sought in the Lifespan course to stimulate the development of skills that will enable health professionals and students to reflect, become more self-aware, cope with uncomfortable emotions and practise with greater cultural safety (Lavery, McDermott & Calma 2017; Townsend-Cross 2018:256; Whiteside et al. 2017).

Following course approvals, Lifespan commenced in 2011 with a compulsory pre-semester three-day workshop covering Stage One of the five-stage FWB program. This was followed by 10 external study modules delivered online throughout the semester. The course's stated aims were to enhance an appreciation of the key challenges experienced across the lifespan by many Aboriginal and Torres Islander people, and assist students to become empathetic, reflective, empowering health professionals who are confident working with Aboriginal and Torres Strait Islander families and communities to achieve positive outcomes. This paper reflects on the value of the three-day workshop in facilitating, through the practice of dialogue and self-reflection, students' understanding of Aboriginal social and emotional wellbeing and empowerment concepts.

Methods

Program translation

Prior to commencement of the workshop, students were emailed material describing the FWB program, a workshop schedule and an invitation from the Faculty's Research Director to participate in Muru Marri's multiple methods evaluation (UNSW Human Research Advisory Committee 28 July 2010; 22 July 2012; 25 July 2014). Held at the start of semester, the workshop opened with an Acknowledgment of Country delivered as a narrative performance by the Faculty's Aboriginal Elder-in-Residence, Aunty Ali Golding, and deep introductions between all present. Over three days, and supported by Aunty Ali, Muru Marri team members and critical friends, a trained Aboriginal FWB facilitator delivered the 10 topics of FWB Stage One:

- 1 Group agreement
- 2 Qualities of a leader
- 3 Basic human needs
- 4 Understanding emotions
- 5 Understanding relationships
- 6 Conflict resolution
- 7 Life journey
- 8 Understanding loss and grief
- 9 Understanding attitudes and beliefs
- 10 Working with our communities for change [adapted] (Laliberté, Haswell & Tsey 2012).

FWB's structured guidelines were consistently followed. Students immersed themselves in each topic through 'brainstorming, personal reflection and journaling, sharing thoughts in dyads and then with the larger group, reading from handouts, and discussing the handout content' (Laliberté, Haswell & Tsey 2012:32). In this way, students were able to reflect and discuss before psycho-pedagogical information was introduced and links drawn with previous topics (2012:36). Each student was given a journal in which they could record their reflections using words and artwork.

The team drew on their experience of participatory processes in enhancing the workshop's setting, inter-relational, educational and experiential elements (2012:33), all of which have been shown to support engagement and change in FWB participants (see Table 1). Student safety was addressed by protocols in the group agreement that encouraged students to seek peer, staff or services support if needed.

Authors Jackson Pulver and Williams added complementary musical, drawing and reflection activities to enhance calmness, openness, creativity and trust. For example, when students engaged in ‘breathing together’ through singing and playing percussion, there was the potential to build unconscious rapport (Bandler & Grinder 1979). Negative space drawing – where students drew the space around and between an object – engaged multimodal learners, was fun, and prompted students to ‘see past’ their first impressions and reflect on different ways the world can be perceived. Formal presentations on Aboriginal health, social and emotional wellbeing, culture, power and empowerment theory were also provided.

Evaluation

The Growth and Empowerment Measure (GEM) was used to assess students’ perceptions of their own empowerment on the first day of the workshop, and again at the end of the semester (reported in Fitzpatrick et al. 2019). The GEM includes both a 14-item Emotional Empowerment Scale (EES) to measure inner peace and self-capacity, as well as 12 Scenarios to measure individual and collective domains of empowerment as defined through FWB (Haswell et al. 2010).

Student experience of the FWB program was then evaluated post-workshop using a semi-structured evaluation form. NVivo was used to manage and analyse the qualitative data, exploring how students experienced and valued the program both personally and professionally, the strengths and limitations of its delivery, and its appropriateness within a postgraduate public health course.

Results

Demographics and baseline GEM

Overall, 72 students out of a total 85 enrolled in Lifespan (2011–15) self-selected into the Muru Marri program evaluation and completed baseline GEMs. Participants ranged from 21 to 77 years of age, with a median age of 34. Fifty (69%) were female, eight (11.1%) identified as Aboriginal and/or Torres Strait Islander, and 43 (64%) lived in Sydney. Fifty-one (72%) were part-time students and 20 (28%) were enrolled full-time.

Responses to individual EES items on the GEM at course commencement indicated wide variation in specific aspects of emotional empowerment. These ranged from a strong sense of hope for a better future and students’ satisfaction with their opportunities, to challenges in remaining calm under pressure and in having a sense of belonging and connection to community (see Figure 1a, minimum score 1, maximum score 5). At the same time, students scored themselves highest on GEM scenarios addressing engagement in learning and creating safety for self and family and lowest in dealing with criticism, thinking about their own spirituality and appreciating empowerment in the community they live (see Figure 1b, minimum score 1, maximum score 7).

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Figure 1a Group means of evaluation participants at baseline – 14-item EES

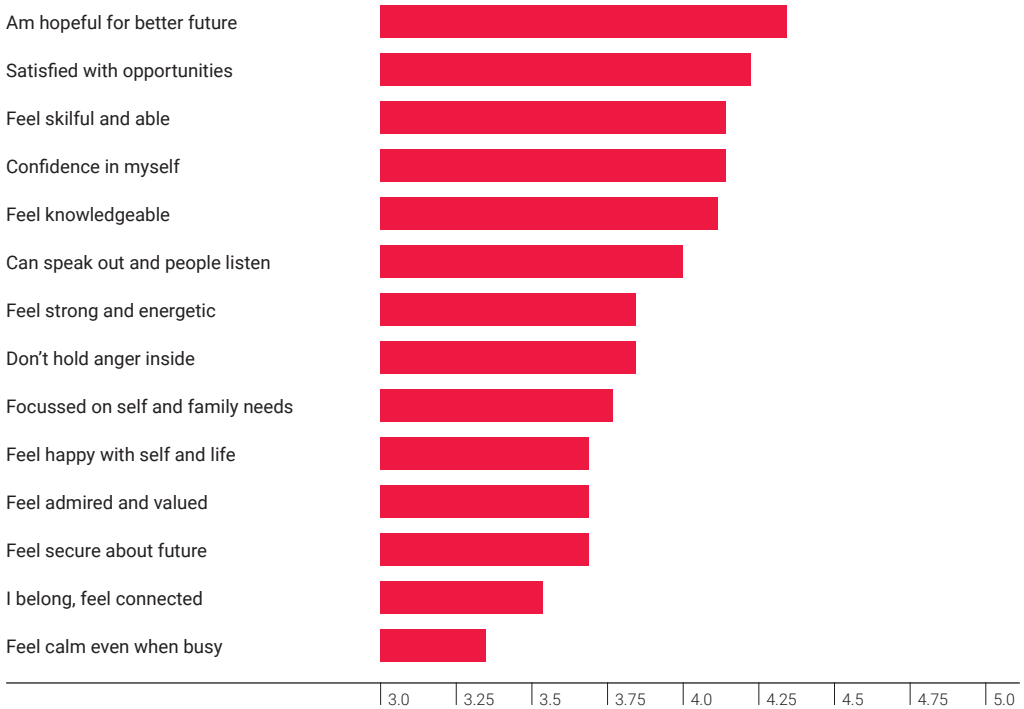
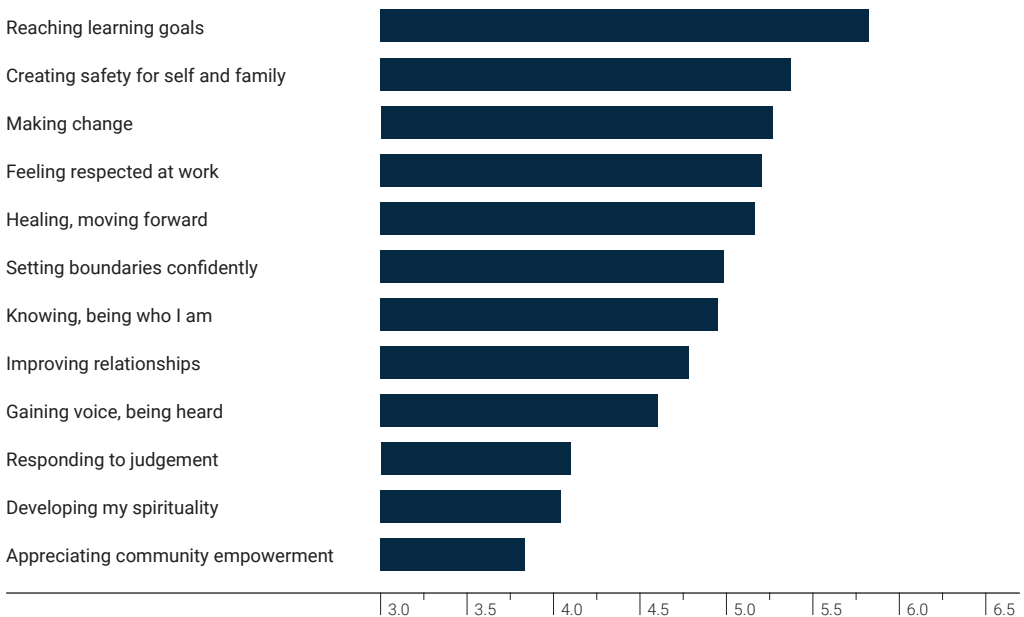


Figure 1b Group means of evaluation participants at baseline – 12 scenarios



Student feedback

In 2011, the translation of the FWB program to the postgraduate context was surveyed using five open-ended questions that explored what students found useful and enjoyable about the course and what could be improved. Of the 12 enrolled, 11 completed the survey. These data were analysed with respect to the four components that support engagement and change, as identified by Laliberté, Haswell & Tsey (2012) and used to complete Table 1.

In the years that followed (2012–15; n=72), completed surveys using a combination of Likert-scale and open-ended questions indicated that almost all students valued the experience and found it relevant to their current and future work. The FWB topics most frequently cited as ‘very useful’ by students were ‘Understanding relationships’ (n=61); ‘Conflict resolution’ (n=56); ‘Life journey’ (n=57); and ‘Understanding loss and grief’ (n=55). Many valued their learning in relationship dynamics, understanding others and the importance of being non-judgmental.

Across all five years, responses to the open-ended questions conveyed the sense of connection felt between students. For example, one described a ‘[s]ense of oneness with others’, another that ‘[w]e are all connected humans, animals, environment’, and another that ‘[c]onnecting to each other strengthens self-esteem and enables change’. Depth of impact was indicated by comments such as, ‘I was able to apply most of the content of the Stage 1 FWB workshop to my personal journey’. Students deeply admired the strength, wisdom and hardships they recognised both in the Aboriginal facilitators, ‘Thank you for showing me what empowerment looks like’, and in the Elder-in-Residence, ‘Meeting and being around Aunty Ali was an absolute honour’.

Figure 2 depicts the 50 most frequent terms students mentioned in response to the question, ‘What are the three main things you will take away from the workshop?’ (2012–15). Empowerment was the most frequently mentioned concept (n=22). As one student remarked, ‘I have learnt that the more empowered we are the better we can empower people.’

Figure 2 Wordcloud 'What are the three main things you will take away from the workshop?'



Students frequently mentioned how rare it was to be given the opportunity to self-reflect, and to recognise their own inner qualities. Some revealed aspects of cultural humility, such as the 'importance of self-awareness to enable us to work most effectively'. The imperatives of 'working with, not working for' Aboriginal people, and discarding the need to rescue or 'fix Aboriginal health' were also explicitly mentioned. Students drew links with external factors such as '[h]ope for the future', and '[r]econciliation requires non-Indigenous population change', as well as how professional roles, organisational dynamics and communication styles can be disempowering. The importance of having a voice was also identified: 'Everyone is more productive if they get a chance to open up and feel heard'.

Others appreciated the multilevel nature of empowerment and the '[s]trength in unity [as] we can be and do so much more together'. Many students valued the safe space provided, and the opportunity to learn from one another. A very small minority found the workshop not to their expectations and reported feeling uncomfortable in the group-sharing exercises. Two students reported they did not have sufficient warning of the nature of the workshop. Many expressed gratitude to Aunty Ali and the Muru Marri team for their support during the workshop, particularly, according to one student, when they were pushed beyond their 'comfort zone'.

Table 1 Effectiveness of FWB program translation to postgraduate context, evaluated against four components identified by Laliberté, Haswell & Tsey (2012:33)

Actions for FWB in postgraduate context	Student responses (2011, n=11)
Setting '... bringing people together and establishing that change starts with oneself' (Laliberté, Haswell & Tsey 2012:33)	
<ul style="list-style-type: none"> • Detailed preparatory information emailed to students • Room is prepared (Nelson & Nelson 2017) e.g. room is cleaned thoroughly; refreshments provided; table symmetry allowing free movement, natural objects and colourful décor; coloured pens, paper and journals for each student, all material displayed on walls can be easily seen • Additional resources from the team's library • Quiet music as students arrive, and in reflective interludes • FWB provenance and approach explained 	<ul style="list-style-type: none"> • Public health postgraduate students elect to enrol and commit to the three-day workshop • Three students note the value of the safe space, one linking this to having a 'space for reflection' • A sense of joyfulness and play and lowering of one's guard is elicited by the drawing, music and percussion activities (Jackson & Buckley 1989) • More than half of respondents spoke positively about the workshop's creative activities, including helping move 'from a thinking space to a healing space'

Table 1 Effectiveness of FWB program translation to postgraduate context... (cont.)

Actions for FWB in postgraduate context	Student responses (2011, n=11)
<p>Inter-relational ‘Engaging and supporting participants to create a safe space based on respect, authenticity, empathy, sharing and trust’ (Laliberté, Haswell & Tsey 2012:33)</p>	
<ul style="list-style-type: none"> • Director’s welcome emphasises deep history of Country on which the university is located • Acknowledgment of Country and welcoming address given by Faculty’s Elder-in-Residence • FWB-accredited Aboriginal facilitators set the scene and lead program delivery • Everyone in the room invited to provide deep introductions about themselves • Written Group Agreement negotiated and displayed, and extended to online environment; confidentiality rules, and it is ‘okay to pass’, supported student safety • Group is respectfully visited by university staff and members of the community and offered support and encouragement 	<ul style="list-style-type: none"> • Respect for Aboriginal leadership shown • Elders and students valued one-on-one connection • Students appreciated wealth of experience in the room • Being in a safe space and sharing was valued by all students despite some feeling discomfort at times, e.g. in terms of ‘having the choice to speak or not’, and by having mixed genders in the room • One student reported feeling unsettled on Day 1, but not the following two days, which was attributed to a guided reflection activity on Day 2 and a shared creative activity closing off Day 3
<p>Educational ‘... eliciting and sharing the participant’s knowledge and providing information in an accessible format’ (Laliberté, Haswell & Tsey 2012:33)</p>	
<ul style="list-style-type: none"> • ‘No wrong question’ emphasised • Reminder of Group Agreement • Brainstorming and reflecting • Dyadic and group sharing • Facilitators reframe and prompt deeper questioning • Alternative standpoints and strengths-focused approaches modelled by facilitators • Application of theory and evidence to practice • Deep listening (Ungunmerr-Baumann 2002) 	<ul style="list-style-type: none"> • Students valued experiential learning approach, ‘learning by experiencing rather than being told’ • Reflective journal writing and sharing was valued and for one ‘was what made this course’ • The content of the sharing was valued, things ‘that we don’t usually talk about’ • Students reflected on their practice, ‘I have learnt to work with Aboriginal people rather than work for them’ • Two students reflected on group interaction, for example, helping them to express themselves ‘through ways other than words (e.g. colours, group participation)’

Table 1 Effectiveness of FWB program translation to postgraduate context... (cont.)

Actions for FWB in postgraduate context	Student responses (2011, n=11)
<p>Experiential The preceding three distinct elements 'are encompassed by the experiential component, which also seeks to enhance awareness of thoughts, attitudes, beliefs, and emotions; enabling a greater understanding of self and others, and supporting sustainable change of behaviour throughout the entire programme' (Laliberté, Haswell & Tsey 2012:33)</p>	
<ul style="list-style-type: none"> • Sense of calm and reflection created • Opportunities for group reflection • Preconceptions of university learning disrupted • Students explore outside of their comfort zones • Strengths-focus is modelled and rehearsed • Application of empowerment theory in group learning context 	<ul style="list-style-type: none"> • Students indicated they found the workshop life changing, challenging, that it pushed them to reflect, and encouraged a 'personal journey' • This is supported by observations from facilitators that there was greater depth and references to spiritual elements on Day 2 • While several students found sharing uncomfortable, they made additional remarks valuing the experience overall, and 'realised I didn't have to share if I chose not to,' as well as 'I now feel that I need the rest of the other stages of the empowerment program' • Appreciated experience as a 'start to understanding the complexity of experiences and wisdom of Aboriginal Australia and the importance of empowerment'

Discussion

Feedback from the highly experienced, multidisciplinary and largely non-Aboriginal cohort of students indicated that the vast majority valued the FWB workshop experience. Feeling safe, sharing, having the chance to learn from others and to reflect were key themes that emerged from the qualitative data. Findings from the GEM suggest that, when entering the workshop, students felt burdened by stressors, including a lack of optimism about the community in which they lived, as well as challenged in terms of responding to criticism. This vulnerability would appear to be reflected in the appreciation showed by students for the topics that explored relationship dynamics and conflict resolution.

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Students also responded well to FWB psycho-pedagogical approach engaging them in dialogue and deep listening rather than merely hearing topic information provided by facilitators. Students tested out voicing their feelings, explore their experiences and creating emergent understandings. This occurred first in small and then larger groups and in written reflection in their own journals. This allowed for in-depth exploration of complex and often confronting assumptions and preconceptions in relation to themselves, Aboriginal peoples, Aboriginal social and emotional wellbeing, and Australian society as a whole. It also honoured student life experience and contextualised empowerment theory in their own lives and potential futures.

Students thus found themselves supporting and contributing to each other's learning, expanding their understanding of evidence-based practice, and engaging in critical self-reflection in relation both to their own and to their collective roles and identities (Townsend-Cross 2018). Student safety was facilitated by FWB's structured and predictable method, which allowed students to anticipate each learning process, including journal writing on each topic. The FWB facilitators provided expert knowledge and constantly reframed the work being done in response to the group. They also paid attention to distributing the power in the room by relaxing the dynamic between facilitators and participants (Author Williams).

Successes

In the process of translating the workshop into a postgraduate course for Public Health students, four key components that support engagement and change were operationalised – setting, inter-relational, educational, experiential (Laliberté, Haswell & Tsey 2012:33). The strong feeling of connection that students reported suggests that techniques used to elicit safety throughout the workshop were conducive to experimentation and facilitating change (Laliberté, Haswell & Tsey 2012; Barlas 2001). Students valued the opportunity to reflect, and processes suggestive of collective healing (Blignault et al. 2014) – such as a deeper sense of being in relationship and social support, as well as identifying the need for healing in Australian society more broadly – were also evident. Most students who felt discomfort in sharing also found value in the experience, suggestive of developing empowerment skills (Townsend-Cross 2018). Several expressed aspects of learning that would influence their practice in Aboriginal health settings as well as elsewhere.

Challenges

Although support from the university and the school enabled the FWB program to occur, each year the FWB facilitator's fee and travel expenses had to be requested, and the mandatory face-to-face workshop justified. However, students who participated in the workshop supported it being a compulsory part of the course, as they found the experience invaluable for understanding Aboriginal peoples' perspectives at a deeper critical and empathetic level. Each year there were suggestions about lengthening the workshop, expanding its reach and including further FWB stages, with some regretting not learning FWB skills earlier in their postgraduate degrees.

Limitations

Workshop enrolments fluctuated annually, ranging from nine to 24 students, making analysis within years and between years unviable. While staff emailed detailed information about the evaluation to students' university email addresses, uptake could not be assured. This potentially limited students' participation in the course evaluation.

Conclusion

The aim of including FWB into the Lifespan course was to shift the lens through which Muru Marri's postgraduate students learned about Aboriginal health and social and emotional wellbeing, and to provide critical insights into multilevel empowerment based on self-reflection. This pilot suggests the value of FWB-based professional development as a way of stimulating such change, which is often unattainable through typical university curricula. It adds further support to the effective transferability of the FWB program to tertiary settings (Fitzpatrick et al. 2019; McCalman et al. 2012; Whiteside et al. 2017). Students felt safe and well supported, which are precursors to sharing, reflection and transformation (Laliberté et al. 2012), and experienced imaginative, integrated and empowering learning processes consistent with Aboriginal ways of knowing, being and doing (Martin & Mirraaboo 2003).

Student feedback expressed strong appreciation of the Aboriginal-developed and delivered program, given that it provided opportunities for reflection and personal growth in their understanding of relationships. It also provided them with evidence-informed knowledge and skills development in relation to strengths-based approaches to the health and wellbeing of First Peoples. The multiple methods data suggests that students experienced new lenses through which to frame concepts of Aboriginal social and emotional wellbeing and empowerment, ones that were appreciative of diverse experiences, contexts, communication styles, cultures and worldviews. Together, these outcomes are consistent with the goals of transformative learning described as valuable by Aboriginal educators (Norman 2014; Mackinlay & Barney 2014; Delany et al. 2016; Bullen & Flavell 2017).

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This study is continuing. Pre- and post-course GEM scores have now been reported (Fitzpatrick et al. 2019) and we are investigating how students' face-to-face and online discussions can provide us with further insight into the GEM's quantitative indicators of change.

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Important business: Community engagement and learning on Country

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Introduction

The School of Medicine Fremantle is a relatively new graduate entry medical school, with its first students having commenced in 2005 and its first graduates in 2008. The School has gradually evolved in its engagement with Aboriginal¹ health teaching and learning, growing from a single seminar in Year One through to a comprehensive vertically and horizontally integrated curriculum across the four years of the medical program. The aim of its Aboriginal health teaching is to graduate practitioners who are better prepared to work effectively with Aboriginal peoples, organisations and communities. To this end, the graduate outcome states that graduates should be able:

To evaluate and apply effective approaches to addressing health disparities for Aboriginal peoples, including a working knowledge of the historical, geographical and socio-cultural context of health care for Aboriginal peoples, and the ability to plan and provide care in a comprehensive, interprofessional and inclusive manner that is respectful and culturally safe.²

The School has operationalised its acknowledgment that it is located in *Walyalup on Whadjuk Noongar Boodjar*³ by providing continuing and substantial executive support to enable the development of a strong Aboriginal Health Team (AHT), which is responsible for the coordination, development, implementation and evaluation of the Aboriginal health teaching and learning within the medical program. The AHT's focus has been on creating a meaningful set of learning experiences for students in a learning and working environment that is safe for all. At the same time, the team has worked towards ensuring that the School continues to develop into a viable choice for Aboriginal students seeking to achieve their goal of becoming medical practitioners.

- 1 The School of Medicine Fremantle is located in the south-west of Western Australia (WA). The School uses the term Aboriginal peoples for the many Aboriginal communities and language groups within WA. This demonstrates respect for the Aboriginal community in Western Australia as it most accurately reflects the identity of Aboriginal peoples within this State. This is consistent with the approach of State Government departments such as the Department of Health. In using the term Aboriginal peoples, no disrespect is intended to Torres Strait Islander peoples and their communities.
- 2 From an internal School of Medicine Fremantle document.
- 3 *Walyalup* – Fremantle; *Boodjar* – land

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This paper focuses on the ways the AHT has sought to achieve meaningful opportunities for all students to develop their understanding of Aboriginal peoples' strengths and resilience. It particularly focuses on the learning on Country experience with Aboriginal people and their communities that occurs during the first two years of the course.

Approach

It has become increasingly common to use cultural immersive experiences to engage medical students in rural settings as part of their learning journey (Dowell, Crampton & Parkin 2001; Lacey et al. 2011). Consistent with trends elsewhere, we also utilise a strengths-based approach in our teaching and learning to move beyond deficit approaches to Indigenous content in curricula (Pitama et al. 2018). This is core teaching and learning business and not a community engagement activity that sits alongside the main curriculum.

Key to these immersion experiences is the centrality of Aboriginal community self-determination and Aboriginal-led programs and strategies that provide students with an understanding of the ongoing capacity, resilience, strength and wellbeing that exists within Aboriginal communities. Utilising this strengths-based approach, our teaching is grounded in Aboriginal ways of working and doing business, embodying respect for land and culture and Elders. By positioning Elders as respected knowledge holders and teachers in the formal curriculum we seek to reinforce the importance of those knowledges. This approach is supported by specific strategies in other parts of our teaching program that focus on addressing racism and white privilege.

Implementation

Through a series of compulsory, elective and selective opportunities, the AHT provides a solid foundation for all students to learn about Aboriginal histories, cultures, resilience and survival on Country. The Team's pedagogical approach embraces constructive alignment and our teaching is built around curriculum outcomes which drive content and assessment that is linked both to learning outcomes and the delivered content (Biggs & Tang 2007). The AHT aims to bridge the gap between the academy and community via a series of activities on Country with Aboriginal Elders and community members using a mixture of ceremonies, lectures, seminars, workshops, field trips and placements. The team would like to note that although some of these activities are held on campus, the School is located on *Whadjuk Noongar Boodjar* so all our teaching occurs on Country.

The Aboriginal health curriculum at the School of Medicine Fremantle is substantial and growing. However, in this paper we are only focusing on the teaching with a specific on Country aspect, which is summarised below.

Year One – Learning on Country

- 2012–18 – Smoking Ceremony and Welcome to Country (100 students)
- Field trips with Elders
 - 2015–16; 2017–18 – Pinjarra massacre site visit (2015–16: 100 students; 2017–18: 50 students)
 - 2016 – Yanchep National Park (30 students)
 - 2017–18 – Wireless Hill and Point Walter (50 students)
- 2013–18 – Aboriginal Health Workshops X 2 (100 students)

Year Two – On Country placements

- 2015 – Five days (10 students)
- 2016 – Six days (13 students)
- 2017 – Six weeks (18 students); six days (13 students)
- 2018 – Six weeks (36 students); six days (15 students)

Year Three – General Practice rotations

- 2017 – Four weeks (Broome, 1 student)
- 2018 – Four weeks (Perth – Derbarl Yerrigan Health Service, 7 students)

Year Four – Rural General Practice and Psychiatry rotations

- 2018 – Eight weeks (Broome, 8 students)

Since 2015, the AHT has been able to increase substantially the opportunities for students to spend time learning on Country. All students now have a core exposure in Year One, which provides a solid foundation for their other learning in Aboriginal health throughout the course. Further, the selective and elective options outlined provide additional opportunities for those with a particular interest. In 2018, this saw 50 per cent of the entire second year cohort spending up to six weeks in Broome as a part of their course. That said, like many Schools, the opportunities for meaningful clinical placements in Aboriginal health are limited. While the AHT has been able to develop these over the past two years, this is an area in which further action is required.

Year One – Learning on Country

Commencing in 2012, first year students began their medical course with a Smoking Ceremony, a Welcome to Country and an Aboriginal cultural performance that included music and stories, all of which preceded their welcome to the School by the Dean. The addition to the first year curriculum of field trips over the past four years has provided students with an opportunity to hear from Aboriginal Elders on the continuing importance of Country, their connection to land and place, the ongoing nature of cultural practices and the traditional and contemporary struggles and achievements of Aboriginal people.

All the stories and teaching from these field trips are connected, be they to Bindjareb (Pinjarra), Mandjoogoordap (Mandurah), Dyoondalup (Point Walter) or Yagan's Lookout (Wireless Hill). For example, the field trip to Bindjareb and Mandjoogoordap begins at the commemoration site of the 28 October 1834 massacre, in which more than 100 Aboriginal men, women and children were killed on the banks of the Murray River by an armed group of colonists led by Captain James Stirling. In preparation for this visit we show the students the DVD of the Bindjareb – Pinjarra play so they are familiar with some of the story (Drandich et al. 2012).

At the commemoration site, students meet two Bindjareb Elders whose forebears were involved in the massacre. They then hear of the events leading up to the massacre, the course of action taken by Stirling, and the divergent accounts of the outcome. The Elders then relate the many years of struggle they have endured to get appropriate recognition at the site of the massacre, including the refusal by the local Shire council, until recently, to allow the Bindjareb peoples their preferred wording on the memorial. On the way to nearby Mandjoogoordap we stop at Jim Jam (Ravenswood) on the river, a historical campsite used by Bindjareb families over generations for fishing and learning to swim. It was also where Stirling's group camped on the night before the massacre.

By contrast, just down the road at Mandjoogoordap, the focus shifts to the Yaburgurt Memorial Project. Yaburgurt (1824–1915), a Binjareb Elder, survived the massacre when still a child and went on to become a respected community leader in the region, well regarded by non-Aboriginal and Aboriginal peoples alike (Our Knowledge, Our Land 2019). The City of Mandurah took a more inclusive and celebratory approach to the Bindjareb peoples' presence, culture, history and contributions by actively supporting the 100-year commemoration of his death with a substantial public art installation at Mandjar Square overlooking the waters opposite the Mandurah Cultural Centre.

The field trips in Year One provide not only experiential learning but also the opportunity to hear from local Elders about the particular struggles that have confronted Aboriginal peoples within the region, and the strengths, resilience and resistance that has been required for their survival and continuity. Further, the diversity of experiences is also reinforced.

Year Two – On Country placements

Building on the demonstrated success of these field trips (reflected in positive student and community evaluations), for Year Two we have been able to harness additional faculty support and commitment to implement several placements and immersions in Broome and the Kimberley. These continue the engagement with Aboriginal community members and organisations, in this case on Yawuru Country (Broome).

The University has three campuses across Australia – in Fremantle and Broome in Western Australia and a campus in Sydney. The Broome campus allows us to provide students with suitable accommodation and access to other resources and facilities that would otherwise not be available. In addition, since 2005 the School has implemented a Derby-based rural immersion for all second year students. We have been able to utilise this existing program to develop the Broome-based immersion as a selective, which a small number of students could choose as an alternative to the Derby-based program.

The focus of the initial short Broome immersion is, again, being on Country with those whose Country it is. The *Broome ~ Learning on Country* program also provides students with an opportunity to learn from local Aboriginal peoples, communities and organisations, and to deepen their understanding of Aboriginal strengths, resilience, innovation and capacity building. While this is a relatively short time on Yawuru Country, it does provide students with some insights into the importance and expression of Aboriginal self-determination in a local context. Despite the focus not being specifically on health and health care, the program does introduce students to the factors that influence health and wellbeing.

During their time in Broome, students have a day-long cultural learning immersion with Yawuru Elder/s or Traditional Owners. This involves an introduction to the land, peoples and cultures of the region, including traditional cultural practices and understandings, local foods, medicines and plants, many of which continue to be practised and used. The students visit several organisations including the local Traditional Owners' representative body (Nyamba Buru Yawuru), the Aboriginal media organisation (Goolarri), the support organisation for people affected by the Stolen Generations policies, men's outreach services, and the youth mental health and wellbeing organisation (Alive and Kicking Goals). Integral to this particular immersion program is a daily debriefing session aimed at highlighting the role of reflection, and the importance of self-care.

The success of the short Broome immersion is realising the Aboriginal Health Team's long-held vision of the School building further opportunities for its students to live and learn in Broome. The six-week *Broome ~ Learning on Country* program enables second year students to continue their usual learning activities away from the Fremantle campus. In addition to this they have a full-day cultural orientation

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and learning activity, as well as six half days (one each week) spent engaging with Aboriginal community organisations, similar to the one-week immersion program. The *Broome ~ Learning on Country* program was piloted in 2017 with 17 students. It was so well evaluated by the students, who were neither advantaged nor disadvantaged in their end of year results, that in 2018 it was expanded to two groups of 18 students for six weeks each. The pilot was funded initially from surplus rural health program monies, and this current year is being funded through the University's commitment to effective longer term rural student placements.

Years Three and Four – General Practice, Rural General Practice and Psychiatry rotations

The General Practice placements outlined above occur in Aboriginal community controlled settings. Although they do not have a specific Elder or cultural component to the placement, they do have the benefit of being prolonged, community-based clinical placements in Aboriginal Community Controlled Services. The Psychiatry rotation in the final year of the course is with the local country health service and is not Aboriginal specific. However, over the eight-week block, students do four weeks in the General Practice rotation and then the four-week Psychiatry rotation.

Aboriginal student engagement

In addition to the formal curriculum available to all medical students, the University has also implemented some initiatives specifically for Aboriginal students on campus. One major project was the appointment of an Aboriginal artist-in-residence, Neta Knapp, who was based in Manjaree⁴ Place, the Aboriginal student space on campus. One of Ms Knapp's roles was to oversee the creation by some of the Aboriginal students on campus of a large mural for Manjaree Place, *Manjaree Mia Kaart*.⁵ Apart from its beauty and the powerful stories that it relates, the painting provided students with the opportunity to connect and reframe (The University of Notre Dame Australia 2018).

4 *Manjaree* – meeting place

5 *Manjaree Mia Kaart* – a place of learning, a place of history and a place of spiritual journey of knowledge

Evaluation

Integral to our pedagogical approach is a strong evaluation program – both of individual components of the Aboriginal health curriculum as well as an evaluation by graduating students utilising a dedicated Aboriginal health curriculum evaluation tool (Paul, Carr & Milroy 2006). Aboriginal health is assessed across the course via a mix of reflective portfolios (both formative and summative), short-answer questions, case-based questions and observed structured clinical scenarios.

All of the Aboriginal health evaluations involve mixed methods and utilise five-point Likert scale-style surveys of the student experience. There are also open-ended questions regarding the most and least valuable part of the learning activity or program and suggestions for improvement. The evaluations have good student participation numbers of around 85 to 90 per cent for larger group evaluations and up to 100 per cent for smaller group evaluations. The Likert responses are consistently positive (4.0 plus) and demonstrate wide acceptance of the activities that have been in place for several years.

Students who undertook the Year Two Broome ~ Learning on Country program reported that they found the concentrated focus both on Aboriginal community initiatives and the strengths-based lens interesting, engaging and useful. Being in a different setting from earlier medical school learning was also welcomed. One student reflected on the value of their time there:

We got to talk to many knowledgeable people and learn more in one week than the last 18 months in regards to health, history and culture.

—Year Two Broome immersion student reflection

Another valued the daily debriefing sessions and the opportunity they presented to reflect on what they had experienced during the day:

The [Aboriginal Health Team] encouraged us to explore our emotions/responses each day. This was helpful during debriefing as it allowed consolidation/closure for the day... it was good for our 'Liyan'⁶...

—Year Two Broome immersion student reflection

With regards to the mural at Manjaree Place, Aboriginal students reported that it gave them an opportunity to slow down during a hectic second semester, to have some time out from studies to regroup and to connect with self, culture, other students on campus and Elders. As one medical student involved in creating the painting commented:

6 *Liyan* – Yawuru for feelings or sense of being

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It was a great experience as it gave me more of a cultural connection to the University. To know I could paint my Country on the mural knowing my family and friends could come to see it, even a long time from now.

And:

I was able to take time out from my exam study to yarn with Aunty who taught me about painting, moreover it really gave me a sense of calm during a stressful time. This truly was the most relaxing time for me during those long weeks of intense study... it helped me reset and focus.

While formal community evaluations have not been undertaken, the process utilised by the Aboriginal Health Team in the development and implementation of learning and teaching activities with community members is consultative, inclusive and responsive. We approach community members and discuss what might be the best learning activity for them to assist with based on their time, resources and settings, and how this might fit best with the overall Aboriginal health learning outcomes for that year. AHT members then attend the learning activity and debrief with the community members both at the end of this session and usually again a couple of weeks later. Further, the team has been fortunate to be able to work with the same community members and Elders each year so are able to discuss how things went previously and what modifications, if any, they wish to implement in the next learning activity.

Discussion

The members of our Aboriginal Health Team have strong, long-term and ongoing community connections across the State that have enabled the facilitation of the on Country aspects of our teaching program. Our connections are mainly in the South West, Pilbara and the Kimberley regions of Western Australia, which means that we are often working with family members and long-term partners, connections that can be useful but also add complexity. The pre-existing and ongoing relationships between the Aboriginal Health Team and members of the communities with whom we work in our teaching has helped to ensure the replication of the teaching and learning experiences from one year to the next. It has also provided the platform, based on earlier successes and experiences, to be able to grow the learning opportunities.

The Aboriginal Health Team in framing its work has been cognisant of the value of transitioning future health practitioners from knowing through to doing and finally to being (see reference to Miller's Pyramid in Cruess, Cruess & Steinert 2016; Delany et al. 2016). To achieve this, the AHT has used a strengths-based approach to learning on Country which is grounded in solid ongoing relationships between members of the team and members of the local Aboriginal communities

with whom they work. They have started with small steps and, as trust and confidence has grown in the processes of having students come to learn on Country or have community members come to the campus to teach about Learning on Country, the AHT has been able to expand its engagement and the learning opportunities for students. The positive experiences and outcomes for both students and community members, who remain enthusiastic to return each year, have supported that expansion. Further, it has meant that the team has maintained consistent engagement with the same community members. This has facilitated the development of more vertically and horizontally integrated teaching with less repetition in each teaching and learning activity.

There are other indicators of the success of the team's approach, including the increasing number of students who are interested in participating in particular selectives. For example, in 2018 more than 60 per cent of the student cohort submitted an expression of interest to be considered for one of the 36 places available for the *Broome ~ Learning on Country* program. In addition, the positive trends in our evaluations, especially the final year preparedness to practise with Aboriginal peoples and communities, indicates we are achieving what we set out to do.

There are, however, areas that require some more work. For example, the success of placement programs in Year Two means that there are not enough space or resources to accommodate the demand. This has led both the team and the School to explore opportunities in other locations in the Pilbara, Mid-West Gascoyne and Wheatbelt regions of Western Australia. Although the Aboriginal Health Team has established relationships with key people and organisations in those areas, other logistics and costs present challenges that will need addressing before such opportunities can be realised. Team members recognise that they are building a bridge between community and the academy, and that this relationship is grounded in reciprocity. They also acknowledge that at present the University is gaining more from their work than the community. The anecdotal stories from colleagues working in the health services are positive about the ability of graduates from the School to work effectively with Aboriginal peoples. In the future, the AHT hopes to formalise this feedback loop from both the health workforce and the community.

Much of the work described above is sustainable, as it is supported both by the community and the Executive level of the School, which also provides core funding. However, the *Broome ~ Learning on Country* placements are dependent on year-by-year agreements and, while it gets evaluated and the School justifies the investment, the School is not able to be certain that this program will continue for the long term. As for the formal artist-in-residence appointment, although this was a short-term contract it has led to other formal teaching, staff development and conference engagements for Ms Knapp within the University as well as the ongoing mentoring of Aboriginal students.

Conclusion

Members of the Aboriginal Health Team have worked consistently since 2012 to increase meaningful learning opportunities on Country, both as part of the School's core learning in Aboriginal health and as part of the selective and elective options available for students. Central to this has been building and sustaining strong relationships between community members and the academy. In doing so we have sought to go beyond single immersive experiences; rather we have reinforced in students that they are always on Country by embedding learning and working on Country across the curriculum.

Being consistent in the Aboriginal Health Team's processes, and ensuring that students are adequately supported and well prepared for the experiences, have also contributed to the positive outcomes for all involved. As confidence and trust has grown from earlier and smaller engagements, the Team has been able to leverage change that enhances not only the number of opportunities, but also the quality of those activities in subsequent years.

Having a relatively large team, and with four of the five members being Aboriginal, significantly assists us to enable and maintain our achievements and endeavours. Further, in our work with Elders and leaders in Aboriginal communities, the staff of the School of Medicine hear their advice and the School acts on it and supports it. In its work, the AHT seeks to model to students effective ways in which Aboriginal and non-Aboriginal people can work together, with the ultimate aim of graduating practitioners who are able to work effectively alongside Aboriginal people, communities and organisations.

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APPENDIX 1

GOOD PRACTICE CASE STUDY ASSESSMENT PROCESS

The LIME secretariat sought expressions of interest from members of the LIME Reference Group to form a Peer Review Committee to assess good practice case study submissions under the categories of:

- Recruitment and support to graduation
- Curriculum design
- Teaching and learning
- Community engagement.

The LIME secretariat called for submissions from those who had presented papers at LIME Connection VII in Melbourne, April 2017. Once the case studies had been submitted, the Review Committee assessed them according to whether a project met its objectives, was evidence based, had supported and developed Indigenous leadership, and was both sustainable and transferrable to other settings. Committee members abstained from reviewing any case studies that posed a conflict of interest.

The Committee met to determine which submissions best met the criteria and, therefore, would be the most suitable for the fifth edition of the *Good Practice Case Studies*. It identified case studies that were accepted with minor revisions as well as those requiring some revision in order to be published. Revised case studies were reviewed a second time to determine the final selection. The LIME Secretariat and Review Committee members then completed a final round of editing of the accepted case studies, before sending these back to authors for their approval or changes. Final case studies were then incorporated into the publication, copy edited as part of the whole document and published.

ACRONYMS

AHT	Aboriginal Health Team
BDMM	Bias and Decision-Making in Medicine
CDAMS	Committee of Deans of Australian Medical Schools
EES	Emotional Empowerment Scale
FWB	Family Well Being
GEM	Growth and Empowerment Measure
LIME	Leaders in Indigenous Medical Education
UNSW	University of New South Wales
WA	Western Australia

GLOSSARY

Aboriginal and Torres Strait Islander Original inhabitant of Australia and its nearby islands

Aotearoa Traditional Māori name for the North Island of New Zealand. Today it is more commonly used to mean the whole of New Zealand

Boodjar land

Liyan Yawuru for feelings or sense of being

Māori Indigenous people of Aotearoa/New Zealand

Manjaree meeting place

Manjaree Mia Kaart a place of learning, a place of history and a place of spiritual journey of knowledge

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