THELIMENETWORK

Leaders in Indigenous Medical Education

LIME GOOD PRACTICE CASE STUDIES

VOLUME FOUR
2017

Medical Deans
AUSTRALIA AND NEW ZEALAND

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

FOREWORD

All doctors working in Australia and Aotearoa/New Zealand should possess the knowledge and skills to work competently with Indigenous people. Medical Deans are committed to improving Indigenous health outcomes by supporting Indigenous medical students and promoting best practice in the teaching of Indigenous health in medical education. The LIME Good Practice Case Studies make an important contribution to these goals and, as President of Medical Deans Australia and New Zealand, it is with great pleasure I introduce Volume Four. This publication showcases the papers presented at the LIME Connection VI and builds on those in previous volumes.

Volume Four of the *LIME Good Practice Case Studies* covers a diverse range of issues including the effects of bias and racism on the health of Indigenous people, the impact of student placements in Aboriginal health services and the use of visual arts to engage students. There are reflections from Australia, Aotearoa/New Zealand and Canada, including the study of medical students at the University of Manitoba and their experiences of racism. It makes for disturbing reading and demonstrates the need for renewed efforts to ensure that all students can study in an environment free from racism. The papers highlight the innovation evident in the field of Indigenous health and medical education and the value in sharing this knowledge.

The LIME Network has grown significantly since its beginnings as an informal collaboration between medical educators, doctors and students, and has received international recognition for its work. I congratulate the LIME Network, and all the contributors to Good Practice Case Studies Volume Four, for your continued support of the collaboration between medical educators to advance the development, delivery and evaluation of quality Indigenous health initiatives.

Professor Nicholas Glasgow
President, Medical Deans Australia and New Zealand Inc.

TABLE OF CONTENTS

TABLE OF CONTENTS

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.

LIME Good Practice Case Studies Review Committee members

Dr Lilon Bandler (The University of Sydney)

Dr Maureen Davey (University of Tasmania)

Ms Cheryl Davis (Curtin University)

Ms Odette Mazel (LIME Network)

Professor David Paul (The University of Notre Dame University, Fremantle)

Associate Professor Suzanne Pitama (University of Otago)

Ms Caitlin Ryan (LIME Network)

Dr Shannon Springer (Bond University)

INTRODUCTION

This fourth edition of the *LIME Good Practice Case Studies* showcases a collection of papers that were first presented at LIME Connection VI in Townsville, Queensland in 2015. The theme of the Connection – 'Knowledge Systems, Social Justice and Racism in Health Professional Education' – encouraged presentations that captured new initiatives, shared innovative methods and sparked visions for the future. Importantly, presenters also discussed the challenges and critiqued current practices. Encounters of racism, pathways to social justice and incorporating Indigenous knowledge systems into health professional education were embedded in a program that was thought-provoking and stimulating.

The papers included in this volume are representative of the breadth and depth of the presentations from LIME Connection VI. They include reflections on:

- Race and racism in health professional education;

- Immersion as a pedagogical approach to Indigenous health curriculum;

- Teaching innovations; and

- Professional development.

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

ABOUT THE LIME NETWORK

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

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

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

- The facilitation of bi-annual **Reference Group** meetings to provide the opportunity for those working in Indigenous health within medical schools to collaborate, share information, provide feedback and peer network

- The biennial **LIME Connection** conference to provide a forum for knowledge exchange and dissemination, and the conference's **LIMELight Awards** to celebrate successes in the field

- The **Indigenous Medical Student and Community Bursary Scheme** providing the opportunity for networking and peer support at LIME Connection

- Publication of the tri-annual **LIME Network Newsletter** promoting best practice and sharing successes in the field

- Maintaining the **LIME Network Website** housing information on LIME Network projects, relevant resources, and other news and events

- Building the evidence base of the efficacy of Indigenous health curriculum development and implementation, as well as Indigenous student recruitment and support to graduation initiatives through publications such as the **Good Practice Case Studies** 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; the Australian Indigenous Doctors' Association gatherings since the formation of the association in 1998; and the Committee of Deans of Australian Medical Schools' (CDAMS) working groups and workshops since 1999.

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

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

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

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

W: www.limenetwork.net.au
E: lime-network@unimelb.edu.au
T: +61 3 8344 9160

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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.

LIME GOOD PRACTICE CASE STUDIES

Keynote Presentation: Race is real and so is racism – Making the case for teaching race in Indigenous health curriculum

Dr Chelsea Bond, The University of Queensland, Australia

Introduction

One could well argue that the case has already been made for including the study of race and racism within the Indigenous health curriculum. More than a decade ago the Committee of Deans of Australian Medical Schools developed the Indigenous Health Curriculum Framework, which recognised the importance of teaching students about racism. The framework states that health services, systems and professionals should be free of racism (Phillips 2004:7), and that key student attributes and outcomes should include the ability to identify features of overt, subtle and structural racism or discrimination in interactions between patients and health professionals and systems, ways of addressing such occurrences, and the acquisition of skills to advocate both for their resolution and to explain the connection between history and present health outcomes – including the forms and impacts of racism.

In 2011, Universities Australia developed a National Best Practice Framework for Indigenous Cultural Competency in Australian universities and identified key content areas which included:

- concepts of culture, race, ethnicity and worldview
- myths and misconceptions about, and stereotypes of, Indigenous people
- notions of whiteness, white privilege and power
- reflection on cultural identity, whiteness, privilege, values, beliefs, attitudes, prejudices and propensity to stereotype
- racism and anti-racist practices (Universities Australia 2011:72).

Yet there remains a deep level of discomfort among health educators in teaching race and racism, as evidenced in a recent national consultation to develop the Aboriginal and Torres Strait Islander Health Curriculum Framework (Taylor, Kickett & Jones 2014). Commissioned by Health Workforce Australia the consultations revealed significant concerns among health educators with teaching content that included 'racism', 'whiteness' and 'stereotyping' as they were deemed to be 'negative'

and focused on 'deficit' (2014:38). Health education stakeholders expressed their discomfort with teaching the concept of whiteness arguing that it 'promotes colourism' (2014:75) and 'binary or reductionist thinking' (2014:46). One health education stakeholder pointed out that 'not all privileged students are white and not all white people are privileged' (2014:49). Others suggested abandoning the term 'race' in favour of 'culture' because race is an 'ideology rather than a biological fact' (2014:73). Respondents also raised concerns about the student learning experience, suggesting there was a need for 'moving away from blaming and shaming' and 'guilt and berating' (2014:6), and that educators should 'keep the politics out of content and education' (2014:7) and ensure 'students aren't polarised' (2014:12).

Instead, health education stakeholders argued that the curriculum should emphasise 'good news statistics/positive stories of shared history and programs which have positive outcomes' (2014:12), and avoid 'historically polluting' in favour of 'recognising – and celebrating history as a shared experience' (2014:17). Health education stakeholders cautioned about the 'delicate nature and potentially offensive associations that may occur by using contentious or "coloured" words such as "white" and "black"'' (2014:14), and expressed concerns with the 'saturation of too many facts and figures where "white people are seen as evil and Aboriginal people as fragile"' (2014:21).

While these concerns did not prohibit the inclusion of racism, anti-racism and white privilege as core curriculum themes within the recently released Aboriginal and Torres Strait Islander Health Curriculum Framework (Department of Health 2016), the consultations that led to its development provide revealing insights into the ways in which health educators are thinking about race and racism. We witness in the consultations various attempts by health education stakeholders to minimise race and racism as categories of analysis in understanding Indigenous health inequality through a pedagogical logic of student 'comfortability', and more specifically white student 'comfortability'. Several claims made by health educators demonstrate a lack of conceptual understanding of race, racism and whiteness, which undermines attempts to understand how race works to produce health inequalities.

Rather than make a case for excluding the teaching of race and racism within Indigenous health curricula the Health Workforce Australia consultation findings demonstrate the critical and pressing need to develop race scholarship within health so as to counter the resistance and reticence among many health educators to exploring race and racism. This paper examines some of the claims about race and racism made by health education stakeholders consulted in the development of the Aboriginal and Torres Strait Islander Health Curriculum Framework, and offers three counter-claims that evidence the 'realness' of race and racism – as lived, as a field of academic inquiry and as a determinant of Indigenous health inequality.

Race is real

The revelation that race isn't real biologically has led to the insistence that race isn't real altogether. We observe in the Health Workforce Australia Consultations the recommendation by health education stakeholders that race be avoided in favour of culture because race is an 'ideology' rather than a 'biological fact' (2014:73). However, just because there are no 'immutable, biologically based differences between "racial" groups' (Smedley & Smedley 2005:16) does not make redundant the concept of race as a category of analysis within the health sciences. Socially 'race remains

a significant predictor of which groups have access to societal goods and resources and which groups face barriers… to full inclusion' (Smedley & Smedley 2005:22). The profound health inequalities that Indigenous people experience is evidence of the pervasive nature of race as a social construct – not talking about race does not render it less powerful or less real. Proclaiming that race is not real does not minimise racism as a lived experience; instead it trivialises the trauma of those who experience it and enables indifference to the very real and ever-present racialised inequalities that exist in our society.

The insistence that culture is an appropriate replacement for race in explaining differential health outcomes is a discursive shift that does not remedy the biologically deterministic claims of race that we are seeking to avoid. While Indigenous people are not a 'race', 'Indigenous status' is a racial category and Indigenous bodies are inscribed with racialised logics, which are not absolved by using the term 'culture'. Let's consider the issue of patients discharging from hospital against medical advice. A recent analysis of data collected between 2011 and 2013 (Department of Prime Minister & Cabinet 2015:146) found that:

> Indigenous status was the single significant variable contributing to whether a patient would discharge themselves from hospital against medical advice, even after controlling for the other factors [emphasis added].

If we focus on culture as an explanation for this behaviour, we can locate the blame with the Indigenous patient and/or Indigenous culture via discourses of compliance and/or cultural misunderstandings and miscommunications. However, focusing on culture instead of race prohibits us from understanding how health care services work systematically to produce this racialised health outcome.

Race, culture and ethnicity are not interchangeable concepts and the task of differentiating between and disentangling them often proves difficult. Indigenous health curricula must provide greater conceptual clarity around these terms if it is to provide students with the 'critical ability to read and interpret the world through the category of race' (Headley 2014:115). Within our health disciplines, we can observe strong disciplinary traditions of operationalising race according to imagined biological, social and cultural differences. However, we have yet to achieve strong disciplinary traditions of attending to race as a category of analysis in furthering our understanding of the production of health disparities.

Teaching race is not teaching guilt

Within the Health Workforce Australia report, student 'comfortability' emerged as a priority in the development of Indigenous health and medical curriculum, which according to health education stakeholders was undermined by the introduction of University Australia's proposed teaching principles of 'stereotyping', 'whiteness' and 'racism and anti-racism practices' (Taylor, Kickett & Jones 2014:67–8). These stakeholders felt that the task of developing students' racial literacies was polarising and politicising as well as guilt inspiring and pedagogically problematic. The insistence that Indigenous health inequality, and any analysis of the conditions that have produced it, be taught in a celebratory and apolitical way is most puzzling.

We all embody racialised positions, and we all hold 'strong emotional ideological commitments… to positions about race' (Hall 1983:259). Thus, conversations about race and racialised inequalities may well be uncomfortable for students (and health educators) because it shifts the gaze away from the culture of Indigenous people and requires us to think critically about our social world and our place within it. Di Angelo (2011:60–1) argues that the expectation of comfort in conversations about race is unrealistic, and is a further example of white race privilege enabling conversations about racism to be avoided.

Health educator inferences that teaching about race and racism is synonymous with teaching blame and guilt demonstrates that health educators are engaging with race and racism emotionally rather than intellectually. As health educators we need to make clear our own commitments and feelings about how we address race and what we say about it, but we also must recognise that teaching about race and racism it is not simply a matter of how we or our students 'feel' about it. Hall (1983:263) advises against teaching race in terms of attending exclusively to discriminatory attitudes, feelings and prejudices, stating:

> We have to uncover for ourselves in our own understanding, as well as for the students we are teaching, the often deep structural factors which have a tendency to persistently not only generate racial practices and structures but reproduce them through time which account for their extraordinarily immovable character.

The task of developing and implementing the Aboriginal and Torres Strait Islander Health Curriculum Framework is paradoxically placed in that it is informed by the experiential knowledge of health care educators who are not trained in critical race studies, and thus fail to discern between 'race talk' and 'racist talk'. The challenge remains for us, then, as to how we can have informed debate about the inclusion of race and racism or race pedagogies if we, as health educators, have limited intellectual engagement with these concepts? How might we get to a position which recognises that to teach about race is not racist, but rather that pretending race doesn't structure health outcomes is?

Remedying racism beyond the Indigenous body

The Health Workforce Australia findings posed important questions regarding the requirements placed upon Indigenous bodies in remedying racialised health inequalities via health curriculum content. Health educators recommended that students be exposed to 'good news statistics' (Taylor, Kickett & Jones 2014:12), and insisted that articulations of Indigenous health inequality should focus on shared celebratory historical narratives and avoiding 'too many facts and figures "where white people are seen as evil"' (2014:21). Given the current state of Indigenous health, these requirements by health educators suggest a preoccupation with preserving the moral virtue of white people in the task of teaching about the health inequalities that Indigenous people experience.

The focus on Indigeneity as a means of moderating the health effects of racism is hardly surprising given that much of Australian public health interest in racism and Indigenous health outcomes attends to Indigenous bodies as the site of intervention. Although the international public health literature refers to racism as operating both structurally and at the level of the individual to produce poor health (Smedley 2012), much of the Australian Indigenous health literature focuses on the incapacity of Indigenous bodies and minds (Paradies 2005; Larson et al. 2007; Ziersch et al. 2011;

Priest et al. 2011; Bodkin-Andrews et al. 2013; Australian Government 2014). Intervening in structural and institutional racism demands of us an understanding of the health effects of racism beyond the Indigenous body. Yet the Australian Indigenous health literature is largely preoccupied with the mental incapacities of Indigenous bodies to withstand racism evidenced by findings which suggest that Indigenous people need to be taught how to be more resilient to racism (Bodkin-Andrews 2013), and/or that Indigenous parents be supported to teach their children how to cope with racism better (Paradies 2005:15). This literature's fixation on strengthening the minds of Indigenous peoples as an effective anti-racist health intervention bears a disturbing similarity to the racist pseudo-scientific theories that insisted Aboriginal people were 'feeble minded' (Anderson 2006:217).

However, the causal pathway between racism and racialised health inequality is not due to Indigenous imaginings or interpretations of racism. Therefore, its health impacts will not be remedied through the better behaviours of Indigenous people either in everyday life or in their presentation within Indigenous health curricula. Race shapes the way in which our world is structured. Even anti-racist discourse in Indigenous health – with all of its good intentions – cannot escape reproducing the racialised logics of the 'Indigenous problem', which 'assume that the locus of a particular research problem lies with the Indigenous individual or community rather than with other social or structural issues' (Tuhiwai-Smith 2012:95). Thus, in the process of teaching about racism we must also be critically conscious of the racialised logics we are deploying.

Conclusion

Race is real, and so is racism, in producing the profound health inequalities experienced by Indigenous Australians. As such, the development of an Aboriginal and Torres Strait Islander Health Curriculum Framework and the teaching of Indigenous health cannot be solely informed by the emotional and experiential knowledge of race and racism. Despite the inclusion of race and racism in successive Indigenous health curriculum frameworks, these Health Workforce Australia consultation findings demonstrate the need for tools and training that will enable health educators to develop conceptual frameworks and cognitive devices to teach race in ways that support students to move beyond their feelings to an informed understanding. It is worth noting that some Australian institutions have already taken up the challenge of engaging in a deeper criticality of health inequality in Indigenous health and medical education (McDermott & Sjoberg 2012).

However, important conversations among health educators about the pedagogics of teaching race, as well as more critical conversations about the various causal pathways between racism (individual and systemic) and health within our classrooms and our research, awaits initiation. This paper contends that our ability to partake in these conversations is hindered by the absence of critical race studies within public health, and Australian scholarship more broadly. As a result, the Aboriginal and Torres Strait Islander Health Curriculum Framework, which could be a critical tool in reducing Indigenous health disparities, remains immobilised by the sector's inability to move beyond the embodied consequences of racism and race as emotive and experiential responses.

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For further information, contact:

Dr Chelsea Bond

Aboriginal and Torres Strait Islander Studies Unit

The University of Queensland

E: c.bond3@uq.edu.au

Keynote Presentation: Externalising a complicated situation – Teaching racism in an Indigenous curriculum: A case study

Ms Tania Huria, Dr Cameron Lacey, Dr Maia Melbourne-Wilcox and Associate Professor Suzanne Pitama, University of Otago, Aotearoa/New Zealand

Introduction

Research undertaken by Harris et al. (2006; 2006a; 2012) and Paradies, Harris & Anderson (2008) has provided evidence of the effects of bias and racism on the health outcomes of the Indigenous peoples of Aotearoa/New Zealand and Australia (see also van Ryn 2016 in reference to the United States). However, little has been written on the design, development and implementation of medical curricula that includes the study of the impact of bias and racism on Indigenous patients, families and communities.

At the Otago Medical School, the content for Years 1–3 of the Indigenous health (Hauora Māori) curriculum uses specific socio-political content to present Indigenous health status, disparities and maintenance of inequities through a decolonised perspective. As a result, students later allocated to one of the three Otago clinical schools for Years 4–6 have already been presented with two specific Indigenous health models – the Hui Process and the Meihana Model (Lacey et al. 2010; Pitama, Huria & Lacey 2014). The purpose of this paper is to document how teaching about the impacts of bias and racism on health has been delivered and assessed at the Otago Medical School (Christchurch campus).

Making a difference

Throughout the development of the curriculum at the Christchurch campus, the Indigenous health teaching team identified the need for students to understand and address the issues of bias and racism and their impact on clinical practice. Figure 1 (below) consolidates the key findings from curriculum evaluations and reviews over the past nine years, and highlights the components required to include the impacts of bias and racism within an Indigenous health curriculum. The components included:

- clear identification of the kaupapa (agenda/topic – in this case bias and racism)
- Indigenous leadership
- a social accountability framework with the ability to inform the curriculum and future development
- faculty support and appropriate resourcing.

Figure 1: Implementing an Indigenous curriculum that includes and assesses bias and racism

The kaupapa

In this case study the 'kaupapa' refers to including the effects of bias and racism on health within the curriculum. Table 1 (see page 15) highlights the multiple points in the curriculum where this was taught. The acceptability and quality of the learning experiences of those recipients and deliverers of the curriculum were determined through extensive formal and dynamic evaluation processes. Every year between 2007 and 2015 approximately 280 students completed the Hauora Māori course. Annual formal student evaluations of the curriculum (anonymised) were completed by the Higher Education Learning Department at the University of Otago, Dunedin. The evaluation was administered during scheduled teaching time over Years 4–6.

Simultaneously, students were offered opportunities, individually and within a group, to provide verbal and/or written feedback to convenors and student education representatives. The evaluation findings reflected that there was a high acceptability among students of including content about bias and racism within the Indigenous health curriculum. As the quote on the next page demonstrates, this inclusion enabled students to clarify their perspectives and challenged their past views regarding Māori health.

Understanding the Māori viewpoint on healthcare and disparities in healthcare – I had always saw it as Māori wanting more, not wanting equal. (S1, 2008)

Students reported the learning methods used in the Indigenous health curriculum that oriented them to the Hui Process and Meihana Model also enabled them to develop confidence in exploring the effects of bias and racism. They reported that they could see the applicability to good clinical practice and had actively applied it in interviews with Māori patients. Students expressed their intention to continue to utilise the Hui Process and Meihana Model in their current and future practice.

Learning how to apply the Meihana model to the Calgary–Cambridge model – I feel far better equipped now to work with Māori patients. (S36, 2010)

I really enjoyed learning the Hui process with respect to engaging future patients and establishing relationships in a clinical setting. (S20, 2012)

Supporting the kaupapa

The Indigenous health teaching team reported that the Hui Process and Meihana Model increased students' engagement in the course content, and that discussions about bias and racism were noted as integrated within the students' clinical enquiry. The Hauora Māori team further described students' increased fluency in deconstructing and articulating the impact of bias and racism on Māori patient outcomes.

In 2015, medical students at the Christchurch campus were invited to be participants in a short video for the LIME Connection Conference, in which they were asked for a detailed account of their experience of being taught about bias and racism and the impact of this on their practice. Seven students took part in the video, all of whom expressed surprise – both at the amount of bias and racism that Māori patients disclosed and that they were prepared to share their experiences with them. Students reflected that inquiring about bias and racism with Māori patients was initially disconcerting, but that the patients' responses were thought provoking.

It does seem a bit uncomfortable in the beginning when you first ask a patient about racism, however once you have done it once it is amazing the amount of information you can gather from your patient. (S3, 2014)

Through learning sessions, students did take opportunities to seek clarification on the process and protocols involved in the exploration of bias and racism with a Māori patient. They identified the need to be able to increase the frequency of simulated patient settings so as to build confidence and competence prior to 'actual' patient contact. Student feedback at the end of the academic year consistently reported that bias and racism become easier to explore with practise, as does the students' ability to articulate their potential and/or actual impact as a determinant of health status and health outcome. That said, there is a need to undertake further research on including the study of bias and racism in the Hauora Māori curriculum, such as sampling graduate/postgraduate students, interviewing a greater number of patients, and undertaking detailed interviews with respondents to explore the findings using dialogue.

Indigenous leadership – Indigenous by design

The development of the Hui Process (Lacey 2010) and the Meihana Model (Pitama, Huria & Lacey 2014) was driven by the need for students to have an Indigenous guide to support meaningful clinical conversations. Both concepts have been explicitly aligned with the Otago Medical School's standard teaching model for clinical interviewing (the Calgary–Cambridge framework) (Kurtz 2003), and include specific components that prompt/encourage students to identify and/or enquire about bias and racism with Māori patients and/or their family/support networks.

Table 1 describes the contact points and learning methods at the Otago Medical School, Christchurch campus. The contact points focus on discussing or demonstrating competency in assessing the impact of bias and/or racism on Māori patients' health and wellbeing.

Table 1: Hui-ā-Rohe attendees, 2014

Session (time allocation)	Description of the session
Introductory lecture – Why Study Māori Health? (2 hours)	This is the first Hauora Māori lecture in the Advanced Learning in Medicine program in Year 4. The lecture is delivered in a situated learning environment on the marae (communal or sacred place). It provides social context regarding colonisation and introduces students to the impacts of bias and racism on the health and wellbeing of Māori.
Introductory Team Based Learning (2 hours)	This session is also completed in the marae environment and students are allocated dimensions of the Hui Process and Meihana Model to study, with relevant readings to answer specific questions. The student groups are required to explore institutional, interpersonal and internalised racism and how it might impact on health outcomes.
Advanced Team Based Learning (4 hours)	These sessions in Years 4 and 5 require students to provide a 360-degree perspective of a Māori patient case including relevant epidemiological profiles and consideration of bias and racism. Students are required to identify effective management strategies that address the presenting complaint as well as any issues pertaining to bias and racism (including institutional).
Lecture and Simulated Patient Sessions (8 hours)	These sessions are taught in the medical school environment during Years 4–6. In all sessions students are required to work through a patient case and develop enquiry questions related to the Meihana Model. This includes enquiring about bias and racism with a patient in a safe simulated environment where students can seek support from teaching staff and peers.
Hauora Māori Patient Cases – Summative Assessments	It is expected in Years 4–6 that students will complete three patient cases (two written and two oral). Students are graded using a marking schedule that clearly outlines that they must explore patient experiences of bias and racism.
Hauora Māori Objective Structured Clinical Examinations – Summative Assessment	Students complete Hauora Māori Objective Structured Clinical Examinations (OSCE) in Year 5 across all three clinical schools of the Otago Medical School. Within this high-stakes OSCE, students are expected to explore patient experiences of bias and racism in the health environment.

Faculty – What type of support is required?

In response to evidence of the impact of institutional and interpersonal health care practices (such as racial bias) on sustaining health inequities (Harris 2006a; Crengle et al. 2005), cultural competence curricula have emerged and become mandated within undergraduate and postgraduate health education in Aotearoa/New Zealand and Australia. National accrediting bodies now require medical schools to include Indigenous health as core curriculum content. The Indigenous health curriculum described in this case study has been formalised by Otago Medical School's ratification of the Hauora Māori learning outcomes. Alongside the graduate learning outcomes, the Otago Medical School requires all Year 5 students to complete a high-stakes OSCE in which students have to demonstrate competency in inquiring about bias and racism with Māori patients.

Support at a faculty level translates to Indigenous representation on all relevant faculty committees, and providing appropriate resources (time, budget and staff) to enable the successful implementation of a program similar to this case study.

Social accountability – How do we know that what we are teaching students about bias and racism in health is ok for the whānau²?

Each year a patient audit is undertaken by the Christchurch campus to ensure the curricula had addressed the needs of the local community, and to form the platform for the social accountability model. The audit randomly selects patients who have consented to be interviewed by a Christchurch campus student, and involves eight specific questions about this interaction via telephone. Ten patients from each clinical year (Years 4–6) are contacted (n=30 patients per year). Overall, patients report the interviews are a positive experience for them, and that they are comfortable about being asked of their past experiences of bias and racism.

> *At first I thought it was a bit of an odd question, but then as I began talking I realised that I did have some experiences that had affected me and it was good to be able to talk with the student about that.* P1 (2014)

> *It really made me think and I am glad that we discussed my experiences.* P2 (2014)

The social accountability framework is positioned by the Indigenous health teaching team as a key component of the Hauora Māori curriculum. As such, the team identified that it influenced the design, development, implementation and evaluation of how bias and racism were included in the curriculum.

Conclusion

This case study contributes to the evidence of teaching about bias and racism within medical education by identifying four key areas that are seen as crucial to ensuring students have an understanding of the impact of bias and racism on Indigenous patients' health and wellbeing.

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2   Whānau is the Māori term for family, support structure or community. In this case study whānau has been used to describe the local community that the students have contact with.

Preliminary evaluation of the Christchurch campus Indigenous health curriculum has reported both student and patient acceptability and satisfaction of including the study of bias and racism in the curriculum.

The challenge for the faculty is that Indigenous medical educators must be supported to be able to lead and design bold curriculum that enables students and practitioners to identify and address the impacts of bias and racism on Indigenous patients' health outcomes.

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For further information, contact:
Ms Tania Huria
Māori Indigenous Health Institute
University of Otago
E: tania.huria@otago.ac.nz

Unsafe learning environments: Indigenous medical students' experiences of racism

Dr Marcia Anderson DeCoteau, Ms Amanda Woods, Dr Barry Lavallee, Dr Catherine Cook, University of Manitoba, Canada

Introduction

Despite an increase in the numbers of Indigenous students studying medicine in Canada (Spencer et al. 2005), very few studies have examined the lived experience of being an Indigenous medical student or graduate, and the impact this has on their personal, professional, family and community life (Spencer et al. 2005; Garvey et al. 2009).

In 2012, the Faculty of Medicine at the University of Manitoba approached the Section of First Nations, Métis and Inuit Health to propose a study on the experiences of Indigenous medical students and graduates so as to better understand the factors that affect course attrition rates.

The purpose of the study was to examine the experiences of Indigenous medical students and graduates at the University of Manitoba, and the influence that being an Indigenous person in this context had on their life. This paper focuses on one particular finding of the research that was universal to all participants — the experience of racism during and after medical school.

Method/Approach

A mixed methods approach was adopted for the study. Quantitative and qualitative data were collected to capture demographic information on participants as well as their personal experiences and perspectives. Following approval from the Research Ethics Board of the University of Manitoba, a recruitment list of eligible participants was generated with the assistance of the university's Faculty of Medicine, Centre for Aboriginal Health Education, and Access and Health Careers Access programs, along with the Indigenous Physicians Association of Canada. The research team then sent invitations to all those eligible. Participant referral was also used, with some of those who agreed to participate and research team members suggesting names of other potential participants for the study. The defined study population was any self-identified First Nations, Métis or Inuit person who was admitted to the University of Manitoba's Faculty of Medicine between 1980 and 2008.

Each participant was asked to fill out a consent form and a demographic information survey, and to participate in an interview. Participant interviews, both in person and by telephone, took place over a five-month period. The interviews followed a semi-structured format to give participants the

opportunity to discuss matters that were important to them, and to encourage them to share their experience of life as an Indigenous medical student and, if relevant, the impact it had had on their life post-medical education. Areas of interest included:

- support systems available to them while at medical school and beyond

- perceptions of their quality of life

- their experiences of racism at and beyond medical school

- the role that their Indigenous identity plays in their experience of being a student and/or doctor.

Each interview lasted from 40 to 90 minutes and was audio-recorded and transcribed. Analysis occurred following the transcription of each interview.

The grounded theory method of inductive coding was used to analyse the qualitative data. As common experiences emerged from the shared stories and reoccurring ideas became evident, they were grouped into themes. These continued to develop when the focus shifted to the qualitative interviews and the critical issues emerging from that data.

Results/Outcomes

Of the 45 potential participants identified and invited to take part in the study, nine responded to the invitation and were recruited. Eight of the nine had graduated from the four-year undergraduate medical program with a modal time of four years and had continued on to careers involving clinical practice, teaching and administration. One participant was still an active student at the time of the interview.

The data from the interviews showed that there were many common or shared experiences of being an Indigenous medical student, including:

- experiences of 'otherness'

- stories of the challenges of studying medicine

- the learning opportunities available to them

- the importance of strength and resilience.

The universal experience highlighted by participants, however, was of racism within the medical school learning environment. Participants reported experiencing multiple levels of racism within the organisational culture of medical school – in both classroom and clinical settings – and felt actively discouraged to challenge or report those experiences. It is this theme of racism, as experienced by study participants, that is the focus of this paper.

One theoretical framework for understanding racism looks at the multi-levels of racism, how each is constructed, the relationship between the levels, and how each impacts upon the individual (Jones 2000). To better understand the various experiences of racism from the Indigenous medical learners' perspective, the study used the three categories of multi-level racism – institutionalised racism, personally mediated racism and internalised racism – as well as racial micro-aggressions.

Racial micro-aggressions

Racial micro-aggressions are often quick and common verbal, behavioural or environmental indignities, said or done either with or without intention in order to communicate hostile, derogatory or negative racial slights and insults towards people of colour or people considered to be of an 'other' racial background (Wing et al. 2007).

Participants described many types of racial micro-aggressions including the following assumptions they experienced as an Indigenous medical student:

- medical school expenses of Indigenous students are paid for

- Indigenous students do not have to meet the same medical school entrance requirements and are, therefore, less qualified

- Indigenous students are experts in 'all things Aboriginal'

- targeted admissions processes confer an unfair advantage on Indigenous students

- Indigenous students are 'too sensitive'.

Institutionalised racism

Institutional racism can be understood as differential access to the goods, services and opportunities of society by race, or unearned privilege, and is manifested both in material conditions and in the access to power (Jones 2000). The pressure to assimilate within the dominant Western medical culture is one example of institutional racism. Such an attitude is supported when racist behaviour is tacitly permitted by the absence of any reporting mechanisms to senior authorities within the institution that are perceived as safe or effective.

Although 100 per cent of study participants described experiencing racism within the medical school environment, only two tried to challenge racism as a learner. Others expressed regret at not having challenged the racism they experienced, but felt unsafe to do so:

> *You can't be an Aboriginal person in medicine you have to be mainstream. And if you're not you're going to sink quickly.* (P7)

> *I certainly observed many episodes of racism. And I did nothing about it… because I think when you're a student you're still so low down on the food chain that you don't really speak up against authority and you don't challenge people.* (P2)

> *I think definitely that racism within our Faculty is so prevalent and so obvious it's really traumatising.* (P7)

Personally mediated racism

Personally mediated racism involves prejudice – differential assumptions about the abilities, motives and intentions of others according to their race – and discrimination – differential actions towards others according to their race (Jones 2000). Indigenous medical student experiences of personally

mediated racism range from rude and ignorant comments from peers or faculty members to life-threatening examples. One participant commented:

> Like when people would say really mean things and so it's like what [to] do in a hierarchical structure like when I was a third year student [on] my obs rotation and the senior resident said... in a room... just a small room not much bigger than this with... five or six medical students and residents in it... and she was the senior, [she] said that the best thing for Canada would be if native people stopped reproducing. Well considering [the] hierarchical structure where most people know that most of the time it's the senior residents who fill out your evaluations and you know the program directors are going to defend their senior residents. And anyone who complains is a trouble maker. (P5)

Another former medical student told the story of how she observed and experienced extreme racism in the hospital setting when her father had had a heart attack. Alerted by family that her father had gone to the hospital emergency room, upon her arrival the doctors attending him did not know she was the daughter of the patient; they assumed she was there because she was working.

> ... my dad had a breathing tube in and he was hooked up to a IV and a whole bunch of monitors and he's sitting on the edge of the bed trying to fight a bunch of people off who are trying to force him to lie down. He was not sedated which is standard of care for people who are intubated. And... I looked at the emergency doctor... and said: 'Why is he not sedated?' And he said: 'Because we didn't know what he was on.' Like they just assumed... he had a cardiac arrest because of intoxication of some kind or other, [but] your first assumption should be heart attack until proven otherwise. Because he was also visibly First Nations the[ir] first assumption was he's high or drunk on something.

> So I looked at the respiratory therapist and said: 'Does he need to be intubated?' He said: 'Yes'. I looked back at the emergency room doctor and I said: 'Sedate him now'. And so they did. And then I said, 'What did the [electrocardiogram] show?', again because cardiac arrest is a heart attack until proven otherwise. And he said: 'We didn't do one'. And I said: 'Why not?' And he said: 'He was fighting too hard'. As if he was not sedated because he was drunk or high so he was uncooperative and fighting so were not going to get him any real medical care. And so I said: 'Well you better call them now'.

> So they called the [electrocardiogram] down, that took a couple minutes. The [electrocardiogram] tech also knew me... and I don't think realised it was my dad [but] also thought I was just working. Printed off the [electrocardiogram] and handed it to me while the emergency doctor was still standing across the bed... dumbly and now it's silent in the room right because everyone knows that they've been caught in this. And he's having a massive heart attack.... and so I hold it around because it's not the kind of thing you need to see close up to know that he's having a massive heart attack.

> And I said: 'Who's going to call the cath lab?' to the [emergency doctor]. And he was just dead silent and he didn't even have an answer. So I just looked at... my friend and said: 'Can you call Dr XXXX please'. Because I knew... exactly who was on call that night for caths and so Dr XXXX was called, I stayed in the room with my dad until he was transferred. I was the one who went

and talked to my family about what was going on and how sick he was because there was no way I trusted that doctor to do it. Plus now he was just terrified because he had delivered substandard care that put my dad's life even at more risk than it already was because of that heart attack that he was having. (P6)

This participant had been deeply impacted by the racism inflicted upon her father in the emergency room. Years later, as she told her story, she was still impacted by the lasting trauma of the incident. It affected her relations with colleagues, her trust in other medical professionals and her trust in the medical system. Never had she been given an opportunity to share her story. Instead, it remained internalised among the many other instances of racism she had experienced as an Indigenous medical student. Despite the trauma, she found the strength to continue on and complete her residency. And she was finally able to share her story when she was asked about her experience of medical school as an Indigenous learner.

Internalised racism

Internalised racism involves acceptance by members of stigmatised races of negative messages about their own abilities and intrinsic worth, which is characterised by not believing both in others who look like them and in themselves (Jones 2000). It was not uncommon for participants to describe internalised racism in their discussions about being Indigenous. Comments included the following:

When I was growing up I actually really believed that it was better to be white… as a child I used to wish for… you know, blonde hair. I used to wish for blue eyes. I used to wish that my family wasn't poor. (P1)

My background is Métis but we didn't know that… because… it was not something my grandma wanted anyone to know or [we] even talked about. (P2)

I looked at the ground because I was sure that if I looked you in the eye you would see nothing. You would see emptiness. (P4)

We might be Indians but we're not like the rest of them. (P5)

Discussion

The data show that Indigenous medical students' experiences of racism regularly impact on their lives from admission through to graduation and beyond. This is because the structural hierarchy evident in medical schools and clinical settings embeds racial power imbalances, and fosters, as a consequence, oppression and disadvantage for Indigenous students. Although there is a body of literature that describes the recruitment options and student support systems available to Indigenous medical students, with the aim of increasing the numbers of Indigenous physicians (IPAC & AFMC 2008; Spencer et al. 2005), these do little to address the structural and systematic violence that Indigenous learners experience in the medical school and learning environments. This violence, represented by the universal experience of racial micro-aggressions and racism, must be addressed as an ethical and rights-based imperative if the successful graduation of Indigenous medical students is to increase.

The data also highlight the critical need to turn the gaze from the students as the primary or sole source of academic or social difficulties to the structure, policies and discourses of the faculty that create an unsafe learning environment for Indigenous medical students. Razack et al. (2015) suggest that the current approaches of medical schools to diversity hamper their efforts to produce Indigenous physicians. Instead, they produce physicians who happen to be Indigenous. In other words, students are forced to abandon their Indigenous identity in order to succeed.

We believe that it is essential that we graduate Indigenous physicians – those who champion their Indigenous identity and context as important to their professionalism. It is a view consistent with the Royal Commission on Aboriginal Peoples (Hurley & Wherrett 1999) and the message emerging from communities who wish to be seen both by an Indigenous health care provider and as Indigenous peoples within the context of an Indigenous perspective on wellbeing.

The following recommendations from this study have been submitted to the College of Medicine at the University of Manitoba to address some of the root causes of the current unsafe learning environment:

- The need for a critical review of all written material that references 'Aboriginal applicants' in the medical curriculum.

- Transparency about the rationale for a separate stream on Aboriginal health.

- Transparency on the requisite information being evaluated for applicants to the Aboriginal separate stream.

- The need to address student and staff perceptions of the status of Indigenous as compared to non-Indigenous medical students.

- Faculty education to redress biases that are being transmitted to learners.

- The introduction of a course requirement that involves a critical examination of historic or contemporary Indigenous issues so as to increase the baseline knowledge of all medical students, to reduce peer bias and to decrease the need for Indigenous medical students to play the role of expert.

Current Faculty education on Indigenous issues – including racism, reconciliation and Indigenous ideologies and methods – has increased and been positively attended, and efforts are being made to move forward with all recommendations from this research.

Continued challenges, however, include resistance to change both by students and faculty, difficulty in obtaining access to student files to better understand the rates of attrition and other factors impacting upon the lives of Indigenous medical students, and lack of funding to support programs to train more Indigenous learners and staff. Further research needs to be conducted with Indigenous medical students to hear and record their shared experiences so that others can also understand the impacts of medical school on the lives of Indigenous learners. Further, without the full support of the College of Medicine, the research team was unable to use student records to collect information on graduation rates of all identified potential participants. However, analysis of this information is crucial for a better understanding of why Indigenous students do or do not graduate from medicine.

Conclusion

In these stories from former medical students, we find evidence that Indigenous learners experience various forms of racism within the medical school learning environment. Little has been described in the literature to date as to how these issues should be addressed. This study highlights the need for an ethical and rights-based approach to combatting racism and racial microaggressions if the successful recruitment and graduation of Indigenous medical students is to occur.

From the data it is evident that First Nations, Métis and Inuit people experience significant socially constructed barriers that have an impact on Indigenous medical students. A commitment has been made by the University of Manitoba to address these barriers, thereby effectively acknowledging these experiences as harmful and detrimental to advancing a healthy First Nations, Métis and Inuit health care workforce.

An example of this are the findings from the Truth and Reconciliation Commission of Canada's final report in December 2015 on the history and experiences of the Canadian residential school system for Indigenous children (TRCC 2015). Included in the report are 94 Calls to Action that must be made to redress the legacy of residential schools in Canada and to work towards true reconciliation. The continuing push to end to all types of racism experienced by Indigenous medical students resonates with the Calls to Action of the Truth and Reconciliation Commission as a step towards healing and self-determination.

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For further information, contact:

Dr Marcia Anderson DeCoteau

Department of Community Health Sciences

University of Manitoba

E: Marcia.AndersonDecoteau@umanitoba.ca

Shifting understandings: Do scenario-based clinical decisions change with immersion?

Associate Professor Deb Askew, Southern Queensland Centre of Excellence in Aboriginal and Torres Strait Islander Primary Health Care (Inala Indigenous Health Service), Professor Shaun Ewen, The University of Melbourne and Professor David Paul, University of Notre Dame Australia, Australia

Introduction

There is evidence that health professionals' decision making contributes to health disparities (Burgess, Fu & van Ryn 2004; Curtis et al. 2010; Dovidio & Fiske 2012; Harris et al. 2012; Smedley, Stith & Nelson 2003). This paper reports on the Inala Project, a study conducted at the Inala Indigenous Health Service (an urban comprehensive Indigenous primary health care service in Brisbane's south-west) as part of the Educating for Equity Decision Making in Health sub-project.

The Inala Project continues our inquiry into factors that might influence the quality and nature of clinical decision making in an Indigenous health context (Ewen et al. 2015).[3] Our previous study, reported in Ewen et al. (2015), involved final year medical students from two graduate entry medical programs (one in Melbourne and one in Honolulu). The participants were given a paper-based patient scenario to explore the impact of patient ethnicity on their assumptions, clinical decision making and construction of the person in the scenario. The Inala Project, using the same paper-based scenario, aimed to explore the influence of a clinical placement at the Inala Indigenous Health Service on participants' assumptions, knowledge and understanding of Indigenous peoples and Indigenous health.

Method/Approach

The primary aim of our research was to determine if a clinical placement in an Indigenous primary health care service influenced clinical decision making. We also sought answers to three sub-questions:

1. What are the factors/assumptions that influence medical student/registrar clinical decision making?

2. What are the contextual influences on participant responses?

3. How do participants understand the influence of the immersion experience on their clinical decision making?

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[3] We use the terms 'Indigenous patients' and 'Indigenous peoples' to refer to Australian Aboriginal and Torres Strait Islander peoples.

The 11 participants in the Inala project – seven medical students and four registrars (three in general practice and one in psychiatry) – undertook clinical placements at the Inala Indigenous Health Service during 2014. At the commencement of their placement, participants were given the paper-based scenario discussed above as part of their orientation to the service. This scenario described the presentation of Liz, a 46-year-old Indigenous woman, to a comprehensive primary health care service for a long consultation following a health check the previous week. The scenario contained a range of information including:

- a diagnosis of Type 2 diabetes mellitus

- symptoms suggestive of poor blood sugar control, particularly tiredness and urinary frequency

- a two-month-old sore on her foot

- HbA1c test result of 9 per cent from 12 months ago as reported by the patient

- a particular set of family social circumstances, including frequent relocations because her partner is in the airforce, and having four children, the youngest of whom is deaf, and one grandchild.

The participants were asked to read the scenario, which deliberately did not include a lot of detail about Liz and her family, and provide written responses to five questions relating to her clinical care. On completion of the written task, participants took part in a semi-structured interview to explore their written responses, their imaginings of Liz as a person and any assumptions underpinning their clinical decision making. At the end of their placement, the participants were asked to review their earlier responses and reflect on any changes in their knowledge, understanding or assumptions about Indigenous people and their health care needs, and what, if anything, they would now do differently as a consequence of what they had learnt.

Both sets of interviews were recorded and transcribed. The preliminary thematic analysis of the pre-placement interviews confirmed the key themes identified in our previous study (Ewen et al. 2015), namely:

- perceptions of the patient as a person

- constructions of the person as a patient

- perceptions of the dynamics and priorities in the patient/doctor interactions

- the impact of the educational setting.

These themes were then used as the analysis framework for both pre- and post-placement interviews.

Additionally, analysis of the post-interviews also focused on identifying changes in participants' assumptions, understanding and knowledge of Indigenous people and Indigenous health, within the analysis framework. In an iterative process the thematic analysis was undertaken by one of the research team and shared with the others to confirm the emergent themes and their interpretation. This process continued until consensus was reached.

Results/Outcomes

Of interest to us was that the Inala participants' written and pre-placement interview responses closely mirrored those of participants in our previous study, reinforcing that data saturation had been reached. This was despite the different nature of the Inala participants, with a mix of medical students and registrars. For example, when considering Liz as a person, respondents tended to be largely influenced by negative stereotypes both of Indigenous people and of those with Type 2 diabetes in the pre-placement interviews, as exemplified in the following extract:

> … [her] physical appearance, well, I'm just – based on the fact that she has Type 2 diabetes, that she would probably be overweight. I'm picturing her as the traditional appearance of an [Indigenous[4]] woman… darker skin, dark hair… (P5)

Post-placement, participants more readily acknowledged their assumptions, and the realisation that people cannot be categorised based on assumptions informed by ethnicity or health status. They now recognised greater complexity and nuance, for example:

> … I guess [Indigenous] heritage and identifying as an [Indigenous] person, they come in all colours and shapes and forms… and so it's very hard to make judgments about people and their backgrounds and their cultures just on physical appearances… yeah, I think I was [surprised at the wide range of Indigenous colours]… cause it's one thing hearing about, you know, people suggesting that in lectures and talks and things, but to experience it yourself… it's reinforced it… (P5)

As a patient, Liz was initially perceived by some participants to be 'frantic' or 'frustrated' and 'pretty poorly' and 'not in good spirits'. She was assumed not to prioritise her health, to focus more on her family than herself, to have low health literacy, and to be unwilling to share information with the doctor, as is highlighted in the following extract:

> … she might be a little dismissive or evasive about details… perhaps to avoid disclosing some of her problems or admitting to not having done things as she had been advised in the past… (P3)

Post-placement, participants reflected on her resilience and strength and her ability to cope with multiple relocations. Some reflected on the possible reasons why her diabetes was not well managed, with a focus on potential access barriers or failures in the health system to provide adequate follow up. There was also an increased realisation of the interconnections between physical health and the ability of a person to maintain effective roles within their family and community as the following quote reveals.

> … I think family roles and community roles… and being able to fulfil those is probably the main priority, and then definitely physical health comes afterwards in spite – obviously they overlap and interplay and very much effect each other… (P5)

Perceptions of the role of the doctor also changed pre- and post-placement. Pre-placement, participants spoke of the need to be patient centred, and to take a holistic approach to care.

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[4] Note: in the case scenario the authors used the term 'Aboriginal' as this was both accurate and the preferred term locally. For this publication the term 'Indigenous' has been used for consistency.

They perceived her Indigeneity as being a factor that increased the complexity of the consultation, with some feeling overwhelmed and a sense of clinical hopelessness, and most tending to focus on the challenges that they and Liz would experience in improving her health and wellbeing. Most participants questioned Liz's health literacy and her desire and ability to engage actively with the health care system.

> … I guess a slightly poorer understanding of health care… the medical side of things… and the processes, and the way the system functions, I guess is what I would have assumed… also probably a bit less willingness to keep coming regularly to the doctor… (P7)

After the placement, participants described how they had gained a deeper understanding of what patient-centred, holistic care actually meant, having gained practical experience to supplement the theoretical knowledge gained at medical school. They also realised that, as a doctor, they had a role in addressing the negative impact of the social determinants of health. Participants also learnt that Indigenous people can be active members of their health care team, and are willing to engage with the health care system.

> … before [the placement] maybe if someone said, 'oh, we've got this available and this available' I might have thought 'oh yeah' but is anyone really going to want to use it?... [I've learnt that] people are keen to… use whatever is available to help themselves… maybe they might be a little bit health-illiterate to start with but… it's not [not] caring, it's just they're not aware of what they need to do and then once it's offered they'll grab hold of it like a lifeline… (P11)

Through the placement, all participants reported that they were stimulated by exposure to Indigenous peoples and doctors who were passionate both about Indigenous health and about health research and evidence-based practice. Additionally, exposure to the local Indigenous community gave participants an appreciation of how patients' social and historical context impacts on their health, and vice versa. As one participant commented:

> … I've got a better understanding of what would be going on with Liz in the environment she lives in… her family… what she would be experiencing… I've got a bit more knowledge of the difficulties and the situations in that place… I've also got a better understanding of what she would have undergone earlier in her life … she might have undergone [things] earlier in her life which could be… not contributing but shaping the way she would cope with the stress at this stage… (P8)

Discussion

As this preliminary analysis shows, all participants at the end of their placement in a well-resourced Indigenous comprehensve primary health care service revealed a consistent shift away from both a narrow focus on biomedical care and, to some extent, a sense of clinical hopelessness compounded by Liz's health status, perceived social situation and Indigeneity. Participants displayed a better understanding of the complexities contained in the presented scenario, a greater awareness of the need to address the social determinants of health, and an increased perception of how their previous assumptions were based on negative stereotypical characterisations of Indigenous peoples. A shift occurred for all participants irrespective of the length of their placement, which ranged from four weeks to 12 months, or the stage of their training.

This research provides evidence that a clinical placement in an Indigenous health service can make a profound difference in student perceptions, clinical decision making and assumptions, and in their ability to adopt a more comprehensive and holistic approach to care. Knowledge gained at university through lectures or textbooks (intellectual knowledge) became practical knowledge, and challenged participants to broaden their thinking about the role of a doctor and their assumptions about the Indigenous peoples of Australia.

However, questions remain. What are the essential elements of the experience that were transformative for participants? Can these elements be replicated in other settings? Is a placement in a comprehensive Indigenous primary health care setting enough or do the resourcing and particularities of the setting play a part? How can this change be sustained as medical students enter the challenging educational environment of the hospitals, with the registrars' focus on passing exams? Are the changes evident in this project able to be translated into long-term changes in clinical reasoning and decision making? If so, does this then necessarily lead to a reduction in health disparities? These are questions that require further research and enquiry.

The small number of placements that are actually available in comprehensive Indigenous primary health care settings also limits the potential to scale up and spread this intervention. This leads us to ask whether the changes in thinking can be facilitated in other settings, and what is the dose response required for positive change? These are all questions that the research team is attempting to answer in the next phase of the Inala Project.

Conclusion

We found that a clinical placement in this Indigenous-specific comprehensive primary health care service expanded participants' perceptions and understanding of the strengths and resilience of Indigenous peoples and communities, and enabled a more inclusive approach to clinical care. Tertiary education institutions have a responsibility to provide meaningful learning and teaching opportunities in Indigenous health, which, given the right setting, duration and resourcing, have the potential to be transformative. However, it is too soon to tell if such opportunities will translate into long-term meaningful shifts in clinical decision making and if, in turn, this would correlate with a reduction in the health disparities experienced by Indigenous peoples.

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For further information, contact:

Associate Professor Deborah Askew

Primary Care Clinical Unit, Faculty of Medicine

The University of Queensland

E: d.askew@uq.edu.au

An immersive model of learning in Aboriginal Community Control Services for MBBS students

Ms Christine Carriage, Ms Jenny Akers and Ms Kristy Payne,
Western Sydney University, Australia

Introduction

The Western Sydney University (Western) Indigenous Health Attachment (IHA) commenced in 2011 following the release of a commissioned report (Morgan & Woolford 2009). This paper details the activities developed in response to that report by Western's School of Medicine to prepare medical students for attachments in Aboriginal and Torres Strait Islander health service environments, and to ensure an effective and meaningful experience for both students and the Aboriginal services and communities they serve.

Western's School of Medicine is dedicated to serving the interests of those who have had poor access to high-quality health care, and to improving the health and quality of life of those living in the Greater Western Sydney community and beyond. As Greater Western Sydney has a large Indigenous population, an important part of the School's vision is to play an active role in addressing the health inequities experienced by the local Aboriginal communities through developing a workforce that is equipped to work effectively with those communities.

The IHA was developed to provide an opportunity for every final year medical student to better understand the medical, social and cultural aspects of Aboriginal health. To achieve this, the program places students in an urban, rural or remote Aboriginal Medical Service (AMS) to facilitate a practical health care experience in a culturally safe environment. It also provides a unique opportunity for the students to observe the complex roles of Aboriginal health professionals, to see multidisciplinary health care in action, and to understand the importance of community control in health care delivery and associated services (Goodall 2012).

Method/Approach

The IHA program is part of the final fifth year curriculum at Western and is compulsory for the entire student cohort (including both domestic and international students). It links to the School of Medicine's rural program by means of Commonwealth reporting parameters. Students participate in a half-day lecture prior to commencing the IHA. This lecture prepares them for their placement by focusing on issues related to travelling and living in rural locations (if relevant); cultural safety and other protocols; Indigenous health statistics; and the structure and function of AMSs. Students are allocated to an AMS in pairs and spend five weeks immersed in the organisation and its community. During this time, they must complete five weeks of reflective journals, a 360-degree assessment, and a project that benefits the organisation.

Each AMS operates the IHA differently, with an orientation provided on arrival by a cultural mentor who orients students into the community, organisational structure and local cultural protocols. Students are supervised by AMS Practice Managers who organise timetables and student projects. Students' placement in GP clinics are scheduled for the minimum amount of time to ensure they have a rounded experience at the health service, one which takes into account the holistic health care approach.

Due to the large number of students in each cohort, and the small number of available places in metropolitan AMSs (Nelson, Shannon & Carson 2013), placements are primarily located in rural and remote areas of New South Wales (NSW). Students who undertake 12-month placements in rural clinical schools complete their IHA with services in the regional towns of Lismore and Bathurst. In total the School attaches students to 22 AMSs across NSW.

The aims and objectives of the IHA program are set out for the students as follows:

- To understand how to work effectively with Aboriginal people
- To understand the concept of Aboriginal community control and self-determination
- To comprehend the range of services offered in an Aboriginal Community Controlled Health Service and how it connects in delivering health care to Aboriginal people and community.

The School has been conducting an annual evaluation of the program with representatives of the AMS partners since 2012. In 2014 the Indigenous Programs Officer and the Rural Program Manager at the School of Medicine included a student survey in the evaluation of the program, the results of which are described in the next section.

Results/Outcomes

Student evaluation

The purpose of the student survey was to gain an insight into the students' experiences of living and working in an Aboriginal community, as well as the benefits and/or challenges for the AMS. The online survey included 30 questions with answers recorded using a Likert scale. Questions were grouped under 'Preparation and arrival/orientation', 'Clinical experience' and 'Reflections on the IHA', and aligned to the following objectives:

- To track students' connection between theory and reality
- To draw out students' awareness of the influence of social determinants on health
- To demonstrate students' awareness of the importance of community involvement
- To understand the students' appreciation of the complexity of the roles of Aboriginal Health Workers and other health professionals in AMSs
- To track factors contributing to the students' development as doctors.

The Attachment has seven teaching sessions throughout the year and can involve between 10 to 20 students per teaching session. Over the course of 2014 a total of 93 (72%) students out of 128 responded to the surveys.

Preparation and arrival/orientation

Students reported that they are generally apprehensive when they first go out into the community as many have had little exposure to any Aboriginal health setting. Some students in rural or remote locations may still be living at home and are anxious about living without family members nearby. The results indicated that a structured welcome and orientation by staff at the AMS is a major contributor to making students feel comfortable, with 93 per cent feeling that this had helped them to overcome their anxiety and assisted with fears about offending people, their safety in the town and their role within the service.

Clinical experience

Students reported having exposure to a wide range of clinical problems (54%) at the AMS, and that this expanded their understanding of the social determinants of health (92%) and the historical impact of colonisation on Aboriginal people (77%). Students felt well supported by the AMS staff and 81 per cent said that their understanding of Aboriginal health improved, while 79 per cent said that working with Aboriginal people contributed to their development as a doctor. Fifty-four per cent of students believed that their interactions with Aboriginal people during the Attachment challenged their pre-conceived perspectives and assumptions, and 79 per cent felt more confident communicating with Aboriginal people by the end of their placement.

Reflections on the Indigenous Health Attachment

Students were asked if the IHA was challenging for them personally. Responses were mixed, with 40 per cent saying that it wasn't challenging and 37 per cent saying they were unsure. Sixty-four per cent reported that their understanding of Aboriginal culture had been changed by their experiences during the Attachment, and 74 per cent thought it had been very worthwhile. When the focus shifted to workforce intentions, less than half of the respondents (48%) indicated they would consider working in an AMS, approximately 36 per cent were unsure and 16 per cent said that they would be interested in returning to an AMS once they graduated.

Qualitative data collected from the 2014 evaluation suggested that placements could be improved by some attention being given to their structure, particularly as at times there were low patient numbers in the clinics and idle time could be better utilised. Some commented that they wanted more time on community projects.

Students reported that the most rewarding aspect of the IHA was the opportunity to be involved in the community. Specific examples of this included: attending community events (including funerals); speaking with Aboriginal people about their personal stories and family histories; being welcomed formally and informally by the community; and being immersed in Aboriginal culture. As one student wrote in the evaluation survey:

> *Experiencing first-hand the things we hear about regarding rural and Aboriginal health, spending time with people in the community and getting to know them; I very much enjoyed yarning. And AMSs indeed are a good place for students: staff are friendly, welcoming and acknowledging students' needs and willing to help in students' learning.* (IHA student evaluation survey)

Aboriginal Medical Services community partners evaluation

AMS community partners have been evaluating the program since 2012 but this paper analyses only the responses to the 2014 survey. The survey was distributed online to those AMS staff responsible for supervising students, with a total of 17 staff participating from a possible 22 AMSs. There was a total of seven questions focusing on relationship building, roles and responsibilities, and concerns about the program.

Of the AMS community partners who undertook the survey, a total of 15 (88%) indicated that they had developed good relationships with the students at their service. Nine (53%) stated that they had no concerns with their role and responsibilities as a supervisor, while eight (47%) indicated some concern. When partners were asked if they had any concerns with regard to the IHA, 20 per cent identified the amount of time needed to supervise students, 40 per cent stated the time it took to coordinate placements and 53 per cent the amount of human and physical resources required of the organisation. Fourteen participants indicated that being part of the IHA provided an opportunity to influence the training of future health professionals and 10 stated that the benefits of working with students outweighed any additional workload.

Since 2012, the School of Medicine has invited AMS Community Partners to the University for an end-of-year workshop, which is designed to further develop the IHA, ensure content is up to date and provide a space for the partners to network and discuss the program. It is also used as a forum to build the capacity of AMS staff to develop skills in supervising, teaching and working with students. The relationship developed over the past five years with the Chief Executive Officers, Practice Managers and staff of the AMSs is evidenced by their regular attendance at these workshops and their participation in the IHA each year.

Discussion

Since the commencement of the IHA in 2011, the program has seen a total of 527 (2015) final year medical students attend a five-week placement in one of 22 Aboriginal Medical Services across NSW. It provides a unique opportunity for students to spend a significant time in an Aboriginal health setting, prepares our graduates to work with Aboriginal patients within hospitals and community settings, and opens up possibilities for students to consider a career in Aboriginal health and/or in rural or remote communities.

The students can, however, find the placement challenging as it can be a very different experience from other clinical attachments and may take them out of their comfort zone. Some respond positively to this experience, while others take some time to understand the benefits and broader learnings (Ross et al. 2013).

While the formal evaluation by students did not commence until the fourth iteration of the program, AMS community partners have been evaluating the IHA since 2012. These earlier evaluations by the partners, although not reported here, have provided valuable insights into the ways in which the relationship between the Medical School and the AMSs could be improved and developed. This includes details on the training needs of community partners and students' preparedness for working in the community, both of which have been actioned over the years.

Although AMS supervisor comments are mostly positive regarding their experience with students, there are some areas of concern. The issues highlighted include the time commitment needed for student supervision, the coordination of placements, and the human and physical resources required during the placement. This indicates that the School of Medicine needs to take these issues into consideration and work with the AMSs on ways to resolve them in future programs. The University does encourage back-to-base contact for both students and supervisors, and values supervisors' regular feedback and suggestions as to how the IHA can be improved.

The relationship between the School of Medicine and the AMS community partners is based on reciprocity and capacity building, with the School providing student placement agreements that outline the roles and responsibility of the School, the student and the service provider. The relationship goes beyond student placements, however, with university academics working in clinics; collaboration on infrastructure grant submission processes; a part-time research officer placed in one AMS; and collaborative input into the development of the IHA program. Financial contributions have also been provided to the AMSs in the form of reimbursement for accommodation refurbishments, office equipment to enable students to complete research tasks, and clinical equipment. Funding of the IHAs (student travel and accommodation) comes from the Rural Clinical Training Scheme budget in line with achieving Parameter 6 (previously Parameter 7) under the scheme.

The IHA program could be further improved by the employment of a full-time Indigenous academic, but despite active long-term recruitment efforts this position is yet to be filled. There is also a need for more lectures on Aboriginal health earlier in the curriculum to better prepare students for their placement. Continuing evaluation of the program will enable the documenting of best practice engagement to ensure benefits for students and organisations.

Conclusion

The IHA program has made a significant contribution to the medical students' learning experience at Western Sydney University, and has been beneficial in engaging the AMSs to contribute to the development of the future medical workforce. It provides the opportunity for students to better understand the social, historical and economic factors that have impacted on Aboriginal peoples' health and the ways in which appropriate health care can be provided to effect change. The 2014 student surveys demonstrate that their placements have led them to a better understanding of the holistic nature of Aboriginal patient care through immersion and experiencing Aboriginal health in a community setting. This conclusion is also reflected in the annual evaluation from the AMS community partners.

The most significant achievement, however, is that the IHA is an Aboriginal-led and engaged program developed over the past five years in close collaboration with the community partners. It is unique for a university to have such close connections to the staff of AMSs, using both formal and informal processes, and the program is supported by the Dean and driven by a team of staff from the Rural Clinical School and the Aboriginal and Torres Strait Islander Programs. Data will continue to be collected from both students and AMSs, and used alongside long-term tracking of alumni in 2016 to generate evidence as to the benefits of the IHA and to inform its improvement.

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For further information, contact:

Ms Christine Carriage

School of Medicine

Western Sydney University

E: c.carriage@westernsydney.edu.au

Judging a book by its cover: A visual artwork assessment for medical students

Assistant Professor Craig Allen, Dr Christine Clinch and Dr Paula Edgill, University of Western Australia, Australia

Introduction

The Centre of Aboriginal Medical and Dental Health (CAMDH) was established in 1996 at the University of Western Australia (UWA) to increase student recruitment and provide support for Aboriginal and Torres Strait Islander students in the medical and dental courses (Paul, Carr & Milroy 2006). In addition, CAMDH was responsible for developing a comprehensive, integrated Aboriginal health curriculum that was implemented horizontally and vertically into the undergraduate medical course from 2000 onwards (Paul, Carr & Milroy 2006). In 2014, UWA transitioned from a six-year Bachelor of Medicine, Bachelor of Surgery (MBBS) course to a four-year graduate entry Medical Doctorate (MD) course. Transitioning to the graduate entry course required all teaching disciplines, including Aboriginal health, to re-evaluate their curriculum to ensure that key content embedded into the new curriculum enhanced student learning experiences and provided a knowledge base to graduate doctors with skills beyond basic medical competencies.

The transition to the graduate entry course presented both opportunities and challenges for CAMDH. The challenge was to ensure that the Aboriginal health curriculum continued to be horizontally and vertically integrated into the four-year course in a meaningful way. The opportunity lay in the ability to conceptualise new ways to engage and assess students. One example of this, and the focus of this paper, has been the introduction of a visual arts assessment for first year medical students.

Within medical education internationally, the visual arts have been used to enhance observational ability, improve diagnostic skills, increase the span of listening to the patient, and deepen compassion for suffering (Elder et al. 2006; Karkabi, Wald & Cohen Castel 2014; Reilly, Ring & Duke 2005; Bramstedt 2016). Art and storytelling remain a powerful means for communicating and understanding information. Medical schools and residency programs have increasingly incorporated various works from the humanities as tools to stimulate dialogue, discussion and awareness among their medical learners, particularly in areas of doctoring, the experience of illness and end-of-life issues (Elder et al. 2006; Karkabi, Wald & Cohen Castel 2014; Reilly, Ring & Duke 2005; Bramstedt 2016; Penn State News 2016).

The aim of introducing a visual arts assignment into the Aboriginal health curriculum was to provide students with an opportunity to explore the realities of Aboriginal health through a cultural

lens. Since colonisation there have been, and still are, multiple factors that influence health and wellbeing in the Aboriginal and Torres Strait Islander population (Griffiths et al. 2016; RACGP 2012). A better understanding of these factors, as well as the utilisation of a holistic framework, is integral to providing culturally safe and secure health care services consistent with best practice health models (Griffiths et al. 2016; RACGP 2012).

Historically, Aboriginal and Torres Strait Islander culture has been expressed in a number of different modalities including oral language, song, dance, paintings and engraving. Stories related to Aboriginal and Torres Strait Islander spirituality, connection to Country, kinship system, and (law) lore facilitate cultural continuity. The assessment requires students to express their early understanding of Aboriginal health in a format that is culturally oriented and unique within the medical curriculum.

In this paper we outline the innovation behind the concept, reflect on the receptiveness of students and staff, examine the influence on student engagement with and understanding of Aboriginal health, and consider the implications for future student cohort engagement and whether it should remain in the curriculum. Finally, we discuss the transferability of this assessment to other health-related disciplines.

Method/Approach

The visual arts assignment implemented within the MD at UWA required students to identify and outline the factors that influence Aboriginal health, show an understanding of the enablers and barriers to promoting health, and evaluate the strategies and resources required to improve health outcomes. The assignment was made up of two parts: a visual arts piece and a 1500-word written component. Through the visual arts piece, students were asked to provide a symbolic representation of the topic identified and communicate a story to the observer. It was assessed based on a student's ability to convey the message(s) and to reflect the central themes, and was considered as a stand-alone piece aside from the written component.

The aim of the written component was to build on the themes identified in the visual artwork, clarifying the symbolism and discussing the themes in greater detail. It was assessed based on a student's ability to consider Aboriginal and Torres Strait Islander culture, and demonstrate an understanding of the issues identified. The activity was designed to promote student self-directed learning by giving students the chance to work independently in a way that builds up their own critical thinking, as well as their confidence in the material (Rasmussen 2001).

CAMDH developed a scenario based on the Australian Government Productivity Commission's report Overcoming Indigenous Disadvantage: Key Indicators, which is a framework that aims to measure the wellbeing of Aboriginal and Torres Strait Islander people and communities (Steering Committee for the Review of Government Service Provision 2014). The report provides information about outcomes across a range of strategic areas and whether policies and programs are achieving positive results for Aboriginal and Torres Strait Islander Australians.

The visual arts assignment task, and the themes from which students could select, are outlined below:

The next edition of the report, Overcoming Indigenous Disadvantage: Key Indicators is scheduled to be released next year. Premier and Cabinet state that the Prime Minister is committed to the National Action Plan. Further to this the Prime Minister recognizes that in order to work through the issues, a more longitudinal approach is required and so has requested that medical students gain a greater understanding of the issues from an earlier age in their careers, as the issues will still exist upon graduation. Therefore, as a medical student here at UWA your assignment task is to create the cover artwork for the Overcoming Indigenous Disadvantage: Key Indicators document. Students are to select a topic from the following themes: Governance, Leadership and Culture; Early Childhood Development; Education and Training; Healthy Lives; Economic Participation; Home Environment; Safe and Supportive Communities.

Students were given the option of creating their visual piece using contemporary and/or traditional artwork. CAMDH allowed them to engage in traditional painting styles using Aboriginal and Torres Strait islander symbols to provide an opportunity for students to explore these cultures through an art medium. As with any assignment there were clear and strict parameters imposed by CAMDH which included the following:

1. Size
    a. A restriction on size was applied to the visual arts component of the assignment to ensure that students would not make the project too big or too small.
    b. Dimensions for the visual artwork component for a minimum size was that of an A4 page and for a maximum size was 80cm x 80cm or 80cm x 60cm.

2. Material
    a. Students wanting to paint on a surface other than paper or canvas had to consult with CAMDH.
    b. Tools at the students' disposal to create the artwork included pencil, charcoal, crayons, textures, water-based paint and other paints.

3. Format
    a. Drawing or paintings were the only acceptable formats.
    b. A definition of the visual arts piece was provided by CAMDH outlining that photographs, collages, sculptures or digital drawings were not acceptable.

Students wishing to change any of the parameters had to get approval from CAMDH prior to commencing.

To increase inter-rater reliability for marking the visual artwork assignment, a comprehensive rubric was created (see Attachment 1). The rubric needed to capture a wide range of items, from the complexity of the visual artwork itself, to the academic components of the writing task and, most importantly, the cultural intricacies conveyed in the stories. The students were given the rubric to guide them when undertaking the assignment.

Results/Outcomes

Faculty response

CAMDH has developed close working relationships with many UWA Medical Faculty staff since its establishment in 1996, which meant that implementation of the Aboriginal health assessment was relatively well supported by a large majority of staff across the four years of the MD. Initially, there were some concerns about the relevance that this assessment had to medicine. However, these concerns dissipated following a comprehensive explanation by CAMDH. The assignment was also submitted to the Faculty's Assessment Committee for review and approval.

Following its implementation, faculty staff were interested in the artwork produced by the students, which resulted in a select number of works being showcased at the UWA Excellence in Teaching Awards Ceremony in 2014.

Student response

Evaluation surveys were conducted in the first semester of the first year MD by the Unit Coordinator and the Medical Education Unit to assess students' perceptions of the new course and its curriculum. The cohort size of survey population was 240 students with a response rate in 2014 of 42 per cent, but a reduced response rate in subsequent years. The students' responses to undertaking this assignment were varied, as outlined below.

Resistance

The assignment was a bit of a joke.

I felt I was being judged on how good of an artist I was irrespective of the other components.

The Aboriginal and Torres Strait Islander Health Assignment was inconsequential in its format; it could have easily become an effective vehicle for learning through the creation of an essay, a debate, even a reflective thinking journal (preferably not), which assesses one's research and new founded insight into some aspects of essential Aboriginal and Torres Strait Islander culture.

… I am medical student, not an arts student so I cannot draw...

Support

… I am really excited about doing a dot style painting, are you sure is it really ok for us to use Aboriginal painting styles and this [not to] be seen as offensive… and … some of my peers need a cultural slap in the face and this assignment might just be exactly what is needed…

… This activity has been the cultural slap in the face that my fellow colleagues needed…

… I enjoyed doing the assignment, it was relaxing, and enabled me to really focus…

… It was different to what I had expected and not time consuming at all…

Discussion

The assignment has been included in the MD now for three years (2014–2016) but there is still a degree of resistance from both students and faculty staff. In Australia, there has been much debate that changing teaching content and methodologies in the medical curriculum will result in reduced preparedness to practise as an intern (Lawson & Bearman 2007). This fundamental tension has arisen with the introduction of Problem Based Learning as a teaching methodology, shorter curricula and a transition to graduate entry medical courses (Lawson & Bearman 2007). The shorter MD course was designed to produce highly skilled doctors capable of meeting future medical challenges in a wide variety of settings, but senior clinicians have expressed concerns that there are inadequacies in science knowledge and an imbalance towards '"touchy-feely" subjects such as cultural sensitivity' (Lawson & Bearman 2007).

The experience at UWA, however, shows that there is merit in providing the opportunity for students to engage in the study of health in a more creative way. The quality of the finished visual artwork in the majority of the assignments indicates that most students have engaged with the assignment in a meaningful and respectful manner. At a faculty level the success of this assessment has been recognised and positively supported, and a number of students have been selected to display their artwork and attend the annual UWA Excellence in Teaching Awards Ceremony. This event is attended by a number of clinical and academic staff, and will give students the opportunity to discuss both their artwork and their experience of undertaking the assignment.

Another challenge for CAMDH has been managing the use of traditional methods to create the visual arts piece. Aboriginal and Torres Strait Islander artists inherit rights to paint certain cultural stories. Artists need authority and permission to paint traditional stories, and this authority is vested in the custodians of the knowledge of these stories. Ownership of stories is transmitted down generational lines, held within certain skin groups or moieties. Therefore, stories are often managed within family groups. Students were asked to avoid the use of any known sensitive subject matter including sacred or secret material, and to be respectful of any gender restrictions.

For situations in which students used sensitive cultural material unknowingly, CAMDH staff worked collectively to identify the risks in undertaking this task and strategies to contain potential cultural breaches. CAMDH staff also consulted with the wider Aboriginal and Torres Strait Islander community to ensure that the assignment was culturally safe and secure for both staff and students.

Overall, CAMDH staff have been pleased with the students' engagement with this assessment within the postgraduate medical program, and believe that the sustainability of this style of assessment as part of the Aboriginal health teaching curriculum at UWA looks promising. The assignment raises students' awareness of the issues associated with Aboriginal health, and allows them to think more broadly, particularly around the need for a holistic approach to address the health disparity.

It also highlights to students how this may influence future engagement with Aboriginal and Torres Strait Islander patients. Anecdotal evidence suggests that those medical students with a greater depth of knowledge and understanding of the factors contributing to Aboriginal and Torres Strait Islander people's health, and who understand the relevance of this knowledge in the clinical

context, will be better prepared to work with Aboriginal and Torres Strait Islander patients in the future. Paul, Carr & Milroy (2006) state that

> by educating medical students to be better informed, more experienced, and aware of the underlying issues, it is hoped that some of the barriers to access to health care services will be significantly reduced.

Conclusion

Applying this knowledge in the clinical context may have an influence on the future clinical practices of these students by enriching their engagement with Aboriginal and Torres Strait Islander patients, improving the collection of patient information, and developing better informed treatment plans. It is envisioned that this will contribute to more effective medical management and better health care outcomes for Aboriginal and Torres Strait Islander people.

CAMDH has proposed displaying all the assignments each year, with the students' consent, to the rest of the student cohort in a larger forum. Many students appear eager to see what their peers have produced. CAMDH has also suggested that this may become a possible fundraiser with the Western Australian Medical Students' Society, with all proceeds donated to a local Aboriginal Community Controlled Health Organisation or program. CAMDH has planned a targeted and formal evaluation of this assessment.

Attachment 1 – CAMDH Artwork Marking Rubric

	Mark
Visual component Portrays the topic or is reflective of the central themes A positive and respectful perspective Painting has a title Incorporates aspects of Aboriginal culture Communicates a story or particular perspective(s) to the observer Contained by the project's parameters as outlined in the guidebook	40%
Connection to the teaching materials Introduces the topic Reflects or outlines the central theme/topic chosen An ability to identify, understand and outline the complexities of the chosen topic Accurately reflects realities of the chosen topic	10%
Cultural connection Demonstrates the holistic aspects and dimensions of Aboriginal culture Connections between the topic and/or Aboriginal health/culture Demonstrates an integration of health and cultural perspective(s) Takes into consideration the cultural subtle similarities and differences Is written from a positive and respectful perspective	10%
Story supporting visual piece Ability to convey the message(s) Discussion of the main theme(s) Presentation of essay follows logical organisation of the information and discussion Demonstrates independent, critical thought of the issues identified	10%
Understanding of the issues Discussion of the issues is respectful, uses appropriate language and is consistent with the introduction Demonstrates independent, critical thought of the issues identified Summarises the main themes of the visual component that were raised Clear, progressive discussion that draws all issues together into a final conclusion Topic covered is accurate	20%
Written expression and presentation Clear and succinct Structured and logical presentation of the issues/topic chosen Correct use of terminology Grammatically correct	6%
Sources/referencing Recognised and standardised referencing system Consistent referencing throughout the documentation Uses sufficient, relevant, credible and reliable published literature and other evidence of high quality to support issues being discussed	4%
Total overall	100%

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For further information, contact:

Dr Paula Edgill

Centre for Aboriginal Medical and Dental Health

The University of Western Australia

E: paula.edgill@uwa.edu.au

Collaborative academic strengthening in Indigenous health: An interdisciplinary experience

Ms Alison Francis-Cracknell, Ms Rose Gilby and Associate Professor Karen Adams, Monash University, Australia

Introduction

The unacceptable inequity in health and life expectancy between Indigenous and non-Indigenous people in Australia is well known (Close the Gap Campaign Steering Committee 2016). Successful programs to improve the health of Indigenous Australians require a well-trained workforce that understands the importance of a holistic approach to health care that takes into account the social, emotional, cultural and economic contexts of people's lives (Osbourne, Baum & Brown 2013; Australian Government 2013).

In 2004 the Committee of Deans of Australian Medical Schools commissioned, endorsed and published the Indigenous Health Curriculum Framework (henceforth, CDAMS Framework) to aid the development and implementation of Indigenous health content in core medical education (Phillips 2004). Aspects of the CDAMS Framework were then incorporated into the Australian Medical Council accreditation standards for medical schools (Australian Medical Council 2006).

From 2010 to 2012, the Faculty of Medicine, Nursing and Health Sciences at Monash University worked with Indigenous and non-Indigenous academic staff to build knowledge and to improve practices with regards to the teaching and learning of Indigenous health in the faculty. This included a review of the curriculum and the faculty's implementation of the CDAMS Framework. Although some progress was made, in 2013 academic staff from the faculty (Authors 1 and 2) attended the Leaders In Indigenous Medical Education conference in Darwin and identified that there was still a need to improve Indigenous health teaching and curriculum to ensure consistency with best practice and policy. It was determined that this was necessary not just in Medicine, but across all of the faculty's health profession disciplines.

The aim of the initial phase of the project described here was to work under the guidance of the Indigenous academics in the faculty to review the applicability of the learning outcomes of the medical-focused CDAMS Framework for other health disciplines both in the Faculty of Medicine Nursing and Health Sciences and in the Faculty of Pharmacy and Pharmaceutical Sciences.

Method/Approach

With the support of a Monash University Teaching and Learning Research Grant a project team was formed in 2014. The team of five who were leading and coordinating the work included the recently appointed Head of the Indigenous Engagement Unit, the faculty's only other Indigenous academic, and members from Physiotherapy, Nutrition and Dietetics, including the Director of Allied Health.

The team planned an inclusive, transparent and participatory approach to the project. This involved the recruitment of a Consultation Working Group made up of stakeholders from across the university's various health disciplines. This included representation from the disciplines of: Pharmacy, Medicine, Physiotherapy, Nutrition and Dietetics, Occupational Therapy, Emergency Community Health and Paramedic Practice, Radiography, Nursing and Midwifery. The Faculty of Medicine, Nursing and Health Science's Indigenous Engagement Unit and School of Rural Health also participated in the Consultation Working Group.

The initial purpose of getting these stakeholders together was to:

- (a.) collaboratively review the CDAMS Framework
- (b.) identify alterations to encompass diverse disciplines
- (c.) gain consensus on a set of learning outcomes.

To form the Consultation Working Group, Heads of Department were contacted via email and invited to review the project plan and nominate an appropriate academic representative from their discipline area. The following characteristics were proposed as ideal attributes for a suitable staff member:

- an existing level of experience with Indigenous health and/or Indigenous health curriculum
- suitably positioned to consider fully the implications of curriculum innovation and implementation
- involved in curriculum decision making within their program.

This consultation process with Heads of Department provided the opportunity to create awareness across the faculties of the existence and intentions of the project, as well as securing commitment at the leadership level before proceeding.

The Consultation Working Group members were expected to attend and participate in six meetings, review and provide feedback on key documents, report back to their respective departments and to seek input as needed. As part of building the capacity of the Consultation Working Group, all members were required to undertake cultural safety training, conducted by staff from Monash's Yulendj Indigenous Engagement Unit, before proceeding with the review. Following that, the group discussed the CDAMS Framework and the context for its application and the development of curriculum across the disciplines. The project team then commenced developing an initial and follow-up survey.

Survey One consisted of an online delphi survey to consider each of the learning outcomes contained in the CDAMS Framework and to rate whether they were:

• suited to their discipline

• suitable for the three student level categories of novice, intermediate or advanced undergraduate teaching and learning

• required or not for their disciplines.

We defined the three student level categories as:

• Novice: year 1 – year 2 students (early years of course)

• Intermediate: year 2 – year 3 (middle years of course)

• Advanced: year 3 – year 5 (later/final years of course)

Consultation Working Group members could select more than one option and provide comment on preferred or alternative wording for the learning outcome. The survey also provided an opportunity to re-word learning outcomes to be inclusive of diverse disciplines.

During this period of the project, Health Workforce Australia began to draft an Aboriginal and Torres Strait Islander Health Curriculum Framework (henceforth HWA Framework) for all heath science disciplines (Curtin University & Australian Government 2015). Consultation Working Group members were asked to indicate whether or not they thought the emerging learning outcomes from the HWA Framework were already covered in the CDAMS Framework, which focuses on Medicine. If members thought they were, we asked them to indicate the existing CDAMS Framework learning outcome that they thought covered the topic from the HWA Framework.

The results from Survey One identified consensus on some learning outcomes and disagreement on others. As a result, a second survey was conducted following the same model to explore further those areas of disagreement, particularly around discipline-inclusive terminology, to decide where emerging ideas from the HWA project best fit and to provide feedback. Where consensus was not able to be achieved easily, the Consultation Working Group asked the project team to take a leadership role in any required rewording and then presented their proposed wording back to the group for agreement.

Results/Outcomes

The participation rate of Consultation Working Group members in the surveys was high, covering most disciplines (see Table 1). Amendments were made to five of the eight CDAMS Framework subject areas (see Table 2). These amendments were minimal and focused on the addition of learning outcomes from the HWA Framework and language that was inclusive of diverse disciplines. All learning outcomes were categorised into novice, intermediate and advanced categories (see Table 3).

Table 1: Consultation Working Group response rate n=11

Survey iteration	Response rate	Disciplines represented
One	9	Nursing Nutrition and Dietetics Physiotherapy Emergency Community Health/ Paramedics Occupational Therapy Pharmacy Medicine School of Rural Health Indigenous Engagement Unit
Two	8	Nutrition and Dietetics Physiotherapy Emergency Community Health/ Paramedics Occupational Therapy Pharmacy Medicine School of Rural Health Indigenous Engagement Unit

Table 2: Summary of amendments to CDAMS Framework

CDAMS Framework Subject Areas	Amendments
History	Consolidation of learning outcomes One new learning outcome*
Culture, Self and Diversity	Four new learning outcomes*
Indigenous Societies, Cultures and [Medicines] Healthcare Practices	Name updated to reflect all disciplines One learning outcomes reworded to reflect all disciplines
Population Health	One learning outcome reworded
Models of Health Service Delivery	No amendment
Clinical Presentations [of Disease]	Name updated to reflect all disciplines Two outcomes moved to population health One new learning outcome*
Communication Skills	No amendment
Working with Indigenous Peoples: Ethics, Protocols and Research	No amendment

*New learning outcomes arose from the HWA Framework

Table 3: Summary student stage of learning categorisation

Subject area	Novice	Intermediate	Advanced
History	1	1	–
Culture, Self and Diversity	5	2	–
Indigenous Societies, Cultures and Healthcare Practices	3	1	2
Population Health	2	3	4
Models of Health Service Delivery	1	3	7
Clinical Presentations	–	1	3
Communication Skills	1	2	2
Working with Indigenous Peoples: Ethics, Protocols and Research	–	1	4

Discussion

The project had several successful outcomes. Firstly, it achieved consensus on 44 Indigenous health learning outcomes for further curriculum development across the two participating faculties. In addition, the interdisciplinary Consultation Working Group members agreed on which learning outcomes most suited each student level. The outcomes were collated into a poster available online that was presented to the Consultation Working Group members (www.med.monash.edu. au/indigenous). The largest success overall, however, was that this project provided the forum that brought together members of nine different health disciplines at Monash University to create an environment of collaboration and consensus on what to teach students in relation to Indigenous health.

Some of the success of the project may be attributed to the membership of the project team and the way the Consultation Working Group membership was recruited. Four of the five academic staff from the project team were long-standing employees who were well known in the faculty, and most had previously been actively engaged in the faculty's earlier work to develop and promote Indigenous health teaching. The project also had high-level support from the Office of the Deputy Dean of Education.

The cultural safety training undertaken by all members of the Consultation Working Group, most of whom had not participated in this kind of professional development before, also had a positive impact. As a result of this process, three discipline representatives (Medicine, Physiotherapy, and Nutrition and Dietetics) then went on to organise cultural safety training for their departments, leading to a further 24 academics completing the training.

The Consultation Working Group was seen to have worked so well at collaborative decision making and innovation that the faculty provided endorsement for this group to lead to the formation of a Faculty of Medicine, Nursing and Health Sciences Indigenous Health Curriculum Committee. This committee now reports to the faculty's Learning and Teaching Committee, which has high-level representation from across the university and provides a further platform for the activities of the Indigenous Health Curriculum Committee to be showcased to key academic staff.

The project also faced some challenges. At the start, there was an initial aim to include more Indigenous representation, but the reality was that there were only two Indigenous academic staff members in the faculty. In addition, not all disciplines participated in the committee so providing effective meeting planning that catered to teaching academics working across several different campuses proved difficult. This was largely overcome by the use of doodle polls and making video and teleconferencing facilities available. The project also needed to be flexible enough to take into account, and respond to, the changing environment with regards to the evolving HWA Framework.

Conclusion

This collaborative project has enhanced understanding and gained consensus about Indigenous health curriculum across various health disciplines from two faculties at Monash University. The project team, in consultation with the Consultation Working Group, has now applied for a second Teaching and Learning Grant to develop novice-level curriculum resources for implementation. This second phase will also provide activities to strengthen staff capacity in teaching and assessing students in Indigenous health. The longer term sustainability of this work will be maintained by the Indigenous Health Curriculum Committee that was established in the faculty as a result of this work.

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For further information, contact:
Ms Alison Francis-Cracknell
Medicine, Nursing and Health Sciences
Monash University
E: alison.francis-cracknell@monash.edu

The impacts of being a 'Roadshow facilitator' on Indigenous health tertiary students

Dr Kennedy Sarich and Associate Professor Suzanne Pitama,
University of Otago, Aotearoa/New Zealand[5]

Introduction

Kia Ora Hauora is a government-funded workforce development program in Aotearoa/New Zealand that aims to support and provide opportunities for Māori to explore pathways into the health workforce (Ministry of Health 2006). In November 2012, Kia Ora Hauora and consultants developed the Kia Ora Hauora Junior Roadshow to travel to high schools promoting awareness around subject choice and encouraging young Māori (12–14 years old) to get interested in and excited about health careers. In the first three years of the Roadshow there were more than 60 interactive sessions and over 5000 secondary students involved. The Roadshows were based on a one-hour lesson plan and involved one team leader and two or three 'Roadshow facilitators' per school.

As part of the Kia Ora Hauora vision, Indigenous tertiary health students were recruited to be Roadshow facilitators. As facilitators, they were primarily responsible for running small group workshops that involved interacting with the secondary students and teaching health-related information and health-specific skills such as undertaking CPR (cardiopulmonary resuscitation) on a manikin, eliciting tendon reflexes and using a stethoscope. Facilitators were recruited from within the regions in which the Roadshow was hosted. They were given a one-day training session before the program began and were financially reimbursed for their time. Twenty-two Roadshow facilitators were involved over the first three years of the program.

The purpose of this research is to investigate the impacts on the Indigenous tertiary health students who were employed as Roadshow facilitators from 2012 to 2014.

Method/Approach

All 22 Roadshow facilitators who had been involved in the program were contacted by telephone and invited to undertake an online survey comprised of 36 questions. Of these nine were multi-choice, one involved a rating scale and the remaining 26 questions provided a free-text comment box for detailed responses. Seven of the 36 questions collected basic demographic data, while 24 questions related to the facilitator's experience of being involved in the Roadshow.

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[5] Kennedy Sarich is a medical student and Suzanne Pitama is Associate Dean Māori at the Otago Medical School.

These fell into three main categories:

1. Why they took part:
   - 'Why did you choose to take part in the Roadshow?' and 'Were there any factors which made participating particularly important to you?'

2. Their opinion of the Roadshow lesson plan and structure:
   - 'What was your overall impression of the Roadshow?' and 'Please comment on the engagement you had with the students.'

3. Their personal outcomes:
   - 'What were three outcomes for you that came from participating?' and 'Do you feel [that] participating had any impact on your studies?'

The remaining five questions enquired about prior engagement with the Kia Ora Hauora program and feedback regarding the Roadshow lesson plan. The responses to these questions, however, are outside the scope of this paper and so are not included in the analysis.

The online program Google Docs was used as a platform to create, deliver, order and analyse the survey and was made easily accessible to all facilitators. All data were de-identified, and descriptive statistics were used to interpret the quantitative data. Google Docs was able to format the data into a spreadsheet that enabled the development of graphs and tables. Demographic and other quantitative data were grouped and the mean calculated. Ethics approval was not required for this survey.

Google Docs also provided a function to order the qualitative data using a search for key words and phrases. Inductive analysis was used to code the data against the key words and to draw together similar codes, which were clustered into broader themes (Saldana 2013). The authors initially coded the data and a review of the coding was then undertaken by the developers of the Roadshow to ensure agreement on the emerging themes.

Results/Outcomes

All the Roadshow facilitators approached to be part of the research project completed the online survey (N=22), as well as completing 100 per cent of the quantitative and qualitative research questions included in the survey.

Roadshow facilitator demographic profile

Of the 22 participants, 21 identified as Māori and one as Samoan. Facilitators came from eight different health professional programs including Medicine, Nursing, Physiotherapy and Radiation therapy. All were studying at one of five tertiary institutions across the country. Fifty-eight per cent of participants were female and 42 per cent were male, and all but two were under the age of 25. Fifty-two per cent of facilitators visited their old high school as part of the Roadshow, and all lived within an hour's drive of at least one school that they visited. At the time of the survey all participants were still on their health career pathway, either currently studying within their degree program or had recently graduated.

Roadshow facilitator experiences

When correlating the quantitative data, three main themes emerged: social accountability; personal and professional development; and renewed commitment to health career. These findings are extrapolated below.

Social accountability

Roadshow facilitators expressed that one of their key motivations for participating in the program was the opportunity to become more engaged with the Māori community. They said that it gave them a forum in which to 'give back' to their community, re-engaged their sense of responsibility and encouraged them to be active stakeholders in their community's future.

I'm very passionate about working with Māori as I see myself in the kids we work with and think how I would've loved to have more Māori role models (P2)

Good opportunity to help those in a similar situation as I was in the past (P3)

I have received a huge amount of support from various iwi [tribe] and Māori community organisations during my studies, I feel it is a duty to give back to the community, as a way of saying thank you for all the support (P4)

Participants were particularly motivated to share the importance of a health career for Māori.

Now that I work in a laboratory it's very obvious how under-represented Māori are in the health workforce (P6)

Being from the region I felt it was important that I try and convince other students to look at a career in health, as the area I am from doesn't usually think of itself as a part of town that can succeed at university (P7)

Personal and professional development

Participants reported that being a Roadshow facilitator gave them an opportunity to be engaged in new personal and professional development opportunities including: practising and improving their skills in public speaking and teaching; learning to consolidate prior health knowledge so as to effectively communicate the content to students; and increasing their likelihood of using te reo Māori (Māori language) in communicating this content.

Some participants reflected that the skills and strategies learned in communicating with students had also transformed the way in which they interacted with their patients; specifically, they felt more confident in translating information because their own health literacy had improved.

Helped with explaining anatomy and physiology at a more simplified level, cutting out a lot of the medical jargon by making concepts and terms simple and understandable – as we should be doing with patients (P8)

Definitely developed confidence in delivering health-related information that I had previously had limited experience with (P6)

Enhanced my ability to work with and understand working with rangatahi [youth] (P9)

Participants explained that being part of the Roadshow had highlighted key areas in which they needed to undertake further personal development, including learning and using more te reo Māori. Sixty-four per cent of participants directly reported an increase in their te reo Māori proficiency and confidence in using it within a presentation, and two noted that they were pursuing further formal education in te reo Māori.

Participants also remarked that they had developed new strategies to work as part of a team, further refining their skills in this context. Eighty-six per cent of participants identified that a key positive outcome of being a Roadshow facilitator was the connections they made with fellow facilitators. They also found that they were more confident as a result of being in the program and more committed to setting personal and professional goals.

I gained confidence in public speaking, and confidence in my knowledge of health (P3)

Renewed commitment to health career

Participants stated that being part of the Roadshow renewed their commitment to becoming a Māori health clinician. They said that it provided a 'real life' context in which to consider the impact that such a career would have on their own communities, and made them realise the importance of their role as health professionals in improving their community's future.

Reminds you of [the] reasons why you are studying (P10)

Participating reinforced that I want to work with Māori communities and rangatahi [youth] within the health sector (P5)

Discussion

The results from this research show that by involving Indigenous tertiary health students as facilitators for the Kia Ora Hauora Junior Roadshow resulted in a number of positive outcomes for participants. Facilitators reported that it had given them the opportunity to develop their sense of social accountability and their role as a stakeholder within their own communities. It also provided them with opportunities to develop personal and professional skills that increased their confidence, including better Māori language skills. In addition, it contributed to improved health literacy, better communication within team environments, and an increased connection with their peers. No challenges in participating were reported by facilitators. The Roadshow sessions were also organised to run outside of the normal university term so as to be respectful of facilitators' study commitments.

The results showed a further commitment by the participants to their future health careers, illustrating how this project is supporting the retention of Indigenous tertiary health students. Previous research on the retention of Māori health students has focused on internal university systems, structures and processes (Nikora 2002; Kelly 2009). This project identified that involvement in 'external' community health programs, which engage Indigenous tertiary health students in their own communities, can also support their journey to graduation at university.

There are currently a number of existing and emerging community engagement projects running throughout Aotearoa/New Zealand with regard to Indigenous health (Ratima 2008; Curtis 2012). By engaging Indigenous tertiary students in these projects, there is significant potential for growth and skill development for these students. Further research is needed to explore how community engagement projects, including those run by Kia Ora Hauora, can better partner with universities to increase the graduation rates of Indigenous tertiary health students.

Conclusion

The results from this research encourage and support the use of Indigenous tertiary health students in community engagement projects, demonstrating that their involvement is useful for them academically, personally and professionally. The number of Indigenous health projects involving the community is consistently increasing (Curtis 2012), and the engagement of Indigenous tertiary health students in them should be considered as an integral part of their design.

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For further information, contact:
Dr Kennedy Sarich
University of Otago
E: Kennedy.Sarich@cdhb.health.nz

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 the LIME Connection VI in Townsville, August 2015. Once the 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 to determine which submissions best met the criteria and would, therefore, be the most suitable for the fourth 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 in order to be published. Revised case studies were reviewed a second time to determine the final selection. The LIME Secretariat and Review Committee members then completed a final round of editing of the accepted case studies, before sending these back to authors for their approval or changes. Final case studies were then incorporated into the publication, copy edited as part of the whole document and published.

Acronyms and Abbreviations

AMS	Aboriginal Medical Service
CAMDH	Centre of Aboriginal Medical and Dental Health
CDAMS	Committee of Deans of Australian Medical Schools
CPR	cardiopulmonary resuscitation
IHA	Indigenous Health Attachment
HWA	Health Workforce Australia
LIME	Leaders in Indigenous Medical Education
MDANZ	Medical Deans Australia and New Zealand
MBBS	Bachelor of Medicine, Bachelor of Surgery
MD	Medical Doctorate
NSW	New South Wales
OSCE	Objective Structured Clinical Examinations
UWA	University of Western Australia
Western	Western Sydney University

Glossary

Aboriginal and Torres Strait Islander	Original inhabitant of Australia and its nearby islands
Aotearoa	Traditional Māori name for the North Island of New Zealand. Today it is more commonly used to mean the whole of New Zealand
clinical school	Usually located within a teaching hospital, it coordinates the clinical training for medical students in the latter years of their course
iwi	Māori tribe
hauora Māori	Māori (Indigenous) health
kaupapa	agenda/topic (in this case bias and racism)
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
rangatahi	Māori young people
te reo Māori	Māori language
whānau	Māori term for family/support systems

THELIMENETWORK
Leaders in Indigenous Medical Education