



THE LIME NETWORK
Leaders in Indigenous Medical Education

LIME GOOD PRACTICE CASE STUDIES

VOLUME TWO

2013



Australian Government
Department of Health and Ageing



THE UNIVERSITY OF
MELBOURNE

© The University of Melbourne, 2013

First published, June 2013

ISBN: 978 0 7340 4847 9

This work is copyright. It may be reproduced in whole or in part for study or training purposes subject to an acknowledgment of the source and no commercial use or sale. Reproduction for other purposes or by other organisations requires the written permission of the copyright holder(s).

Additional copies of this publication can be obtained from:

Leaders in Indigenous Medical Education (LIME) Network
Faculty of Medicine, Dentistry and Health Sciences
Level 2, 161 Barry Street
The University of Melbourne
Victoria 3010 Australia

T: +61 3 8344 9160

E: lime-network@unimelb.edu.au

W: www.limenetwork.net.au

Author: Leaders in Indigenous Medical Education Network

Managing editor: Cristina Lochert

Artwork: Michelle Smith & Kevin Murray

Design and printing: Inprint Design

For citation: Leaders in Indigenous Medical Education Network, *LIME Good Practice Case Studies Volume Two, 2013*, Onemda VicHealth Koori Health Unit, The University of Melbourne.

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 my pleasure, as President of Medical Deans Australia and New Zealand (Medical Deans), to present the second volume of the Leaders in Indigenous Medical Education (LIME) Network *Good Practice Case Studies* publication. The first edition of this resource was published in 2012 and presented a snapshot of the varied and innovative work being undertaken in the field of Indigenous health and medical education. One of the primary aims of the LIME Network is to encourage and support collaboration among peers, and the *LIME Good Practice Case Studies* publication has certainly achieved this aim, receiving excellent feedback from people working in a broad range of educational settings across Australia and Aotearoa/New Zealand.

Like Volume One, this edition presents case studies related to teaching and learning, curriculum design, and community engagement within Indigenous health and medical education, as well as the recruitment and retention of Indigenous students. It is hoped that sharing these case studies will inspire those working in the field as they undertake their ongoing work to improve Indigenous health outcomes through strengthened health education.

Professor Justin Beilby

President, Medical Deans Australia and New Zealand Inc.
Executive Dean, Faculty of Health Sciences
The University of Adelaide

As a former chair of the Indigenous Health Sub-Committee of Deans (now the Indigenous Health Expert Advisory Group), Medical Deans and a long-time member of the LIME Network, I am pleased to present Volume Two of the *LIME Good Practice Case Studies* publication.

Over the past decade, I have worked closely with those involved in the Indigenous Health Curriculum Project and the LIME Network Program. I have seen the LIME Network develop from a small group of dedicated medical educators with an interest in Indigenous health to a network of around 900 individuals and organisations working towards better health care delivery for Indigenous peoples through strengthening Indigenous health curriculum and increasing the numbers of Indigenous health professionals across both Australia and Aotearoa/New Zealand.

The work of the LIME Network in leading approaches to teaching and learning, developing resources for distribution, and networking Indigenous and non-Indigenous academic leaders in medical education has been outstanding. The program's partnerships with Medical Deans, as well as with Reference Group members from universities around Australia and Aotearoa/New Zealand, ensure that the work of the program is relevant and practical and has ongoing influence in the design and development of medical education nationally and internationally.

Principles of collegiality and support underpin the LIME Network, and those involved have shown a great willingness to share their work in an effort to strengthen initiatives, develop expertise and build the evidence base of Indigenous health across all medical schools. The *LIME Good Practice Case Studies* volumes are an example of the work being done in this regard.

Volume One of this resource, published in 2012, presented examples of the innovative work being driven by LIME Network members. This second volume builds on those case studies with papers that were first presented at LIME Connection IV, *Medical Education for Indigenous Health: Building the Evidence Base*, held in Auckland from 29 November to 1 December 2011. The LIME Connection is a flagship event of the program and provides an opportunity for participants to discuss and critique current practices and explore emerging tools and techniques to drive improvements in the field.

Having attended all four LIME Connections, I have listened to the impressive breadth of work being undertaken. These collective efforts ensure that medical schools are constantly challenged to provide a more comprehensive approach to Indigenous health content, strengthened support for Indigenous medical students, and increased engagement with Indigenous community members in the development of curriculum. I commend this publication to you and look forward to seeing the benefits that this ongoing sharing will bring.

Professor James Angus

Dean, Faculty of Medicine, Dentistry and Health Sciences

The University of Melbourne

Former President, Medical Deans Australia and New Zealand Inc.



TABLE OF CONTENTS

Foreword	iii
Acknowledgments	vii
Introduction	1
About LIME	3
LIME Good Practice Case Studies	5
CURRICULUM DESIGN	5
Native Hawaiian Health Past, Present, Future: The genesis of a course, by Dr Martina Kamaka	5
Same words, different stories: Transferring an Aboriginal health curriculum across disciplines, by A/Prof. David Paul, Mr Craig Allen and Dr Paula Edgill	10
TEACHING AND LEARNING	14
Elders are the educators: Transmitting Elders' knowledge in health sciences for increased cultural competency, by Ms Danielle N. Soucy and Elders Bertha Skye, Elize Hartley, Gerard Segassige and Lorna Hill	14
Demonstrating cultural safety in communication through standardised role play, by Ms Courtney Ryder, Prof. Della Yarnold, Ms Colleen Hayes, Ms Laney MacKean, Mr Dave Sjoberg and Mr Michael Porter	19
The use of research-based Indigenous case studies for teaching undergraduate medical students, by Mrs Bernadette Jones and Dr Tristram R. Ingham	24
Developing health student placements in partnerships with urban Aboriginal and Torres Strait Islander Community Controlled Health Services, by Dr Alison Nelson, Prof. Cindy Shannon and Mr Adrian Carson	29
COMMUNITY ENGAGEMENT	35
Friends with benefits: Should Indigenous medical educators involve the Indigenous community in Indigenous medical education?, by Ms Tania Huria, Mr Cameron Lacey and Ms Suzanne Pitama	35

TABLE OF CONTENTS

A successful engagement between a medical school and a remote North Queensland Indigenous community: Process and impact, by Ms Simone Ross, Mr Donald Whaleboat, Ms Glenda Duffy, Dr Torres Woolley, Prof. Sundram Sivamalai and Mr Shaun Solomon	39
Faculty of Dentistry community engagement with Māori oral health providers, by Prof. John R. Broughton	44
RECRUITMENT AND RETENTION	50
Tātou Tātou/Success for all: Improving Māori student success, by Dr Elana Curtis	50
Appendix – Good Practice Case Study Assessment Process	56
Acronyms and Abbreviations	57
Glossary	58

ACKNOWLEDGMENTS

Many people have contributed to the development of this publication. LIME Network staff members acknowledge and thank all authors who submitted case studies for their commitment to Indigenous health and medical education. The excellent work highlighted here represents only some of the important initiatives occurring in the field.

We also thank the members of the LIME Good Practice Case Studies Review Committee who generously provided their time and expertise to peer review all incoming submissions for this volume.

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.

LIME Good Practice Case Studies Review Committee members:

Mr Gerard Finnigan (formerly of Deakin University)

Dr Shirley Godwin (formerly of The University of Notre Dame, Fremantle)

Dr Jane MacLeod (formerly of Griffith University)

Ms Odette Mazel (LIME Network)

A/Prof. David Paul (The University of Western Australia)

Ms Caitlin Ryan (LIME Network)

Mr Donald Whaleboat (James Cook University)



INTRODUCTION

This second edition of the *Leaders in Indigenous Medical Education (LIME) Good Practice Case Studies* builds on the papers included in Volume One (2012) to showcase the outstanding programs of work that are being conducted in the field of Indigenous health and medical education. Both volumes detail initiatives occurring across medical schools in Australia and Aotearoa/New Zealand, and in this edition we are pleased to include programs from Canada and the United States of America, highlighting the many linkages and shared lessons that are being acknowledged internationally. The case studies identify work being carried out in the areas of curriculum design, teaching and learning, community engagement, and Indigenous student recruitment and retention.

The papers offered in this volume are drawn from presentations made at LIME Connection IV in Auckland in 2011. The LIME Connection is the biennial conference of the LIME Network and provides a forum for the quality review, professional development, networking, capacity-building and advocacy functions of the Network. It brings together Indigenous and non-Indigenous medical educators, Deans of medicine, Indigenous health specialists, policy makers and community members from Australia, Aotearoa/New Zealand and further afield. It aims to encourage and support collaboration and sharing within and between medical schools and to build multi-disciplinary and multi-sectoral linkages. In 2011 the theme for the conference was *Medical Education for Indigenous Health: Building the Evidence Base*. Specifically, the conference addressed leading approaches to the inclusion of Indigenous health in medical education and showcased the growing body of evidence that illustrates the relationship between medical education and Indigenous health.

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 and to developing a body of work that builds the evidence base for informing good practice approaches in the field. By acknowledging and celebrating the innovative work being championed here, we hope this publication inspires new initiatives and the further development and support of current programs with the aim of improving the delivery of medical education for better health outcomes for Indigenous people.



ABOUT LIME

The Leaders in Indigenous Medical Education (LIME) Network is a dynamic network dedicated to ensuring the quality and effectiveness of teaching and learning of Indigenous health in medical education, as well as best practice in the recruitment and retention of Indigenous medical students. We seek to do this through establishing a continuing bi-national presence that encourages and supports collaboration within and between medical schools in Australia and Aotearoa/New Zealand and by building linkages with the community, medical colleges and other health science sectors.

The LIME Network has achieved significant outcomes including:

- the facilitation of biannual Reference Group meetings to provide the opportunity for those working in Indigenous health within medical schools to collaborate, share information, provide feedback and network with peers
- the biennial LIME Connection, which provides a forum for knowledge transfer and dissemination
- publication of the triannual LIME Network Newsletter to promote best practice and share successes in the field
- the LIME Network website (www.limenetwork.net.au), which houses information on the LIME Network, its projects, 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 retention initiatives, through publications such as the *LIME Good Practice Case Studies* booklets and the special edition of *Focus on Health Professional Education* (vol. 13, no. 1, 2011), the journal of the Australian and New Zealand Association for Health Professional Educators
- developing and implementing internal review tools to support medical schools to reflect and evaluate their performance
- the Indigenous Pathways into Medicine – Online Resource (www.limenetwork.net.au/pathways)
- 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.

The LIME Network recognises and promotes the primacy of Indigenous leadership and knowledge. It is a program of Medical Deans Australia and New Zealand, funded by the Australian Government Department of Health and Ageing, and is hosted by the *Onemda* VicHealth Koori Health Unit within the Melbourne School of Population and Global Health at The University of Melbourne. It was developed as a standalone project in 2008 and stemmed from the Committee of Deans of Australian Medical Schools Indigenous Health Project, which began in 2002. Major outcomes of the Indigenous

Health Project include the Indigenous Health Curriculum Framework and the Critical Reflection Tool, which remain important resources for the current program.

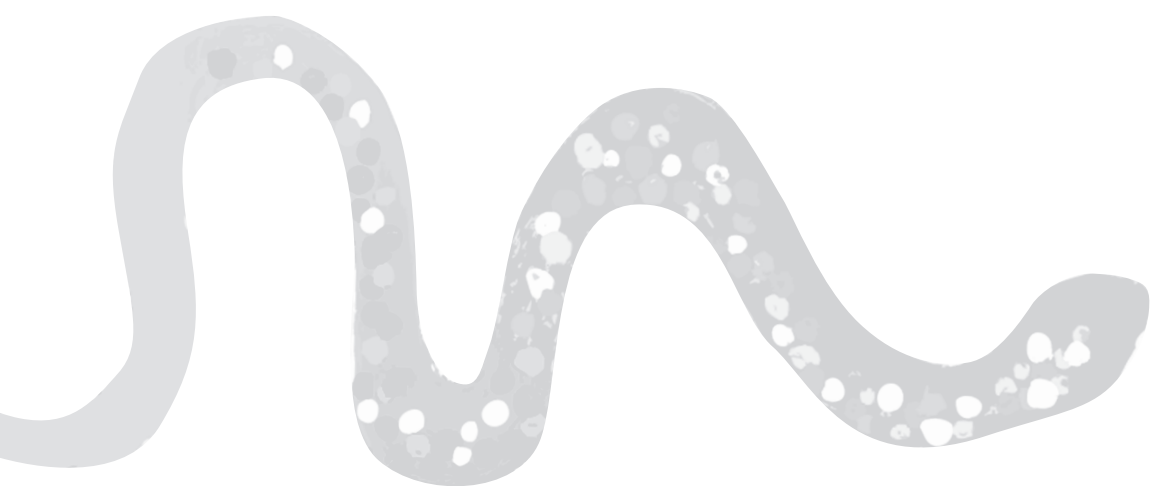
Contact Details

If you would like more information regarding LIME Network activities, please contact us:

W: www.limenetwork.net.au

E: lime-network@unimelb.edu.au

T: +61 3 8344 9160.



LIME GOOD PRACTICE CASE STUDIES

CURRICULUM DESIGN

Native Hawaiian Health Past, Present, Future: The genesis of a course

Dr Martina Kamaka, University of Hawai'i, United States of America

Introduction

Native Hawaiian Health Past, Present, Future is one of eight Community Health selectives (all students must 'select' one of eight elective options) that medical students at the John A. Burns School of Medicine in Hawai'i might choose during their first year of medical school. The course is popular and routinely filled with students for whom the course is their first choice. We can accommodate ten students each year.

The course is offered by the Department of Native Hawaiian Health and is run by two faculty members, Dr Martina Kamaka and Dr Vanessa Wong. Both are board-certified family physicians. The overarching goal of the course is to provide educational opportunities and experiences for medical students in Native Hawaiian culture, health and health care practices that will enable them to provide better, more holistic health care not only to the Native Hawaiian population, but also to the rest of Hawaii's people.

The course features 'community classrooms' where much of the teaching occurs. Our community partners include community health centres; sites where governmental, non-profit organisations and cultural groups work to preserve traditional cultural practices and/or sacred sites; and a Native Hawaiian language immersion school. Guest instructors include traditional Native Hawaiian healers, Native Hawaiian academics, and scholars, as well as consultants with expertise in Native Hawaiian health, culture and related topics. 'Service learning' or community service projects are focused on the importance of land and environment in the fall (autumn) semester and on youth nutrition education in the spring semester.

The course has undergone a significant process of review, redevelopment and growth in recent years. It has now developed into a course that provides a focused and comprehensive opportunity for medical students to explore Native Hawaiian culture, health and health care practices in detail.

Why was this program initiated?

The first iteration of the course was originally offered in 1999 as the Native Hawaiian Health and Research Methodology selective. It was developed in response to a requirement within a federal government grant to increase Native Hawaiian researchers, as well as research in Native Hawaiian health disparities. In addition, the Dean of John A. Burns School of Medicine at the time wanted to give students more training in, and opportunities to conduct, research. The course became one of the community health selective sites for first-year medical students and was the only course offered at the time that addressed Native Hawaiian health issues, as well as cultural competency training.

In 2006 the Department of Native Hawaiian Health initiated several new cultural competency training initiatives for medical students. However, due to lack of curricular time, many of the topics covered could only be dealt with superficially. In response, a new ten-week elective was designed and was called Native Hawaiian Health Past, Present and Future. Taught for the first time in 2008, the goal of the elective was to explore Native Hawaiian health and healing practices in much more depth.

In the meantime, the Native Hawaiian Health and Research Methodology course was experiencing decreasing enrolment, decreasing funding and loss of faculty staff. In 2009 the Department decided to combine the two existing courses on Native Hawaiian health to save resources. Research methodology was woven into the 'present' and 'future' sections of the Native Hawaiian Health Past, Present and Future course and the revised course was offered as a community health selective.

Aims and objectives

The original aim and objective of the course was to teach research methodology, assist students in developing research projects addressing Native Hawaiian health and weave cultural competency into the research methodology. The latter was important to address the negative attitude many Native Hawaiian communities developed as a result of bad research experiences.

In response to evaluations of the course, and as a result of the merger with the Native Hawaiian Health Past, Present and Future elective, the course changed over a period of four years. New aims and objectives evolved to reflect a focus on providing educational and training opportunities and experiences for medical students in Native Hawaiian culture, health and health care practices.

Course directors hoped that students would become more culturally competent and would be better able to care for Native Hawaiian patients through consideration of culture, spirituality, family needs and community resources. Research was incorporated as a didactic topic on current research efforts on the community and its implications for the future of Native Hawaiian health. The new course objectives included being able to:

1. Discuss the role of traditional Native Hawaiian healing and cultural practices in both pre-contact and current Native Hawaiian health.
2. Describe the current health status of Native Hawaiians and identify possible causes of health disparities.
3. Gain a better understanding of the holistic approach to Native Hawaiian health.
4. Engage in service learning projects that promote Native Hawaiian health.

5. Gain a better understanding of Native Hawaiian history and culture.
6. Consider the utilisation of community and cultural resources in treatment plans.

A significant change in the course involved shifting more of the classroom time into 'community classrooms' and adding service learning projects. Students currently travel off-campus for much of their learning experience.

Approach to achieve aims and objectives

Currently, the selective is held every Tuesday morning for four hours over the course of a year. Students are off-campus for 53% of the time. Of the classroom time, 25% is spent with traditional healers who come in to undertake demonstrations and hands-on workshops. Off-campus experiences emphasise community strengths and resiliency. Community members from each of the learning sites lead the sessions. Some of these community sites, especially the non-profit organisations, already have educational curricula in place. All of the sites are chosen for either their relevance to Native Hawaiian health or to Native Hawaiian cultural practices that are indirectly related to health. In addition, students participate in two longitudinal service learning projects.

For the fall semester, students work once a month with a non-profit organisation that is restoring Native forests, kalo (taro) terraces, streams and watershed areas and cultivating native plants. Efforts focus on restoring the health of the 'āina (land, environment). Hawaiians believe that you cannot have a healthy people without a healthy 'āina. In the spring, students develop a nutrition curriculum for Native Hawaiian elementary students.

Challenges

Evaluation of the course has always been multipronged. Students complete post-curricular evaluations (incorporating Likert scales and open-ended questions) and reflection papers, and have an oral debrief with faculty staff. Student evaluations are compiled, and along with faculty debriefs, are reviewed by the Cultural Competency Curriculum Project (C3) team at the Department of Native Hawaiian Health.

After review, the course historically has been modified as needed. For example, in 2011 it became clear that the blended course was not fulfilling all of its objectives. Post-course evaluations reflected the conflicting focuses and interests of the students, illustrated in this quote from one student evaluation:

I'm actually torn about the direction of the course. I joined to explore the research work within the Native Hawaiian community. I now feel there is more to gain by focusing on the community service aspect with research talks sprinkled in between. Also, I'm leaning towards the concept of removing the project aspect from the course.

First, there did not seem to be enough time to address the two main aims of the course adequately. Second, many of the students who joined the course were more interested in one aspect, for example research, and not the other (culture and health), and vice versa. Finally, a service learning project was not part of our original blended course. Instead, students were expected to be involved in a research project. However, students in other selectives were heavily involved in service learning projects and our students indicated a desire to also do a service learning project.

The C3 team decided that a significant overhaul of the course was necessary. Additional input was sought from external evaluators. International peer feedback from LIME Network colleagues, as well as external reviews by three cultural consultants, contributed to the process of modifying the course. We believe that using this multipronged process of evaluation represents a best practice approach for the evaluation of cultural competency-related curriculum and has been critical to the current success of our course.

A new major challenge for the course is funding. A government grant that funded the course over the past four years has not been renewed. Staff members are actively looking for other funding sources to ensure its continuation.

Finally, long-term assessment of the impact of the course is a challenging task. Notably, any sort of assessment for cultural competency-related curriculum is a difficult undertaking. Our current course is fairly new and our students won't graduate from medical school for at least two more years. Ideally, we would like to see if our efforts are successful once the students are in clinical practice. However, it would be more realistic for us to try to assess our students upon graduation. At this point in time, we are considering developing a cultural standardised patient for the senior year graduation Objective Structured Clinical Examinations (OSCEs). We would like to see if there is a difference in the performance of the students who take the selective versus those who do not.

Successes

In its current form, the course appears to be fulfilling its goals and objectives. Evaluations are overwhelmingly positive. The selective site is popular and continues to enrol students who select it as their first choice out of at least seven other sites. One concern we have is whether students are able to 'connect the dots' between Native Hawaiian health and the various activities, service learning projects and guest speakers that we include as part of our course. The following is a recent comment from one of our students that demonstrates that this is indeed occurring:

It finally clicked in my head that all of the programs and service learning projects we have been exposed to/participated in are projects which promote and create opportunities for Indigenous healing, both for the organisers and participants. I remember leaving the lecture on cultural trauma really wanting to create an opportunity for Indigenous healing for the local ethnic communities, but it was nice to realise that Indigenous healing is already happening... Saturday definitely inspired me to look past my future patients' disease states and strive to help them heal and achieve psychological and emotional well-being.

What are the impacts?

The evaluation of the impact of this course currently consists of student self-reports, including post-curricular surveys, oral debriefs and reflection papers (see our evaluation strategy in the 'Challenges' section above). Ultimately, we hope that the course will impact how students go on to practise medicine. Currently, the plan is to develop a cultural OSCE that can be used to assess their cultural competency-related skills prior to graduation. We are striving to produce a physician who can:

- acknowledge the impact of culture in medicine
- interact effectively with not only Native Hawaiians but also those of other cultures

- approach health and health care holistically
- recognise and address the impact of history and societal factors on patient health
- consider the needs and resources of the patient's family and community in treatment recommendations
- be comfortable interacting with other health care practitioners, including traditional healers.

How has the project developed Indigenous leadership?

The program highlights Indigenous leadership in several ways. First, it highlights the leadership shown by members of our Indigenous community. Some of them are doing incredible work with very little support or funding. Bringing our students to these sites and helping them to 'connect the dots' between their work and health helps to validate the work of our community partners. It is important for students to see that there is this kind of passionate leadership outside of medicine and it is important for us to show our support of the work that is occurring.

Second, the course is taught by two Indigenous physicians. Dr Kamaka is Native Hawaiian and Dr Wong is Palauan. As a result of this work, we have collaborated with incredible Indigenous mentors and colleagues, presented our work at conferences (local, national and international), designed educational research projects and, most importantly, developed and matured as people through participating as teachers, as well as 'learners' in this course.

What's next? Program sustainability

Funding continues to be a major issue for the course. We provide honoraria for our traditional healers, cultural consultants and external educators. Some of the non-profit organisations, such as the group restoring the native fishponds, have fees for their educational programs. Also, we do not charge the medical students to participate in a mini cultural immersion weekend in a rural community. We continue to address the challenge of securing sustainable funding for the program.

On a positive note, the leadership of our department recognises the importance and legitimacy of the course. For example, funding for the external reviews by the cultural consultants came from outside the course budget. In addition, course staff have been given specific time in their schedules to work on the course and continue with course development. There is strong support from department leadership, which is actively assisting course staff to find new funding. The course is currently very popular and is achieving its objectives, which helps to justify its cost and has helped to rally support. Overall, course staff are optimistic and plan to continue to offer this unique selective in Native Hawaiian health.

For further information, contact:

Dr Martina Kamaka

Department of Native Hawaiian Health
John A. Burns School of Medicine
E: martinak@hawaii.edu



Same words, different stories: Transferring an Aboriginal health curriculum across disciplines

Associate Professor David Paul, Mr Craig Allen and Dr Paula Edgill, The University of Western Australia, Australia

Introduction

The development and implementation of a comprehensive Aboriginal medical curriculum presents its own unique collection of rewards and challenges. Within this context, medical students are taken on a journey through Aboriginal cultures and exposed to culturally safe/secure frameworks in order to produce a better clinical experience for Aboriginal clients. The comprehensive horizontally and vertically integrated curriculum we have implemented in the medical program at The University of Western Australia has resulted in significant shifts in student-reported preparedness to practise. Based on this success in medicine, we have implemented similar Aboriginal health curricula in the nursing, podiatry and dental programs at The University of Western Australia with the aim of better preparing the students in these programs to work more effectively within Aboriginal contexts.

Why was this program initiated?

Aboriginal peoples' health and wellbeing depends in part on the quality of the health care services people have, or choose to have, access to. Although many factors influence the utilisation of health care services, one key factor that determines whether people access services is the acceptability of that service. Given the multidisciplinary nature of the health care workforce, it is important that all practitioners have the ability to better meet the health and health care needs of Aboriginal peoples and communities. The documented success of the comprehensive vertically and horizontally integrated curriculum that the Centre for Aboriginal Medical and Dental Health staff developed and implemented in the medical curriculum, and the presence of five other health disciplines within the Faculty of Medicine, Dentistry and Health Sciences, provided the opportunity to trial the applicability and relevance of a similar curriculum in those other disciplines.

Aims and objectives

1. To have a health workforce that is better prepared and better able to meet the health and health care needs of Aboriginal peoples and their families and communities.
2. To test the transferability of a comprehensive Aboriginal health curriculum developed for an undergraduate medical program into other health disciplines.

3. To identify the customisation required in a comprehensive Aboriginal health curriculum for it to be effective in other disciplines.
4. To determine if a common Aboriginal health curriculum is feasible for different health discipline courses.

Approach to achieve aims and objectives

The lessons learned within the medical school context provided a useful starting point to reflect on what is required to create shifts in the other health professional courses within the broader faculty. The introduction of two new health professional courses within the faculty, nursing science and podiatric medicine, provided the opportunity to embed Aboriginal health teaching and learning from the beginning. The existing curriculum that was mapped to year level and graduate outcomes in the medical course provided a template for the year and graduate outcomes for the new courses. Once there was agreement on how the template was to be implemented, it was possible to structure the Aboriginal health curriculum for each discipline, drawing on the content and approaches already successfully implemented in the medical course but customised for each. This customisation was particularly relevant given the different structure of each course, the differences in each student cohort and the cultures of each discipline.

Challenges

Evolving a curriculum in partnership with others within the medical course has led to the development of longer-term collaborative partnerships with colleagues who have developed a shared commitment and ownership of the Aboriginal health curriculum initiatives and their continuity. The development and implementation of similar curricula in each of the new courses has been different and raises questions of process and outcomes and how they impact on the quality of the experience for us as educators. Establishing and reinforcing the leadership role that Aboriginal health academics have in this field can, at times, challenge the hierarchical structures within academia, as well as the autonomy of unit co-ordinators. Negotiating the potential issues around territory, authority and expertise with new cohorts of colleagues is time consuming and can feel repetitious. Enthusiastic inclusion of content without the associated partnership and collaboration, and subsequent ownership, can result in an all-too-frequent and unsatisfactory guest lecture feeling. In other words, integral but not integrated – appearing slightly out of context and not perceived to be the main game by students.

Obvious challenges that needed to be negotiated as we engaged with academics new to Aboriginal health ranged from containing enthusiastic paternalism through to educating the naive. Content, and its ease of transferability, can be the least relevant issue to address when relationships and partnerships that we had taken as given in one course have to be negotiated, nurtured and built in new courses.

Successes

There are now nine years of end-of-course evaluation for the medical course but only two years for nursing and podiatry programs. Although we have a number of years of evaluation data for the dentistry program, we have not been able to implement a comprehensive across-the-course Aboriginal health curriculum.

By the end of 2011, seven cohorts of students who undertook a course-long Aboriginal health curriculum had graduated from the medical course and two cohorts of students had graduated from the podiatry and nursing courses.

The longer-term aim is to have a better-informed health workforce that respects Aboriginal knowledge and leadership, and is able to work in partnership with Aboriginal practitioners, patients and communities. Demonstrating that achievement, beyond the anecdotal, will require substantial further research looking at student and graduate preparedness to practise, as well as patient satisfaction and, in the longer term, shifts in patient outcomes.

What are the impacts?

In 2003 the Centre for Aboriginal Medical and Dental Health staff developed, in collaboration with the Faculty Education Centre, an Aboriginal health evaluation tool that was designed to assist with monitoring the effectiveness and utility of the Aboriginal health curriculum initiatives we were implementing. This tool has been validated and is now used across all the health courses that we teach into. We have done some early comparison of the evaluation data across the different disciplines but due to relative low numbers of students in some of the courses, as well as low participation rates in the evaluation process for some courses, we have not been able to complete a comparative analysis of the data yet. We hope to be able to do this over the next year. However, the nine years of data that we have, which evaluate final-year medical students, show a very substantial shift in student-reported preparedness in relation to Aboriginal health and health care. Table 1, from unpublished Year 6 Aboriginal Health Evaluation Reports from the Faculty of Medicine, Dentistry and Health Sciences, indicates this shift.

Table 1: Medical student perceptions of Aboriginal health preparedness to practise

Skills in Aboriginal health	Yr 6 – 2003 Mean & % agree		Yr 6 – 2004 Mean & % agree		Yr 6 – 2005 Mean & % agree		Yr 6 – 2006 Mean & % agree		Yr 6 – 2009 Mean & % agree		Yr 6 – 2010 Mean & % agree		Yr 6 – 2011 Mean & % agree	
Communicate appropriately with Aboriginal people	3	29	3.61	69	3.54	58	3.65	56	3.75	68	3.95	89	3.89	85
Apply knowledge of Aboriginal Health to provide culturally secure health care	2.65	14	3.55	62	3.88	78	3.88	71	3.62	65	3.96	90	3.89	87

* Note, participation rates in 2007 and 2008 were too low to be reliable so are not included. Mean from a 5-point Likert scale.

How has the program developed Aboriginal leadership?

The Centre for Aboriginal Medical and Dental Health is Aboriginal led and the programs are developed and implemented by a team of Aboriginal and non-Aboriginal health academics. The Centre provides the opportunity for graduates to engage in and inform the academic realm and seeks to further build the capacity of the health and academic sectors.

What's next? Program sustainability

Increasing teaching into more courses and more units within the respective courses is demanding in terms of time, energy and emotions. Ensuring that workloads do not increase beyond capacity is an ongoing issue that needs to be addressed. Although the framework of the Aboriginal health curriculum can be used to guide implementation in other disciplines, the particular cultures, expectations and contexts of each discipline mean that there is an ongoing challenge to customise content, expectations, and processes of delivery and assessment to reflect this.

For further information, contact:

Associate Professor David Paul

Centre for Aboriginal Medical and Dental Health
Faculty of Medicine, Dentistry and Health Sciences
The University of Western Australia

E: david.paul@uwa.edu.au



THE UNIVERSITY OF
WESTERN AUSTRALIA
Achieve International Excellence



TEACHING AND LEARNING

Elders are the educators: Transmitting Elders' knowledge in health sciences for increased cultural competency

Ms Danielle N. Soucy and Elders Bertha Skye, Elize Hartley, Gerard Segassige and Lorna Hill, McMaster University, Canada

Introduction

The Elders-in-Residence program is an initiative of the Aboriginal Students Health Sciences (ASHS) office within the Faculty of Health Sciences at McMaster University, Canada. Acknowledging the success of Elders-in-Residence programs elsewhere, ASHS sought not only to develop its own program, but to be innovative in providing increased cultural support and learning opportunities for health science students and staff.

The program, developed in 2010, has involved Elders and invited guest speakers representing Métis, Inuit and First Nations from across Canada who come from urban, rural and reserve communities and organisations. McMaster University's Elders-in-Residence program started with two in-house Elders during the 2010–11 academic year: Elize Hartley (Métis) and Bertha Skye (Cree). In response to student needs, the program was expanded in the 2011–12 academic year to include Elders at the Waterloo and Niagara campuses: Gerard Segassige-Ojibway (Mississauga) and Lorna Hill (Cayuga), respectively.

Why was this program initiated?

The ASHS office identified a gap in the provision of services for the socio-cultural, spiritual and intellectual needs of Aboriginal students – namely, the need for greater access to Elders and their knowledge. It is believed that an environment acknowledging, reflecting and respecting Elders' (Métis, Inuit and First Nations) knowledge will create an atmosphere where students feel a sense of meaningful engagement in their education process, and will attract Aboriginal students interested in studying health sciences to McMaster University.

The program was extended beyond traditional Elders-in-Residence programs to include the use of social media to increase access to content on First Nations, Inuit and Métis traditional health, healing and medicines; expanded involvement of students from regional campuses; and the option of both face-to-face and virtual access to traditional knowledge holders.

While the initial and primary focus of the Elders-in-Residence program was to meet the needs of Aboriginal students in health sciences, ASHS recognised the importance of knowledge sharing

opportunities with non-Aboriginal learners and faculty members in increasing cultural safety within learning environments, and the program was opened to all interested members of the McMaster community.

Aims and objectives

Through the Elders-in-Residence program, ASHS is working towards:

- improving support services for Aboriginal students
- providing a learning space for future health care practitioners to engage in a collaborative discourse on health and healing
- creating practitioners who will become champions to challenge and change the western model of health care delivery
- breaking down barriers to information
- preserving Indigenous knowledge/medical knowledge
- removing the elitism associated with accessing health education.

To this end, Elders are available to answer questions, offer support and to listen.

Our overarching objectives are to:

1. Have Elders recognised as experts in the field within the academy (Elders receive the same stipend/honorarium as physicians do for their work).
2. Increase cultural competency and safety for health care practitioners and patients.
3. Create a positive impact on learners by presenting traditional medical knowledge in a palatable way to the biomedical model enthusiasts.
4. Dismantle stereotypes and beliefs about health education.

Approach to achieve aims and objectives

The intention of this program has always been to create and maintain a safe space for Aboriginal and non-Aboriginal students to have access to Elders' knowledge. In order to do this, we designed the program to make use of the internet and social media, developing our own website, YouTube channel, and Facebook and Twitter pages. For Aboriginal students, this meant that they could easily feel connected to the Elders in the program. For non-Aboriginal students, creating spaces of respect, learning and productivity was essential to bridging the divide between epistemologies. Through knowing what traditional knowledge was available and how Aboriginal/non-Aboriginal knowledge relationships could be harmonised, the Indigenous versus western dichotomy could be shifted.

Elders now teach the core of the Aboriginal Health Elective and the Inter-professional Day in Education – Aboriginal Health, provide lunchtime sessions and are on site at regional campuses. Urban and off-reserve learners who do not have access to traditional knowledge can access Elders' knowledge through podcasts on our website and YouTube channel. Elders also travel with students and staff to communities to recruit future medical students.

Challenges

The Elders-in-Residence program has faced some of the common logistical challenges most Aboriginal initiatives experience in tertiary institutions, such as acquiring physical space and funding according to the demonstrated need. Through buy-in from key internal stakeholders, we have secured space and in-kind logistical support. Funding for the program is part of a larger envelope of Aboriginal funding provided by Ontario's Ministry of Training, Colleges and Universities. The funding period is for a limited term, with no promise of continuation.

Another challenge is ensuring the program continues to be engaging and broadly accessible to the new 'techno' student. Further, with regard to non-Aboriginal learners, creating a sense of trust and inclusion in a discourse that is often critical of the society in which they exist can be difficult. There is a fine balance between creating a respectful discomfort in an educational setting (leading to inquiry) and causing anger and defensiveness (leading to emotional/intellectual barriers and a 'shutting down' of the learning process).

Successes

The Elders-in-Residence program has successfully provided current and incoming Aboriginal and non-Aboriginal students with access to traditional knowledge. For those Aboriginal students with little understanding of their culture, the Elders-in-Residence program provides important insight and develops a sense of connectedness and pride. The program also plays a role in encouraging and motivating Aboriginal students to enrol at McMaster University and to remain through to completion of their studies. Twenty-five per cent of Aboriginal students use the program to fulfil the need for a sense of home and community; and 16% use it for stress relief and wellness support – these numbers speak as a successful retention strategy. The Elders-in-Residence program creates a sense of community, decreases alienation and demonstrates student support.

The program has been particularly successful in developing and sharing approaches to integrating traditional and western epistemologies for health sciences students – informing their future practice and patient-care plans. Tutorial groups bring case scenarios to the Elders to discuss what traditional health or healing is about and how it should be considered to ensure that, as future practitioners, they can be more culturally safe. Students also access podcasts of the Elders' teachings, and, in a classroom setting, discuss what they learned with the Elders. Hard-copy resources are made available for the students to collect for further study.

Use of Elders-in-Residence resources has extended to preceptors and faculty staff, as well as staff from other faculties and programs within the university. They are linking our website to theirs and sending out hyperlinks to their students as a useful resource. Elders had more than 145 meetings with students, faculty and staff within the twenty-three possible in-house dates available for all four Elders.

When we surveyed Aboriginal and non-Aboriginal participants of the Elders-in-Residence program, we found that 80% of the participants referred the program to others, 100% would use the program again, and 80% rated the program as very important to their educational experience. With regard to the regional Elders-in-Residence program, 80% felt it was very useful, with an average of 2.8 visits per participant. Notably, 100% of the program users considered Elders as experts in their field of practice (Indigenous knowledge).

What are the impacts?

The impacts of the program have been far reaching. For the Elders it has meant an increase in income and a sense of intellectual and spiritual worth. The opportunity to give back to the community and the ability to evoke positive change for their people through education has been widely noted. As Elder Bertha Skye stated:

The creator has left me for a purpose. There were some things I had to share with the people.

For Aboriginal and non-Aboriginal students and staff of the faculty, the impacts have been seen in their increased understanding of cultural teachings/Indigenous knowledge and traditional health and healing practices. One hundred per cent of program users felt that Aboriginal peoples' perspective on health is an important part of health sciences education and felt Indigenous knowledge and western practices could complement each other. Fifty per cent of program users felt that their curriculum should contain content that is one-third Aboriginal specific, followed by 25% of the participants who indicated that half of the curriculum content should be Aboriginal specific; a further 25% believed that 60% of the curriculum should be Aboriginal specific. Although these numbers are unrealistically high in terms of changes to curriculum such as medicine, they do suggest the desire of learners for more than the current practice. Thirty-four per cent of students accessed the program for educational purposes, and 25% accessed it for personal (psycho-social) reasons. As stated above, for Aboriginal students, the sense of home and community the program created for them was notable.

When asked if their perspective of Aboriginal culture has remained the same or changed after meeting an Elder, 25% of Aboriginal and 75% of non-Aboriginal respondents said that it had changed. When asked if their perspective on Aboriginal health care, practice and delivery had changed, 75% of both Aboriginal and non-Aboriginal respondents said, yes, it had changed.

The 2012 Aboriginal Health Elective medical students were asked if the lectures by the Elders on traditional medical and Indigenous knowledge were relevant to their education/career. Sixty-two per cent thought the relevance was excellent, 20% thought it was very good, 13% thought it was good and 5% thought it was fair. Of the Aboriginal Health Elective students, 29% were Aboriginal and 71% were non-Aboriginal.

Forty-three per cent of participants who heard Elders' public lectures at health forums stated that they would definitely access the Elders-in-Residence program and 53% stated they would access the Elders' podcasts. Eleven per cent stated they would not use the Elders-in-Residence program and 6% would not access the podcasts. Of the participants at the public lectures, 47% were Aboriginal and 53% were non-Aboriginal.

In relation to the use of social media, from June 2011 to April 2012, podcasts of Elders were downloaded for viewing 3578 times. Of those participants who viewed the Elders-in-Residence podcast series on YouTube, 67% felt it was useful and 60% would like to access teachings in a companion book/video format.

How has the project developed Indigenous leadership?

Developing leadership was not a specific goal for the Elders-in-Residence program, yet the program has fostered leadership in our Aboriginal students through the recognition, support and validation of themselves as people and scholars. Students have gone on to speak at, or organise, student initiatives where they share their experiences as Aboriginal people and students in the health sciences. One student went from being a Doctor of Medicine Resident and ASHS Mentor to becoming the ASHS Aboriginal Faculty Advisor.

The Elders, already leaders in their communities, also stated an increased sense of empowerment.

What's next? Program sustainability

Our goal is to maintain the program (with twenty-five new podcasts this year) and to continue to solicit feedback from users on how to best meet their needs. This will be achieved through ongoing evaluation of data from website, podcast, YouTube, Facebook and Twitter demographics. ASHS has also produced a free print version of the podcasts as a companion text for Aboriginal community organisations, schools, youth centres and health centres, and an electronic version will shortly be available via our website.

The ASHS office will continue to seek guidance from Elders and communities on short- and long-term goals for the program. We will continue to seek long-term external funding, as well as pursuing an increased budget commitment from the university with the aim of being fully supported by the university in the future.

For more information, contact:

Ms Danielle N. Soucy

Department of Family Medicine, Faculty of Health Sciences

McMaster University

E: soucy@mcmaster.ca



Demonstrating cultural safety in communication through standardised role play

Ms Courtney Ryder, Professor Della Yarnold, Ms Colleen Hayes, Ms Laney MacKean, Mr Dave Sjoberg and Mr Michael Porter, Flinders University, Australia

Introduction

Structured Clinical Instruction Modules (SCIMs) involving standardised role play are an innovative way for students to learn a variety of clinical skills in a safe, friendly environment for both the patient and student. The original mode of delivery and style was designed by a small surgical teaching team at the University of Kentucky (Sloan 1995). The School of Medicine at Flinders University, under a modified approach, has been using SCIMs for a number of years. These sessions have predominantly been education focused on the clinical environment (for example, Musculoskeletal Medicine) to improve students' clinical skills (Smith et al. 2002). Teaching stations are designed to provide an entirely simulated clinical situation to meet specific learning objectives. Each station is developed to give every student an equivalent range of clinical skills experience covering the main aspects of each learning objective. Indigenous health SCIMs were developed to enhance second-year medical students' skills in treating Indigenous patients in the clinical environment.

Why was this program initiated?

Years One and Two of the Flinders University School of Medicine Program provide students with eight dedicated Indigenous health teaching sessions, a range of Problem Based Learning Cases on Indigenous health, and an Indigenous Health Elective for students who wish to explore Indigenous health and cultural safety further. The Indigenous health SCIMs were introduced so that students could practise a range of clinical skills relating to cultural safety in both a student- and patient-safe environment. These modules add to prior teaching in Indigenous health and provide the opportunity for medical students to utilise and integrate their knowledge base further through enacting core skills in a simulation-based environment before participating in clinical rotations in their third and fourth years across the various Flinders University placement sites. Furthermore, these sessions were integrated as core to the second year of the graduate entry medical program in the subject Introduction to Clinical Performance, which, prior to this, had no Indigenous health content.

Aims and objectives

The medical curriculum at Flinders University has been designed to meet specific graduate outcomes through a community values consultation process. The teaching in Indigenous health across all years of the medical course corresponds with both the *CDAMS Indigenous Health Curriculum Framework* (Phillips 2004) and the Medical School's cultural safety graduate outcome. The curriculum in second year, involving the Indigenous Health SCIMs, focuses on building skills associated with Indigenous health covered in the first year of study. The three main Indigenous health learning objectives for students in their second year are to:

1. Build on developing crucial communication skills for use in relation to Indigenous health.
2. Understand and be aware of models of health service delivery and their impact on the health of Indigenous people.
3. Understand the social/multiple determinants of health for Indigenous people.

The initial aim of the standardised patient sessions was to facilitate students' hands-on experiences within a safe simulation environment to improve their understanding of Indigenous health before clinical placement. Over time, these sessions have developed further and now present real-life simulation situations (gathered from past events) that students may face when undertaking their clinical placements. Many of these sessions were devised through a 'values consultation' interview process with community Elders, Aboriginal Health Workers and a range of community representatives. Other sessions have been developed from key teaching processes that have been successful in a range of Indigenous community settings, for example:

- The Sugar Man: an interactive storytelling process to explain the complexities of diabetes along with prevention and management options; the teaching process was designed by diabetes educator Michael Porter (2007), in consultation with remote Aboriginal communities in northern South Australia
- The Heart of the Matter: a DVD resource that teaches students a consultative approach with Aboriginal communities and families to explain rheumatic heart disease through visual diagrams and drawings.

The SCIMs aim to contribute to the Medical School's Indigenous health learning objectives and equip students with a range of skills to enable them to handle different and sometimes challenging situations when they treat an Indigenous patient. These sessions are about growing future doctors who practise in a holistic way with a patient-centred approach.

Approach to achieve aims and objectives

In the Flinders University School of Medicine Program on average there are 130 students in second year. For the SCIM program to run in a manageable format, the student cohort is divided into three groups, with an average size of forty to forty-five students. This requires the SCIM program to be run three times over one semester, so that each student group can experience the same program. This is undertaken once a month over a three-month period. Generally, the Indigenous Health SCIM program is run for around two-and-a-half to three hours. In this time students rotate through six to

eight different Indigenous health modules. To allow students a better opportunity of interaction each student group is broken down into smaller groups of around seven to nine students. Each group spends around twenty minutes at each Indigenous health module with a simulation tutor. This ensures that every student is given the opportunity to take part in each station. Generally, one of these sessions is utilised as the basis of an assessment in the second year Objective Structured Clinical Examination (OSCE) at the end of the year.

Before the teaching date, the Indigenous health teaching team undertakes a call-out to various Indigenous community members and organisations inviting them to be part of the simulated teaching sessions. Members of Karpia Ngarratendi, the Aboriginal Health Unit located in the Flinders Medical Centre and attached to the School of Medicine, often play a very active role as Indigenous community simulation tutors. Each session is uniquely designed in collaboration with the tutor, so that the delivery and format suit their needs as an educator. At the teaching stations, the simulation tutor plays the role of the patient, alongside a facilitator, with the aim of testing and building specific teaching and learning objectives. Involvement in these sessions has become increasingly popular and there is always a long list of community members and organisations wishing to participate.

The modules are designed to give every student an equivalent range of clinical skills experience covering the main aspects of the expected learning outcomes within the Indigenous Health Medical Curriculum at Flinders University, as stated above. These overarching learning objectives are further refined to instruct the development of specific standardised patient sessions. For example, in 2011 the Aboriginal Program of Experience in the Palliative Approach was a simulated case study session. The second overarching Indigenous health learning objective was revised for this session as follows: Understand the unique services in South Australia available to Indigenous patients and family in palliative care. In this case an Elder wished to return home to country before end of life. The session allowed students to interact with an Indigenous patient around difficult topic material. The student had to explore what is critical to the patient, family and community at this time, while learning about services available in South Australia around palliative care.

Challenges

The SCIMs program is becoming increasingly popular, not only in medicine but in other health science programs at Flinders University. Unfortunately, the administration and design process of these teaching stations requires substantial staff resources, which are becoming much more limited with increasing teaching demand across the Faculty of Health Sciences.

The sessions can also be challenging for some students who find the cases difficult to grapple with due to their own worldviews. We find, however, that this method of learning is beneficial in this situation, enacting the transformative unlearning requirements needed for the development of culturally safe practice. In these cases, more often than not, it is the students' peers who challenge their worldviews rather than the simulation tutor. For instance, where a student is enacting culturally unsafe behaviour, peers may suggest an alternative approach or employ one themselves. In other cases where this may not occur, the simulation tutor or facilitator might stop the role play and open a small group discussion on alternative approaches in a non-threatening way. At the end of each role play the facilitator engages students with a demonstration of culturally safe approaches and reinforces prior learning in this area.

An ongoing challenge for Indigenous medical educators is assessing whether the learning outcomes, as reported by the students (see below), are carried on to practice in a clinical setting upon graduation. In 2013 we will begin to assess the students' skills in Indigenous health before and after they participate in the SCIMs. However, it remains difficult to validate whether this learning carries onto practice.

Successes

Student evaluations from 2008–10 have been recorded to benchmark the usefulness of these sessions for students' clinical placements. Feedback from these evaluations is utilised to build and improve the sessions for students in subsequent years. In 2010 ethics approval was sought to evaluate the program for a third of the class in second year. From this class 66% of students (N = 47) participated in an evaluation survey, with 82% of respondents rating the Indigenous health SCIMs session as a minimum of four out of five for usefulness. Overall, the students enjoyed the learning environment because they could see direct links between these sessions and their future clinical placements. Comments from the 2010 evaluation included:

The cultural safety and respect tips were very valuable. Sugarman was awesome.

Being in smaller groups, very interactive and being able to ask questions.

Much more useful than lectures – more role plays would be good! Thanks.

We want a full day, or more sessions!

What are the impacts?

All community members are paid at the highest tutor level for their involvement in the Indigenous health SCIMs program. The funding for this program is provided by the School of Medicine and does not rely on external grants. It is a teaching method that builds on Flinders University School of Medicine's social accountability framework by involving Indigenous community representatives in directing and participating in teaching sessions. Past evaluations with Indigenous community members found that students were respectful in their sessions and actively participated and appreciated the education experience.

Another major impact of this program is that students are given an opportunity to build their cultural safety knowledge base before their clinical placements. Not only is this potentially beneficial to Indigenous patients and the staff they will work with in the future, but it allows students to develop best practice approaches in a safe simulation environment. From these experiences we hope that students are able to carry this best practice approach through to their professional practice.

How has the project developed Indigenous leadership?

The initial design and continued development of this teaching program is underpinned by Indigenous leadership, not only within the university but across the wider Indigenous community that Flinders University engages with. Indigenous tutors and facilitators collaborate with university staff to develop teaching strategies. This enhances their capacity as educators and health/

community workers and develops their leadership skills. This program could not run without the fundamental support from the various Indigenous community members who participate and help to design these important teaching sessions.

What's next? Program sustainability

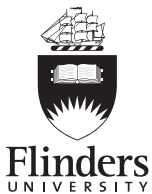
This program is a core part of the teaching curriculum within the second-year medical program of Flinders University and, as such, is funded to continue. A small grant has recently been obtained to develop an evaluation tool to assess the learning and cultural safety skills obtained by students participating in these sessions. This tool will assess students' cultural safety skills before and after they participate in these sessions in 2013. Based on feedback from students so far, it is envisaged that more technology-based simulation environments will be developed with the involvement and direction of Indigenous community members.

For further information, contact:

Ms Courtney Ryder

Poche Centre for Indigenous Health and Wellbeing
Flinders University

E: courtney.ryder@flinders.edu.au



References

- Phillips, G. 2004, *CDAMS Indigenous Health Curriculum Framework*, VicHealth Koori Health Research and Community Development Unit, Melbourne.
- Porter, M. 2007, 'The Sugar Man: An interactive model for diabetes education', paper presented at the 9th National Rural Health Conference, Albury, NSW, 7-10 March.
- Sloan, D., Donnelly, M., Zweng, T., Lieber, A., Yu, G., Griffith, C. et al. 1995, 'The Structured Clinical Instruction Module: A novel strategy for improving the instruction of clinical skills', *Journal of Surgical Research*, vol. 58, pp. 605–10.
- Smith, M. D., Walker, J. G., Schultz, D. W., Ash, J. K., Roberts-Thomson, P. J., Shanahan, E. M. et al. 2002, 'Teaching clinical skills in musculoskeletal medicine: The use of structured clinical instruction modules', *Journal of Rheumatology*, vol. 29, no. 4, pp. 813–17.

The use of research-based Indigenous case studies for teaching undergraduate medical students

Mrs Bernadette Jones and Dr Tristram R. Ingham, University of Otago, Aotearoa/New Zealand

Introduction

Hauora Māori (Māori Health) is taught as a vertical module in the fourth and fifth (Advanced Learning in Medicine) years of the undergraduate medical curriculum at the University of Otago. The course, which builds on a theoretical grounding gained in the earlier (Early Learning in Medicine) curriculum, aims to ensure positive health outcomes for Māori populations by equipping students with the knowledge and skills necessary to effectively engage with Māori patients. Students are required to demonstrate cultural competency in clinical practice, to understand the basis of ethnic disparities in health, and to become effective agents in the reduction of these disparities.

The University of Otago, Wellington, is one of three clinical schools within the Faculty of Medicine delivering the Advanced Learning in Medicine curriculum. At the Wellington clinical school two key components of the course comprise a Noho Marae (overnight marae stay) for contextual cultural learning (Huria 2012) and small group 'case-based learning', which is used to promote students' critical thinking and decision-making skills (Boehrer & Linsky 1990). A similar program has been developed by the staff at the other University of Otago campuses, particularly the University of Otago, Christchurch, where staff members have pioneered many of the Hauora Māori clinical teaching methods (Lacey et al. 2012; Pitama et al. 2007).

Why was this program initiated?

Despite receiving comprehensive public health teaching on the determinants of health and the effects of racism, medical students often find it challenging to conceptualise how disparities arise and how they impact at an individual patient level. Consequently, in their clinical placements when faced with Māori patients suffering the burden of chronic disease, many students revert to stereotyping and assumptions, such as unhealthy lifestyle behaviours and treatment non-compliance, as explanations for the poor health outcomes (Betancourt 2003).

As part of the Hauora Māori curriculum, we encourage students to take a more holistic health history, using the Meihana Model (a Māori model of health), in order to consider the broader health and social issues impacting on Māori patients (Pitama et al. 2007). Case studies allow students to examine

an individual patient history and to put the components of the history into the model, identify gaps, and visualise how societal influences have impacted on presentation and outcomes. To be effective, however, case studies need to be relevant, realistic, engaging, challenging and instructional (Kim et al. 2006). Indigenous case studies also need to portray cultural concepts, and at the same time avoid stereotyping (Hays 2001). One way of incorporating all of these attributes is to develop the cases from actual research. Given the lack of research-based Indigenous case studies in the literature, we undertook a community partnership research project to explore the perspectives of Māori whānau (families) managing a chronic illness to inform a series of case studies for medical education.

Aims and objectives

The overall aim was to increase the students' understanding of Māori whānau perspectives of chronic disease management, and hence improve their ability to engage with Māori patients. More specifically, we aimed to:

- provide the medical students with real-world examples of the challenges that many Indigenous families face in managing chronic illnesses
- incorporate true case histories as examples of Indigenous health care experiences to illustrate the role and impact of social determinants of health on individual patient outcomes, while avoiding risks associated with introducing stereotypes
- provide a vehicle for Māori communities to have their stories told in a manner that can positively influence the understanding and behaviour of future doctors.

Approach to achieve aims and objectives

We approached a local Māori health provider, the Tu Kotahi Māori Asthma Trust, and established a Kaupapa Māori partnership research project funded by the Health Research Council of New Zealand. Kaupapa Māori research was the methodology underpinning a longitudinal, qualitative study exploring Māori parents' perspectives of managing chronic asthma. Experiences were thematically analysed within a Māori cultural framework using Interpretive Phenomenological Analysis. Several individual participant stories were then developed into case studies that highlighted the complex nature of their health care journey and provided contextual and cultural insights.

At the Noho Marae, small group workshops were conducted under the supervision of trained facilitators. Students were initially asked to read a biomedical-focused introductory vignette of the case and to form an opinion as to the relevant issues. Second, students were asked to separate the case scenario line-by-line into the domains of the Māori model of health, thus demonstrating the uni-dimensional nature of the initial vignette. We then used an interactive approach involving role-playing to allow students to elicit further in-depth information, expand the other domains of the model, and give a broader perspective of the context of the case. Feedback was obtained from students and staff regarding the relevance of this case-based exercise in relation to their understanding and ability to apply the knowledge to their future practice.

Challenges

One of the challenges was empowering whānau, who had often had negative health experiences, to feel comfortable sharing their stories. This was aided by the use of specific Māori-centred research principles, and the establishment of in-depth trusted relationships throughout the longitudinal study (Jones et al. 2010).

In order to provide a setting where students could understand and reflect on the cultural aspects of the case, small group sessions were held in an immersed community setting (an urban marae). Teaching off-site, and in small groups, posed a challenge in terms of personnel resources, since our team comprised a small number of Indigenous clinical staff.

Successes

A significant part of the success of this case study approach, as described by a student below, relates to selecting a real-life situation that conveys the Māori patient perspective and communicates the relevance of culture in health:

This case study made us think about how our first impressions can easily be incorrect and it made us think about health and health care from a Māori perspective.

Active engagement and overwhelming positive feedback from students highlighted the effectiveness of this Indigenous case-based learning:

I found the case exercise was the most valuable to my training as a doctor... It gave us an insight as to what challenges Māori face with access to health care services, and how we can adjust our clinical practice to improve care for Māori.

Delivering the case-based teaching within a marae setting reinforced the cultural aspects of the case and ensured a captive audience. One student noted:

The case study brought up several new ideas for me... it is incredibly important to understand your patient and their cultural beliefs in order to provide effective care, both for diagnosis and for treatment.

What are the impacts?

Two methods of evaluation were conducted. First, a brief survey was administered by the University of Otago Higher Education Development Centre; second, critical reflective essays were submitted by all students. Both these methods validated this Indigenous case-based method of teaching as acceptable to students and a highly effective way of demonstrating the practical application in a clinical setting.

Spontaneous feedback was also received from convenors and clinical supervisors and from General Practitioners during community clinic placements. They commented on the improved cultural awareness of students and their use of holistic history-taking skills since the introduction of the program.

Evidence of the impact of this case study workshop was clearly demonstrated by the positive comments reflected in many of the medical student evaluations:

This case was based on a true story and it showed me how important it is to use [this] process to communicate with Māori patients and manage their care effectively.

Although I had learned about Hauora Māori many times during my medical studies, I had never thought of actually applying these principles to a patient before. I found it really useful... to discuss different factors that could influence someone's health.

I was already aware of the many health disparities between Māori and non-Māori, yet I had little idea of what to do to decrease these. I feel that I now have many more skills at my disposal to help me ensure the best care is given to Māori patients.

Although student feedback through evaluations indicates that the cultural learning was well received, a challenge for this program, and for Indigenous medical educators more broadly, is to determine whether self-identified learning is transferred into the clinical space upon graduation and translated into culturally aware clinical practice with Indigenous patients. We examine this challenge within the program by identifying correlations between student feedback on the program and later examination results. We have seen a high correlation (82%) between self-identified positive experiences (expressed in students' critical reflective essays in Year Four) and clinical excellence in interviewing Māori patients (as assessed by oral presentations of clinical cases in Year Five).

During follow-up dissemination events Māori participants expressed overwhelming support and approval, stating that they felt privileged that their stories would directly influence the future doctors who will be providing health services to their communities.

You know you've empowered a lot of parents in this [Indigenous case development process] to make a change in the health system which is a good thing.

How has the project developed Indigenous leadership?

As Indigenous clinicians and health educators, conducting the research, developing the cases, and then observing the effect with students and whānau has been a rewarding experience. This has been a capacity-building exercise that has increased our research and teaching skills and encouraged us as Indigenous leaders to look for new ways to foster cultural understandings between medical students and Māori communities to improve health outcomes for our people.

What's next? Program sustainability

International Indigenous medical educators have expressed an interest in collaborating with us to use this method with their students. Currently we are developing a range of research-based case studies, in partnership with the Māori community, for use in other specialty modules taught within the wider curriculum. This program has been implemented successfully for the past three years. This core module is now an official part of the curriculum and receives regular program funding, and will continue as an integral part of the undergraduate medical curriculum at the University of Otago, Wellington. We continue to explore avenues to expand and develop additional learning opportunities funded by subspecialty modules.

For further information, contact:

Mrs Bernadette Jones

Centre for Hauora Māori
School of Medicine and Health Sciences
University of Otago, Wellington
E: bernadette.jones@otago.ac.nz



References

- Betancourt, J. R. 2003, 'Cross-cultural medical education: Conceptual approaches and frameworks for evaluation', *Academic Medicine*, vol. 78, no. 6, pp. 560–9.
- Boehrer, J. & Linsky, M. 1990, 'Teaching with cases: Learning to question', *New Directions for Teaching and Learning*, vol. 42, pp. 41–57.
- Hays, R. 2001, 'One approach to improving Indigenous health care through medical education', *Australian Journal of Rural Health*, vol. 10, pp. 285–7.
- Huria, T. 2012, 'Hauora Māori – Introduction to clinical immersed learning', in LIME Network (ed.), *LIME Good Practice Case Studies*, Onemda VicHealth Koori Health Unit, The University of Melbourne, pp. 39–41.
- Jones, B., Ingham, T., Davies, C. & Cram, F. 2010, 'Whānau Tuatahi: Māori community partnership research using a Kaupapa Māori methodology', *Mai Review*, vol. 3, pp. 115–28.
- Kim, S., Phillips, W., Pinsky, L., Brock, D., Phillips, K. & Keary, J. 2006, 'A conceptual framework for developing teaching cases: A review and synthesis of the literature across disciplines', *Medical Education*, vol. 40, pp. 867–76.
- Lacey, C., Huria, T., Beckert, L., Gilles, M. & Pitama, S. 2012, 'The Hui process: A framework to enhance the doctor–patient relationship with Māori', *New Zealand Medical Journal*, vol. 124, no. 1347, pp. 72–8.
- Pitama, S., Robertson, P., Cram, F., Gillies, M., Huria, T. & Dallas-Katoa, W. 2007, 'Meihana Model: A clinical assessment framework', *New Zealand Journal of Psychology*, vol. 36, no. 3, pp. 118–25.

TEACHING AND LEARNING

Developing health student placements in partnerships with urban Aboriginal and Torres Strait Islander Community Controlled Health Services

Dr Alison Nelson, Professor Cindy Shannon and Mr Adrian Carson, Institute for Urban Indigenous Health and The University of Queensland, Australia

Introduction

This program is being jointly carried out by the Institute for Urban Indigenous Health, a regional community-controlled health organisation, and The University of Queensland. The project's aim is to increase the placement opportunities available to a variety of health profession students from multiple universities in a well co-ordinated way. It provides students with a valuable learning experience while simultaneously increasing the range of health services available to Aboriginal and Torres Strait Islander clients using the Community Controlled Health Services (CCHSs) in South-East Queensland.

The program targets final-year or advanced-level students with a view to developing a confident and effective workforce in Aboriginal and Torres Strait Islander health. Students do not need to be Aboriginal and/or Torres Strait Islander, although this is encouraged where possible.

Why was this program initiated?

Student placement experiences provide an important opportunity for health students to learn the clinical skills they need in a context where their cultural awareness and knowledge can also be developed. Aboriginal and Torres Strait Islander CCHSs have the potential to provide an invaluable learning experience for students due to the nature of the professional and clinical skills they can learn in this environment, and the knowledge and awareness they can gain from their Aboriginal and Torres Strait Islander supervisors and colleagues.

Traditionally, however, students have often been placed with minimal university support and health services have been expected to supervise students without a clear understanding of the placement expectations and requirements. This has resulted in students reporting a less than ideal experience and health services feeling overloaded and under-resourced.

There have also been limitations on the variety of students who can access these placements. In the past, placements have generally been available to students studying to be nurses, doctors, and Aboriginal and Torres Strait Islander health workers, while allied health students may not have had the opportunity due to a lack of appropriate professional supervision.

This program was initiated to streamline student placement processes and provide a well co-ordinated and supported placement experience for both students and health services.

Aims and objectives

1. To increase the number of student placement opportunities available within Aboriginal and Torres Strait Islander CCHSs in South-East Queensland.
2. To increase the variety of health professionals available to health services through the development of student placement opportunities beyond medical and nursing students, increasing and enhancing allied health student placements.
3. To provide a well co-ordinated and sustainable model of student placements that provides support to students and health services.
4. To evaluate student experiences regarding the strengths and challenges of the placement and their likelihood to work in the sector in the future.

Approach to achieve aims and objectives

Placements are organised and co-ordinated by a dedicated staff member at the Institute for Urban Indigenous Health to enable appropriate preparation, orientation and supervision of students. This has involved working closely with health services to develop a well-designed placement program with explicit expectations. The role of the central co-ordinating staff member, funded by The University of Queensland, is to relieve the CCHSs of the burden of co-ordinating the placements and of the need to negotiate with multiple parts of multiple universities in order to set up placements and manage timeframes. One health service, for example, had approximately twenty memorandums of understanding with different parts of different universities prior to the establishment of this new model. A central conduit also prevents services being overloaded with students, as one person has oversight of all the placements. The co-ordinating staff member is accountable to two key Aboriginal leaders, the Chief Executive Officer of the Institute for Urban Indigenous Health and the Pro-Vice Chancellor for Indigenous Education at The University of Queensland.

A regional orientation and cultural awareness session was developed for students prior to their placements commencing. These are conducted inter-professionally, where possible, so that students gain a sense of the other professionals operating in the organisation at the same time. Orientations are delivered by the central co-ordinating person, with input from other staff, and take place in either the Institute for Urban Indigenous Health head office or one of the CCHSs. The orientation session includes information about the South-East Queensland CCHSs and successful ways to work with urban Aboriginal and Torres Strait Islander people in a health setting, emphasising the value and knowledge of Aboriginal and Torres Strait Islander health workers and colleagues. Students are also provided with a location-specific induction by a staff member from their health service site and assigned a local preceptor throughout their placement.

Different models of student placements were trialled as part of the program beyond the traditional one-to-one model where one student shadows one clinician. These included group supervision models and multiple mentoring, where a group of students is supervised by one or more clinical educators (Nolinske 1994). Multiple mentoring of students, if organised well, has been found to provide benefits to organisations, supervisors and students, such that students are perceived to learn more and be more competent at the end of their placements (Copley & Nelson 2012).

New student-led clinics were also trialled as an approach to increasing opportunities for student placements without overburdening already busy clinics. 'Work it Out', an inter-professional education and exercise program for Aboriginal and Torres Strait Islander clients diagnosed or at risk of a chronic disease, is an example of the establishment of a new student-led clinic at one health service. The health service staff had identified that there was a need for rehabilitation services and the program was developed in partnership with Rehab+Fitness, a private gym. Students from medicine, nursing, occupational therapy, exercise physiology, pharmacy and psychology deliver educational content and assist in exercise supervision, monitoring clients' health status and making recommendations within their scope of practice and level of experience.

The success of this program is demonstrated through research conducted by an additional group of students, with results used to leverage federal government funding for the ongoing delivery and expansion of this program. Feedback from staff indicates that the program filled a need in the health care of clients with chronic diseases:

I think what you're doing here is you're explaining things and these people have never had it explained to them before.

Clients also reported the benefits of this program:

I am now able to hang the washing out myself. Before coming here I would have the carer do it for me, but now I can get my shoulders to work and reach the line.

As an Elder with arthritis I have benefitted from the advice and counselling I have received.

In addition to the 'Work it Out' program, increased allied health student placements have enabled services to access new or additional support. This has included occupational therapy, speech and language pathology, psychology and social work services where they did not otherwise exist and where accessing these services through mainstream channels often proved difficult for clients. These student placements have demonstrated a need and demand for ongoing services, resulting in the funding of several new positions. One of these positions has already been filled by an Aboriginal graduate who completed her placement in this sector.

Challenges

The central co-ordinator oversees placements across a large region and, as a result of the geographical distance, some areas are proving easier to co-ordinate than others. In addition, there are multiple universities that place students in this region, and challenges arise around providing opportunities for students from a range of disciplines at a number of universities with little or no co-ordination from within the universities. This results in the central co-ordinating staff member at the Institute having to negotiate with multiple departments at a range of universities. Universities other

than The University of Queensland are now being requested to provide resourcing for a dedicated staff member to be the conduit for their university in order to address this challenge. Although ongoing funding for the central co-ordinator position has been secured from The University of Queensland, further expansion of the program will depend on other universities providing funding.

Despite overwhelmingly positive feedback from most students about the program, there are still some challenges around ensuring that placement requirements and expectations are clearly stated and understood. There is great variance in the preparation of students for working in Aboriginal and Torres Strait Islander health at the university level, and further work is required in developing guidelines for choosing which students gain placements in which services and what preparation is required by the universities even before the orientation program. Some students reported feeling overwhelmed by the complexity of medical conditions they encountered and one student felt that his/her contribution was not valued.

There are some additional challenges for staff in the CCHSs, including finding space for additional people and organising appointments for clients to see students. This is off-set by having a central co-ordinating person to make sure space can be managed and many new placements come with their own supervisor so there is less burden on staff to provide supervision. Due to the increase in access to allied health services, which has been partially stimulated by student placements, some CCHSs have appointed an allied health co-ordinator to assist with appointment scheduling and follow-up.

Successes

A central co-ordination point at the Institute for Urban Indigenous Health has meant that rather than each health service needing to negotiate with multiple parts of multiple universities, university staff now liaise with one person who then consults with health services about their needs and capacity, and monitors student placements over time.

In the eighteen months since the project commenced, student placements in South-East Queensland region CCHSs have grown from around thirty students per semester across the region to approximately 150 students in semester one, and more than eighty students in semester two of 2012. There are now student placements across seven locations in medicine, nursing, pharmacy, exercise physiology, occupational therapy, speech pathology, music therapy, social work and psychology.

Placements are designed so that students requiring one-to-one supervision are still provided with this level of attention, while those who would benefit from a group or multiple mentoring model are engaged in this style of placement. The number of medical students placed within the CCHSs in the one-to-one supervision model has remained fairly constant at about twelve students per semester. However, forty-three additional students have engaged with opportunities developed through attendance at healthy living community days (where they assist with health checks) and visits to the Institute for Urban Indigenous Health to learn about the South-East Queensland CCHSs sector. In addition, five general practitioner registrars have commenced their training in CCHSs.

Student learning is supported through face-to-face supervision and online resources. Students note that the inter-professional learning opportunities they have gained are highly beneficial:

[This placement] taught me how to tailor and deliver culturally sensitive treatment sessions and work constructively and collaboratively with a student from another allied health discipline. It also taught us

how to be resourceful, creative and innovative. These skills are invaluable for working within a professional team and providing services to individuals who have a different cultural background to my own.

What are the impacts?

Preliminary research (via a survey) about the experiences of students in these placements has revealed the following:

- 78% felt they had adequate orientation
- 89.2% felt their contribution was valued
- 92% felt they gained clinical learning and skills
- 86% increased their awareness of health issues faced by Aboriginal and Torres Strait Islander people
- 32%, however, were unsure or disagreed they would be more likely to consider working in Aboriginal and Torres Strait Islander contexts as a result of the placement. This will be explored in more depth through interviews with students.

In comments provided through the survey, students reported that they felt supported through the placement and received high-quality supervision:

Supportive staff who were encouraging helped me to stay motivated, on task as well as to ask for help when I needed it. [I have gained] increased knowledge about Indigenous communities through experts in their area. This allowed me to learn from the best and provided first hand experiences to me.

Another medical student provided this feedback:

The placement was very enjoyable. Everyone was willing to share their skills and knowledge and I had a lot of good teachers!!! Honestly, this placement opened my eyes and really makes me think about working in Indigenous Health once I finish my study.

Students identified that their placement gave them an increased understanding of how to work with Aboriginal and Torres Strait Islander clients:

[I am more] able to understand the cultural differences and Indigenous people's health perspective. All these [knowledges] allow me to take a different approach when working with Indigenous people.

Fifty per cent of the exercise physiology and final-year occupational therapy students involved in the practicums in 2011 expressed interest and/or actively sought work in Aboriginal and Torres Strait Islander health in 2012.

How has the program developed Aboriginal and Torres Strait Islander leadership?

This project and the development of new student-led clinical services have resulted in a demonstrated demand for a full-time exercise physiologist in one CCHS, and this position has been filled by an Aboriginal professional. She now assists with student supervision and manages the

chronic disease rehabilitation program. An Aboriginal psychology graduate has also been employed following her successful placement in two of the CCHSs. In addition, several Aboriginal and Torres Strait Islander staff have been involved in the local co-ordination and supervision of students. The success of this program has also resulted in Aboriginal and Torres Strait Islander management staff now identifying student projects and initiating requests for students so that placements are being driven more by the agenda of the CCHSs and the Institute for Urban Indigenous Health.

What's next? Program sustainability

As a result of the exponential growth of student placements, further work is being done to refine processes for student applications and preparation in order to increase efficiencies, improve selection processes and ensure adequate preparation of students prior to their placements. An additional staff member, funded by the Institute for Urban Indigenous Health, is being appointed to assist with this. As identified above, further expansion depends on resourcing from additional universities to ensure that the central co-ordination of student placements from the many universities in the region is well run.

The model of student-led clinics, which demonstrates a clinical need and a viable clinical model, will continue to be used to further enhance services available to South-East Queensland Aboriginal and Torres Strait Islander people. Training is also being developed to help support those Aboriginal and Torres Strait Islander staff members who may have had little or no experience in supervising students.

Ongoing support for CCHSs to manage the exponential growth of student placements will also be undertaken through increasing the central co-ordinating hub to include additional on-site support through financial support from other universities (if forthcoming), as well as an additional allied health co-ordinator in most sites. Some funding is also being provided for general practitioner registrar training through the Central and Southern Queensland Training Consortium. Further expansion of clinical learning opportunities is possible with increased investment in space and personnel.

For further information, contact:

Dr Alison Nelson

Institute for Urban Indigenous Health and The University of Queensland

E: alison.nelson@iuih.org.au



**THE UNIVERSITY
OF QUEENSLAND**
AUSTRALIA

References

- Copley, J. & Nelson, A. 2012, 'Practice educator perspectives of multiple mentoring in diverse clinical settings', *British Journal of Occupational Therapy*, vol. 75, no. 10, pp. 456–62.
- Nolinske, T. 1994, 'Multiple mentoring relationships facilitate learning during fieldwork', *American Journal of Occupational Therapy*, vol. 49, no. 1, pp. 39–44.

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

Ms Tania Huria, Mr Cameron Lacey and Ms Suzanne Pitama, University of Otago, Aotearoa/New Zealand

Introduction

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

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

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

Why was this project initiated?

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

Aims and objectives

The purpose of this study was to:

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

Approach to achieve aims and objectives

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

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

Challenges

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

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

Successes

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

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

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

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

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

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

What are the impacts?

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

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

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

How has the project developed Indigenous leadership?

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

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

What's next? Project sustainability

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

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

For further information, contact:

Ms Tania Huria

Māori Indigenous Health Institute
University of Otago, Christchurch

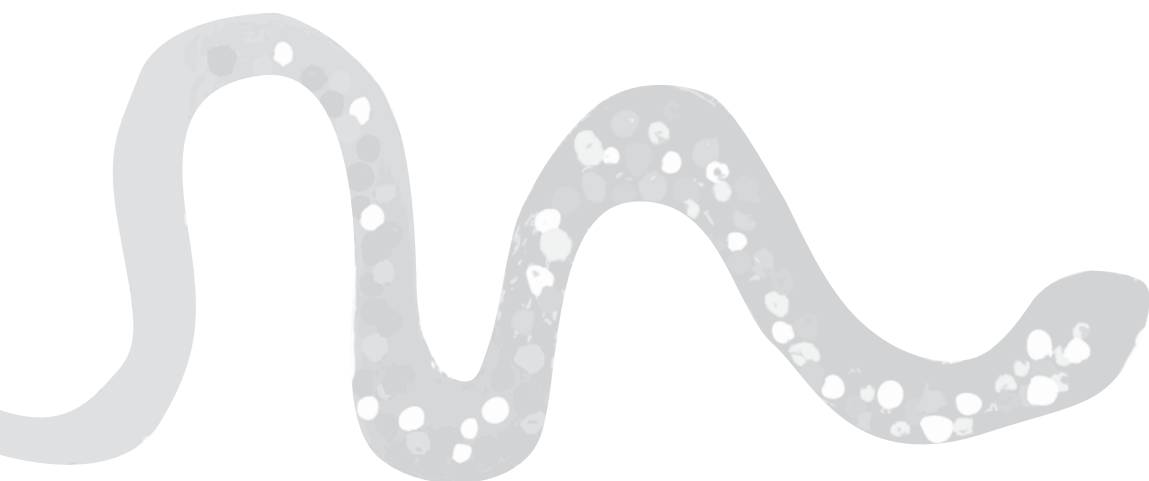
E: tania.huria@otago.ac.nz



References

Lacey, C., Huria, T., Beckert, L., Gillies, T. & Pitama, S. 2011, 'The Hui process: A framework to enhance the doctor–patient relationship with Māori', *New Zealand Medical Journal*, vol. 124, no. 1347, pp. 72–8.

Pitama, S., Robertson, P., Cram, F., Gillies, M., Huria, T. & Dallas-katoa, W. 2007, 'Meihana Model: A clinical assessment framework', *New Zealand Journal of Psychology*, vol. 36, no. 3, pp. 118–25.



COMMUNITY ENGAGEMENT

A successful engagement between a medical school and a remote North Queensland Indigenous community: Process and impact

Ms Simone Ross, Mr Donald Whaleboat, Ms Glenda Duffy, Dr Torres Woolley, Associate Professor Sundram Sivamalai and Mr Shaun Solomon, James Cook University, Australia

Introduction

The James Cook University School of Medicine and Dentistry is the only medical school in North Queensland. The School was established in 2000 with the mission to work with rural, remote, Indigenous (Aboriginal and Torres Strait Islander) and tropical populations. A significant proportion of the undergraduate learning at the School takes place in community settings, including fourteen weeks of rural placement across Years Two, Four and Six, and a one-week placement in an Aboriginal and Torres Strait Islander Community Control Health Service in Year Four.

In 2010 the School of Medicine and Dentistry expanded its community engagement by developing a systematic process for conducting face-to-face consultations with local Indigenous health workers in remote communities.

This study describes the process of how the School collaboratively established an Indigenous Reference Group with a cross-section of Indigenous (predominantly Aboriginal) health leaders, Elders and non-professional but highly valued community representatives in the remote North Queensland town of Mount Isa.

The university's research team included Ms Glenda Duffy, Ms Simone Ross, Dr Torres Woolley and Associate Professor Sundram Sivamalai, along with Indigenous academics Mr Donald Whaleboat and Ms Priscilla Page, who assisted with data analysis and advice on the cultural integrity of the project. Resource support in the form of a meeting room and administration for the project was provided by the Mount Isa Centre for Rural and Remote Health (MICRRH).

The Mount Isa Aboriginal and Torres Strait Islander Reference Group included Mr Ron Page, Ms Leanne Parker, Ms Nancy George, Mrs Renee Blackman, Miss Stephanie King, Mrs Caterina Walden, Mr Darren Walden, Mr Graham Page, Mrs Frances Page, Mrs Dolly Hankin, Ms Fiona Hill, Ms Kerry Major, Mr Shaun Solomon, Ms Elizabeth Dempsey and Mrs Mona Phillips.

Why was this project initiated?

Since its inception, the School of Medicine and Dentistry has established ad hoc relationships with individuals from local mainstream and Indigenous health organisations to facilitate student learning in regards to rural community placements, cross-cultural awareness, and rural, remote, Indigenous and tropical health.

In 2010 it was decided that the School should build stronger and long-lasting relationships with Indigenous health organisations and Indigenous health leaders by collaboratively establishing an Indigenous Reference Group in Mount Isa. The Reference Group would provide advice on culturally appropriate graduate attributes and better inform the School of the necessary knowledge, skills and attitudes required of students to appropriately engage with local communities while on placement.

Aims and objectives

The main aim of the project was to build a sustainable and strong relationship with Indigenous health leaders in Mount Isa. The objectives were to:

1. Create a long-lasting connection between the James Cook University School of Medicine and Dentistry and the Mount Isa Indigenous community.
2. Improve program governance within the James Cook University School of Medicine and Dentistry and improve the quality of graduates working in North Queensland communities in a culturally appropriate way.
3. Build a set of good (and bad) engagement principles with the Mount Isa Indigenous community for university staff and students.

Approach to achieve aims and objectives

The project was developed utilising a participatory action research design. We recruited an Indigenous project officer, seconded from the State Government, who was a well-respected member of the local community (a Kalkadoon woman), with extensive experience in community engagement. The position was operational for the initial twelve months of the project to establish a reference group and mechanisms for communication and formal decision making on medical education and engagement with the local community. The project officer was responsible for approaching key Mount Isa Indigenous health workers to form the Indigenous Reference Group.

Reference Group members include Elders, community members and representatives from key health and wellbeing community organisations. Members were selected based on their previous engagement with the university, their willingness to volunteer time for the project and their active involvement and interest in Aboriginal health.

The Indigenous project officer and Indigenous Reference Group members then collaboratively developed Terms of Reference. These were based on the principal of reciprocal benefits and strategies to promote sustainability, and followed the National Health and Medical Research Council values and guidelines for ethical conduct in Aboriginal and Torres Strait Islander health research. The Terms of Reference were used to guide the engagement process between the School of Medicine and Dentistry and the Indigenous Reference Group.

Facilitated by James Cook University staff, the group brainstormed statements of good and bad community engagement using the 'yarning circle' approach (roundtable discussions). This approach facilitates an exchange of views between people with different professional and non-professional expertise, in a manner where everyone is treated as an equal. This encourages participants to speak without fear of repercussion. One of the Terms of Reference developed by the Reference Group that assisted this process was 'Free dialogue and respect for all views, no matter if an Aboriginal Elder or junior health worker'. Indigenous Reference Group members agreed the yarning circle worked for their purpose of allowing all members to have an equal say in discussions.

Community engagement statements identified by the group were clustered into themes by the School staff assisted by the School's Indigenous academics. The themes were agreed by the group and when the project results were presented to the School, the Indigenous Reference Group attended via a video-conference link up.

Challenges

To ensure community needs were met, the project and the development of the Reference Group had a flexible approach. This, however, can create some challenges when there are competing work priorities. In initial discussions around forming the Reference Group, it was decided that meetings should be made at a time convenient for the community. To ensure that this occurred, James Cook University staff attended the community over a three-day period – a day before, the day of, and the day after the planned meeting – to be flexible and to respect any sorry business or other community priorities.

Successes

The School of Medicine and Dentistry received valuable feedback from the Reference Group about the undergraduate community placement and Indigenous Health Experience programs that were running in the Mount Isa area, with recommendations for how staff and students could better engage with Mount Isa Indigenous communities. Collaboratively, staff from the School and the Indigenous Reference Group also created a 'Black Engagement Mount Isa Indigenous Community' pamphlet, highlighting practical tips on how to engage with the Mount Isa Indigenous community. These are distributed to staff and students at the university who work or intend to work in the area.

The Indigenous Reference Group members received training and support from the School to ensure reciprocal benefits. This included:

- assistance to write an application for the Certificate IV in Indigenous Leadership Program at the Australian National University
- secretariat support, a meeting room and refreshments during the meetings
- support for media skills training
- assistance to organise an inaugural 'Healing Day Expo' for the Mount Isa Indigenous community.

What are the impacts?

One of the major impacts of the project has been the strengthening of the relationship between the School and the Mount Isa Indigenous community and community organisations. Clear protocols

around engagement, particularly in relation to student placements in community-controlled health organisations, have increased communication and understanding and provided further opportunities to collaborate.

The inaugural Healing Day Expo for the Mount Isa Indigenous community, designed to increase the health and wellbeing of a community that had recently experienced much sorry business, was hosted by the Reference Group, the School and MICRRH. The expo was linked to an annual football carnival, and successfully attracted many hundreds of participants. An informal evaluation on the day, completed by the eight participating organisations, provided an overall rating of nine out of ten for effectiveness in spreading the healing message. It is expected the Indigenous Reference Group will continue an annual Healing Day for many years to come.

The School of Medicine and Dentistry also now has a protocol for setting up an effective and sustainable engagement process with Indigenous communities. This protocol includes a complete list of good and bad engagement strategies for staff and students to consider when interacting with the Mount Isa Indigenous community. Staff and students who work with the Indigenous community are now more aware of the importance of building and sustaining individual relationships, good communication, establishing strong cultural and community foundations, and taking a holistic approach to treating Indigenous patients, while avoiding tokenism and racism.

MICRRH continues to take a role in maintaining the Mount Isa Indigenous Reference Group, and this support continues to increase MICRRH's profile in the local community, and the awareness of local health organisations about MICRRH training opportunities.

How has the project developed Indigenous leadership?

The project works on the premise that Indigenous leadership capabilities exist in local communities such as Mount Isa, and this project has enabled that capacity building through the development of a formal, interactive loop between the community and the School.

This project has directly resulted in the Indigenous Reference Group members having the skills and confidence to advocate for improving Indigenous health and social issues in Mount Isa, both with external organisations (such as the media and the local government) and internally (within the local Indigenous community). The Healing Day Expo was a great example of this. In addition, one Indigenous Reference Group member was assisted by the School to submit a successful application to the Australian National University Indigenous Leadership program in 2012.

What's next? Project sustainability

The Indigenous Reference Group was established to work with the James Cook University School of Medicine and Dentistry. It has since developed into a collective and representative health voice for the Mount Isa Indigenous community. The management of MICRRH has adopted the Reference Group as a key reference point in the community and, as stated above, has a staff member available in its organisation to support future Indigenous Reference Group deliberations.

As no two Indigenous communities or language groups are alike, the School is planning to conduct an Indigenous community engagement project in the Atherton Tablelands to determine if this Indigenous community has different views on how staff and students should engage with the community.

We are planning to measure the long-term outcomes of this project to assess success of community engagement approaches. We aim to measure this through future evaluations incorporating the views of students, community members, health workers and others.

For further information, contact:

Ms Simone Ross

School of Medicine and Dentistry

James Cook University

E: simone.ross@jcu.edu.au



Faculty of Dentistry community engagement with Māori oral health providers

Professor John R. Broughton, University of Otago, Aotearoa/New Zealand

Introduction

In 2011 the Faculty of Dentistry of the University of Otago implemented a new program in which final-year dental students participate in a community-based placement with Māori oral health providers. The primary aim is to enhance students' educational experience with the goal that, upon graduation, students are better prepared to engage with Māori people.

This program had its origins with the Tipu Ora Charitable Trust, a mother and child wellness service in Rotorua in 2000. In this initial program a small group of final-year dental students gave up a week of their mid-year break, paid their own travel expenses to Rotorua, and provided free dental treatment to the parents and caregivers of the Tipu Ora whānau (families). This student volunteer, Māori community-based service has grown significantly and is now incorporated into the undergraduate curriculum in which all final-year students have a five-week clinical placement with one of six Māori health providers throughout the country.

Why was this program initiated?

The Tipu Ora Charitable Trust provides health and wellness support for Māori parents and their babies and infants. The kaitiaki (Māori health community worker) provides an active link for the mothers and their babies to the various health services that may be required for the growth and development of a healthy child.

Tipu Ora established its own dental service in 1997 with a contract from the then Midland Health Regional Health Authority to provide dental care for its registered clients, Tipu Ora babies. This dental service did not extend to the parents and caregivers of the tamariki (children). The dental student clinical placement was developed to 'fill the gap' by providing much-needed dental treatment to the parents and caregivers at no cost to the patient group.

Aims and objectives

The specific aim of the marae-based dental clinical placement for the students is to promote *oranga niho* (oral health) among the local Māori community at the Tunohopu Health Centre, Ohinemutu, Rotorua.

The objectives are twofold:

1. Provide basic dental care for whānau (families), rangatahi (young adults), pakeke (adults) and kaumātua (the elderly) within the local Māori community who are not currently accessing dental care.
2. Provide a Māori community-based learning experience for dental students working with a Māori health provider.

Approach to achieve aims and objectives

Over the ten-year period that this dental student community service program has been operating, the aim and objectives have not changed. What has changed, however, is that this one-week student volunteer program in the semester break is now integrated into the final-year dental curriculum in which the students engage in a five-week compulsory clinical placement during semester time. The Māori health provider Tipu Ora has gone from hosting students for just one week in the year to thirty weeks in the year. Further, the program has been extended to encompass five other Māori oral health providers.

The two underlying principles used to implement and maintain the program are, first, whakawhanaungatanga (relationships) and, second, rangatiratanga (leadership).

When initiating the program in 2000, Tipu Ora and the Faculty of Dentistry built on a breadth of already-existing activities developed over several years between respective colleagues to establish working whakawhanaungatanga, or working relationships. To make this program work, relationships between the Faculty and both the Lakeland Health School Dental Service and other local health professionals needed to be enhanced. It is essential, for instance, to engage a local dentist to whom referrals can be made for clinical procedures that are beyond the available facilities and resources, and who can be available for any follow-up procedures after the students have left, including post-extraction care. A local pharmacist is also an important part of the program, engaged to supply the necessary prescriptions, such as prophylactic antibiotics for rheumatic fever patients.

The relationship with the dental students is equally as important, as it is the students who undertake the clinical work. Those students who participate in this volunteer dental program speak very highly to their peers on their return to the Faculty of Dentistry, resulting in a considerable demand for placements in the following year.

The second important principle is rangatiratanga, or leadership, which is essential for building and maintaining stakeholder trust and confidence in the program. The key outcome is that there is never any shortage of patients wishing to access this dental care. The support from the Faculty of Dentistry is provided through the loan of dental instruments and the donation of dental materials. Support is also provided from dental supply houses through the donation of dental care products, dental materials and some financial assistance.

Challenges

The challenges in this program are threefold: first, to meet the expectations of the client group, the patients; second, to meet the expectations of the Māori health provider; and, third, to meet the expectations of the student volunteers.

The patients who receive dental treatment are identified by the provider's Māori health community workers, who are aware of those people in their community who would benefit most from the service. Although the students are able to provide basic dental treatment, some procedures, such as prosthetics (dentures) or orthodontics, cannot be undertaken. Great care is taken to ensure that the patient group appreciates the clinical tasks that can be provided to them.

Tipu Ora, as the Māori health provider, has its own processes and procedures for its professional activities, and the students are given a thorough briefing on all appropriate aspects of the host organisation prior to their arrival in Rotorua, including the Kaupapa Māori approach to the provision of health services and the principles of whānau ora (family health). The program commences with a mihiwhakatau (formal welcome and introductions), along with an explanation of the local provider's infrastructure and management details, health and safety issues, and the process of clinical supervision.

The increased number of students participating in the program over the ten years of operation has been welcomed by the provider as there has never been a shortage of people wishing to access this service.

The students themselves are all very enthusiastic about participating in the program and are very keen to engage in the clinical work and to experience a range of clinical procedures. The dental surgery at the marae is supplemented by a double unit mobile surgery that is loaned by the Lakeland Health School Dental Service. However, these dental facilities are only equipped to treat infants and children, so the instrumentation is augmented by the loan of periodontal instruments and oral surgery packs from the Faculty of Dentistry.

Successes

A gauge for the success of the program can be ascertained by looking at three aspects: the patients, the provider and the students.

The patients are always very thankful for the free dental treatment provided to them and they never hold back in telling the students directly how much they appreciate the dental work that they receive. A typical case is a kaumātua (elder) who, on his first presentation, required as many as six different clinical procedures; the next year he required only two and thereafter none. He returns every year for a dental check-up and routine prophylaxis.

The provider has seen an improvement in the overall health and wellbeing of many of its clients as a result of the improvement in oral health status, as oral health impacts directly on other health indicators, including mental health and self-esteem. The provider was also able to raise the profile of the organisation as a result of the media attention surrounding the oral health program. Over the ten-year period the program has received wide coverage in print media and on television. In addition, in later years a number of dental graduates who had participated in the program as students returned as clinical supervisors on a volunteer basis to further support and participate in the work of the health service.

The students gain considerable clinical experience and also benefit from living and working in a Māori community. The fact that so many students wish to participate in this program each year is a testament in itself to the program's success in engaging dental students in Māori health during their study.

What are the impacts?

Impacts of the program can be seen across the three groups involved. The patients receive free dental care and there is an improvement in patients' quality of life as a result of restored dentition. The students gain valuable experience – both clinically and culturally. The impact for the community is reflected in the following comment from the General Manager of the Tipu Ora Health Service:

The week was an enormous success for our community, who once again were attracted to the wonderful service... we were all able to relish in the sheer numbers and attendance throughout the week.

At the end of the program the students were given an evaluation form. Over the ten-year period from 2000 to 2009, ninety-two students participated and eighty-one evaluation responses were returned. The one key question was: 'What did you gain most from this clinical placement?' What came through very clearly were the themes of the whole experience, the clinical experience, the cultural experience and the confidence gained.

With regard to the 'whole experience', one student commented that:

I have more understanding of Māori health. You can read about things in a text book, you can read books and reports on Māori health, but this was real life experience. The whole experience was just so good; I think that one of the most valuable aspects was seeing and treating the whole whānau (family).

One student referred to the experience of interacting with a group of family members:

Often the patient presented with other family members; mum was there in the chair while the grandmother came as well to look after the children. Sometimes there were kids everywhere and it was no bother at all.

The clinical experience was a major highlight for the participating students. One student summed this aspect up by saying:

It was the ability to work faster and having a 'real life' clinical experience of seeing patients all day, making a diagnosis and carrying out priority treatment.

The clinical confidence gained through participating in such a program was a frequent response by the participating students, highlighted in the two responses below:

I gained confidence, confidence, confidence!

The one thing that I gained out of it was the confidence – the confidence in myself to engage with patients, to make clinical decisions and to know that I did all the right things well.

The evaluations elicited many comments about the cultural experience that they were immersed in. Typical responses were:

I gained a wider perspective of the Māori community and an appreciation of Māori beliefs and value.

Being on the marae and interacting with the Māori people of that area – it was such a buzz.

Learning more about the culture and the dental needs has made me appreciate dentistry as a course, and the services that we can offer.

A significant outcome of this program is that living and working in this Māori community with Tipu Ora gave the students first-hand appreciation of 'Te Whare Tapa Whā', the Māori model of health and wellbeing. This encompasses te taha tinana (the physical dimension), te taha hinengaro (the mental dimension), te taha whānau (the family dimension) and te taha wairua (the spiritual dimension). In the evaluation one student commented:

This has been the best week in my whole time at Dental School.

How has the program developed Māori leadership?

The Māori oral health providers have shown remarkable leadership in the Aotearoa/New Zealand oral health sector. The mainstream oral health sector tends to be somewhat fragmented in that pre-school children and primary school children receive their oral health care through the School Dental Service, and teenagers receive care through the Adolescent Oral Health Scheme up to their eighteenth birthday, after which the user pays with registered dentists. Māori oral health services, however, aim to provide a seamless service for all age groups with dental therapists and dentists working together as a team. Following the success of the placements at Tipu Ora in Rotorua, a further five Māori oral health providers have embraced the new program, each hosting students in a community placement for up to thirty weeks a year.

What's next? Program sustainability

During the development of the program, the Faculty of Dentistry was eager to ensure its sustainability and extend the experience of all students by having a community-based placement embedded in the final year of the undergraduate course. The response from the Māori oral health providers was very supportive as they saw it as adding value to their existing services.

In 2010, thirty-five students participated in a one-week community placement in six different locations with Māori providers during their mid-year semester break. In 2011 the five-week clinical placement began as a formal part of the undergraduate curriculum with the two semesters each being divided into three lots of five-week rotations. Two students were assigned to each provider at a time, and although their participation that year was voluntary, almost the whole class chose to participate.

In 2012 the clinical placement was made compulsory for all final-year dental students, with the students undertaking a clinical placement with six Māori oral health providers: Tipu Ora Charitable Trust in Rotorua; Ngati Hine Health in Kawakawa; Raukura Hauora O Tainui in Hamilton; Te Manu Toroa in Tauranga; Te Taiwhenua O Heretaunga in Hastings; and Ora Toa in Porirua and Ashburton. An additional program has been established on the East Coast involving Ngati Porou Hauora.

Considerable support for the Māori oral health providers has come through the Ministry of Health's Quality Improvement Group. This Māori provider group has enabled providers to build a dedicated dental surgery for the students' use. Funding has also been made available through the Division of Health Sciences of the University of Otago to assist the students with travel and accommodation expenses for their community placement. Some additional support for the program has also come from the dental supply house Henry Schein Shalfoon.

The program's sustainability relies on the leadership of the Māori oral health providers who value the participation of the students in adding a unique dimension to their existing services. Leadership from within the Faculty of Dentistry is also important to ensure that all the necessary support for both the Māori oral health providers and the students is maintained.

A formal Memorandum of Agreement has now been signed between the University of Otago and each respective Māori health organisation that hosts the students. In every case, a team from the University of Otago, led by the Chancellor and the Dean, travels to the location of each provider for a signing ceremony. This process ensures not only that the dental clinical placements continue well into the future, but that other joint partnerships in Māori health research and Māori student recruitment and retention can be developed. The current program is undergoing an extensive evaluation from both the students' and the providers' perspectives.

What began as a dental student community volunteer program with a Māori oral health provider developed into a Māori community placement for the entire final-year dental class as a formal part of their undergraduate curriculum. The partnerships that have been established between the Faculty of Dentistry and the Māori oral health providers enable the students to engage in a valuable clinical service that benefits the local community and the oral health provider.

For further information, contact:

Professor John R. Broughton

Faculty of Dentistry and Department of Preventive and Social Medicine
Dunedin School of Medicine

University of Otago

E: john.broughton@otago.ac.nz



RECRUITMENT AND RETENTION

Tātou Tātou/Success for all: Improving Māori student success

Dr Elana Curtis, The University of Auckland, Aotearoa/New Zealand

Introduction

Tātou Tātou was a qualitative research project, funded by Ako Aotearoa National Centre for Tertiary Teaching Excellence, involving Māori students within medicine, health sciences, pharmacy and nursing in the Faculty of Medical and Health Sciences at The University of Auckland. Tātou Tātou was Indigenous-led via Te Kupenga Hauora Māori (the Department of Māori Health) in collaboration with non-Indigenous academic representatives from the Schools of Pharmacy, Medicine, Nursing and Health Sciences who worked alongside the Māori and Pacific Admission Scheme (MAPAS) student support staff.

The project explored the ways in which non-lecture teaching and learning helps or hinders Māori student success. It aimed to foreground the Indigenous student voice and provide recommendations in a toolkit for quality tertiary teaching to better support Māori students to succeed in their study within health disciplines.

The project team included Dr Elana Taipapaki Curtis, Ms Erena Wikaire, Ms Torise Lualua-Aati, Dr Bridget Kool, Mr William Nepia, Dr Myra Ruka, Ms Michelle Honey, Ms Fiona Kelly and Associate Professor Phillippa Poole.

Why was this project initiated?

Targeted secondary and tertiary education sector initiatives that successfully recruit and retain Māori students and achieve student success are vital to Māori health workforce development and meeting Māori health needs (Ratima et al. 2007). Central to Māori student success in health programs is the teaching and learning involved (Greenwood & Te Aika 2008). Literature shows that teaching and learning factors can both help and hinder student success and that Māori and Pacific student success can be facilitated through key teaching and learning factors, particularly within the non-lecture context (Airini et al. 2011; Madjar et al. 2009).

Understanding the distinctive worldviews of Māori students is critical to the knowledge base that drives teaching and learning practices in tertiary health programs. While some evidence has been gathered about lecture-based learning in universities, little is known about non-lecture teaching and learning activities (i.e. less than fifty studies) that complement traditional en masse teaching, with few studies focused on representing Indigenous student voices.

Aims and objectives

The following research questions guided the project:

- What teaching and learning practices in non-lecture contexts help or hinder Māori student success in degree-level study in nursing, pharmacy, medicine and health sciences?
- What changes are needed to teaching and higher education practices in order to best support Māori success in degree-level study designed to prepare students for work in the health professions?

Key objectives for the project included:

1. The delivery of high-quality research on the nature of non-lecture teaching and learning practices that help or hinder Māori students studying in degree-level programs within the Faculty of Medical and Health Sciences.
2. Identification of factors in non-lecture teaching and learning that help and hinder Māori student success within the Faculty of Medical and Health Sciences within non-clinical and clinical contexts.
3. Production of a toolkit for quality tertiary teaching targeted at tertiary institutional change.

Approach to achieve aims and objectives

This qualitative study incorporated Kaupapa Māori research methodology and the Critical Incident Technique (Airini et al. 2011; Flanagan 1954) within two phases:

1. The production of critical incidents narratives from student interviews using the Critical Incident Technique.
2. The development of a Quality Tertiary Teaching Profile from the analysis and interpretation of the narratives.

Kaupapa Māori research practice is embedded in research design, implementation, analysis, report writing and dissemination. The research was led by Māori researchers, with MAPAS and academic program staff within the research team. The Kaupapa Māori research framework provides a methodology in which a non-victim blaming, non-deficit approach is taken (Smith 1999). Overall, the research team committed to a Kaupapa Māori research approach by:

- utilising Māori input into the research via consultative and participatory processes, including an Advisory Group with Indigenous and research expertise
- proceeding in a manner appropriate to the cultural contexts concerned
- ensuring that members of the research team acknowledge cultural limitations and work in culturally safe ways
- ensuring that all aspects of the research are monitored closely for relevance and excellence in methodology.

The Critical Incident Technique is an established form of narrative inquiry that has been used to reveal and chronicle the lived experiences of students undertaking tertiary studies (Victoroff & Hogan 2006).

By asking students to describe specific important events during their time as undergraduate students and their outcomes, a critical incident is able to capture well-defined key experiences that inform the research objective. The Critical Incident Technique allows analysis and categorisation of qualitative information that provides deep insights into the situational experience and has been successfully implemented in a number of health care studies (Airini et al. 2011; Pavlish et al. 2011).

One-on-one interviews of between forty and sixty minutes were conducted with forty-one Māori participants currently enrolled in, or recently graduated from, the Bachelor of Medicine (seventeen), Bachelor of Nursing (seven), Bachelor of Pharmacy (three) and Bachelor of Health Sciences (fourteen) courses at The University of Auckland. In accordance with the Critical Incident Technique, interviewers repeatedly asked participants the key question, 'Can you describe a time when the teaching and learning approach used in your undergraduate program has helped or hindered your success as a student?' Participants were not provided definitions for terms (e.g. help, hinder, success), consistent with the Critical Incident Technique methodology and the project approach, to frame these concepts broadly as linking with individual and community notions of potential, effort and achievement (Airini et al. 2011).

A complete incident story comprises three parts: trigger (the source of the incident), associated action and outcome. Once MAPAS and academic program staff identified the critical incidents within each interview, they assigned a subcategory to label the types of issues being discussed by the student within any given narrative and whether they were considered to be examples of helpful or hindering practice. Additional team analysis then collapsed the subcategories into three broad contexts representing groupings of incidents into areas of focus for potential institutional development.

Research findings have been reported elsewhere (Curtis et al. 2012). A total of 1346 incidents that both helped and hindered student success were identified from the forty-one interviews. Approximately two-thirds (67%; 898) helped and one-third (33%; 448) of all incidents hindered Māori student success. Incidents related to the provision of Māori Student Support Services made up the majority of student stories (59%; 789), with 69% being helpful and 31% hindering success. Three hundred and seventy five incidents (28%) related to the Undergraduate Program, with a mix of helpful versus hindering (53% versus 47%), and 182 incidents (14%) represented stories associated with Māori Student Whanaungatanga (family bonding), with most being helpful rather than hindering (87% versus 13%). Thirteen subcategories describe incidents as being associated with MAPAS/tuākana tutorials; resources; academic transition; MAPAS staff and Māori academic staff; Māori mentoring and role models; racism/stigma towards Māori; teaching staff characteristics; program organisation; linking theory to practice; program incorporation of Māori cultural values; first-year health study competition; supporting whakawhanaungatanga (relationships); and group learning.

Project team meetings reviewed the three contexts and context subcategories identified via incident analysis to inform the development of a Quality Tertiary Teaching Profile, which represents the Tātou Tātou data by linking the incidents, contexts and context subcategories into five broad levels of institutional instruction:

1. Use effective teaching and learning practices.
2. Provide academic support that is culturally appropriate.
3. Provide pastoral support that is culturally appropriate.
4. Provide a culturally safe learning environment.
5. Encourage cohort cohesiveness.

Challenges

Although Tātou Tātou included Māori students across the four health disciplines, small Māori student numbers within the pharmacy and nursing programs have limited the ability to provide a between-discipline analysis. Specific exploration of helpful and hindering factors in each of the clinical, non-clinical and non-program domains was also limited due to a smaller number of incidents directly relating to the clinical context. While Tātou Tātou has developed the Quality Tertiary Teaching Profile to inform teaching and learning of Indigenous students within tertiary institutions, ongoing challenges remain in measuring the translation of the research findings into action, given that the specific implementation of the Quality Tertiary Teaching Profile in educational institutions was outside the scope of this research project.

Successes

The success of Tātou Tātou as a research project offering unique methodology and findings that foreground the Indigenous student voice is already becoming apparent. Dissemination to date (within six months of project completion) has been extensive with:

- multiple internal presentations to the Faculty of Medical and Health Sciences boards of studies, school/department research seminars, and university committees and network meetings
- multiple presentations at research colloquiums that inform the broader tertiary education sector
- a national launch of the research findings within an Indigenous tertiary education conference, Tuia Te Ako
- national Indigenous and health conference presentations, including to the Australian and New Zealand Association for Public Health Education and Hui Whakapiripiri
- international conference presentations at LIME Connection IV, 2011, the Association for Medical Education in Europe Conference 2012 and Ngā Pae o Te Maramatanga.

Tātou Tātou has recently received a University of Auckland Excellence in Equity Award 2012 that further acknowledges the actual and potential impact of this research project.

What are the impacts?

Research findings are already informing changes within the university, including development and/or refinement of equity-focused initiatives to improve the teaching and learning environment (for example, a MAPAS tutor training program, and careers events); school action to lobby for the maintenance and creation of appropriate MAPAS student space; program self-reflection on the safety (or not) of teaching and learning contexts within clinical settings; and high-level acknowledgement of the importance of the findings. Involvement of non-Indigenous academic staff has led to greater networking (and understanding) between MAPAS and program staff who have now been exposed to the value of research framed within a Kaupapa Māori approach. Additional research, informed by Tātou Tātou methodology, is being conducted within the university (for example, in the Faculty of Arts masters project) to look at similar issues for Pacific student success.

Overall, Tātou Tātou findings support the need for tertiary institutions to provide additional Māori student support services, with a particular focus on fostering cultural bonding between students and their peers. The undergraduate program was at times unsafe and hindering to Māori student success.

Our findings highlight the important role of the educator, which can be both helpful and hindering within non-lecture contexts. Key success factors included the ability of educators to develop relational trust, demonstrate cultural safety and utilise high-quality teaching and learning methods while having an excellent grasp of the content. Our findings support the need to explore notions of a hidden curriculum that may be operating within clinical and non-clinical health professional training programs. Institutional changes need to occur within the broader context of the tertiary environment that have an influence on the educator and the student, and this research project provides a platform for these changes to occur.

How has the project developed Indigenous leadership?

The next phase of dissemination for Tātou Tātou is submission of research methods, findings and the Quality Tertiary Teaching Profile to peer-reviewed journals for publication and dissemination to a broader national and international audience to better inform the tertiary education sector. Ako Aotearoa, the funding agency for the Tātou Tātou research project, is actively engaged in dissemination of the findings via its website, which includes publication of the final report (Curtis et al. 2012) and together we are exploring other ways to translate the research findings into action (for example, through regional or national training workshops).

For further information, contact:

Dr Elana Curtis

Te Kupenga Hauora Māori
The University of Auckland
E: e.curtis@auckland.ac.nz



References

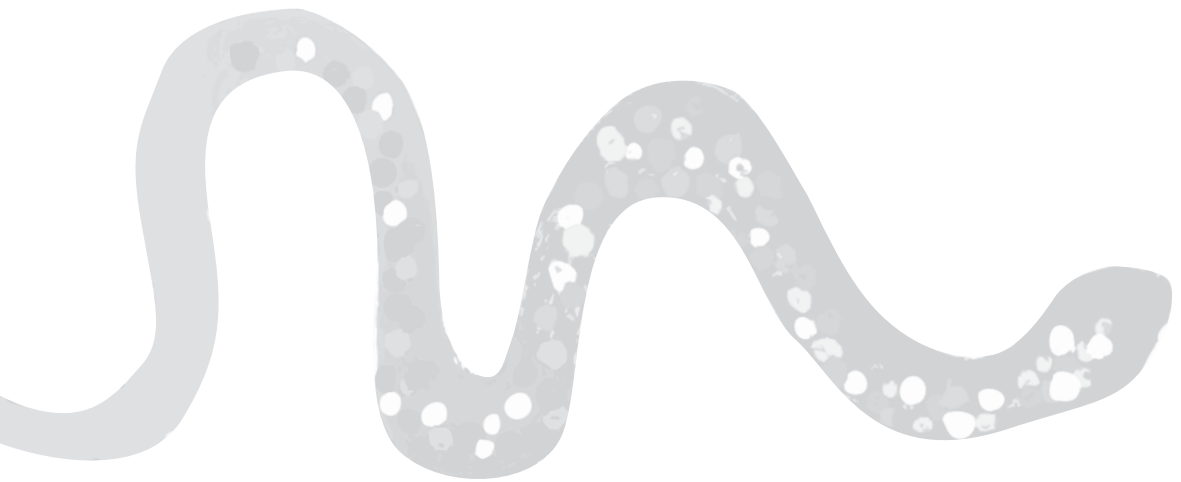
- Airini, Curtis E., Townsend, S., Rakena, T., Brown, D., Sauni, P, Smith, A. et al. 2011, 'Teaching for student success: Promising practices in university teaching', *Pacific-Asian Education*, vol. 23, no. 1, pp. 71–90.
- Curtis, E., Wikaire, E., Lualua-Aat, T., Kool, B., Nepia, W., Ruka, M. et al. 2012, *Research Report – Tātou Tātou/Success for all: Improving Māori student success*, Ako Aotearoa National Centre for Tertiary Teaching Excellence, Wellington.
- Flanagan, J. 1954, 'The Critical Incident Technique', *Psychological Bulletin*, vol. 51, pp. 327–58.
- Greenwood, J. & Te Aika, L. H. 2008, *Hei Tauira: Teaching and learning for success for Māori in tertiary settings*, Ako Aotearoa National Centre for Tertiary Teaching Excellence, Wellington.
- Madjar, I., McKinley, E., Jenssen, S. & van der Merwe, A. 2009, *Towards University: Navigating NCEA course choices in low-mid decile schools*, Starpath Project, The University of Auckland, Auckland.

Pavlish, C., Brown-Saltzman, K., Hersh, M., Shirk, M. & Nudelman, O. 2011, 'Early indicators and risk factors for ethical issues in clinical practice', *Journal of Nursing Scholarship*, vol. 43, no. 1, pp. 13–21.

Ratima, M., Brown, R., Garrett, N., Wikaire, E., Ngawati, R., Aspin, C. & Potaka, U. 2007, 'An Indigenous medical workforce: Strengthening Māori participation in the New Zealand health and disability workforce', *Medical Journal of Australia*, vol. 186, no. 10, pp. 541–3.

Smith, L. 1999, *Decolonizing Methodologies: Research and Indigenous peoples*, Zed Books, New York.

Victoroff, K. Z. & Hogan, S. 2006, 'Students' perceptions of effective learning experiences in dental school: A qualitative study using a Critical Incident Technique', *Journal of Dental Education*, vol. 70, no. 2, pp. 124–32.



APPENDIX: GOOD PRACTICE CASE STUDY ASSESSMENT PROCESS

The LIME Secretariat sought expressions of interest from members of the LIME Reference Group to form a Review Committee to assess good practice case study submissions under the categories of recruitment and retention; curriculum design; teaching and learning; and community engagement.

The LIME Secretariat called for submissions from those who had presented papers at LIME Connection IV, held in Auckland, November 2011. Once case studies had been received, the Review Committee assessed the case studies according to whether the project met its objectives, was evidence based, had developed Indigenous leadership, was sustainable and was transferrable to other settings. Committee members abstained from reviewing any case studies that they considered posed a conflict of interest.

The Committee met formally twice. The first meeting was to determine which submissions best met the criteria and would therefore be the most suitable for the second edition of the *Good Practice Case Studies* booklet. It identified case studies that were accepted without revision and also identified case studies that required some revision. The second meeting was to review case studies that had been resubmitted incorporating feedback from the Committee, and to determine the final selection of case studies for the *Good Practice Case Studies* booklet. 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 AND ABBREVIATIONS

ASHS	Aboriginal Students Health Sciences
CCHS	Community Controlled Health Service
LIME	Leaders in Indigenous Medical Education
MAPAS	Māori and Pacific Admission Scheme
MICRRH	Mount Isa Centre for Rural and Remote Health
MIHI	Māori Indigenous Health Institute
OSCE	Objective Structured Clinical Examination
SCIM	Structured Clinical Instruction Module
AIDA	Australian Indigenous Doctors' Association

GLOSSARY

Aboriginal and Torres Strait Islanders	Original inhabitants of Australia and its nearby islands
Aboriginal Health Worker	Aboriginal or Torres Strait Islander person employed to provide health services or health programs directly to Aboriginal people and/or Torres Strait Islanders
Aotearoa	Traditional Māori name for the North Island of New Zealand. Today it is more commonly used to mean the whole of New Zealand
Clinical school	Usually located within a teaching hospital, it coordinates the clinical training for medical students in the latter years of their course
Elder	A moral and spiritual leader of Indigenous communities in Australia. Elders are also the teachers, who pass knowledge on to the next generation
Hauora Māori	Māori Health
kaitiaki	Māori health community worker/someone who has a role to 'take care' of someone
kaumātua	Māori term for the elderly
Māori	Indigenous people of Aotearoa/New Zealand
marae	A communal building complex for Māori to gather, including the marae atea (area of engagement in front of the meeting house), whare hui/nui (meeting house) and whare kai (dining room). Affiliation of Māori to a specific Marae is based on ancestral tribal links
Meihana Model	A Māori model of health developed by Pitama et al. (2007)
mihiwakatau	Māori term for formal welcome and introductions
noho marae	Overnight marae stay
oranga niho	Māori term for oral health
pakeke	Māori term for adults
rangatahi	Māori term for young adults

rangatiratanga	Māori term for leadership/ability to have power to make decisions for oneself and those in one's care
tamariki	Māori term for children
Te Whare Tapa Whā	A Māori model of health and wellbeing. This encompasses te taha tinana (the physical dimension); te taha hinengaro (the mental dimension); te taha whānau (the family dimension) and te taha wairua (the spiritual dimension)
whakawhanaungatanga	Māori term for relationships
whānau	Māori term for family/support systems
whānau ora	Māori term for family health



Leaders in Indigenous Medical Education Network

Faculty of Medicine, Dentistry and Health Sciences

Level 2, 161 Barry Street

The University of Melbourne

Victoria 3010 Australia

T: +61 3 8344 9160

E: lime-network@unimelb.edu.au

W: www.limenetwork.net.au



THE LIMENETWORK

Leaders in Indigenous Medical Education