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Leaders in Indigenous Medical Education

LIME GOOD PRACTICE CASE STUDIES

VOLUME THREE

2015

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The Leaders in Indigenous Medical Education (LIME) Network is a program of Medical Deans Australia and Aotearoa/New Zealand, supported by financial assistance from the Australian Government Department of Health. The LIME Network is hosted by the Faculty of Medicine, Dentistry and Health Sciences at 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

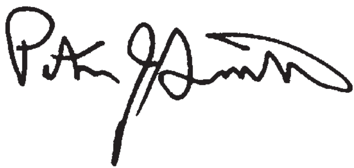
As President of Medical Deans Australia and New Zealand Inc. I am pleased to present the *LIME Good Practice Case Studies Volume Three 2015*.

Like the preceding two volumes, this third volume represents the accumulated wealth of experience from a number of leaders in this field while also demonstrating the maturation both of the LIME Network and of Indigenous health education in Australia and Aotearoa/New Zealand.

The nine case studies in this volume also demonstrate the diversity in approach across both the two countries and in our universities' medical and health faculties. For example, the Whakapiki Ake project from the University of Auckland and the Pre-entry to Medicine program at the Universities of Newcastle and New England address the challenging issue of Indigenous student recruitment and graduation.

The Yorta Yorta OnCountry4Health program at the University of Melbourne and the Indigenous health stream at the University of Western Australia examine ways to strengthen a selected group of medical students' skills and experience in Indigenous health. A case study presented by the LIME Network also demonstrates the power of community action in this discipline.

I recommend these case studies to you as essential insights into current initiatives in health professional education. Such initiatives will ensure that we all continue to learn, improve and remain focused on the key outcome of 'Closing the Gap'.



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ACKNOWLEDGMENTS

Many people have contributed to the development of this publication. The LIME Network secretariat acknowledges and thanks all authors who submitted case studies for their commitment to Indigenous health and health professional 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 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.

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INTRODUCTION

This third edition of the *LIME Good Practice Case Studies* builds on the papers included in Volume One (2012) and Volume Two (2013) to showcase the outstanding programs of work that are being conducted in the field of Indigenous health in health professional education. All three volumes detail initiatives occurring across universities in Australia and Aotearoa/New Zealand as well as further afield. The case studies identify work being carried out in the areas of Indigenous student recruitment and support to graduation, community engagement, curriculum design, and teaching and learning.

The papers in this volume are drawn from presentations made at LIME Connection V in Darwin in 2013. LIME Connection is the biennial conference of the Leaders in Indigenous Medical Education (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 health professional educators, Deans, Indigenous health specialists, policy makers and community members. It aims to encourage and support collaboration and sharing within and between universities and to build multi-disciplinary and multi-sectoral linkages. In 2013 the theme of the Conference – 'Re-imagining Indigenous Health Education: Harnessing Energy, Implementing Evidence, Creating Change' – built on the focus on evidence-based practice from previous LIME Connections and captured new initiatives, shared successful methods and workshopped visions for the future.

The translation of these presentations into papers for publication is part of the LIME Network's ongoing commitment to advancing the discipline of Indigenous health education and to developing a body of work that builds the evidence base for informing good practice approaches in the field. By acknowledging and celebrating the innovative work being championed here, we hope this publication inspires new initiatives and the development and support of current programs, thereby furthering our aim of enhancing the delivery of health professional education to improve health outcomes for Indigenous people.

ABOUT THE LIME NETWORK

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

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

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

- The facilitation of bi-annual **Reference Group** meetings to provide the opportunity for those working in Indigenous health within medical schools to collaborate, share information, provide feedback and peer network
- The biennial **LIME Connection** conference to provide a forum for knowledge exchange and dissemination, and including the **LIMELight Awards** celebrating successes in the field
- The **Indigenous Medical Student and Community Bursary Scheme** providing the opportunity for networking and peer support at LIME Connection
- Publication of the tri-annual **LIME Network Newsletter** promoting best practice and sharing successes in the field
- Maintaining the **LIME Network Website** housing information on LIME Network projects, relevant resources and other news and events
- Building the evidence base of the efficacy of Indigenous health curriculum development and implementation, as well as Indigenous student recruitment and support to graduation initiatives through publications such as the **Good Practice Case Studies** and the Special Edition of the **ANZAHPE Focus on Health Professional Education Journal**
- Developing and implementing internal **review tools** to support medical schools to reflect and evaluate their performance
- Supporting Indigenous secondary school and mature age students to understand the pathways to studying medicine through the online **Indigenous Pathways into Medicine Resource** and **Indigenous Pathways into Medicine Videos**
- Strengthening capacity and sharing knowledge among network membership through **Slice of LIME Seminars**

- Developing a **Peer Support Statement and Strategy** that operates across universities
- Building linkages across health disciplines and with medical colleges through **networking and information sharing**
- Supporting collaboration between medical schools and their local Indigenous Community Controlled Health Organisations through the facilitation of **Regional Meetings**.

Background

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

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

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

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

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

Enabling good practice in Indigenous health and medical education: The role of the LIME Network

Ms Odette Mazel and Ms Caitlin Ryan for the LIME Network Program, Australia and Aotearoa/New Zealand

Introduction

The status of Indigenous peoples' health in both Australia and Aotearoa/New Zealand remains well below that of their non-Indigenous counterparts, with a greater burden of disease and lower life expectancy (ABS & AIHW 2012; NZ Ministry of Health 2010). A range of historical, social and economic factors influences this situation, but both ensuring access to appropriate health care services and the quality of care provided are also influential (Anderson 2008). The medical schools that educate our doctors, therefore, have an important responsibility in developing a workforce that is responsive to the needs of Indigenous people (Hays 2002).

Historically, education on Indigenous health has been sporadically taught and poorly implemented in medical education (Garvey & Brown 1999; Phillips 2004). The Leaders in Indigenous Medical Education (LIME) Network was established in 2005 to be a 'sustainable, functional and effective network' of Indigenous and non-Indigenous medical educators who could collaborate and support each other in the delivery of Indigenous health curriculum and the development of strategies to recruit and support Indigenous medical students (Phillips 2005).

While recently searching our archives we discovered an article by Beacham et al. (2005) on the nature and purpose of networks generally. Densely marked with highlighter, the paper may have informed the initial development of the LIME Network during its establishment phase.

In this paper we explore the role and function of the LIME Network's organisational support structure and its value in driving systemic and institutional change to enable best practice in Indigenous health and medical education. We utilise Beacham et al.'s framework to analyse the operational aspects of the Network and to see where improvements can be made to further its aims.

Aims and Objectives

Networks are becoming a key feature in the health and education sectors and play an important role in connecting people around a common goal or issue (Armstrong & Kendall 2010; Beacham et al. 2005; Briggs et al. 2012; Clark 1998). They are considered an effective way of responding to

local challenges and instigating change through a shared sense of purpose (Armstrong & Kendall 2010). With allocated structures to support growth and sustainability, networks can build collective knowledge, guide planning and innovation and develop solutions for common concerns (Scott & Hofmeyer 2007).

The LIME Network has been developed with the dedicated purpose of supporting quality and effectiveness in the teaching and learning of Indigenous health in medical education, as well as best practice in the recruitment and support through to graduation of Indigenous medical students.

The LIME Network's objectives are as follows:

- **Quality review processes:** Encourage medical schools to devise and implement sound internal review processes by which they can evaluate the quality of Indigenous health curriculum and the effectiveness of initiatives to support the participation of Indigenous people in medical education programs.
- **Professional development, capacity building and support:** Encourage Network members and their colleagues to engage with and deliver initiatives in Indigenous health and medical education through information sharing, mutual support, peer feedback and celebrating successes.
- **Research and evaluation of good practice in Indigenous health and medical education:** Encourage scholarly work on good teaching practice, resource development, assessment and program evaluation to support Indigenous medical education and the recruitment and retention of Indigenous students.
- **Professionalisation of the discipline:** Encourage the development of Indigenous health as a discipline in its own right by providing opportunities for networking and collaboration, developing publications and other forms of information sharing and feedback.
- **Multi-disciplinary and multi-sectoral networking:** Encourage network members and their colleagues to work collaboratively, build linkages and share information across disciplines in health and medical education, Indigenous health networks, postgraduate medical education councils, Indigenous communities and organisations, specialist medical colleges, medical student representative bodies and health education networks.
- **Advocacy and reform:** Contribute to Indigenous health and medical education, and related workforce issues, through the provision of policy advice and recommendations to Medical Deans Australia and New Zealand Inc. (Medical Deans), and other organisations, as appropriate.
- **LIME conference:** Ensure that there is a biennial professional conference (LIME Connection) for people interested or engaged in Indigenous health and medical education. The conference will provide an opportunity where the quality review, professional development, networking, capacity building and advocacy functions of the network are realised. It will feature theoretical and scientific presentations and debate, and will engage with other health science disciplines, sectors and networks.

Since the Program's inception, the Network's Program Team has worked to help realise the aims of medical educators across Australia and Aotearoa/New Zealand who specialise in Indigenous health.

Approach

A Network, as defined by Beacham et al. (2005), is the coming together of a group of people with shared goals and expertise, who regularly and systematically take group action to realise those goals. These groups are designed to develop and strengthen knowledge, which can then be shared and used by the wider community (Beacham et al. 2005; Briggs et al. 2012; Clark 1998).

The power of a network lies in the coming together of many specialists, the theory being that a unified group of experts holds more power than an individual to enhance knowledge, encourage debate, develop research, innovate and influence action around a shared area of interest. If supported and managed appropriately, networks provide increased opportunities for collaborative development of ideas, professional learning and support, and influencing positive change (Beacham et al. 2005; Clark 1998; Creech & Ramji 2004). Importantly, network vibrancy is dependent on the network reflecting the common needs of its membership and ensuring diversity, fluidity and sustainability – all while maintaining structural stability (Beacham et al. 2005).

Networks can be self-maintaining, but it is widely acknowledged that those with funded organisational structures or secretariats are more likely to be effective and sustainable in the long term (Beacham et al. 2005; Conklin et al. 2013; Scott & Hofmeyer 2007).

The LIME Network was first established in 2005, and has been fully funded since 2008. The role of the Network has primarily been to build linkages, develop resources, and share ideas and successes among its membership. With Beacham et al.'s model in mind, it has done this through developing relationships built on trust, responding to needs on the ground, and working collaboratively to harness ideas and implement strategies for change.

Over time, the portfolio of work has expanded to provide quality review, professional development, capacity building, research and advocacy functions for Network members, and to develop linkages with specialist medical colleges and educators from other health disciplines. Importantly, the Network is founded on Indigenous leadership and celebrates the many successes that are occurring in the field.

The Network is made up of around 1000 individual and organisational members. The majority work in Indigenous medical education in universities (n=355), are medical students (n=171) or medical practitioners (n=89). Figures 1 and 2 overleaf give details of the LIME Network membership.

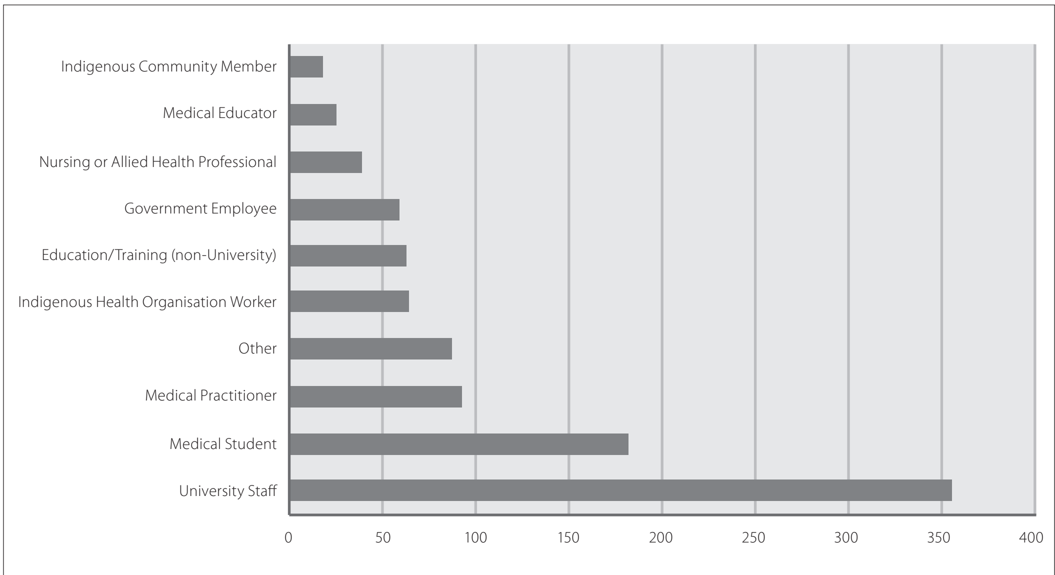

Figure 1: LIME membership by profession, December 2014

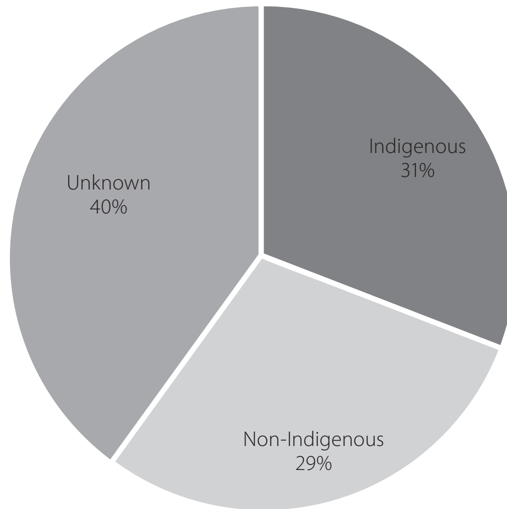

Figure 2: LIME membership by Indigenous status, December 2014

The LIME Program has been governed by a Steering Committee of representatives from a range of organisations who review the Network's strategic objectives, and provide advice on the maintenance of key relationships and the development of its national and international profile. At present, the Steering Committee structure is being revisited and an overarching Committee for all Indigenous health projects of the Medical Deans is under consideration.

A Reference Group made up of representatives from each medical school in Australia and Aotearoa/New Zealand supports the development and implementation of specific program initiatives and regular meetings provide peer networking, professional development and support opportunities. Where possible and appropriate, members of this group are Indigenous and have a role in teaching Indigenous health, and/or are involved in Indigenous student recruitment and support.

A core component of the Network's operation is the inclusion of a funded Program Team to progress the work of LIME. At present, three full-time positions are externally funded by the Australian Government Department of Health (DoH) through Medical Deans, with in-kind support provided by medical schools to ensure their representation on LIME Network committees and activities.

Results

Beacham et al. (2005:12) describe the role of a program team or secretariat as one of creating 'strong cohesive ties between members' by:

1. Influencing members to actively participate – being a motivating source and a catalyst for engagement by harnessing knowledge and producing resources to sustain the network
2. Securing a commitment to develop cooperation and collaboration among the group, and a common and clear set of objectives
3. Creating a favourable environment for members to interact and undertake network activities by minimising the costs and time of individual members undertaking program work.

Here we will look at how the LIME Network Program Team operates against the management roles, as set out by Beacham et al., through building linkages, developing resources, sharing ideas and channelling expertise.

Building and securing relationships to strengthen Network aims

1. Influencing members – harnessing knowledge

The main purpose of networks is to create and disseminate knowledge (Beacham et al. 2005). Beacham et al. suggest that a useful and active network must be a motivating source, as well as a catalyst for engagement by harnessing knowledge and producing resources to sustain the network (2005).

The LIME Network's program of work is informed by our Reference Group and Steering Committee, and endorsed by Medical Deans and the Australian Government DoH. The program of work is devised through a collaborative process that harnesses ideas from a range of members and maps a strategy for action.

The Program Team operates with the core understanding that the body of work produced is owned and driven by Network members but is implemented with the support of the Team. This serves to increase members' sense of ownership over the Program and encourages increased engagement. It also ensures ongoing relevance and responsiveness to current issues that arise while meeting contractual obligations to the funding bodies.

The body of work produced with the engagement of Reference Group members, as part of specified working groups, pools skills and distributes knowledge by developing evidence-based resources and activities that are relevant and useful to Network members more broadly. As one Reference Group member stated:

> *The Network has helped me to develop and advocate for Indigenous health in a very strong and often dominating environment. The resources available through the Network have been very useful and meant that I could build on the work already done and not start from scratch* (LIME Network Reference Group Member).

Projects and resources of the Network include:

- The publication of the LIME Network Special Edition of the ANZAHPE *Focus on Health Professional Education* journal which provided a unique opportunity for Indigenous and non-Indigenous academics to publish scholarly work in this emerging area and share knowledge regarding teaching and learning with others in the field (Craig 2011).
- *LIME Network Good Practice Case Studies* publications, which bring together good practice initiatives in the key areas of Indigenous student recruitment and support, curriculum design, teaching and learning and community engagement (LIME Network 2012; LIME Network 2013).
- Assistance with the implementation of the Committee of Deans of Australian Medical Schools (CDAMS) Indigenous Health Curriculum Framework (Phillips 2004a).
- Quality review tools to assist members implement teaching and learning initiatives, including the Periodic Systemic Review of Indigenous health and the Critical Reflection Tool (LIME Network 2014).
- The online Indigenous Pathways into Medicine resource designed to help future Indigenous students determine which university will be the best fit for them as they study to become a doctor (LIME Network 2014).
- An online resources database housing publications specifically relevant to Indigenous health and medical education (LIME Network 2014).
- The publication of a tri-annual newsletter, detailing initiatives in medical and other health professional education, to which Network members submit articles (LIME Network 2014).

2. Securing commitment – working collaboratively

Beacham et al. (2005) argue that working collaboratively must be coupled with the development of trusting, strong relationships for a network to be successful. Many of our members, and in particular the LIME Reference Group, find themselves working in relatively isolated roles within their own universities, and many face institutional barriers in their efforts to strengthen Indigenous health in medical education. Developing trust between the Program Team and Network members,

and between Network members themselves, has been essential to creating a space within which members feel safe to explore the challenges of their work and secure in the knowledge that the Team will support their efforts to implement change with sensitivity and a sense of collegiality.

By supporting the development of strong, interconnected relationships between Network members through regular meetings, this safe space is enhanced. This has been achieved through the maintenance of a core group that values peer support and reciprocity, openness, sharing and capacity development.

> *LIME provides me with the opportunity to continue doing what I do. To have colleagues that share some of my challenges and stories gives me the strength to carry on. We are building a way of learning that provides a model for others to contemplate and learn from… I think LIME enables us to be solid together and to work together* (LIME Reference Group Member).

The LIME Connection biennial conference provides the ultimate forum for collaboration and sharing among the wider membership group. This is an important event in which around 200 members meet to present their work and engage with one another on a personal and professional level. Indigenous medical student participation is also an important element of LIME Connection and is encouraged through the provision of student bursaries.

> *The opportunity to meet and interact with people with a shared vision and common goal was strengthening for me and affirming for my orientation toward improving the health status of Indigenous peoples* (Student bursary recipient, LIME Connection).

Importantly, the Network celebrates successes among the membership at the conference through the presentation of the LIMElight awards. The awards acknowledge both leadership, and innovative programs or initiatives that address critical issues, bring people together collaboratively and implement innovative solutions in curriculum implementation and student recruitment through to graduation.

3. Creating a favourable environment – supporting members

Creating a favourable environment for members to interact and undertake Network activities, by minimising the costs and time of individual members undertaking Program work, is important to the functioning of a network (Beacham et al. 2005). The LIME Network Program Team works with the sole aim of providing the necessary support to achieve the Network's aims. It is responsible for organising meetings, developing resources, maintaining the website, running LIME Connection, applying for funding, reporting on activities and assisting Network members where necessary. These activities allow members to participate without adding administrative burdens on their time. Costs of these activities are covered by financial and in-kind support.

Armstrong and Kendall suggest that information technology has become an important part of networks by providing a 'means whereby knowledge can be stored and shared by multiple users at multiple locations' (2010:15). By effectively sharing information, networks can support an agenda for reform and facilitate the development of localised and meaningful action plans for applying evidence to practice (Armstrong & Kendall 2010).

The development of the LIME Network website, for example, has been an important aspect of the Program's success. By acting as a portal through which information is distributed, it allows members 24/7 to access tools and resources developed as part of the Program (LIME Network 2014). As such, it is an essential platform for sharing collective knowledge and is well utilised with more than 5000 page views per month.

> *I feel as though I am now equipped with the knowledge and possible skills needed to use within my university or put forward to possibly improve cultural safety within my university* (LIME Network Member).

Initially, it was envisaged that the Network Program Team would move from university to university, every two years, in order to distribute responsibility across the medical schools. However, retaining the team in one place has ensured structural stability and the maintenance of corporate knowledge (Beacham et al. 2005). Importantly, the Team utilises the skills of its staff members in terms of administration, engagement, research and knowledge expertise. All current Program staff have been in their roles for 4–6 years and this has been integral to team engagement with the aims, issues and challenges of the Network. The value of retained corporate knowledge, trusted relationships and ways of working together that have been developed both within and outside the team has contributed substantially to the growth and productivity of the Network.

Discussion

Successes

As the Network has grown – membership has risen from 35 in 2008 to more than 1100 in 2014 (see Figure 3 below) – it has become more sophisticated in its demands for knowledge, and in allowing for critique and suggestions as to how it could be improved. Armstrong and Kendall suggest that measuring the impact of networks and gauging systems of change can be difficult (2010). At present the growth and development of the Network is measured at a number of levels.

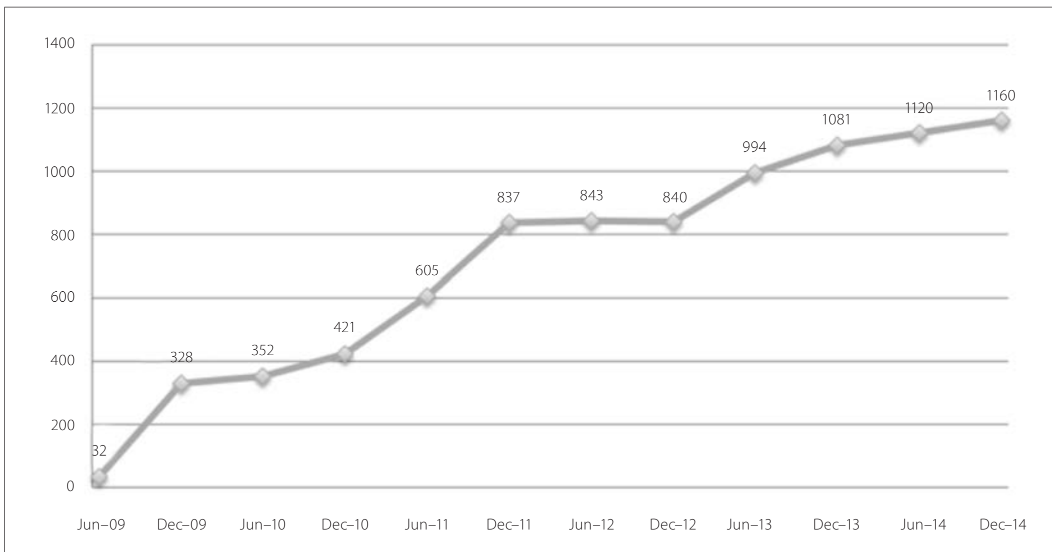

Figure 3: LIME membership (individual and organisation), June 09–December 14

Quarterly reports are provided to funding bodies and evaluations are conducted at LIME Reference Group meetings and the LIME Connection. These show that members find the Network supports their work, creates a safe and encouraging collegial space, and provides vital resources that contribute to the development of this emerging field. It will be important, however, to ensure that the Program Team operates flexibly and progressively while continuing to meet the needs of members into the future.

> *The collegiality and the way that the LIME Network has enabled a whole range of discussions, activities and research grants is very valuable. The buy-in from so many schools across both countries over a long period of time is outstanding* (LIME Reference Group Member).

Challenges

The LIME Network and Program Team now face a number of challenges. The Network has been funded on a string of shorter term contracts, which means that long-term planning and extending the scope of work can be difficult. It also means that jobs for staff are not secure, highlighting sustainability as an ongoing issue.

In addition, time commitments of Steering Committee and Reference Group members can be limited. Participation in the Network is, of course, additional to their core work, but most participate actively because they are aware of the overall benefits. However, at times, continued involvement in multiple working groups can become difficult to manage. To counter this, LIME developed a proxy member system for committees that ensures continued engagement, but also supports professional development of other staff within universities and associated organisations.

Another challenge is around where the boundaries for interdisciplinary work are drawn, given that the focus of the LIME Network objectives is on medical education. Encouraging diversity and supporting collaboration with new members in other health disciplines is important and can lead to cross-disciplinary innovation. As such, there is an opportunity here for some further exploration of how an expansion of the Network could work across all of the health sciences.

The Program Team is aware of the importance of evaluation, and is currently exploring how its work might be strengthened through appropriate and broader evaluation of its operations (Creech & Ramji 2004).

Conclusion

The LIME Network has facilitated exchanges among a group of people with similar concerns and interests, and has helped to create, explore and apply knowledge in the field of Indigenous health and medical education (Conklin et al. 2013). In relation to the three key organisational aspects that Beacham et al. (2005) outline – working collaboratively; developing relationships built on trust; and providing support – the Program Team has supported the Network to ensure its growth and maintain its relevance. The Team's commitment to knowledge exchange and engagement – through meetings, publications, resources, the website, newsletters and the LIME Connection conference – alongside the dedication and work of committee members has ensured that all members develop and maintain connectedness and involvement.

Despite ongoing issues of sustainability, the LIME Network has developed a strong bi-national voice. As a conduit through which Indigenous health educators can unite, the Network now wields influence internationally to advocate for change and organisational advancement to improve the quality of health care given to Aboriginal and Torres Strait Islander peoples in Australia and Māori in New Zealand.

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Recruiting via Hui-ā-Rohe: How the Whakapiki Ake Project has increased engagement with Māori students, their whānau (families) and communities

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Introduction

The Whakapiki Ake Project (Whakapiki Ake) is a tertiary recruitment program that targets Māori secondary school students wishing to pursue a career in the health professions (medicine, nursing, pharmacy, health sciences and optometry) at the University of Auckland. Indigenous-led, Whakapiki Ake is situated within a comprehensive health workforce development program known as Vision 20:20, which involves three integrated core components:

- Whakapiki Ake (recruitment)
- Certificate in Health Sciences (bridging/foundation)
- Māori and Pacific Admission Scheme (admission and academic/pastoral support) (Curtis & Reid 2013).

Vision 20:20 receives funding from the Faculty of Medical and Health Sciences at the University of Auckland, the Ministry of Health and Tertiary Education Commission Equity Funding.

In 2012, Whakapiki Ake conducted a formal literature review exploring national and international evidence associated with 'best' practice for the recruitment of Indigenous students into health careers (Curtis et al. 2012). It identified six principles of 'best' practice , including the need to increase engagement with parents, families and Indigenous communities within all recruitment measures, particularly early exposure activities. This principle highlighted an area of concern for Whakapiki Ake, as the historical model of student recruitment targeted Year 13 students via secondary school engagement (Curtis & Reid 2013). Broader contact with students' families and their communities was, therefore, limited.

In response, Whakapiki Ake introduced a new intervention known as Hui-ā-Rohe – referring to multiple gatherings across different regional areas – to increase engagement with secondary school students, their parents and whānau (families). This case study presents the Hui-ā-Rohe approach to share with other student recruitment programs how Whakapiki Ake responded to one principle of recruitment 'best' practice: that of greater engagement with families and Indigenous communities when recruiting Indigenous students into health careers.

Aims and Objectives

Hui-ā-Rohe aims to provide geographically accessible forums that enable direct contact between Whakapiki Ake staff and Indigenous secondary school students, their parents and whānau.

The objectives of Hui-ā-Rohe are to:

- increase engagement between Whakapiki Ake and the whānau of secondary school students who are considering a career in health;
- increase engagement between school, hapū/iwi (Māori sub-tribes and tribes) and community stakeholders;
- provide appropriate recruitment information targeted at different year groups (Years 9–10, Years 11–12, Year 13) and their whānau;
- advise students, parents and whānau of the secondary and tertiary educational factors and decisions that may impact on a career in health; and
- promote Indigenous student and whānau aspirations towards a career in health.

Approach

Whakapiki Ake took the following approach in implementing Hui-ā-Rohe:

1. Identifying Hui-ā-Rohe regions.

Appropriate regions were identified based on Whakapiki Ake student numbers and Māori population proportions for any given region. Regions with the highest Whakapiki Ake student numbers and Māori population are prioritised.

2. Increasing outreach to Māori-medium schools, hāpu and iwi.

Whakapiki Ake purposively targeted Māori medium schools known as Kura Kaupapa Māori and Whare Kura for the delivery of Hui-ā-Rohe. These schools provide students with an education immersed in te reo Māori (Māori langauge) and tikanga Māori (Māori customs) and are often localised within regional iwi and hapū contexts. This focus has allowed Whakapiki Ake to extend Hui-ā-Rohe to a broader outreach of Māori students and whānau (including younger ages from Years 6–8) and to increase liaison with local iwi and hapū.

3. Selecting the timing for Hui-ā-Rohe.

Selecting the right timing to provide Hui-ā-Rohe requires knowledge of the secondary school calendar and Indigenous community events in any given year. Influencing factors include the timing of secondary school subject choices (timed to precede the deadlines given to students for subject selection for the following year) and the potential of competing interests for student or whānau attendance (timed to avoid major sporting or cultural events for students and whānau).

4. Identifying potential Hui-ā-Rohe participants.

The following activities assisted Whakapiki Ake to identify potential participants:

- Maintenance of a Whakapiki Ake registration process.

  The Whakapiki Ake registration process requires any students who are interested in a health career and are engaged in a Whakapiki Ake activity to register formally with the recruitment program via the on-line Pukatono Form. This process captures individual and family contact details so that Whakapiki Ake can promote activities directly to whānau members as well as students.

- Maintenance of a Whakapiki Ake database.

  Whakapiki Ake invested in the development of a comprehensive database populated with student and whānau information. Whakapiki Ake staff are now able to produce region-specific listings of potential participants that can be provided to secondary schools and/or used directly by the program for Hui-ā-Rohe promotion.

- Accepting referrals and non-registered attendance.

  Whakapiki Ake accepts school referrals and non-registered involvement for any students, whānau and/or community stakeholders interested in attending the Hui-ā-Rohe. This open-door policy allows the intervention to be inclusive, rather than restricting involvement.

5. Clarifying the contribution of secondary schools and identifying a Whakapiki Ake advocate.

Secondary schools are asked to provide a suitable venue and audio-visual equipment for Hui-ā-Rohe, and identify a Whakapiki Ake advocate or school champion who can be contacted by the recruitment program for liaison support. The advocate's activities include sending pānui (meeting notifications) to students and whānau and promoting the Hui-ā-Rohe throughout their school.

6. Maintaining responsibility for Hui-ā-Rohe delivery with Whakapiki Ake.

Whakapiki Ake maintains responsibility for the delivery of the Hui-ā-Rohe, including: identification of potential participants; coordination of attendance confirmation; responding to any direct communication requests from students and their whānau; arranging catering; sourcing inspirational speakers; and developing/providing targeted workshops. The intention is to limit the demands on Whakapiki Ake advocates and secondary schools.

7. Providing Hui-ā-Rohe in a whānau-friendly approach.

Hui-ā-Rohe are held outside of normal work hours to assist with parental and whānau attendance (usually with a 6–6.30pm start time). Venues are intended to be easily accessible and familiar for whānau, e.g. meeting spaces within the secondary school, local marae (traditional Māori meeting houses) and community halls. Dinner is provided for all Hui-ā-Rohe participants.

8. Conducting Hui-ā-Rohe within tikanga Māori context.

All Hui-ā-Rohe utilise tikanga Māori to ensure appropriate cultural practices are observed. This includes beginning hui with a mihi whakatau (Māori welcome), utilising appropriate karakia (Māori prayers) and ensuring whakawhanaungatanga (Māori process of establishing relationships) are undertaken. In addition, the sharing of kai (food) further supports a culturally appropriate approach.

9. Utilising Māori health professional role models for inspiration.

Local Māori health professionals are invited as guest speakers to provide an inspirational talk in which they share their own journey into a health career. Whakapiki Ake acknowledges the contribution of these voluntary speakers with a koha (gift).

10. Providing targeted workshops.

Whakapiki Ake staff provide an overview of Whakapiki Ake as the recruitment arm of Vision 20:20. Staff then split the hui into three groups to facilitate the following interactive workshops.

Years 9–10

Topics include: raising aspirations/expectations for health careers; introducing the importance of school subject choices; understanding University Entrance and the National Certificate of Educational Achievement (New Zealand's national qualifications for senior secondary school students); highlighting the importance of creating good learning behaviours early in secondary school; promoting positive Māori cultural messages; exposure to Māori role models in health; and emphasising the need for future Māori health professionals. An introduction to the Whakapiki Ake pipeline approach to health workforce development (see Figure 1) and an invitation to be part of it is provided by Whakapiki Ake staff.

Years 11–12

This workshop builds on the Years 9–10 workshop, but with a greater emphasis on the importance of subject choices given that senior students are required to confirm these (necessary for access to health professional careers). Students and their whānau are taken through National Certificate of Educational Achievement credit mapping and shown how to calculate a Rank Score (used by universities to determine health professional program entry). Messages regarding the importance of positive study habits are aimed both at students and their whānau (who potentially control family, community and work commitments that may impact on academic performance). Future Year 12–13 Whakapiki Ake interventions are presented to encourage application and attendance. These include MASH or Māori Achieving Success in Health; COACH or Creating Options for a Career in Health; Whakapiki Ake Study Wanānga; and Online Academic Support.

Year 13

This workshop focuses on advice that will assist Year 13 students and their whānau with tertiary applications and transitioning into university study. Topics include: specific details on application dates; an overview of the Māori and Pacific Admission Scheme process; accommodation options; greater detail on available scholarships; and the importance of budgeting. Students and whānau are provided with an overview of the tertiary environment including: reviewing the university Rank Score; understanding the tertiary enrolment process; calculating the university Grade Point Average; and reviewing first year course content at the University of Auckland. Information on future recruitment activities for Year 13 students and their whānau is also provided, including the NEXT STEPS to UNI program and Whakapiki Ake financial support.

11. Providing resources – leaving students and their whānau with practical tools.

Resources used to support workshop delivery include: trained Whakapiki Ake staff facilitators; audience-focused Powerpoint presentations; multi-media vignettes showcasing current Whakapiki Ake students and/or activities; and resource packs targeting each year group. The resource packs include:

- Years 9–10: Vision 20:20 prospectus; pad; pen; highlighters; and 'How to Study' pamphlet.
- Years 11–12: Vision 20:20 and Faculty of Medical and Health Sciences prospectus; pad; pen; study planner; and National Certificate of Educational Achievement credit map (Level 1 or 2).
- Year 13: Vision 20:20 and Faculty of Medical and Health Sciences prospectus; Māori and Pacific Admission Scheme application form; National Certificate of Educational Achievement credit map (Level 3); budgeting advice; study planner; application resource; accommodation comparisons; pad; and pen.

12. Data tracking attendance.

Whakapiki Ake records basic demographic information on all intervention attendees via its database. This assists reporting and informs the development of Whakapiki Ake activities.

Results

In 2014, Whakapiki Ake provided 11 Hui-ā-Rohe across the North Island to 625 participants (Table 1). Of these, 310 (50%) were students ranging from Years 6–13, 264 (42%) were whānau members and 51 (8%) were school staff or external organisations representatives. Just over half of all student attendees were not registered with Whakapiki Ake (161, 52%) suggesting that they had not been reached by Whakapiki Ake Hui-ā-Kura (secondary school visits) held earlier in the year. Given this, it appears that Hui-ā-Rohe have enabled a geographically accessible forum for increased direct contact between Whakapiki Ake staff and Indigenous secondary school students. Importantly, Hui-ā-Rohe have also facilitated Whakapiki Ake to engage for the first time with whānau, Indigenous organisations and communities, who made up half of all attendees.

Whānau have responded positively to Hui-ā-Rohe, with one participant writing:

> *Firstly, thank you for the information [at the] hui last night. We all found it very useful, helpful and [it] clarified a whole lot of stuff. My younger two [children] also really enjoyed being involved, I think that's a good initiative to touch base with the students at a younger age too. Both [my children] and I have been very impressed with the work you and the team do, the support now and potentially later at University is a real treasure. Such a great resource.*

Whakapiki Ake advocates have also acknowledged the positive whānau feedback and responded by offering to re-host future Hui-ā-Rohe, alongside commitments to increase engagement. For example, one Careers advisor wrote:

> *Thank you both for everything... I didn't get to sleep until 12.30am... just reflecting on possibilities regarding [the] future of Whakapiki Ake here in our region ;-). All our crew that I spoke to... found it very worthwhile and your motivational kōrero [talk] – every junior student should hear this... I have heard similar but yours was more interactive and engaging.*

Table 1: Hui-ā-Rohe attendees, 2014

Total	Students	Whānau	Staff/External Organisations	Registered Attendees	Non-registered Attendees
625	310 (50%)	264 (42%)	51 (8%)	337	288*

** 161 of the non-registered attendees were secondary school students*

Discussion

Successes

Prior to the introduction of this intervention, Whakapiki Ake was focused on student contact within primarily mainstream secondary school settings. In 2014, more than 600 students, whānau and external stakeholders participated in Hui-ā-Rohe, and were exposed to important recruitment messages contextualised to pursuing a career in health.

It is clear from anecdotal whānau feedback, that more concise explanations are required of the secondary education environment and the National Certificate of Educational Achievement, particularly as they relate to university entrance and tertiary success within health contexts. Hui-ā-Rohe have allowed Whakapiki Ake to provide this specialised and often complex tertiary entry and admission advice to students and their whānau, information that they need to navigate both secondary and tertiary educational settings (Madjar et al. 2009). Formal research and/or evaluation to explore these issues further within the Whakapiki Ake context are recommended.

The introduction of Hui-ā-Rohe (alongside other early exposure interventions) has enhanced Whakapiki Ake's ability to influence or reaffirm the cultural development of Māori students considering a career in health. Whakapiki Ake promotes positive cultural messages where Māori excellence is normalised, Māori culture is seen as legitimate and valuable, and the need to maintain Māori cultural connection is supported and encouraged (Smith 2012). Given this context, there may be wider benefits associated with the delivery of Hui-ā-Rohe that extend beyond health recruitment, to Māori development in general.

Overall, the introduction of Hui-ā-Rohe has highlighted the importance of working collaboratively in order to support a comprehensive pipeline approach to Māori health workforce development (Ratima et al. 2008).

Challenges

A key challenge that may impact upon future delivery is program funding. The development and delivery of community-based interventions are resource-intensive, requiring substantial staff input and time alongside significant operational costs. Although Whakapiki Ake has purposively expanded the number and type of interventions to increase its focus on early exposure, the overall funding pool for program recruitment has remained relatively static. Unfortunately, further expansion of Hui-ā-Rohe (and other upstream recruitment interventions) may be limited if program funding fails to keep pace with the increasing demand generated by the success of early exposure interventions.

Another challenge, also sensitive to funding, is the need to ensure that Whakapiki Ake can deliver age- and year-appropriate interventions that avoid duplication of recruitment messages or activities. Understanding how to scaffold recruitment interventions to ensure that activities are engaging, appropriate for the different contexts and, therefore, meet the intended recruitment outcomes will require additional staff time, energy and resources.

Conclusion

Whakapiki Ake is a successful, Indigenous-led, tertiary recruitment program focused on supporting the growth and development of the Māori health workforce. A willingness to review the evidence base and respond to principles of 'best' practice in the recruitment of Indigenous students into health has assisted Whakapiki Ake to develop new Indigenous and community-focused interventions. We hope that by sharing our experience, Whakapiki Ake can contribute to the broader evidence base, celebrate our successes, and be mindful of the ongoing challenges to maintaining and enhancing Indigenous potential.

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Figure 1: Whakapiki Ake Pipeline

The Miroma Bunbilla Pre-entry to Medicine program for Aboriginal and Torres Strait Islander people

Mrs Vicki Holliday, Associate Professor Peter O'Mara and Dr Anita Watts, University of Newcastle and University of New England

Introduction

The University of Newcastle and the University of New England both offer a five-year Bachelor of Medicine Program that delivers the same curriculum content, known as the Joint Medical Program. In 2012, the Miroma Bunbilla Pre-entry to Medicine program was developed to increase the number of Aboriginal and Torres Strait Islander students successfully completing the Joint Medical Program. This case study reports on the development, implementation and evaluation of the first pilot program of Miroma Bunbilla by the Discipline of Aboriginal and Torres Strait Islander Health in the School of Medicine and Public Health at the University of Newcastle, and discusses student outcomes.

The University of Newcastle has played an historic role in graduating Aboriginal and Torres Strait Islander students from its medical program. Professor Sandra Eades and Dr Louis Peachey were the first Aboriginal doctors to graduate from the University in 1985. Since that time the School of Medicine and Public Health has made the recruitment and graduation of Aboriginal and Torres Strait Islander medical students a priority with a number of targeted initiatives which began with Indigenous entry program developed after researching the barriers to enrollment and exploring pre-entry programs offered in Canada and New Zealand (Lawson, Armstrong & Van Der Weyden 2007; Kay-Lambkin, Pearson & Rolf 2002).

In 2004 the total number of Aboriginal and Torres Strait Islander medical students in Australia was 102, with 24 (23.5%) enrolled in the Joint Medical Program (Minniecon & Kong 2005). In 2014 it was estimated that there were 260 Aboriginal and Torres Strait Islander medical students (AIDA 2014), 48 (18.46%) of whom were enrolled in the Joint Medical Program. In that same year, there were around 180 Aboriginal and Torres Strait Islander doctors in Australia (AIDA 2014); of these 66 (36.6%) graduated from the University of Newcastle or the University of New England.

The requirements for the Aboriginal and Torres Strait Islander Entry Pathway at the University of Newcastle, and more recently through the Joint Medical Program that commenced in 2006, have changed over the years. In the mid 1990s, Aboriginal and Torres Strait Islander applicants were interviewed in their home community prior to being invited to attend a mandatory, one-week pre-entry to medicine program. Following the completion of the program, the applicants were then assessed based on their performance during the week – along with their academic ranking and the medical program interview – to determine if they would be offered a place. This program ceased

in the late 1990s and was replaced with an assessment of the applicant's academic ranking, an interview (the same as for all other applicants) and an interview to confirm the Aboriginality of the applicant.

From 2008–2011 a one-week orientation program was offered to successful applicants prior to the commencement of Semester 1. In addition, ongoing student support also involved one-on-one and group tutoring for each subject via the Indigenous Tutorial Assistance Scheme, cultural camps, pastoral support and a mentoring program. Additional student support was provided by a past graduate of medicine from the University of Newcastle Aboriginal and Torres Strait Islander Entry Pathway, who was employed to provide intensive academic support.

Despite these additional supports, it was concerning that Aboriginal and Torres Strait Islander medical students were still not achieving the required marks to continue through to graduation. In one of the student cohorts of that period, only 25% of students commencing first year continued on to second year, with the completion of the medical science and professional practice courses being identified as significant barriers to success. Outcomes such as this motivated a review of the selection and support processes and resulted in a revision of the Aboriginal and Torres Strait Islander entry process.

Aims and Objectives

The Miroma Bunbilla Pre-Entry to Medicine program was developed as a five-day intensive course with the aim of better preparing Aboriginal and Torres Strait Islander students for the Joint Medical Program with a view to improving graduation rates. Miroma Bunbilla was offered as a pilot program in 2012 and 2013, and following a positive evaluation became a mandatory component of the Aboriginal and Torres Strait Islander Entry Pathway into the Joint Medical Program.

The objectives of Miroma Bunbilla program are to:

- strengthen the selection process for potential Aboriginal and Torres Strait Islander medical students;
- ensure Aboriginal and Torres Strait islander students accepted into the Joint Medical Program have the required skills to graduate; and
- provide appropriate support for Aboriginal and Torres Strait Islander students to graduate from the Joint Medical Program.

Approach

Before planning of the Miroma Bunbilla program commenced, we conducted a review of the literature and a web search of existing pre-entry programs offered in universities across Australia. The review highlighted that there was no definitive length or common content for any of these pre-entry programs. While many universities had no pre-entry programs for Aboriginal and Torres Strait Islander students, those that did varied in length from four weeks to 12 months (LIME 2014).

The Miroma Bunbilla program was funded and developed by the Wollotuka Institute and the School of Medicine and Public Health. The name Miroma Bunbilla comes from the Awabakal language and means 'Permit… take care of', which is reflective of the program's aim to take care of and support

Aboriginal and Torres Strait Islander medical students. It was developed as a five-day pilot program that aligned with the first year learning outcomes of the Joint Medical Program. Five days was chosen as a suitable length of time to ensure the program was accessible to prospective students, after taking into consideration their family, community and work commitments (Holliday 2013).

Once finalised, the program was presented for approval to the Joint Medical Program Admissions Committee and the Pro Vice-Chancellor (Academic) both of whom approved it to be offered as a pilot program in 2012 and 2013. As a pilot program, an evaluation of its content and structure was an important element. The subsequent evaluation of the program took into account the assessment tools used by tutors to rate students' performance, students' participation and engagement in the activities, and the method of collation and review of the marks that informed offers of placement in the Joint Medical Program (Holliday 2013). Those participating in the pilot programs of 2012 and 2013 still had to apply through the existing channels to be offered a place in the Joint Medical Program, and were given no special consideration as a result of participating in the Miroma Bunbilla program (Holliday 2013).

Aboriginal and Torres Strait Islander applicants who applied to the Joint Medical Program through the Universities Admissions Centre were contacted by phone. Those applicants who satisfied the minimum academic criteria, or whose results were pending, were invited to attend. In addition, those students who were required to repeat Year 1, Semester 1 were invited to participate.

Regular communication by phone, email and mail was an important element of engaging with the students. An information booklet was specifically designed that provided information about the University, the program and the accommodation (Holliday 2013). Accommodation was arranged at the Durungaling Aboriginal Hostel and a mini bus was rented to transport the students to Wollotuka and drop them back to the hostel in the evening. Staff of Wollotuka prepared all meals.

The program timetable and content were developed to maximise the experience for participants and to measure the student performance with assessment, feedback and evaluation. On the first day, time was allowed for introductions and information about the program, including an orientation of the anatomy laboratories (mandatory for all students). There was also a discussion about the problem-based learning model, the opening of the first learning problem and the requirements of 15-minute viva voces (oral presentations). Time was allocated throughout the week for research so that students could prepare for these tasks.

Across the week, two problem-based learning tasks were included, each having an opening and closing session. The aim of this was to provide participants with an insight into elements of Year 1 of the medical program. Students were assigned groups and given different tutors for each task. Tutors then assessed students according to the relevance of their contribution to the topic, participation, and how they worked within a group setting.

On the first day of the program each student was asked to select a learning target from one of five topics that was to be the subject of their viva voces to be presented on Day 4. Two tutors were assigned to assess each student using the following criteria: how the student was able to summarise the problem; how the learning target arose; their approach to the learning target; the information from the learning target; and how they conceptualised the learning target.

Staff members also conducted an individual assessment of each student's participation, motivation, timeliness and teamwork, and Confirmation of Aboriginality interviews were scheduled throughout the week. Toward the end of the program, Multiple Station Interviews and Personal Quality Assessments (Personal Qualities Assessment, 2015) were undertaken, aligning with the requirements for all applicants to the Joint Medical Program (University of Newcastle 2015).

An orientation workshop was organised for the problem-based learning tutors to discuss the program, their role, the assessment tools and the content of the evaluation. To further strengthen the program, current Joint Medical Program Year 1 tutors were engaged to facilitate the problem-based learning tasks (Holliday 2013). At the end of the program, the students completed an evaluation that gave them the opportunity to reflect on the value of the program and the ways in which it could be improved. At the same time, tutors completed the tutor feedback sheets, which gave them the opportunity to reflect on the program and the assessment tools, and to suggest improvements to the overall assessment of future participants.

Results

In total, two cohorts of applicants attended the Miroma Bunbilla pilot programs in 2012 and 2013. In 2012 a total of 18 Aboriginal and/or Torres Strait Islander people attended the Miroma Bunbilla Pre-entry to Medicine program, with offers of a place in the Joint Medical Program made to 12 of them. All of the offers were accepted with 11 commencing in 2013 and one deferring until 2014. Participants of Miroma Bunbilla who were not offered a place in the Joint Medical Program were later contacted, given feedback and offered alternative study pathways to allow them to apply again at a later date. Three students indicated they would be commencing other programs and then reapplying in 2013.

A multi-layered approach to student recruitment and graduation is required as single strategies will have little or no impact (Watts et al. 2011). Thus, the students who accepted their offer to the Joint Medical Program were encouraged to enrol in the Summer School courses of Introduction to Human Biology, Foundation Chemistry and Introduction to Physics, which are offered at the University of Newcastle at no cost to the student. The students were also invited to a two-day orientation workshop, which was held prior to the commencement of Semester 1. As part of this orientation, a first aid course was offered and students were given an opportunity to complete the required paperwork for tutoring via the Indigenous Tutorial Assistance Scheme and scholarships.

Discussion

Through their evaluations, students provided constructive feedback on how to improve future programs. Some of these suggestions included the following:

- amend the scheduling of the problem-based learning opening and closing days to allow more time for research;
- include a Fixed Resource Session (lecture) after the anatomy laboratory to reflect the medical program curriculum;
- include visits to the University, John Hunter Hospital and Awabakal Aboriginal Medical Service;

- provide temporary library access to allow the participants to research problem-based learning tasks and viva voce;
- provide clear information regarding footwear requirements for the laboratory; and
- allow time in the laboratory session to mark and discuss the worksheet.

Other learnings from the pilot program include:

- involving staff from Oorala, University of New England to work in partnership with staff at the University of Newcastle;
- ensuring current Aboriginal and Torres Strait Islander students are there to discuss their experiences with participants;
- inviting the Head of School and Deputy Head of School and Program Officer of Medicine and Public Health to meet the participants and answer any questions;
- asking the Scholarships and Indigenous Tutorial Assistance Scheme Co-ordinators to provide information; and
- inviting Aboriginal Employment Co-ordinators from the Hunter New England and Central Coast Local Health District to discuss employment opportunities.

Successes

Although it is early days, there are promising outcomes from the two Miroma Bunbilla pilot programs, with all 11 students completing Year 1 with a 100% retention rate in 2013 (Holliday 2013).

The students who commenced the Joint Medical Program in 2013 after participating in the pilot program were asked to give feedback about the usefulness of the Pre-entry to Medicine program, six weeks into Semester 1. The responses were overwhelmingly that the program, especially the problem-based learning component, had been invaluable to their learning experience. In particular, it had helped students to become aware of the depth of knowledge required for the learning targets (Holliday 2013).

Throughout the week of the Miroma Bunbilla program there is an opportunity to assess the communication skills and ability of the participants to adapt to a new learning environment. In some cases, there was a noticeable change in the students over the course of the program, with several students being shy and introverted at the beginning, but by the end of the week participating actively as team members. This also gave the staff insight into the kinds of academic and tutorial support that participants would need if they were offered a place in the Joint Medical Program (Holliday 2013).

The students who had completed the Miroma Bunbilla program had formed relationships and were familiar and comfortable with each other. This provided an added support mechanism for those who later started the Joint Medical Program (Holliday 2013).

Challenges

The challenges faced when developing alternative pathways into medicine for Aboriginal and Torres Strait Islander people are multi-faceted. These include creating entry processes for potential students who may not meet the standard academic entry requirements (Shannon 2004), and countering the idea that by differing the entry requirement there is a risk of also lowering academic standards (Hensley, cited in Lawson, Armstrong & Van Der Weyden 2007). It was, therefore, important that the Miroma Bunbilla program was carefully developed and piloted.

Although the program was fully supported by the Wollotuka Institute and the School of Medicine and Public Health, approval for the 2012 program was only given three and a half months before it was scheduled to start. This resulted in a number of challenges around scheduling, sending out information to applicants, securing accommodation and confirming staffing – just to name a few (Holliday 2013).

When planning the Miroma Bunbilla program, another challenge was timing. We needed to ensure that the scheduling aligned with that of programs from other universities, the completion of school and university examinations, and the Joint Medical Program interviews for students. If times conflicted with any of these considerations, applicants may have had to choose another medical program.

Conclusion

The outcomes of the 2012 Miroma Bunbilla Pre-entry to Medicine program are preliminary and will form part of continuing research to examine the efficacy of the program and to improve student recruitment, retention and graduation (Phillips 2004). Ethics approval will be sought to allow for ongoing evaluation both to measure and to report on student outcomes. It is hoped there will be a future opportunity to review the outcomes of the participants in the Miroma Bunbilla Pre-entry to Medicine program who are also offered a place in the Joint Medical Program.

The Miroma Bunbilla Pre-entry to Medicine program has now been approved by the Senates of the University of Newcastle and the University of New England. From 2014 it has been a mandatory component Aboriginal and Torres Strait Islander pathway and forms part of a multi-layered approach to student recruitment (Watts et al. 2011).

A further initiative being planned to strengthen Aboriginal and Torres Strait Islander entry is to analyse the results of the Personal Qualities Assessment, which is a psychometric, non-cognitive admissions test (University of Newcastle 2014). By collating the results of those Aboriginal and Torres Strait Islander people completing the Personal Qualities Assessment, we will have the data needed to identify any cultural biases, with a view to using the results to inform the selection process of Aboriginal and Torres Strait Islander students to the Joint Medical Program (Holliday 2013).

Acknowledgment

In the initial planning stages of the Pre-entry to Medicine program, staff from the University of Newcastle visited the University of Western Australia and met with Professor Helen Milroy and staff; there were also discussions with other universities. The information gained from these visits and discussions were invaluable.

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OnCountry4Health: Yorta Yorta Elders lead tomorrow's doctors

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Introduction

The Yorta Yorta OnCountry4Health Program for students in the Doctor of Medicine Course at the University of Melbourne is a joint initiative developed collaboratively between Yorta Yorta Elders, Traditional Custodians and the Melbourne Medical School. This four day, Indigenous–led educational experience for selected Second, Third and Final Year medical students provides an opportunity to hear from Elders and Traditional Custodians about the culture and history of the Yorta Yorta people, how their health has been affected by colonisation and their responses to addressing health needs.

At the University of Melbourne in 2009, transition planning from a Bachelor of Medicine, Bachelor of Surgery (MBBS) undergraduate course to a Doctor of Medicine graduate course was underway. Since 2007 the Australian Medical Council Accreditation Standards have specifically required every medical program in Australia and New Zealand to provide comprehensive coverage of Indigenous health, which includes studies of the history, culture and health of the Indigenous peoples of Australia or New Zealand (AMC 2012). At the time of transition planning, in the MBBS course, these were taught using didactic methods in class room spaces, or in case studies that often saw Indigenous people in a negative light due to the severity of their health issues.

We were also discovering through course feedback that Indigenous health presented a challenge for many students in our existing course, and that the content required deeper thinking and learning in order for them to appreciate Indigenous views and circumstances. Holbrook et al. (2007) note that among students preferring didactic lectures, 'scholarly critical appraisal prove(s) difficult to conceptualise and challenging to accomplish'. Bruce (1994) found that students have to '…attain significant shifts in understanding in order to conceive (their work) as a tool for demonstrating their grasp of theory'.

In addition, Transformative Learning Theory (Mezirow 1997) asserts that individuals must critically reflect on life events in order to change their beliefs or behaviours. Comments from our students indicated widespread disengagement, for example, 'we don't see how history still affects health today' and 'we don't have time for extra reading' (student feedback).

Therefore, the Melbourne Medical School felt a fresh approach was required to address challenges in the teaching and learning of Indigenous health, which led to the establishment of OnCountry4Health.

Aims and Objectives

Our aims and objectives were ambitious! OnCountry4Health aims to increase student engagement with Indigenous health teaching by providing students with an opportunity to hear and see how Indigenous people and organisations are solving health related issues, and to meet Indigenous people while on their lands.

Objectives of the program were that students:

1. Understand the nature and extent of Indigenous occupation and connections with the ancestral lands, past and present
2. Demonstrate an ability to work more effectively with Indigenous communities
3. Be able to articulate a more informed view of Indigenous history culture and health related issues in regional Australia
4. Recognise and respect the Elders as the experts in Indigenous Knowledge.

These four objectives link very closely to the Australian Medical Council's recommendation 3.4 that graduates

> … *understand and describe the factors that contribute to the health and wellbeing of Aboriginal and Torres Strait Islander peoples, including history, spirituality and relationship to land, diversity of cultures and communities, epidemiology, social and political determinants of health and health experiences. Demonstrate effective and culturally competent communication and care for Aboriginal and Torres Strait Islander peoples.* (AMC 2012)

Approach

To begin development of OnCountry4Health, a review of the curriculum was undertaken according to the principles outlined in the CDAMS Indigenous Health Curriculum Framework (Phillips 2004), and applicable graduate attributes chosen with a further brief to seek out engaging pedagogies.

The major gap uncovered in our review of the existing curriculum was around enabling student learning to understand their own worldview, and then being able to use that lens to analyse the health inequities present in many contemporary Australian Indigenous communities. Relating historical events and policies involving loss of cultures, languages, land and spirituality to present-day poor social and emotional wellbeing and life expectancy is complex and demanding of students. If not undertaken carefully, there is a high risk of disengagement and hostility. Many medical schools have sought to counteract this by successfully bringing the wisdom of Indigenous Elders to students, and thereby reasserting their traditional role as 'knowledge keepers' and teachers (for examples of this, see abstracts from LIME Connection IV Auckland 2011 and LIME Good Practice Case Studies 2013).

To this end, we engaged directly with Uncle Wayne Atkinson, Yorta Yorta Elder and accomplished academic, who had been running On Country Learning on his ancestral lands for decades. Together in 2011–12, we adapted the existing program for medical students and incorporated new learning objectives into a subject which became OnCountry4Health 2013 (Atkinson 2013). The resulting program was a transformative experience with traditional Indigenous storytelling meeting transformative (Mezirow 1997) and experiential learning theory (Kolb 1984).

Students had to apply for the limited places available in the program by answering questions about their motivation and prior engagement with communities. This was important because self-awareness around one's own culture and an openness to learn are essential pre-requisites for demanding learning such as this. It was especially important that all our medical students would be mindful of each other – including our Indigenous student participants who may have come from other communities with different cultures and experiences and should not be expected by fellow students to be 'expert'.

Community members had commented in the consultation process that lack of sensitivity on the part of past students during cultural training sessions was painful and caused harm (especially while stories of trauma were being recounted). Because of this, it was important to choose students who demonstrated respectful attitudes. It was also not possible to take the entire cohort of medical students for logistical reasons.

Selected students were required to attend a two-hour pre-course briefing involving cultural protocols (the Protocol of Welcome to Country versus Acknowledgment). This was delivered jointly by Elders and Melbourne Medical School staff, and included questions regarding the pre-course readings (on history, culture, policies and self-determination), as well as an essential health and safety briefing and completion of the risk forms. This briefing also enabled students to ask questions in a culturally safe space.

The course was residential for four days on Yorta Yorta Lands, which included the Barmah–Millewa Forest National Park historical sites where important events for Yorta Yorta Nations took place before and after colonisation (see Atkinson 2013).

Once on site on Yorta Yorta land, students organised themselves into small groups for their accommodation and then three larger groups for the preparation and cooking of an evening meal for the entire group. This student-driven activity was supported by a limited budget to give them a practical experience of the economics, logistics and skills of nourishing large family groups, which is a daily reality for many community members.

The students then met the leaders of the larger Indigenous organisations in the area – Rumbalara Health Service and Rumbalara Football and Netball Club – which provide learning, employment, sports, healing and health services. In 2014 a further medical placement with Yenbena and Viney Morgan Aboriginal Medical Service were added to the experience. There were also separate activities for men and women on one day of the program.

On the last day of the course the students presented their reflections to Elders and Community leaders either individually or in groups, according to student preference. This was an essential component to give the Elders oral feedback and express respect. They also completed a pre-course and post-course attitudinal survey (Paul, Carr & Milroy 2006), which included a qualitative and quantitative survey to gather the students' opinions and assess their engagement with the program.

In the first year of the program, video footage was taken, including student views for educational and community feedback purposes. In keeping with the principles of Indigenous research, there was follow-up with the Elders and Community leaders asking for their feedback and reporting back to them about the outcomes of the student evaluations. These findings are summarised below.

Results

By the conclusion of the four-day program, students were expected to have developed the following attributes, as measured in the comprehensive evaluation:

- An understanding of Indigenous Australians including their history, cultural development and the impact of colonisation on ongoing health disparities (addressed via site visits, film and discussion, Days 1 and 2)
- The ability to respect community values, including an appreciation of a diversity of backgrounds and cultural values*
- An understanding of and respect for the rights of patients including patient choice, dignity and privacy*
- An understanding of the principles of continuity and coordination of health care*
- The ability to learn from patients, health professionals and the community in a broad range of settings.

(Addressed via visits to Aboriginal Community Controlled Organisations, discussions with community members and patients, stories and reflection on Days 3 and 4).*

Students were given hardcopy evaluation forms to fill in while instructors were out of the room. Feedback from the formal evaluation of programs by students in 2013 and 2014 was outstanding.

Table 1: Feedback from formal evaluation of programs by students, 2013 and 2014

Question: This (experience) covered the core content (learning outcomes) rating out of 5 (1 = disagree strongly, 5 = agree strongly)			
2013	**Rating (mean)**	**2014**	**Rating (mean)**
Minimum 23 responses		Minimum 21 responses Excluding Day 3 split	
Day 2 – Morning Visit Historical pre-colonisation sites	4.6	Day 1 – Morning Visit Historical pre-colonisation sites Yenbena Training Organisation	4.4
Day 2 – Afternoon Visit Important post-colonisation event sites	4.2	Day 2 – Afternoon Visit Important post-colonisation event sites	4.4
Day 2 – Evening Discussion Film 'Lousy Little Sixpence'	4.6	Day 2 – Evening Discussion Film 'Lousy Little Sixpence'	4.6
Day 3 – Morning Tour of Rumbalara Health Service	4.6	Day 3 Women: Yarning day with women at Viney Morgan Health Service Men: Further views of the community with Elders	W:4.3
Day 3 – Afternoon Panel and Discussion: Mr Leon Saunders and Mr Lee Joachim Aboriginal stories of health, management of environment	4.6	Day 4 Tour of Rumbalara Health Service and discussion with Mr Leon Saunders (Community Officer)	M 4.0

Table 1 cont...

Question: This (experience) covered the core content (learning outcomes) rating out of 5 (1 = disagree strongly, 5 = agree strongly)			
Day 4 – Morning Feedback to Elders Student presentations	4.2	Day 4 Feedback to Elders Student presentations	4.6
Day 4 – Afternoon Rumbalara Football and Netball Club – watched games and learned about health promotion	3.9	Day 4 Rumbalara Football and Netball Club – learned about health promotion	4.5

The students readily identified the importance of going on Country to participate in innovative learning from the Elders and Traditional Custodians. All respondents who answered the question (N=23/30) reported they would recommend this experience to other students.

Student comments regarding their experience and why others would benefit from doing the course included the following direct quotes:

> *Eye opening, very helpful, enlightening.*
>
> *On Country is the best environment for cultural learning, speaking to Elders and particularly the time spent at Rumbalara.*
>
> *More informative than any other experience so far for increasing understanding of Indigenous health – better than lectures which can be misunderstood.*
>
> *Most effective way of learning about culture and can foster personal interest in the subjects discussed.*
>
> *Provides an essential perspective and context for Indigenous health and future roles as a health care professional.*
>
> *Before the program I had a superficial understanding about Aboriginal culture.*
>
> *The course... touches your humanity and… grows your heart.*

Students also made suggestions for improvement such as:

> *Content on Day 1 and 2 was more difficult to relate to.*
>
> *More time [needed] in Rumbalara Health Service.*
>
> *Readings should have been given earlier and should have been more selective [as] not enough time to read them all.*

One of the 2014 students wrote a challenging reflective piece on the experience, and posted it on the Outlook University of Melbourne Rural Health Club website (Wood-Sit 2014).

Evaluation of the 2015 OnCountry4Health is currently being undertaken, which will result in around 96 students having completed the evaluation in total.

Discussion

Successes

Through the qualitative and quantitative evaluation results, there is good evidence that the program achieved its immediate objectives of supporting students to:

- understand Indigenous occupation and connections with ancestral lands;
- demonstrate an ability to work more effectively with Indigenous communities;
- be able to articulate a more informed view of Indigenous history, culture and health-related issues in regional Australia; and
- recognise and respect the Elders as the experts in Indigenous knowledge.

There is a need for longer term follow-up to see if the students' commitment to good practice in Indigenous health is evidenced by further engagement in relevant electives and scholarly selectives and practices in the workplace. The final more elusive aim relates to having a positive impact on Indigenous health, which would require complex longitudinal tracking.

Indigenous leadership has been supported through the engagement with local Yorta Yorta community members, who have expressed their willingness and excitement at the prospect of training their future doctors. Our Elders and community leaders would like to see a longer term student involvement with the community as further evidence of the students' commitment, leading ultimately to a better experience of health services and equality of health outcomes for Indigenous people. This could happen, for example, through volunteering at sports training. Community members have also expressed interest in mentoring students educationally before they commit to work in the community, post-graduation. However, resources such as employment of Indigenous community liaison staff must be in place to support this respectful exchange.

Challenges

Challenges included limited time to engage students, who are widely spread through nine different clinical schools. This was addressed in part by the enthusiasm and commitment of participants in the course, particularly the Indigenous students, whose proud identification enriched the program and helped to develop significant student engagement in a short time.

The logistics of taking students away from the standard curriculum and their 300 peers in the Medical School was an unexpected difficulty. It involved a variable degree of buy-in from their clinical supervisors in different placements, even though the supervisors had agreed to the students' participation.

Taking students to a somewhat uncomfortable place emotionally, due to their own perceived lack of knowledge in the area, and presenting a different world view to highly accomplished non-Indigenous learners, requires a lot of experience and a careful balance of information and activities. Trying to build trust, while engaging in a critical discourse on the actions of many of the students' colonial predecessors was a balancing act. This was largely successful due to prior supportive conversations with, and learning from, other leaders in Indigenous medical education (for example, at LIME Connection 2011, 2013) and, most importantly, the vast experience of our Indigenous Community leaders.

Basic facilities were available to students, with limited phone and Internet access while On Country, which provoked anxiety in some.

The pilot status of the programs meant that we experienced late notice of funding approval and, therefore, there was some delay in consulting with the Aboriginal Community Organisations.

A challenge to sustain the initiative will be working out how to bring this experiential learning to the other 300 or more medical students enrolled annually at the University. Our Yorta Yorta Elders and Traditional Custodians suggested that we engage with other Elders in other communities. After taking this advice we are now fortunate to have Elders from more communities engaged in developing new programs that aim to provide transformative experiences of Indigenous Knowledges. These include at Bunjilaka Melbourne Museum, and on the land occupied by the Melbourne Medical School through 'Billibellary's Walk', which all of our Year 1 class undertook in 2014 (353 students) and 2015 (360 students). This Aboriginal walk around the University's Parkville campus provides the students with a cultural interpretation of the landscape of the Wurundjeri people's connection to Country.

The final outcome of this program would be to have an impact on the outcomes for Indigenous patients, to close the gap between their health outcomes and those of non-Indigenous peoples. To improve health we need at least State-wide statistics to be able to demonstrate possible effects. This would first involve bringing this Indigenous learning to many more medical and health sciences students training in Victoria. Our own students suggested that all University of Melbourne health science students should do the course, which would be logistically very challenging. Several thought that students in Arts, Social Work, Law and Engineering would also find the course relevant, reflecting their appreciation of the inter-sectoral collaboration required to influence health outcomes.

Conclusion

We have learnt that there is no substitute for On Country Learning to build respect, trust and 'two-way thinking.' We acknowledge that the Elders and Traditional Custodians have a long tradition of sharing unique and complex knowledge in many contexts and that some medical schools have taken this further, for example, by having Elders in Residence as part of their programs and advising at governance level within the medical schools. This will be an avenue to pursue further in the coming years.

OnCountry4Health adds to the increasing body of knowledge supporting Indigenous knowledge and on Country learning as a critical component in the training of doctors to address Indigenous health inequity. In so doing, it moves the curriculum towards increasing social accountability (Boellen & Wollard 2009).

Acknowledgments

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Documenting the process and completing the evaluation was essential to ensure ongoing sustainability and Faculty support.

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Developing a cultural immersion approach to teaching Aboriginal and Torres Strait Islander health and culture

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Introduction

For more than a decade, medical schools in Australia have had defined standards and guidelines to follow in implementing their Aboriginal and Torres Strait Islander health curriculum. However, like many other medical schools, Bond University struggled to implement these professional standards and guidelines into its curriculum (Phillips 2004; AMC 2012; RACGP 2011).

In 2011, Bond commenced the renewal of its Bachelor of Medicine and Bachelor of Surgery (MBBS) curriculum and developed an innovative Aboriginal and Torres Strait Islander health program that is now fully integrated into the first three years of the undergraduate medical program. The First Year program focuses on 'building awareness' (Smith 2013), and the Second Year on 'respecting difference', with students undertaking three one-week cases that are identified as Aboriginal or Torres Strait Islander focused (Smith 2013). Third Year looks at 'building resilience', and contains a significant component of social and emotional wellbeing content and a challenging discussion about racism (Smith 2013). The role of Aboriginal Community Controlled Health Services is included to enable students to understand different models of care and services offered.

This case study focuses on using cultural immersion as part of the First Year of this integrated Aboriginal and Torres Strait Islander health curriculum.

Aims and Objectives

The overall aim of the program was to enable Bond medical students to provide culturally appropriate care to Aboriginal and Torres Strait Islander peoples and thereby contribute to improving their health status.

The learning objectives of the cultural immersion program were drawn from the Committee of Deans of Australian Medical Schools (CDAMS) Indigenous Health Framework (Phillips 2004). They include having an understanding of Aboriginal and Torres Strait Islander history as a continuum from pre-contact to the present and its relevance to current day health outcomes; and on students realising and acknowledging, through self-reflection, their own attitudes, beliefs and cultural values and the implications of these on providing culturally appropriate health care.

Approach

As a first step to developing the new curriculum, the Indigenous Health Team reviewed the available literature to identify what had worked well elsewhere. We found that cultural immersion was identified as a plausible and well-defined initiative for introducing cultural awareness training to medical students (MDANZ & AIDA 2012). Therefore, we decided to use immersion as our method for delivering Aboriginal and Torres Strait Islander health content early in the program.

The next step was to consult with the right people. In 2011 we established a high-level, multi-cultural Indigenous health group (n= nine), which comprised two Aboriginal doctors, an Aboriginal Elder and educator, a non-Indigenous doctor who works in an Aboriginal Medical Service (all external with fractional academic appointments), as well as five non-Indigenous academic staff – two senior educationalists, a clinical ethicist, an anthropologist and a research psychologist. The group met on a regular basis, both face-to-face and via teleconference, to discuss the design and development of the immersion program.

We mapped the learning objectives against the Australian Medical Council Accreditation Standards (AMC 2012), the Royal Australian College of General Practitioners (RACGP 2011) and the CDAMS Indigenous Health Framework (Phillips 2004) to determine the Aboriginal and Torres Strait Islander educational content to be taught; and then developed our teaching and learning approaches to meet the standards set by the profession. Our implementation plan was guided by seven principles upon which to base our activities:

1. Commence the program early
2. Teach international perspectives first
3. Conduct the program in safe interactive environment
4. Teach confronting issues later in the program to avoid interpersonal barriers to difficult topics, i.e. racism
5. Undertake the compulsory cultural immersion offsite
6. Make the program innovative and fun using methods that engage and inspire the learner rather than disempower
7. Continually evaluate and publish the work.

We then developed the immersion materials, which included educational resources, a step-by-step facilitator guide, a program and information about facilitators, as well as undertaking significant administrative processes – organising buses, consent forms, finding a site and lodging arrangements for 110 people, insurance, risk management, food and so on.

In November 2012 we conducted a pilot cultural immersion activity after approximately six months of preparation. We took the whole cohort (n=93) of First Year medical students on an overnight cultural immersion activity to a camping location at Springbrook in the Gold Coast hinterland. This was scheduled early in the semester, some 21 weeks after their course enrolment.

So what did we teach? Prior to the immersion we introduced students to cultural issues from an international perspective, to avoid any preconceptions and biases about Aboriginal and Torres

Strait Islander Australians. This was done through two prerequisite lectures: ‘What is culture?’, from an international perspective, and ‘Social determinants of Aboriginal and Torres Strait Islander health’, using a storytelling approach.

We briefed the students and the facilitators the week prior to the immersion. Students then travelled on two buses to Springbrook and were divided into four smaller groups of approximately 24 people. The immersion consisted of multiple 50-minute cultural education sessions (eight in 2012; nine in 2013 and in 2014) conducted by Indigenous and non-Indigenous facilitators (n=14). Table 1 describes the sessions and a brief description of the activity.

Table 1: Session titles and descriptors

Session (50 minutes each)	Description of the session
Culture and identity	Students draw their culture on butcher’s paper – their cultural beliefs, values, traditions – and discuss their drawing with the group.
Storytelling	An Aboriginal woman tells her own personal story that raises many historical issues, e.g. poverty, the stolen generation, racism, oppressive history.
History maps	Using history maps (Education Queensland [n.d.]) students, in groups of three, examine the historical pictorial messages. They then present the historical account to the whole group and discuss.
Torres Strait Islander session	A Torres Strait Islander facilitator describes the history of the Torres Strait while two women weave during the storytelling. Students then have an opportunity to weave and ask questions.
Join the dots	Students are given a postcard with a dot painting and health promotion message on it, upon which to write the story of the postcard, and send it to someone. The whole group discusses the painting message. It is based on the Karulbo resource (Karulbo – Gold Coast Aboriginal and Torres Strait Islander Partnership Advisory Council [2012]).
Culture and community survival	Students bring their drawing from the previous day and categorise their culture into one of three categories – concrete, behavioural and symbolic – using sticky notes. These are placed on the wall in order of priority. The facilitator then removes one of the categories and discusses how it felt to lose this part of their culture, and relates it to Indigenous history.
Talking circle evaluation	Based on the Canadian model, the students sit in a circle and take it in turns to speak. They do this by passing a stick around and talking, only when they have the stick, about what they learnt, what was good, what wasn’t, and what they learnt about themselves during the immersion. Other students can’t speak when the person holding the stick is talking.
Evening session	This is a relaxed fun session that we have undertaken in two different ways. The first was a cultural festival evening in 2012–13. The second, in 2014, was run by BUSHFIRE Bond’s rural health club and included a games night with multiple activities and a trophy for the winners.
Written evaluation	Students completed the written evaluation form about all aspects of the immersion.

All activities were conducted in small groups and included an interactive activity, discussion, reflection and feedback.

We used a variety of educational methods such as history maps (Education Queensland [n.d.]), the Canadian talking circle, and having the students draw and then discuss their own culture in an effort to assess the impact their own cultural beliefs and traditions have on another's culture.

A comprehensive evaluation process was undertaken. This included a confidential talking circle evaluation, and a paper-based evaluation form with a ranking of statements of agreement, using a five-point Likert scale, based on the learning outcomes (Smith 2014a). Following refinements, the cultural immersion was repeated in 2013 with 95 students and again in 2014 with 94 students. Ethics approval was gained through Bond University Ethics Committee in 2012.

Assessment of the learning outcomes involves a compulsory assignment, whereby students are required to draw a concept map, which graphically makes the links between the history of Aboriginal and Torres Strait Islander Australia with the resulting health outcomes. The students then write a 500-word explanatory statement and reflection. This is proving to be a powerful process as it enables students to personally link their own thoughts and emotional reactions to the history of Aboriginal and Torres Strait Islander Australia with their own cultural and personal experiences.

In 2013, as a result of student feedback, a lecture was added the day following the immersion that applies the links between Aboriginal and Torres Strait Islander history and health outcomes, as an appropriate clinical end cap to the event.

Results

The response rate to the evaluation was 96.8% (n=271, pooled cohorts 2012–2014). Data from the pooled cohort evaluation forms were entered separately into SPSS analytics software and three reports were written to the Faculty with recommendations for improvement. Descriptive statistics were reported alongside themed qualitative data.

Students overwhelmingly reported a very positive experience, and identified the greatest strength of the immersion as being the facilitators. This group consisted of the initial development team of nine, as well as three Torres Strait Islander facilitators, three Aboriginal dancers and the Bond Indigenous Support Officer who told her own personal story, which had the most significant reported impact on the students.

Students (n=271, pooled cohort 2012–14) strongly agreed that the workshop was well organised (M=4.23); that the facilitators contributed very positively to their experience (M=4.33); and that they were very satisfied overall with the activity (M=4.23). They also agreed that the preparation materials provided them with sufficient information about the workshop (M=3.87). As a result, students felt they met the workshop's overall objectives and stated they could describe the influence of culture on perspectives, attitudes, assumptions, beliefs and behaviours (M=4.25); that they could identify their own cultural values and reflect on the related implications for health care (M=4.18); and that they could identify their own emotional reactions to the history (M=4.26). Students agreed that they now felt more confident with Aboriginal and Torres Strait Islander peoples (M=4.15) and could explain the connection between history and health outcomes (M=3.92).

In the evaluation of the individual sessions the students (n=271) strongly agreed that the Storytelling session enabled them to understand first-hand the impact that the history of Aboriginal Australia has on health outcomes (M=4.71).

> *Hearing the first-hand experiences and interactive nature of activities, it was all really engaging and made issues at hand more real and tangible.*

> *Having Aboriginal and Torres Strait Islander people able to personally tell us what's important to them and what has shaped their lives – we can learn history and health care in lectures, but it's invaluable for them to share their culture with us.*

The 'best thing' identified by 57.5% of students about the immersion was overwhelmingly (n=104) the 'Storytelling' session, followed by bonding with the cohort, the Torres Strait Islander session and learning more about culture. Some described it as a life changing experience.

> *Before I came here I thought I could find all this information in a book or on the web, but having experienced what I have the past two days is something that will stay with me for the rest of my life.*

The item identified as needing most improvement was the food (n=77), followed by the accommodation (n=55).

Discussion

Successes

The cultural immersion activity provides a platform upon which students can learn about Aboriginal and Torres Strait Islander health issues in a safe and culturally appropriate environment, and through fun and innovative activities. In many cases it has given students a hunger for more, with several third year students reporting that the immersion sparked in them a keen interest to work in this important area.

The immersion is now a standard, fully integrated and compulsory part of the MBBS program (Smith 2013). This was achieved through having strong leadership, a dedicated team and support from the Faculty – providing a solid platform from which to base the program.

The features that make this immersion such a success are:

1. Strong leadership and support from the Faculty and School Deans throughout
2. The diverse cross-cultural team who work closely and collaboratively on all aspects together
3. That this is a normal part of the normal curriculum – it is compulsory, it is assessed, it comes from the normal budget, it is not something extra that can be cut in times of budgetary restraint
4. Educating all academic and administrative staff about why it is important and what we do, so that they can become our supporters and champions
5. Having a set of implementation principles upon which to base it.

As well as the positive student feedback, another positive outcome of the ongoing program has been the 0.6FTE employment of an Aboriginal doctor as the Aboriginal and Torres Strait Islander discipline lead, in early 2015. And in 2014 the team won both the Faculty and the Vice Chancellors

Awards for Teaching Excellence for this work. In 2015 we are establishing remote Indigenous community placements for final year students where they can apply the knowledge and skills they have gained throughout the program.

Challenges

The main challenges related to organising the teaching and administration team, who lived in various parts of the nation and worked on fractional appointments. The administration and logistics required in getting 100 people in one place at one time and making it work was at times challenging.

An additional challenge was that students found some of the content difficult and confronting.

> *The self and community survival session really effectively gave me more a personal perspective on a loss of culture by using Indigenous cultures as a vehicle to also learn about the cultures of other members of the cohort; identifying what's important about my culture and reflecting about what would happen is something is taken away… it was really powerful* (Student, 2014).

Conclusion

We believe that undertaking cultural immersion so early in a program is proving to be extremely successful in providing the platform for students to learn more about Aboriginal and Torres Strait Islander health. However, it is only one part of an overall three-year program at Bond based on the standards and guidelines of the profession. It is now time to consolidate and build upon this important work, which will hopefully enable Bond medical students to work towards improving the health status of Aboriginal and Torres Strait Islander peoples by providing culturally appropriate care.

We are also in the process of publishing our evidence-based work (Smith et al. 2015; Smith 2013a; Smith et al. 2013; Smith 2014 & 2014a; Springer & Murphy 2013), and have made videos, developed workshops, written nine one-week Indigenous cases, delivered lectures, and provided opportunities for students to discuss these issues in safe learning environments. We are also sharing our learning with others in the field, with one representative attending the 2014 cultural immersion with the aim of implementing a similar initiative in their own institution.

The Indigenous Health Group is also undertaking a five-year longitudinal study to measure the impact of these cultural awareness activities on students, as there is currently little documented evidence about the impact of such activities (Sopoaga et al. 2012). Initial results indicate an attitudinal shift in, and improved cognitive links between, the immersion activity and the students' comprehension of the social determinants of health.

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'Don't make it a specialisation... Make it mandatory...'

Professor David Paul,[1] Dr Paula Edgill and Assistant Professor Craig Allen, The University of Western Australia, Australia

Introduction

The Centre for Aboriginal Medical and Dental Health (the Centre) has responsibility for the Aboriginal health curriculum within the health professional courses offered by the Faculty of Medicine, Dentistry and Health Sciences at the University of Western Australia (UWA). In 2000, the Medical School introduced a refreshed and updated curriculum for its six-year Bachelor of Medicine, Bachelor of Surgery (MBBS) program. Staff at the Centre used this opportunity to introduce a more comprehensive horizontally and vertically integrated approach to teaching and learning Aboriginal health. The new curriculum included core Aboriginal health content for all students and the creation of Aboriginal health-specific options, selectives and electives across each of Years 2 through 6.

Given the substantial commitment and engagement that some students were showing by enrolling in every option in Aboriginal health across the medical course, it was decided this should be appropriately recognised by the Faculty and University. Consequently, in 2007 an Aboriginal Health Specialisation was formally approved at School, Faculty and University levels, and students who successfully completed all of its requirements would have this recorded on their official academic transcript.

In 2012, an evaluation was undertaken with the relatively small number of graduates (five) who had to date completed the Specialisation and finished their internship to gain feedback on their experience of its value and impact on their work. This case study presents the results of this evaluation of the Aboriginal Health Specialisation.

Aims and Objectives

The aim of the enhanced Aboriginal health curriculum has been to graduate medical practitioners who have a greater preparedness and effectiveness when working with Aboriginal people, communities and organisations. In other words, it aims to contribute to improving the quality of health care available to Aboriginal people.

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1 David Paul was the long-term Deputy Director of the Centre for Aboriginal Medical and Dental Health and oversaw the development, implementation and evaluation of the Aboriginal Health Specialisation. He is currently the Associate Dean of Aboriginal Health, School of Medicine, University of Notre Dame Australia, Fremantle, WA.

Objectives of the Aboriginal Health Specialisation are to:

- encourage students in the MBBS to enrol in more of the Aboriginal health options; and
- recognise more appropriately those students completing all of the Aboriginal health options offered.

The aim of the evaluation presented in this case study is to capture a sense of the utility of the Specialisation and to assess the influence it may have had on graduates, with a particular focus on their chosen locations for work.

Approach

The development of the new teaching and learning initiatives in the MBBS were guided by agreed year and graduate level outcomes in Aboriginal health, which were developed and formally approved in 2003 (Paul, Carr & Milroy 2006; Paul 2012).

Throughout Years 2 to 6 of the MBBS, students have some choice in relation to one of the required areas of study. This enabled the Centre to develop, implement and offer an opportunity to engage in more detailed teaching and learning activities in Aboriginal health in each of those five years, to form the Aboriginal Health Specialisation. These activities are:

- Year 2 – A semester-long Aboriginal health and wellbeing unit (the equivalent of 25% of a full-time load for the semester – with the unit coordinator a Centre staff member)
- Year 3 – A semester-long Aboriginal community organisation placement unit (the equivalent of 25% of a full-time load for the semester – with the unit coordinator a Centre staff member)
- Year 4 – An approved Aboriginal research project to meet the requirements of the Research and Discovery unit (at least one Centre staff member is usually a supervisor of the project)
- Year 5 – Two approved two-week, Aboriginal health related selectives
- Year 6 – An approved Indigenous health-related, six-week elective (either in Australia or overseas).

The Coordinator of the Specialisation kept a record of all of the students enrolled in the Specialisation. For components that included some choices available to students, especially in Years 4 through 6, the Coordinator consulted with them about their options. Students were required to get the Coordinator's approval of their final choice to ensure that the requirements of the Specialisation continued to be met.

Some elements of the Specialisation were offered thanks to the partnership and collaboration developed with colleagues via the Leaders in Indigenous Medical Education (LIME) Connection and Pacific Region Indigenous Doctors' Congress. For example, some of the Year 6 clinical elective sites undertaken by the graduated Specialisation students have included:

- Derbarl Yerrigan Health Service, Perth, Western Australia, Australia
- Moose Factory and Queens University, Canada
- Elbow River, Calgary, Canada
- John A. Burns School of Medicine, Hawaii
- Baker Institute, Alice Springs, Northern Territory, Australia.

Ethical approval for this evaluation was obtained from the UWA Human Research Ethics Committee (RA/4/1/6196). Approval was also sought from the Western Australian Aboriginal Health Ethics Committee, which decided that its approval was not required for this project.

All of those who had completed the Aboriginal Health Specialisation were well known to its Coordinator, which meant that the work location of the potential participants was also known. In order to reduce the influence of the established connection between graduates and students, and the Centre's staff, on potential participants agreeing to participate or not, a research officer working at the Centre on the Educating for Equity project (funded by the National Health and Medical Research Council) undertook the recruitment and data collection.

The evaluation was in the form of semi-structured interviews, carried out in the middle of 2013, that were recorded for some participants but, for technical reasons, not all. Rather, for some interviews, notes taken by the interviewer were used as data. The interviews were conducted face-to-face, by telephone or via Skype as participants were working across Australia including in Perth, the Kimberley, the Northern Territory and Victoria. Only those graduates who had completed their internship were approached to participate in the evaluation in an attempt to better capture more accurately the influence that the Specialisation may have had on graduates chosen locations for work.

Results

Definitely resulted in me working where I am now...

The first two students completed the requirements of the Aboriginal Health Specialisation in 2008, and by the end of 2012, 41 students had commenced the Specialisation. At the time of the evaluation 11 of these had completed the Specialisation, 23 were still undertaking it and seven had finished their MBBS degree but had not completed all the requirements of the Specialisation. Twenty per cent of all the students undertaking the Specialisation have identified as Aboriginal (Table 1).

Table 1: Aboriginal Health Specialisation (AHS) – Total commencements 2008–12

Graduated with AHS	Currently completing AHS	Graduated without completion of AHS	Total AHS commencements
11	23	7	**41 inc. 8 (20%) Aboriginal**

Of the 11 graduates who had completed the Specialisation at the time of the evaluation, only five had also completed their internship, with the remaining six still undertaking it (Table 2). As noted above, this evaluation was particularly focused on gaining a deeper understanding of the choices and experience of graduates who had begun to decide on their work location. For this reason, interns were not included in the evaluation, as they have more restricted options regarding location of work.

Table 2: Aboriginal Health Specialisation graduates

Internship completed	Internship being undertaken	Total AHS graduates
5	6	11

The following summarises the work locations of these five graduates (graduating between 2007–2011)[2] since completing their internship:

- Completed internship in rural location – 2
- Currently working in an Aboriginal health setting – 2
- Rural practice experience since graduating – 5
- Pursuing further study – 2 (1 in an Aboriginal health context).

It is of interest that all five participants have worked in rural settings since graduation. Across the whole of the MBBS student cohort, 4.7% chose to work in rural settings (Playford et al. 2014) compared with 100% of the Specialisation graduates so far. Further, in the core and optional teaching in Aboriginal health at UWA, particular care is taken to counter assumptions that Aboriginal people in Western Australia live predominantly in rural areas.

As noted at the beginning of this section, one graduate who is now working in the Aboriginal Community Controlled Health sector stated that the Aboriginal Health Specialisation 'definitely resulted in me working where I am now...'. Such a claim captures the value of having a structured, course-long engagement with Aboriginal health. Having established the Specialisation with the explicit aim of building the future Aboriginal health workforce, such sentiments are reassuring. However, our aim has not been solely about graduating practitioners interested in working in Aboriginal health, but also training practitioners who are better prepared to work with all. One participant commented that the Specialisation had helped them to be a better practitioner 'even if you do not end up working in an Indigenous setting…'

Discussion

Successes

> *I feel that you and CAMDH [Centre for Aboriginal Medical and Dental Health] have put me on this path, so I am very grateful :)*

The Aboriginal Health Specialisation was established to provide an incentive to encourage students in the Bachelor of Medicine, Bachelor of Surgery program to enrol in more of the Aboriginal health options offered across the six-year course, as well as to recognise more appropriately those students who were completing all of the options offered. The small numbers completing the Specialisation to date mean it is hard to draw substantial conclusions from this evaluation.

However, with a significant number of students commencing the Specialisation and a relatively good completion rate so far, it appears to be providing focused learning opportunities that are helping to guide graduates along the 'path' of working in Aboriginal health. The enthusiasm for the Specialisation from those graduates interviewed was considerable. Being driven by an Aboriginal-led Centre within the Medical School, with a majority of Aboriginal staff, has also helped to model the leadership, skill and capacity of Aboriginal people in the Aboriginal health field and to provide

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2 While the Specialisation was not approved until 2007, its electives and other components were offered from 2001. Hence, the first graduates were able to complete the Specialisation in 2008.

evidence of collaborative partnership of Aboriginal and non-Aboriginal professionals working together in partnership.

In 2013, the restructuring of the UWA degree program – to offer only four-year undergraduate degrees and to move all professional courses to Masters level – meant the Centre was able to develop and implement an Aboriginal health and wellbeing major for students in Bachelor of Arts or Bachelor of Science programs.

Challenges

Developing and maintaining the Aboriginal Health Specialisation requires an ability to engage with partner organisations and colleagues to ensure we have adequate numbers of suitable student placements in Years 3–6. It can sometimes take up to six months, for example, to arrange an elective outside of Australia, requiring considerable resilience and patience on the part of the students and those trying to organise the elective. Managing such things, as well as keeping track of each student's journey to ensure that those who successfully complete the Specialisation get the appropriate recognition from the Faculty and University, takes time and effort despite an already full workload.

Changing over to the four-year Doctor of Medicine program led to a review of the Aboriginal Health Specialisation, and the following modifications to its existing requirements:

- Year 2–4 – A scholarly activity (either at a community organisation placement or a research focus)
- Year 4 – A clinical elective (approved by the Centre for Aboriginal Medical and Dental Health and in an Indigenous health setting)
- Reflective portfolio (Aboriginal health-related reflections across all years)
- A detailed reflective Aboriginal case report from each clinical year.

The new structure of the Specialisation in the Doctor of Medicine, which began in 2014, was formally approved at Faculty and University levels in 2013. Whether this has the same uptake or impact as in the MBBS program is yet to be seen. Managing the Specialisation across the MBBS and the Doctor of Medicine, as well as the Aboriginal Health and Wellbeing major in the undergraduate degrees, will be a time-consuming task. Whether this remains sustainable without additional resources is an unknown at this stage.

Conclusion

> *Don't make it a specialisation... make it mandatory...*

We recognise that this is an early evaluation of the utility and impact of a program, but given the strength of our anecdotal evidence – that many of those who had completed the Specialisation were working in locations where it was likely that Aboriginal health would be a significant part of the graduate's usual work – we wanted to be able to confirm this, or not. The evaluation has shown that a significant proportion of the students completing the Aboriginal Health Specialisation now work in both rural areas and locations with a high proportion of Aboriginal peoples. Two (40%) of the graduates are working in Aboriginal-specific health services and one (20%) is undertaking an Aboriginal health research project at Masters level.

In other words, a structured enhanced learning program such as the Aboriginal Health Specialisation, that students can choose to undertake within a medical course, could provide a significant shift in future work choices. From this early evidence, the Specialisation appears to be making a substantial contribution to building the future Aboriginal health medical workforce. We look forward to following the career choices of its graduates to see if the dream continues to be realised.

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- Our Centre for Aboriginal Medical and Dental Health colleagues who contributed to the development and teaching of the Aboriginal Health Specialisation.
- Staff of UWA's Faculty of Medicine, Dentistry and Health Sciences who supported and enabled the initiatives to be formally ratified and then implemented.
- The students and graduates who are completing or who have completed the Aboriginal Health Specialisation as a part of their medical degree.

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Developing an enhanced Aboriginal health curricula for medical student engagement

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Introduction

Flinders University School of Medicine delivers a four-year Doctor of Medicine program across South Australia and the Northern Territory. Since its establishment as a Graduate Entry Medical Program in 1996, the program has followed a Problem Based Learning pedagogy. This approach allows students to clinically analyse a patient case to achieve core learning outcomes, with limited guidance and facilitation from tutors. Student learning is then supported through lectures and practical sessions.

Aboriginal health has predominantly been treated as non-core material in the medical curriculum, an 'add on' that is not considered critical to achieving key clinically orientated learning outcomes in medicine. This is despite the Medical Deans Australia and New Zealand's endorsement of the Committee of Deans of Australian Medical Schools (CDAMS) Indigenous Health Curriculum Framework that provides guidelines on how to deliver Indigenous health into core medical education (Phillips 2004).

To date, Aboriginal health has been delivered at Flinders University through the occasional lecture, elective, and Problem Based Learning cases with limited student engagement. Problem Based Learning tutors have been known to spend little time on the Aboriginal health component, in part due to the course's strong focus on Western medical sciences, but also due to the tutors' own discomfort with Aboriginal health content (staff and students personal communication and informal self-reporting). Even though the Australian Medical Council's (2012) Accreditation Standards stipulate that Aboriginal people should be employed to work on the development and management of all Australian universities' medical programs, staffing for teaching Aboriginal health continues to be under-resourced.

For these reasons a project was conceived to develop a robust curriculum and pedagogical approach for integrating Aboriginal health into the core medical curriculum, with a focus on the principles of cultural safety.

Aims and Objectives

Over the years, Student Evaluation of Teaching surveys have demonstrated that large numbers of past students have a clear lack of understanding as to the rationale for, and importance of, learning about Aboriginal health. This is particularly evident with the content around history, society and culture, and understanding how these are relevant to their future medical practice.

Written feedback from students has varied from positive to negative and often contradicted the core learning in this area (Table 1). Rasmussen (2001) suggests such feedback demonstrates a student cohorts' own uncertainty with the topic material, which can be related to the pedagogical approaches utilised.

For some medical students, educational content relating to Aboriginal health and cultural safety training is challenging in nature, as it often requires them to confront deep-seated assumptions and stereotypes they have held for years. Other students report feeling 'guilty', 'blamed' or 'assumed to be racist' when the material is presented to them (Ryder et al. 2011; Ryder & Burton 2012; Ryder et al. 2013). Macdonald (2002) has demonstrated that when students feel confronted and personally challenged in their learning, a supportive learning process is necessary for them to unpack and work through their own emotional response to the material. As a result, Rasmussen (2001) and Phillips (2004) suggest that Aboriginal health pedagogical approaches relying primarily on lecture-based formats can be a significant barrier to learning in this area, as these environments do not allow students to explore and challenge their assumption base to the same extent that tutorials with peers do.

Table 1: Student feedback – 2010 half-day Cultural Safety Workshop: Year 1 students' first introduction session to Aboriginal health in the medical program

Positive feedback	Constructive feedback
Concept of Aboriginal people and their life and recent history was valuable.	Lots of white people have had different abusive lives but no recognition is given to them.
It wasn't just 'throwing facts' at the audience, I thought about Indigenous health in a way I haven't expected! Very moving, especially the video!	Information about other 'less' appealing aspects of Aboriginal society instead of portraying Indigenous people as having no say in what happens to them, just victims of white people.
Panel was fantastic – great speakers and I felt privileged to hear their personal experiences and views.	A lack of non-Aboriginal cultural issues, e.g. what about Muslim/Asian patients?
Practical considerations in working with Aboriginal patients!	Need more PRACTICAL examples of PATIENT good vs bad.

This project aimed to develop a new curriculum and pedagogical approach for teaching Aboriginal health in the Flinders University Doctor of Medicine course. Its objectives were to:

- increase medical students' engagement with and understanding of Aboriginal health
- increase medical students' understanding of the relevance of Aboriginal health to their future practice
- situate Aboriginal health as core curriculum within the Medical School
- update the pedagogical approach to teaching Aboriginal health within the Doctor of Medicine.

Approach

The project was managed by the Indigenous health lecturer (Project Manager) responsible for Aboriginal health in the Doctor of Medicine program, through the Adelaide Poche Centre for Indigenous Health and Well-Being. The Australian Medical Council Accreditation Standards and CDAMS Indigenous Health Curriculum Framework were used to inform the development of the new curriculum and pedagogical approach, which includes both a focus on social accountability and on the Aboriginal communities with whom Flinders University engages (Arrernte, Boandik, Bungarla, Gunditjmara, Jawoyn, Kaurna, Larrakia, Nauo, Ngarrindjeri, Peramangk, Ramindjeri, Wurundjeri, Yolgnu).

In order to embed Aboriginal health in the curriculum, both the first and second year Health Professions and Society topics in the medical program required redesign. This necessitated collaboration and negotiation with key stakeholders in ethics, law, public health, statistics, epidemiology, research methods and pharmacology to make room in the curriculum for Aboriginal health. These collaborations led to an enhanced Health Professions and Society curriculum that integrated complementary learning themes. The Flinders University School of Medicine's Medical Course Committee approved the inclusion of five tutorials and one workshop in first year, and four lectures in second year, all focusing on Aboriginal health and cultural safety. This increased the teaching time of Aboriginal health in the curriculum from 10 hours to 21 hours, of which 15 hours were newly created content.

Before designing the lectures, tutorials and first-year workshop, the Australian Medical Council Accreditation Standards and CDAMS Indigenous Health Curriculum Framework were thoroughly reviewed. In addition, past feedback from the Flinders University Indigenous Reference Groups (Darwin, Alice Springs and Adelaide) was considered to establish a foundation for a curriculum that met the needs of local Aboriginal communities as well as satisfying national standards. Adelaide Poche Centre staff workshops were then held to develop learning objectives, assessment, pre-tutorial work, and tutorial pedagogical approaches to align with accreditation requirements and community needs.

Table 2: Indigenous Health in Year 1 and Year 2

Session	Title	Content
1: Year 1	Cultural Safety Seminar	Students examine various definitions of health and are introduced to cultural safety and patient-centred care in Aboriginal health.
2: Year 1	Introduction & Context of Indigenous Health	Students explore the definition of Aboriginal health in context of their future practice, with a strong focus on Aboriginal identity and correct terminology.
3: Year 1	Policies Past & Present	Students review past Australian government policies and their continued impact on Aboriginal health today, along with their own individual emotional reactions.
4: Year 1	Indigenous Health Models	Students consider holistic health and critically analyse implications from competing health theories including their own definition of health.

Table 2 cont...

Session	Title	Content
5: Year 1	Racism and Indigenous Health	Students examine different forms of racism in health practice and identify strength-based approaches to targeting such racism in the health workplace.
6: Year 1	Communication in Indigenous Settings	Students explore resilience, reciprocity and ownership, recognise strength and capacity, and explain their roles working in Indigenous health spaces.
7: Year 2	Aboriginal Health in Mainstream Settings	Students examine Aboriginal health in mainstream health settings, considering services available and the role of Aboriginal Health Workers.
8: Year 2	Aboriginal Community Controlled Health Organisations	Students explore Aboriginal Community Controlled Health Organisations, consider how they differentiate from other Aboriginal health services and examine the importance of capacity and resilience in these settings.
9: Year 2	Cultural Safety	Students examine specific cultural safety tools used in the health setting for their future health practice.
10: Year 2	Reflection of Practice	Utilising teaching sessions from first and second year students consider the importance of reflection for their future practice.

An important element of the curriculum has been the introduction of pre-tutorial vignettes into the Health Professions and Society curriculum, providing a different approach to learning about Aboriginal health. The vignettes consist of a short, recorded interview in which the questions were designed to underpin the learning objectives and tutorial work. Vignette participants included a range of non-Indigenous health professionals and academics, along with Aboriginal health professionals, academics and senior community representatives from Aboriginal communities across Flinders University's sites.

Each vignette started with two main questions:

- So tell me a little bit about yourself, what do you do?
- What culture or cultures to you identify with?

Other questions relate specifically to the topic being taught, for example, holistic health practice:

- How do you define holistic health practice?
- What role do health professionals play in holistic health planning?

All interviewees were approached by the Project Manager to participate in the vignettes. Those who were willing to be included were provided with the interview questions before the recording and asked to sign a release form allowing the Adelaide Poche Centre to use their vignette through the Flinders University online learning environment. All vignette recordings, editing and publishing were conducted by the Project Manager.

While the vignettes are not currently linked to Problem Based Learning cases, it is intended that they will be linked in the future as part of the Doctor of Medicine curriculum.

Results

The pilot Aboriginal health curriculum was first run in 2013 with 100% of the student body participating in the Student Evaluation of Teaching survey at their last tutorial. Students were asked to comment on what components of the curriculum best helped them to learn and how their learning could be better supported.

Table 3: Student Evaluation of Teaching feedback from 100% of Year 1 medical student body, 2013

Positive feedback	Constructive feedback
Applying history to current events and patients.	The pre-tutorial work was too long.
I found engaging with and listening to real-life Aboriginal stories and health scenarios was the best part of this course for me.	I felt reflections were a waste of time, as did many other people. We could have been taught some real-life strategies and protocols in how to deal appropriately with Aboriginal patients.
The case studies really helped build clinical experience.	I would've preferred a little less reflecting and a bit more how-to when dealing with Aboriginal patients.
Real-life scenarios/case studies.	
Open discussions with peers in tutorials.	

The surveys provided important feedback to enhance the curriculum for 2014. The feedback clearly showed that students most enjoyed those clinical case studies developed from real-life scenarios that Adelaide Poche Centre staff and their families had experienced. The case studies connected to the learning objectives and built on the pre-tutorial vignette material. Modifications following the evaluations included altering tutorial session activities, and changing the assessment task to a major reflective piece and weekly online multiple-choice questions strongly linked to pre-tutorial material.

Student Evaluation of Teaching surveys were conducted again in 2014 with an 88% completion rate. Of these students, 94% agreed they had developed/enhanced their understanding of Aboriginal perspectives and knowledge. This was supported by improved student assessment performance that year. Table 4 shows Student Evaluation of Teaching feedback utilising the same questions as in 2013.

Table 4: Student Evaluation of Teaching feedback from 94% of Year 1 medical student body, 2014

Positive feedback	Constructive feedback
The Aboriginal tutorials were the most valuable part of the course, engaging me in the topic and allowing me to consider issues from different perspectives. It really helped me understand some of the issues and relevance to my future practice.	Sometimes there was too much reading to do beforehand… a lot of tasks to complete during the tutorials, and not enough time to do them.
The group activities and the videos helped me understand about the problems involving race, and the disadvantages Indigenous Australian people have when it comes to health care.	I honestly believe that students would gain more from spending a week in an Indigenous community.
I found the Aboriginal health tutorials the most beneficial, especially as we got first-hand perspective and stories.	
The tutorials were the aspect that most assisted my learning. Mostly, the pre-readings were thought provoking and generated much (useful) discussion within our tutorial group. I found that the assignment was a useful way to tie the information together, despite being difficult to get under the word limit with all the things I wanted to talk about!	

In 2014 the Adelaide Poche Centre obtained ethics approval from the Flinders University Social and Behavioural Research Ethics Committee (project number 6038) for validation of a Cultural Safety and Indigenous Health questionnaire. This questionnaire is in the process of being published, and in 2016 will be utilised to evaluate student engagement and the curriculum further, along with staff evaluation of teaching.

Discussion

Successes

Student Evaluation of Teaching surveys from the 2014 Aboriginal health component demonstrated improved student engagement and satisfaction with teaching methodologies and content from previous years. The modifications for the 2014 curriculum were led by an Aboriginal academic and supported by other senior Aboriginal academics in the Adelaide Poche Centre. All of the staff involved had full carriage and ownership of the curriculum development process, and were able to demonstrate quality and consistent leadership. An effort was made to recruit Aboriginal tutors for 2014, which enhanced the cultural learning, as well as medical practitioners with experience in Aboriginal health.

Time was scheduled each week for tutors to meet as a team before and after teaching to discuss the aims of the tutorials and to debrief. This enabled staff to consider and discuss the positive aspects of the tutorials as well as any concerns they had. Feedback from tutors following the introduction of the new curriculum in 2013 highlighted their frustration with many of the students who did not complete the required pre-tutorial work and were, therefore, unprepared for the tutorials. This often resulted in the students being disengaged with the weekly learning themes, and meant they didn't work through the difficult or challenging aspects of the learning. Changes to the 2014 curriculum were made to improve the likelihood of students preparing for the tutorial. Weekly multiple-choice questions were introduced and the pre-tutorial material was closely linked to the assessment task. This resulted in improved student preparedness.

The teaching team also focused on creating culturally safe learning spaces, and on including more interactive classroom activities such as the use of the vignettes and more real-life medical case studies. In 2014 tutors reported that students engaged in more in-depth class discussions, and demonstrated a greater understanding of topic content and learning outcomes. This was supported by improved student performance in assessment that year.

Challenges

In 2013 the two main challenges were to improve the student cohort's knowledge base and to address a reluctance to learn about Aboriginal health that was resulting in a lack of engagement and self-reflection. In 2014, despite a lot of positive feedback, some students still had differing expectations of what they needed to learn in this area. Some, for example, held the view that a 'real-life, tourist' experience was sufficient for them to work in the area of Aboriginal health. While such experiences may be interesting, they should happen after students have been able to undertake their own self-examination, understand their own power and privilege, and been given the opportunity to practise before being provided with the chance to work in Aboriginal communities, families and patients (Wilson et al. 2014).

Further, a small proportion of students do not feel Aboriginal health is relevant to their learning experience. Some hold the view that a simple dos and don'ts list, or a checklist, is sufficient for gaining an understanding of how to treat Aboriginal patients:

> *Why are we learning this topic?* (2013 Student feedback)
>
> *I would like to have been given more practical tips – a list of dos and don'ts would have been helpful* (2013 Student feedback).

In the majority of cases, it is these students who feel most confronted when reflecting on their own cultural bias and 'invisible' privilege (Wilson 2014).

Furthermore, a whole-of-School approach, including clinical champions who model and advocate for culturally safe patient interactions with Aboriginal clients, is important to improving student engagement (Phillips 2004). As such, teaching staff in the School of Medicine may also need to be involved in an Aboriginal health educational sessions and to undergo their own journey of transformative unlearning. All too often, students can find themselves in situations where their medical education around cultural values and providing patient empathy is undermined by the actions of teachers in the clinical environment (Branch 2010).

In order to continue to improve the teaching and learning of Aboriginal health in medicine, the authors recommend that the following activities be undertaken within the School of Medicine across both campuses:

- Training of School of Medicine staff in cultural safety by Poche (Adelaide and Alice Springs) staff and Indigenous Transition Pathways staff
- Better integration of Aboriginal health with Problem Based Learning cases
- Training Problem Based Learning tutors in Aboriginal health and cultural safety
- Recruitment and training of more appropriate tutors in Aboriginal health
- Reviewing and updating of Aboriginal health curriculum across each year and site on an annual basis to ensure consistency and up-to-date information
- Support for further evaluation – particularly peer evaluation of teaching and evaluated questionnaire use.

Conclusion

This project resulted in the development of an alternative pedagogical method for engaging students in Aboriginal health education, a method that could also be transferred across a number of health areas. With its focus on Aboriginal-led and developed curriculum, principles of cultural safety, highly qualified tutors, and innovative, interactive teaching methodologies and content the learning outcomes of students were found to improve. However, as different cohorts require slight modifications to curriculum to keep them engaged, yearly and ongoing evaluation of the Aboriginal health component of the curriculum is necessary to ensure student interest, course relevance and adequate staffing requirements.

A willingness to take student feedback seriously, and to review, modify and adapt the curriculum, has been critical to increased levels of student engagement. In addition, creating culturally safe environments in which sensitive and complex issues can be addressed has been an essential component of the learning experience.

This curriculum has introduced a new approach to the teaching of Aboriginal health to medical students at Flinders University. It will continue to evolve each year through strong evaluation and continuous improvement processes. Supported by high-level leadership and commitment, this project can contribute to the ongoing and effective teaching of Aboriginal health.

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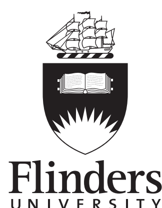

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Aboriginal and Torres Strait Islander Health Practitioner student perspectives on an interprofessional education program

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Introduction

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

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

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

Aims and Objectives

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

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

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

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

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

Approach

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Results

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

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

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

Three major themes emerged from the dataset:

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

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

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

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

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

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

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

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

Discussion

Successes

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

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

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

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

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

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

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

Challenges

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

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

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

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

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

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

Conclusion

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

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

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

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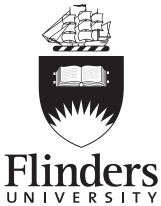

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Training emergency medicine specialists in Indigenous health and cultural competency

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Introduction

The Australasian College for Emergency Medicine (the College) is the peak professional organisation responsible for training emergency specialists and the advancement of professional standards in emergency medicine in Australia and Aotearoa/New Zealand. In 2013 the College established a two-year project to develop education resources for emergency medicine doctors that are related to Indigenous[1] health and culture. The Indigenous Health and Cultural Competency Project was funded by the Australian Government as part of a suite of projects aimed at improving Australia's emergency department (ED) medical workforce and in particular supporting international medical graduates.

The limited literature that specifically explores Indigenous peoples' experiences of emergency departments suggests that Indigenous patients can find emergency departments culturally unsafe.[2] This is due to a range of reasons, some specific to the emergency department and some a general reflection of non-Indigenous health care systems (e.g., Thomas, Anderson & Kelaher 2008; Einsiedel et al. 2013; Cunningham, Cass & Arnold 2005; Durey, Thompson & Wood 2012).

The unique context of emergency departments creates significant challenges in delivering culturally safe care to Indigenous patients. Emergency department care is delivered in a high-pressured, time-critical environment and continuity of care is greatly disjointed. This means that establishing rapport and an effective therapeutic relationship, so crucial for culturally safe care with Indigenous patients, is difficult. Due to its 24-hour a day, 7-day per week mode of operation, there is also restricted access to essential resources, such as Indigenous hospital liaison officers and interpreters, and difficulty in arranging appropriate follow-up with community services, such as Aboriginal Community Controlled Health Organisations. These factors are problematic and can contribute to a care environment that supports the dominant cultural paradigm, often to the detriment of colonised peoples.

Furthermore, due to the large numbers of complex presentations to emergency departments – especially those involving frequent attendance, drug and alcohol use, violence and mental health –

1 In this article, 'Indigenous' refers to Aboriginal and Torres Strait Islander peoples who the College acknowledge as the Traditional Owners of the many and diverse nations within Australia. The term is used except when referring to the education materials, where 'Aboriginal and Torres Strait Islander' or the local group name of Indigenous peoples were used, as this was the preference of the Aboriginal and Torres Strait Islander members of the project reference group.

2 The author acknowledges the complexity of, and contention surrounding, terminology in education related to culture and health practice. In this article, 'cultural competency' is used to refer to the attitudes, knowledge and actions of practitioners, and 'cultural safety' is used in relation to the experience of patients within the health care environment.

there can be a significant level of apathy, frustration, misunderstanding and negative stereotyping by emergency medicine staff when working with Indigenous patients.

There is also a lack of access to comprehensive educational resources aimed explicitly at overcoming these emergency-specific barriers. Those training options that are available are rarely applied to the emergency department context and, as such, do not address the unique challenges of delivering culturally safe care in this environment. Even where attendance at generic cultural safety programs is considered mandatory, there is limited uptake by emergency medicine doctors.[3] The reasons for this are multi-faceted, but the perceived irrelevancy of available training to daily practice in the emergency department is a factor.

Focus groups conducted during the needs-analysis phase of this project revealed that a proportion of emergency doctors do not see the immediate relevance of Indigenous health education to their practice. Some focus group participants held the view that the socio-economic determinants of health are the predominant causative factor in the disproportionate burden of ill health for Indigenous people, and that the responsibility for addressing Indigenous health issues, therefore, lies with the community sector. While the community sector is undoubtedly essential, Indigenous people attend emergency departments at over twice the rate of non-Indigenous Australians (Thomas, Anderson & Kelaher 2008). There are also very real factors that influence Indigenous peoples' experiences within emergency departments that impact on patient outcomes as well as access to care across the entire health system. It is, therefore, essential to address directly the misperception that a change in emergency department practice is not important in improving Indigenous health.

The College's Indigenous Health and Cultural Competency Project was initiated to provide applied learning in emergency-specific contexts to address this gap in education resources and delivery. In addition, a number of insights have emerged as a result of the project around the challenges and opportunities for improving postgraduate education in Indigenous health regardless of the speciality.

Aims and Objectives

The primary aim of the Indigenous Health and Cultural Competency Project was to transform attitudes, increase knowledge of culture and health, and improve the cultural competency skills of emergency medicine doctors thereby improving the likelihood of culturally safe care for Indigenous people.

A number of objectives were developed to meet this aim:

- Raise awareness of the importance of Indigenous health and cultural competency in emergency medicine contexts
- Incorporate Indigenous health and cultural competency vertically and horizontally within the College's training curriculum, including specialist training and continuing professional development
- Develop comprehensive educational materials specific to emergency medicine, with multiple access points, that would be relevant across the geographically and culturally diverse regions of Australia.

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3 For example, attendance at the mandatory Cultural Practice Program delivered by Queensland Health is as low as 9 per cent for emergency doctors in one Queensland hospital, significantly lower than for other hospital staff (unpub. data).

Approach

A reference group was established that included members from peak organisations such as the Australian Indigenous Doctors' Association, the Centre for Ethnicity, Culture and Health, and the Leaders in Indigenous Medical Education Network. Membership also included Indigenous liaison officers with experience in emergency medicine, international medical graduates, Fellows and trainees of the College.

Focus groups and individual video interviews were conducted in several urban, rural and remote regions with emergency department doctors and nurses and Indigenous hospital liaison officers, interpreters, academics and cultural educators. The insights gained, alongside a broad literature review, facilitated the development of a detailed curriculum framework of emergency medicine-specific issues that were of importance to both patients and practitioners.

This curriculum framework informed the development of the central component of the project, a comprehensive 10-module e-learning series, both of which had two foci. The primary focus was Indigenous health, in which the ongoing impact of colonisation, institutional discrimination and racism on Indigenous health outcomes, and access to and experiences of, emergency departments were key learning objectives. The secondary focus centred on applying the principles of cultural competency and cultural safety to the delivery of care in the emergency medicine context.

Module series content

Section 1 of the e-learning series covered core skills such as inter-cultural communication, health literacy, health beliefs, patient-centred care, taking a 'cultural history' and working with interpreters. These were applied to common emergency department presentations, explored the challenges specific to the emergency department environment and suggested strategies to negotiate these.

Section 2 focused on a culturally competent approach to a range of emergency medicine-specific issues, such as disproportionately high rates of Indigenous patients' discharged against medical advice ('take own leave'), 'late' or delayed presentations, and frequent attendance at the emergency department. The historical and contemporary lived experience of Indigenous peoples was explored, including institutional discrimination and the impact of past policies such as those inflicted on the Stolen Generations. Also covered in Section 2 was the importance of collaborative care with Indigenous hospital liaison officers and family, establishing effective relationships between emergency departments and the Aboriginal Community Controlled Health Sector, and the unique challenges of dealing with death and dying in the emergency department, including how to negotiate a culturally safe space for grieving relatives.

Section 3 modules explored complex presentations, such as aggression, intoxication, victims of violence and self-harm. Practitioner attitudes were overtly addressed, including stereotypes perpetuated by these common presentations, through a process of separating out poverty and the colonial determinants of health from Indigeneity, and exploring the breadth of underlying factors associated with these presentations. Skills were introduced, including culturally safe de-escalation strategies and brief motivational interviewing for lessening drug and alcohol harm.

The central role of the practitioner's own culture in any and all clinical interactions was the foundation upon which all other learning was built. A case-based learning approach was used, linked to videos of expert stakeholders discussing their own experiences and approaches. These were supported by a range of critical reflective exercises that encouraged learners to extrapolate

principles of care to their own practice. This enhanced the relevance of the materials to the geographically and culturally diverse contexts of Australian emergency departments. The material was presented via a mix of multi-media, including animations, audio, text and interactive elements to ensure sustained engagement. The nature of clinical content in the modules was deliberately uncomplicated so as to maintain the focus on cultural safety.

Importantly, Indigenous voices were prioritised and all content was linked to the daily reality of Indigenous peoples and emergency medicine practice. For example, a video of Indigenous peoples talking about their own experience of the Stolen Generations was linked to the current experiences of anxiety and powerlessness Indigenous patients may face when contemplating attending and/or arriving at an emergency department, due to children historically having been forcibly removed within hospital settings. Learners were then encouraged to explore how understanding this reality could lead to a change in the way they interacted with their patients to reduce poor outcomes such as a patient 'taking own leave'.

Results

In its first year, more than 650 people began the e-learning series. Due to a staggered launch, the numbers of people completing each subsequent module steadily decreased, but the figures do indicate that people are continuing to work their way through the series (see Table 1). Given the reluctance of many emergency doctors to see this learning as relevant to their practice, prior to the project commencement, and that current membership of the College is a little more than 4000, the College considers these completion numbers over 10 months or less as quite successful.

Table1: E-learning series by module view

Module no.	Title	Release date	No. of module views as at 30/11/14
Section 1: Applying core concepts of culturally competent care in the Emergency Department (ED)			
1	Introduction to culturally competent care in the ED	31/01/14	665
2	Culturally competent communication in the ED	31/01/14	264
3	Understanding health literacy and diversity of health beliefs	31/01/14	155
4	Understanding language diversity and working with interpreters	31/01/14	116
Section 2: Caring for Aboriginal and Torres Strait Islander and other culturally diverse patients in the ED			
5	Improving ED access and experiences for Aboriginal and Torres Strait Islander patients	11/04/14	109
6	Collaborative practice: Understanding the role of Aboriginal Liaison Officers and families in ED care	11/04/14	64
7	Culturally competent discharge planning	11/04/14	64
8	Culturally competent end-of-life-care	25/09/14	34

Table 1 cont...

Module no.	Title	Release date	No. of module views as at 30/11/14
Section 3: A culturally competent approach to challenging presentations			
9	Aboriginal and Torres Strait Islander patients	25/09/14	32
10	Refugees, asylum seekers and migrant patients[4]	25/09/14	17

An initial evaluation of the e-learning series was conducted through user acceptance testing. Following the launch, participants completed voluntary surveys at the end of each module. Results from Likert scales and qualitative responses indicate that the modules significantly improved self-assessed knowledge and skills in Indigenous health of both trainees and specialists. Importantly, participants have found the learnings highly relevant and valuable to their daily practice. One trainee commented:

> *Up until now I haven't known how we can improve the quality of the care we give to our Indigenous patients. It's only since completing this module series that I can see they are a crucial tool for bridging that gap between the current care that we deliver and the ideal level of care that we'd like to practise. I've been really impressed with the detail, the case histories, the videos that are within the modules. Because for me it's the first time I've seen something that is as complete as this; that covers such a wide range of topics. These are the real, day-to-day cases that we treat in ED. The modules have really changed the way I think and make me want to improve the way I interact with all my future patients* (Emergency medicine trainee).

As with all teaching of this kind, it is difficult to measure the actual impact on health outcomes for Indigenous patients (Ewen, Paul & Bloom 2012) given the highly distributed nature of participants completing the modules – i.e. a self-selection of practitioners from emergency departments practising anywhere throughout Australia – and the need to monitor improved processes over time. However, some evidence gathered through the evaluations reveal instances in which the application of learning is having an impact on individual cases.

Discussion

Successes

One example from the qualitative feedback highlights an instance in which the course had an impact on the approach an emergency medicine trainee took with an Indigenous patient. The trainee was attempting to undertake an aerial retrieval from a rural community of an injured Indigenous man who was agitated, had a history of violence in the emergency department and was wanting to discharge against medical advice. The trainee was under pressure from senior staff to either forcibly sedate and transfer the patient, or simply let him leave.

4 The final module in the e-learning series focused solely on providing culturally competent care for complex presentations involving asylum seeker, refugee and migrant patients. Although the project reference group agreed to include diverse cultural groups in the e-learning series, this module is not detailed in this paper.

Instead, the trainee applied their learning about dealing with the significant time-pressures associated with emergency department care, and used their newly learned skills to establish a rapport with the patient by asking about the his family and Country. The trainee also asked the patient to describe why he was in hospital and his understanding and beliefs about his illness. It was thus discovered that there was a discrepancy between the patient's understanding of his illness and the doctor's, so the trainee explained in more detail the medical reasons why the patient needed a transfer. The trainee then asked the patient to repeat back what he had heard them say, to ensure that the patient fully understood the risks of leaving the department, with surprising results:

> *It was amazing to see what happened next. This aggressive, agitated man who was previously trying to pull out his intravenous lines and walk out of the emergency department, just lay back on the bed, closed his eyes and calmly said 'Doc, you can take me now'.*

The patient was transferred for further management without complications.

In developing the modules, the project team focused on creating usable, real-life examples of culturally safe care. The early and sustained collaborative contributions of both Indigenous and non-Indigenous experts in emergency medicine and Indigenous health education, as well as the broad participatory research phase, meant that the final product incorporated best practice adult education principles, was relevant to the experiences of the target audience, and respectful of Indigenous cultures and lived realities.

A key success of the project has been the development of robust working relationships with a number of peak Indigenous professional organisations, such as the Australian Indigenous Doctors' Association. The College now has external Indigenous representation on its Indigenous Health Sub-Committee, and a renewed commitment to supporting both the development of Indigenous trainees and the leadership aspirations of Indigenous Fellows within the College.

The active partnership between the College and Indigenous hospital liaison officers and cultural educators, established as a result of the project, has led to a broader understanding of the collegial nature of working with Indigenous professionals within the context of an emergency department.

The lessons learned from the module development process and the evaluations have also led to Indigenous health and cultural competency being included in other College programs such as the Quality Mentoring Initiative, which now has Indigenous content in both its face-to-face and online training.

Challenges

One of the challenges of developing this educational resource is that doctors come to postgraduate training with varied exposure to education in Indigenous health and cultural safety. Approximately 37% of the College membership, for example, is currently international medical graduates and overseas trained specialists, who may have limited or no understanding of Indigenous health issues. But even Australian-trained doctors, particularly more senior practitioners, may not have had any Indigenous health education either during their undergraduate or vocational training.

In order to address this, the e-learning series consistently invited learners to ask, 'What do I already know and do?', and then reflect upon the content presented (be it a case study, a video, the

evidence base etc.) and ask, 'What can I now do better?'. This approach, centred on critical self-reflection, recognises that, regardless of previous learning, all practitioners can continue to strive for improvement in the care they deliver. One participant commented that:

> *[the modules] are excellent and should be read by everyone who is working or dealing with Indigenous health. I spend regular time providing medical care to Indigenous communities and I found a lot of new and interesting information in the modules* (Overseas trained specialist, senior emergency department doctor).

Some content was explicitly optional and provided for those learners requiring more introductory knowledge, for example, international medical graduates new to the Australian health care context. While the e-learning series was developed such that each module built upon the learning in previous modules, learners could access them in any order. This allowed learners to enter the content depending on their interest and level of previous experience and knowledge.

The delivery of training is also challenging in the postgraduate setting. Specialist training in hospitals is delivered mostly by senior doctors, not cultural education specialists. As discussed, senior medical practitioners have a range of expertise, understanding and interest in this area. There is also distinct competition for teaching time, particularly for junior staff who are trying to 'learn the ropes' of their speciality.

In emergency medicine contexts, time pressures for training are further exacerbated by the highly shift-based nature of the work. To address this challenge, the modules were made freely available online so as to be accessible for a self-directed style of learning that is not reliant on senior staff time, expertise or interest. They were also distributed on USB sticks to more than 200 Directors of Emergency Medicine Training.

> *This online training is going to be really good for access for trainees, as on-the-job training is very difficult to fit into rostering* (Emergency medicine specialist).

Furthermore, a considerable effort was made in promoting both the project and the educational resources, and in particular the need for learning in this subject area at all levels of training and specialisation. Promotions via conference presentations, membership communications, social media and website presence prioritised the message that Indigenous health and cultural safety are relevant both in emergency medicine and for all doctors. The large numbers of module views in a short period of time is evidence of the success of this approach to encourage use of the e-learning series.

> *I thought it was going to be just another 'tick the box' module series, but I actually learnt something. They're fantastic. I'm going to get all my registrars to do them* (Emergency medicine specialist).

Conclusion

Indigenous health and cultural competency training at the postgraduate level should be designed specifically for each speciality. Continuing to provide generic or introductory content risks disengagement and irrelevancy, and will continue to posit Indigenous health and cultural safety education as a 'special interest' subject area rather than as a core learning for all doctors.

This project developed educational resources founded upon evidence and extensive consultation. The emphasis on experiential learning and critical reflection of the practitioner's own self supports learners to incorporate increasingly culturally safe practice at multiple levels of training and specialisation.

Most postgraduate medical training is undertaken on-site by senior doctors. However, when developing and delivering effective training in Indigenous health and cultural safety relying on these senior doctors alone is insufficient. Rather, the collaborative model developed by the College – including targeted focus groups, expert stakeholder interviews and a diverse reference group – could be used. Such a model could also be replicated across other speciality colleges, enabling close working partnerships with the relevant Indigenous health professionals to that speciality.

This project has begun to demonstrate that a speciality-oriented Indigenous health curriculum has the potential to engage learners, reveal the relevance of this skill base to their daily practice and teach new expertise in cultural safety.

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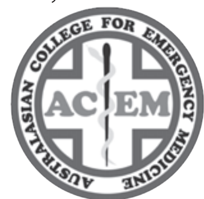

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Appendix 1 – Good Practice Case Study Assessment Process

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

The LIME secretariat called for submissions from those who had presented papers at LIME Connection V held in Darwin in August 2013. Once case studies had been received, the Review Committee assessed them according to whether a project met its objectives, was evidence based, had supported and developed Indigenous leadership, and was both sustainable and transferrable to other settings. Committee members abstained from reviewing any case studies that posed a conflict of interest.

The Committee met formally twice, the first time to determine which submissions best met the criteria and would therefore be the most suitable for the third edition of the *Good Practice Case Studies* publication. It identified case studies that were accepted with minor revisions as well as those 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 for the *Good Practice Case Studies* publication. 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

ABS	Australian Bureau of Statistics
AHS	Aboriginal Health Specialisation
AIATSIS	Australian Institute of Aboriginal and Torres Strait Islander Studies
AIDA	Australian Indigenous Doctors' Association
AIHW	Australian Institute of Health and Welfare
CDAMS	Committee of Deans of Australian Medical Schools
CDU	Charles Darwin University
DoH	Department of Health (Australian Government)
ED	emergency department
LIME	Leaders in Indigenous Medical Education
MDANZ	Medical Deans Australia and New Zealand
MBBS	Bachelor of Medicine, Bachelor of Surgery
NT	Northern Territory
UWA	University of Western Australia

Glossary

Aboriginal and Torres Strait Islander	Original inhabitant 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
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 Aboriginal communities in Australia. Elders are also the teachers who pass knowledge on to the next generation
Hui-ā-Rohe	Referring to multiple gatherings across different regional areas
hapū/iwi	Māori sub-tribes and tribes and community stakeholders
Hauora Māori	Māori health
kai	food
karakia	Māori prayers
kōrero	talk
Kura Kaupapa Māori	Māori medium schools
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
mihi whakatau	Māori term for formal welcome and introductions
pānui	meeting notifications
te reo Māori	Māori language
tikanga Māori	Māori customs
Traditional Custodians/ Owners	Original inhabitants and caretakers of Australia and its nearby islands
whakawhanaungatanga	Māori term for relationships or process of establishing relationships
whānau	Māori term for family/support systems
Whare Kura	Māori medium schools

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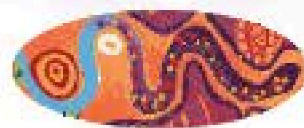

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