Medical Deans
AUSTRALIA AND NEW ZEALAND

Indigenous Health Project Critical Reflection Tool

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Abbreviations

AIDA	Australian Indigenous Doctors' Association
AMC	Australian Medical Council
AMCG	Australian Medical Council's Guidelines
AMS	Aboriginal Medical Service
CBL	Case-based Learning
CDAMS	Committee of Deans of Australian Medical Schools
CF	*CDAMS* Indigenous Health Curriculum Framework
FTE	Full-time Equivalent
GAMSAT	Graduate Australian Medical School Admission Test
HF	Healthy Futures Report
ITAS	Indigenous Tutorial Assistance Scheme
OSCE	Objective Structural Clinical Examination
PBL	Problem-based Learning
TER	Tertiary Entrance Rank
UAI	University Admission Index
UMAT	Undergraduate Medicine and Health Sciences Admission Test

Introduction

The Critical Reflection Tool or CRT is a dynamic document that addresses broad contextual issues that impact on Indigenous[1] health curriculum development.

Its purpose is to support medical schools implement, monitor and sustain a nationally accredited Indigenous health curriculum framework and to adopt initiatives related to Indigenous student recruitment, retention and support.

The CRT is designed to encourage internal reflection, critical thinking, a review of current practice, and focus on future planning among Australian and New Zealand medical faculties/schools. It is intended that the CRT will stimulate internal discussion that allows faculties/schools to identify areas of strength, and areas that need improvement, to identify the drives for, and barriers to change, and what ought to be done next and why.

The CRT can be understood as a management tool for faculties and schools where responsibility for Indigenous health is shared across the organisation. The tool has been designed to encourage coordination and the 'whole-of-school partnership' approach. It is not intended that the CRT be an evaluation or reporting tool, but an internal working document that allows for reflection on progress. Such a reflective process may assist in developing learning and collegiate culture that will improve Indigenous health teaching and learning outcomes.

Background

The Medical Deans Australia and New Zealand[2] Indigenous Health Project has conducted a national audit[3] of Indigenous health content and context in medical faculties/schools, and has achieved a nationally agreed Indigenous health curriculum framework. This has been formally endorsed by the Australian Medical Council, and is reflected in its revised guidelines[4]. The 2004 *CDAMS Indigenous Health Curriculum Framework*[5] provides a set of guidelines to assist medical schools to develop and deliver Indigenous health content in core medical education. This work is complemented by the *Healthy Futures: Defining Best Practice in the Recruitment and Retention of Indigenous Medical Students*.[6] report of the Australian Indigenous Doctors' Association (AIDA).

Indigenous health in medical education is an emerging field and, as such, medical schools are at differing stages of curriculum development. In recognition of this, the CRT is designed to support the work that is already being conducted, with the intention of enhancing the internal processes.

The structure of the CRT

The CRT is arranged around eight overarching categories, some which may address more than one theme. Each theme is accompanied by a descriptive background; key questions; references to the *CDAMS Indigenous Health Curriculum Framework* (hereafter referred to as CF), AIDA's *Healthy Futures Report* (hereafter referred to as HF) and the AMC guidelines (hereafter referred to as AMCG); examples; and prompts for responses.

Themes: The CRT themes correspond with those identified in both the CF and HF, and broadly conform to the categories used in the AMC guidelines. The themes relate to professional areas and, as such, the questions are designed to engage a range of staff expertise.

Background: The background describes the contextual factors surrounding Indigenous health in medical education. These narratives are derived from the documents listed below and the experience of the working party.

Key questions: The key questions provide the main focus for reflection.

References: The key documents referred to are the CF, HF and AMC guidelines.

- The direct references to CF refer to the ten key Pedagogical Principles and Approach, i.e. CF 1 refers to Pedagogical Principle 1. (See Appendix 1)
- The references to HF are drawn from the document in its entirety and the approach to this framework is based on the five interrelated principles. (See Appendix 2)
- The document refers throughout to the AMC guidelines, and is also informed by the Forty Attributes of Graduates. (See Appendix 3)

Examples: The de-identified examples were developed by the working party as illustrations rather than exemplars, designed to facilitate reflection that focuses on individual and faculty/school-wide performance. It is our goal that as this tool evolves it will incorporate 'best practice' examples provided by faculties and schools.

Responses: The document provides prompts for structured responses to the key questions. The CRT asks that you:

- describe your current practice, as it applies to each theme;
- identify contextual factors that influence your practice (issues, difficulties, limitations, such as structural barriers, resource allocation, etc.);
- identify what you would like to achieve or what needs to be done (goals, objectives), and;
- consider how you will achieve your aims (strategies, plans, priorities, responsibilities, timeframes).

Guidelines for the use of the CRT

The themes of the CRT encompass a range of areas, and responses rely on staff expertise: consequently the tool is onerous for one person.

It is envisaged that the process will involve individual reflection, a multiplicity of points of view, and a collective response by a working group or committee. Each group member responds individually to CRT questions that are most relevant to their area of expertise. The working group or committee then critiques current practice, establishes goals and objectives, devises strategies and plans the next steps. This process supports the Dean and other decision makers in the implementation of the Indigenous health strategy.

The CRT is designed to be a working document, adaptable to the individual characteristics of each faculty/school, whose staff are encouraged to use this tool as may best benefit them. The CRT may also contribute to the preparation of documents for accreditation. In addition, the CRT offers the opportunity to measure and record progress, for future use.

For the purposes of the trial we ask schools to use the document in its entirety.

[i] In this document we use the term 'Indigenous' to refer to Aboriginal and Torres Strait Islander peoples of Australia, and the Māori people of Aotearoa/New Zealand.

[2] Formerly the Committee of Deans of Australian Medical Schools.

[3] Phillips, G. & The Project Steering Committee, Committee of Deans of Australian Medical Schools 2004, *National Audit & Consultation Report*, Discussion Paper 11, VicHealth Koori Health Research and Community Development Unit, The University of Melbourne, Melbourne.

[4] Australian Medical Council (AMC) 2006, Replacement for Part 2 of the Australian Medical Council's Guidelines: *Assessment and Accreditation of Medical Schools: Standards and Procedures 2002*, AMC, Kingston, ACT.

[5] Phillips, G. 2004, *CDAMS Indigenous Health Curriculum Framework*, VicHealth Koori Health Research and Community Development Unit on behalf of the Committee of Deans of Australian Medical Schools, The University of Melbourne, Melbourne.

[6] Minniecon, D. & Kong, K. 2005, *Healthy Futures: Defining Best Practice in the Recruitment and Retention of Indigenous Medical Students*, Australian Indigenous Doctors' Association, Manuka, ACT.

1A. The context of the medical schools Indigenous health unit—location and brief

Background/Questions

Background

The organisational arrangements and the location (structurally and physically, on/off campus), of Indigenous health units/programs varies between faculties/schools. This positioning affects the role of the Indigenous health units/programs in terms of their teaching brief, faculty/school-wide coordination, accessibility and resource allocation.

Key Questions

Does your faculty/school have an Indigenous health unit?

Where is the Indigenous health unit located, structurally and physically?

What is the unit's teaching brief?

Reference

CF 1, 2, 4, and 5 / AMCG 1.4

Examples

e.g. 1

The Indigenous health unit at a large medical school originally had a faculty-wide brief. In a restructure the unit was relocated to the school of rural health. As a result, the unit lost the ability to coordinate and influence Indigenous health developments throughout the faculty, while increasingly being expected to teach throughout the curriculum, across the faculty, with the resources and brief of a school unit only. While it is encouraging that more schools and departments want this unit to help them teach Indigenous health, this is not a realistic expectation unless the unit's brief is elevated and resourced to meet the whole-of-faculty demand.

e.g. 2

A medical school started with one lecturer in Indigenous health based in a rural health school. With the Dean's support, the lecturer was able to build significant partnerships with the Indigenous health general education centre on campus, and attract external resources to employ administrative support staff. In addition, the Dean allocated core funding to academic staff to assist with the growing teaching load, and to map Indigenous health across the curriculum. Through the tenacity of the Indigenous health lecturer and the Dean's funding and strategic commitments, the Faculty is swiftly moving towards a comprehensive and well-resourced Indigenous health strategy (curriculum and Indigenous student support initiatives).

e.g. 3

In recognition of the importance of Indigenous health within its curricula, a medical school made the decision to include Indigenous health in the school's title. This entailed the development of an Indigenous health unit, which resulted in the employment of more Indigenous staff, as well as an opportunity for increased coordination across the medical curricula and greater collaboration with course coordinators. This change allowed for Indigenous health to be seen as the responsibility of all staff in the medical school.

With reference to the key questions in the preceding page, describe your **current practice**.

Type in here...

What are the contextual factors that influence your practice (issues, difficulties, limitations, such as structural barriers, resource allocation, etc.)?

Type in here...

What would you like to achieve or what needs to be done (goals, objectives)?

Type in here...

How will you achieve your aims (strategies, plans, priorities, responsibilities, timeframe)?

Type in here...

1B. The context of the medical school: Indigenous community partnerships

Background/Questions

Background

Partnerships with local Indigenous organisations and communities need to be developed in order to facilitate the most effective learning. Grounding Indigenous health in local contexts will enable the faculty/school to improve the quality of learning, facilitate specific strategies like community placements, and demonstrate its commitment to Indigenous health. Well-managed partnerships of this nature are also likely to enrich Indigenous students' experience on campus.

Key Questions

What partnerships exist between your faculty/school and Indigenous communities or organisations?

How are these partnerships fostered and nurtured?

Do these partnerships contribute to the curriculum, and how?

Reference

CF 7 / AMCG 1.4 and 1.6

Examples

e.g. 1

A new medical school with no Indigenous staff contacted the general university Indigenous education centre to facilitate a meeting with some of the local Indigenous health organisations. This resulted in the establishment of a community reference group. The reference group included staff from the local Aboriginal Medical Service (AMS), Indigenous Elders and community health workers, faculty staff, a government representative, and a member of the Australian Indigenous Doctors' Association (AIDA). The reference group assists the medical school in selecting and supporting Indigenous students, designing locally appropriate Indigenous health curriculum, and making the whole faculty aware of Indigenous health issues in areas like research ethics. The reference group members receive payment for any lectures or seminars they give and are offered adjunct lectureships where appropriate. They also have the capacity to streamline the coordination of student placements through the AMS. In return, the AMS finds it valuable to be teaching medical students about their community's needs.

e.g. 2

With the help of an Indigenous staff member, an established medical school started a successful community relationship. They have found that the partnership requires true commitment and respect for each other's needs, and that sometimes they cannot meet all of the community's requests. In this situation, the Indigenous academic and support staff were best placed to initiate, broker and develop partnerships and ongoing relationships. However, partnerships of this nature require time and coordination. Staff (Indigenous and non-Indigenous) and community representatives must be adequately resourced to undertake these functions.

With reference to the key questions in the preceding page, describe your community partnerships.

Type in here...

What are the contextual factors that influence these relationships (issues, difficulties, limitations, such as structural barriers, resource allocation, etc.)?

Type in here...

What would you like to achieve or what needs to be done (goals, objectives)?

Type in here...

How will you achieve your aims (strategies, plans, priorities, responsibilities, timeframe)?

Type in here...

1C. The context of the medical school: Human resources

Background/Questions

Background

Teaching Indigenous health across the curriculum will require adequate human resources and coordination. Indigenous staff should be employed across the faculty/school in a spectrum of roles and seniority.

Key Questions

Are there staff specifically allocated to teach Indigenous health?

How many Indigenous staff are employed in academic (including teaching Indigenous health), student support and administrative roles?

Reference

CF 2, 3, 5, 6 and 8 / AMCG 1.4, 1.7, 1.8 and 1.9

Examples

e.g. 1

With the assistance of 1.0 FTE academic, an Indigenous health unit was established. The unit's focus was to develop core curriculum, and then to branch into other areas. From the beginning, the unit consisted of Indigenous academics. Collaborations with non-Indigenous academics have been instigated within fields where Indigenous health perspectives are essential. There are now three lecturer positions (senior lecturer and lecturers) and a teaching fellow position in the unit, and a 0.5 FTE position is currently dedicated to an administrative role. The teaching coming directly from the unit has allowed the Indigenous health teaching to have a significant presence within the medical school, evidenced by a visible location.

With reference to the key questions in the preceding page, describe your **current staffing arrangements**.

Type in here...

What are the contextual factors that influence your current practice (issues, difficulties, limitations, such as structural barriers, resource allocation, etc.)?

Type in here...

What would you like to achieve or what needs to be done (goals, objectives)?

Type in here...

How will you achieve your aims (strategies, plans, priorities, responsibilities, timeframe)?

Type in here...

1D. The context of the medical school: Indigenous staff professional development

Background/Questions

Background

Indigenous staff can be used optimally as coordinators and to train others to perform the separate functions required in the teaching of Indigenous health and associated tasks, avoiding the expectation that Indigenous academic staff perform all tasks related to Indigenous health. Indigenous academic and general staff will require recognition, adequate support, and professional and career development opportunities.

Key Questions

What strategies are in place to ensure there is adequate support for Indigenous staff?

What mechanisms, through coordination and/or professional development can be implemented to maximise resources and manage the workload?

What professional and career development opportunities exist for Indigenous staff members?

Reference

CF 2, 3, 5, 6 and 8 / AMCG 1.4, 1.7, 1.8 and 1.9

Examples

e.g. 1

An established medical school recently began revamping its Indigenous health strategy: they developed a close partnership with the general Indigenous education centre; they use an existing Indigenous partnership group to assist in curriculum design; and they utilise their one Indigenous full-time academic to train non-Indigenous staff in an appropriate Indigenous framework. They also contract extra sessional teachers when required. These strategies are cost effective and are carried out in a supportive environment.

e.g. 2

A postgraduate medical school employed an Indigenous health academic to integrate the *CDAMS Indigenous Health Curriculum Framework* project across its curricula. The medical school then reviewed the aims and objectives of the academic position and realised they were complex. In recognition of that, and the importance of Indigenous health, the medical school decided to upgrade the position to Associate Professor and to increase the number of Indigenous staff.

With reference to the key questions in the preceding page, describe your **current practice**.

Type in here...

What are the contextual factors that influence your practice (issues, difficulties, limitations, such as structural barriers, resource allocation, etc.)?

Type in here...

What would you like to achieve or what needs to be done (goals, objectives)?

Type in here...

How will you achieve your aims (strategies, plans, priorities, responsibilities, timeframe)?

Type in here...

1E. The context of the medical school: Induction and training—including cultural safety

Background/Questions

Background

The attitude of all teaching, clinical and administrative staff counts towards effective learning. Staff who design, deliver, evaluate and administer the Indigenous health curriculum should be confident, informed and committed to improving Indigenous health outcomes. All staff will require training in the goals and intent of the faculty/school's Indigenous health strategy, and encouraged to become active participants in the process. New staff should be inducted and trained on the pedagogical principles of the curriculum framework.

Cultural safety is about ensuring that individuals and systems delivering health care are aware of the impact of their own cultural values on the delivery of services, and that they have knowledge of, respect for, and sensitivity towards the cultural needs of others. Faculty/schools should recognise that the need for cultural safety training is ongoing. Indigenous health and the cultural safety needs of Indigenous communities should not be subsumed in general cultural safety teaching.

Key Question

What opportunities are available to induct, train and encourage all staff in the area of Indigenous health?

What training is available that specifically addresses cultural safety?

Reference

CF 2, 3, 5, 6 and 8 / AMCG 1.4, 1.8 and 1.9

Examples

e.g.

A new medical school had limited initial funding to develop an Indigenous health program. Recognising the importance that all staff participate in the development of such a program over time, they were required to attend cultural safety training. This training was initiated, developed and co-taught by two academics: one from the medical school who had experience in this area, and one Indigenous academic from the university's Indigenous Studies Unit. To ensure this was not a 'one-off', the developed cultural safety teaching module was integrated into the faculty's broader professional development program.

With reference to the key questions in the preceding page, describe your **current practice**.

Type in here...

What are the contextual factors that influence your practice (issues, difficulties, limitations, such as structural barriers, resource allocation, etc.)?

Type in here...

What would you like to achieve or what needs to be done (goals, objectives)?

Type in here...

How will you achieve your aims (strategies, plans, priorities, responsibilities, timeframe)?

Type in here...

1F. The context of the medical school: Funding for teaching

Background/Questions

Background

Indigenous health teaching should be considered a core responsibility of the medical faculty/school, and reflected in the budget. In order that Indigenous health is intrinsic to the faculty/school activities, and does not only exist as a result of external funding and in-kind support, resources allocated to Indigenous health should reflect the teaching brief of the unit.

Key Questions

How are your teaching positions in Indigenous health funded?

Do you believe you are adequately resourced to carry out the teaching?

Reference

CF 2, 4 and 10 / AMCG 1.5.

Examples

What proportion of your funding for Indigenous health is:

1. Core faculty funding
2. Specific university-allocated funds
3. Competitive research grants
4. External project funding

With reference to the key questions in the preceding page, describe your **current funding practice** for Indigenous health teaching.

Type in here...

What are the contextual factors that influence your funding and are you adequately resourced to carry out the teaching (issues, difficulties, limitations, such as structural barriers, resource allocation, etc.)?

Type in here...

What would you like to achieve or what needs to be done (goals, objectives)?

Type in here...

How will you achieve your aims (strategies, plans, priorities, responsibilities, timeframe)?

Type in here...

2A. The outcomes of the medical course: Mission statement

Background/Questions

Background

A mission statement outlines the faculty/school's goals and approach to Indigenous health. It identifies how these goals are embedded in the life of the faculty/school as a core function of the corporate plan.

Key Questions

Does your faculty/school mission statement and strategic plan articulate a commitment to Indigenous health teaching and learning?

Are there other ways/fora that this commitment is expressed?

Reference

CF 1, 2, 3, 4, 5, 6, 8 and10 / AMCG 2.1

Examples

e.g. 1

A medical school has publicly stated that Indigenous health is one of the areas in which its graduates should make a difference. The school has included in its mission statement and strategic plan a commitment to improving Indigenous health outcomes through the provision of quality medical education. The school is still developing specific initiatives to implement its mission statement and strategic plan, including employing Indigenous staff and identifying senior staff to lead and drive the process. The strategic documents give the staff, students and stakeholders an understanding that positive values and attitudes towards Indigenous health teaching and learning are a core component of the curricula.

With reference to the key questions in the preceding page, please describe how your faculty/school's commitment to Indigenous health is expressed and documented.

Type in here...

What would you like to achieve or what needs to be done (goals, objectives)?

Type in here...

How will you achieve your aims (strategies, plans, priorities, responsibilities, timeframe)?

Type in here...

2B. The outcomes of the medical course: Executive coordination based on the principle of Indigenous leadership, faculty responsibility

Background/Questions

Background

Medical faculties/schools would benefit from clearly identified leadership, responsibility and reporting structures for the coordination and implementation of an overarching Indigenous health strategy (including curriculum, student admission, recruitment and support, teaching and research, etc.). Indigenous staff are a critical part of, but not responsible for, the strategy. Whole-of-school partnerships require engaging staff across the institution to work collaboratively to actively promote the spirit and intent of the *Curriculum Framework* and the *Healthy Futures* reports.

Key Questions

Who provides leadership within the faculty to ensure that an overarching Indigenous health strategy is implemented (including recommendations of the *Curriculum Framework* and the *Healthy Future* report)?

In terms of process, would you describe this as a collaborative faculty/school approach, or is there a reliance on a particular person(s)?

Reference

CF 4, 5 and 6 / AMCG 2.1, 1.2, 1.3 and 1.4

Examples

e.g. 1

A medical school has designated an Assistant Dean for Indigenous Health (an Indigenous person) at the faculty level to undertake Indigenous health teaching, research, Indigenous student affairs and community engagement projects across the health sciences. This person negotiates effectively with heads of school across the health disciplines for the development of curricula and Indigenous student recruitment and retention. The medical school has employed an Indigenous person as a student support officer, and a part-time academic to assist with teaching.

e.g. 2

A medical school has demonstrated a commitment to Indigenous health by employing an academic to undertake Indigenous health curriculum development. The various tasks involved in curriculum development, Indigenous student recruitment, retention and support, as well as other strategic matters, has proved to be a very large workload. The staff member has presented the need for a coherent Indigenous medical education strategy to the Dean, who is supportive, and to senior management at faculty/school and university levels. However, the active promotion of Indigenous health teaching and learning is undermined by the lack of strategic and planning documents.

With reference to the key questions in the preceding page, describe your **current practice**.

Type in here...

What are the contextual factors that influence your practice (issues, difficulties, limitations, such as structural barriers, resource allocation, etc.)?

Type in here...

What would you like to achieve or what needs to be done (goals, objectives)?

Type in here...

How will you achieve your aims (strategies, plans, priorities, responsibilities, timeframe)?

Type in here...

3A. The medical curriculum: Indigenous health as core curriculum

Background/Questions

Background

The Medical Deans Indigenous Health project is a response to recommendations from numerous studies, inquiries, reports, policies and strategies emerging from the fields of Indigenous health, medical education and medical workforce development. Over the last few decades, these documents have consistently recommended the development and strengthening of both core and vocational medical education with regard to the health and wellbeing of Aboriginal and Torres Strait Islander Australians, and Māori in New Zealand.

Key Questions

Is there core Indigenous health content to which every medical student will be exposed?

Do students have a choice to follow up their Indigenous health interest in electives?

What are the factors that influence the delivery of a quality Indigenous health curriculum?

Reference

CF 1, 2, 3, 4, 5 and 7 / AMCG 1.3 and 1.4.

Examples

e.g. 1

With the *CDAMS Indigenous Health Curriculum Framework* guiding redevelopment, Indigenous health is a compulsory component of the curriculum. Indigenous health has discrete sessions that include a cultural safety aspect and an introduction to Indigenous health. Indigenous health is also integrated into a number of key topic areas such as: holistic models of health care and health determinants, comprehensive primary health care, rural health, cardiovascular disease and risk factors, chronic conditions, and mental health. Discrete sessions have specific identified learning objectives, case-based learning (CBL) and case questions. Cultural safety from an Indigenous perspective is introduced in the first semester of first year. Field trips offer opportunities for one CBL group who report back to the whole cohort and present an abstract. All sessions are delivered by Indigenous people and/or medical practitioners working in the area.

With reference to the key questions in the preceding page, describe your **current practice** in terms of core and elective Indigenous health content in the curriculum.

Type in here...

What are the contextual factors that influence your practice (issues, difficulties, limitations, such as structural barriers, resource allocation, etc.)?

Type in here...

What would you like to achieve or what needs to be done (goals, objectives)?

Type in here...

How will you achieve your aims (strategies, plans, priorities, responsibilities, timeframe)?

Type in here...

3B. The medical curriculum: Curriculum maps, student outcomes and attribute statement

Background/Questions

Background

Indigenous health teaching and learning should be embedded in curriculum maps, student outcomes, and attribute statements. This establishes a structure for coherent learning plans and outcomes and provides a measurement for quality assurance and accreditation purposes.

Key Question

Is Indigenous health incorporated in the faculty/school's curriculum planning documents and overall student outcomes and attribute statements?

Reference

CF 2, 4, 5, 6 and 7 / AMCG 1.3 and 3.1

Examples

e.g.1

Until a recent redevelopment of the curriculum, there was no structured Indigenous health teaching at an established university. Teaching was based on the 'goodwill' and the personality of certain individuals within various faculty units. The Dean wanted to formalise the teaching of Indigenous health throughout the medical program and ensured that this was reflected in the new curriculum. These changes were driven by the Dean and initiated at a time when there were no Indigenous staff members in the faculty. This allowed for the groundwork to be laid before an Indigenous employee came on board, which also increased the appeal of the university to other Indigenous academics and students. The entire curriculum has recently been mapped and today comprises scenario-based learning, where all cases (Indigenous and not) are presented to students and learning is gained by structured experiences. Such experiences include interactions with the patients, their families and communities in the context of their home, school and work, across the lifespan. These scenarios demonstrate the complexity of the experiences encountered by individuals engaging with health and illness in our society.

e.g. 2

An established medical school redeveloped its curriculum to introduce greater teaching and learning opportunities in Indigenous health. Using a stepwise learning pathway, graduate and year level learning outcomes in Indigenous health were developed. These have been used to guide the implementation of a comprehensive vertically and horizontally integrated curriculum. Learning is situated within existing units in each year of the course, with year and graduate level outcomes. The initial progress was quick and relatively easy, drawing on existing partnerships and some opportunistic development of new partnerships with unit coordinators who were 'on side'.

Describe how Indigenous health has been incorporated in the faculty/school's curriculum planning documents and overall student outcomes and attribute statements?

Type in here...

What are the contextual factors that influence the process of incorporating Indigenous health teaching and learning documentation (issues, difficulties, limitations, such as structural barriers, resource allocation, etc.)?

Type in here...

What would you like to achieve or what needs to be done (goals, objectives)?

Type in here...

How will you achieve your aims (strategies, plans, priorities, responsibilities, timeframe)?

Type in here...

3C. The medical curriculum: Curriculum design coordination

Background/Questions

Background

The coordination of Indigenous health content across the curriculum is important to ensure a stepped, developmental approach. Indigenous health content should be vertically integrated such that a 'staircase' approach is taken, where foundation or basic learning in the earlier years is built upon to more advanced skills. Indigenous health content can be horizontally integrated to the broader curriculum. This can be identifiable in curriculum maps.

Indigenous staff should participate in the design, delivery and evaluation of curriculum content. Content should be locally accurate as well as broadly translatable to a national context where appropriate.

Key Questions

Does the faculty/school have a process to ensure the coordinated design, delivery and evaluation of the Indigenous health curriculum?

What involvement do Indigenous staff and community members have in this process?

Reference

CF 2, 4, 5, 6, 7, 8, 9 and 10 / AMCG 1.3, 1.4 and 3.3.

Examples

e.g. 1

By utilising a stepped learning outcome model (at both year and graduate levels), an established school was able to develop and implement a six-year curriculum that provided a solid framework for teaching and learning in Indigenous health. This task was made easier by strong executive support, a well-supported Indigenous health unit and some strong initial partnerships with existing unit coordinators. This was, and continues to be, informed by Indigenous perspectives in planning, implementation and evaluation. Building on that framework, with the aim of embedding Indigenous health learning opportunities across a wider spectrum of units, has been less successful.

With reference to the key questions in the preceding page, describe your **current practice**.

Type in here...

What are the contextual factors that influence your practice (issues, difficulties, limitations, such as structural barriers, resource allocation, etc.)?

Type in here...

What would you like to achieve or what needs to be done (goals, objectives)?

Type in here...

How will you achieve your aims (strategies, plans, priorities, responsibilities, timeframe)?

Type in here...

5A. Assessment of student learning: Assessment of Indigenous health

Background/Questions

Background

The inclusion of Indigenous health in the broader curriculum necessitates specific assessment requirements for the Indigenous health component.

Key Questions

How is student understanding of Indigenous health assessed?

Is this reflected in an overarching assessment map across the medical course?

Is your current assessment of Indigenous health learning appropriate/adequate?

Reference

CF 2 and 4 / AMCG 5.1, 5.2, 5.3 and 5.4

Examples

e.g. 1

All first year students are required to submit an abstract on Indigenous health. Work is marked, reviewed and included in the student's portfolio. Indigenous health is assessed in a summative way using short answer questions. A short answer question is developed covering the broad thematic areas as a case introduction. Separate stems are then added to the introduction with individual theme areas.

e.g. 2

Students are explicitly assessed on their knowledge of Indigenous health and history through an essay question, which is supported with reference material and lectures. Development of professional practice is assessed through an Objective Structured Clinical Examination (OSCE), which has cross-cultural communication as its focus. Leading up to the OSCE, students are exposed to interviews with Indigenous simulated patients.

e.g. 3

Indigenous health is used as an example to teach some elements of population health and understanding of demography. Students are assessed in an exam with questions that ask them to reflect on field visits, or during problem-based learning (PBL) sessions, and they may use an Indigenous case as an example. Equally, they may use a different demographic case as an example. However, the principles around population health demographics are assessed.

e.g. 4

In addressing learning needs in the domain of 'the scientific basis of medicine', a PBL with a biomedical focus on diabetes is used. The demographics of the case are based on an Indigenous example, and the students are assessed on this through the completion of the PBL, as well as exam questions.

With reference to the key questions in the preceding page, describe your current assessment practice in Indigenous health teaching and learning.

Type in here...

What are the contextual factors that influence your assessment practice (issues, difficulties, limitations, such as structural barriers, resource allocation, etc.)?

Type in here...

Is your current assessment appropriate/adequate and what would you like to achieve or what needs to be done (goals, objectives)?

Type in here...

How will you achieve your aims (strategies, plans, priorities, responsibilities, timeframe)?

Type in here...

6A. The curriculum—monitoring and evaluation: Review and evaluation

Background/Questions

Background

The regular evaluation of Indigenous health curriculum is important. A partnership between community groups and staff charged with the design and delivery of the Indigenous health content will assist with the development of evaluation tools and methodologies. Partnerships between staff and community representatives are critical to this process. Evaluation tools might include qualitative feedback from staff, students and community members, as well as statistical profiles of participation in subjects, camps and seminars, and of student results over time.

Key Question

What evaluation measures of your Indigenous health curriculum content do you undertake?

Reference

CF 1, 2, 3, 4, 5, 6 and 7 / AMCG 1.4, 6.1 and 6.3

Examples

e.g. 1

At a university, an Indigenous health committee is established as an advisory board. The task of this board is to assist the development and implementation of the Indigenous health curriculum content within the faculty, at undergraduate and postgraduate levels. The committee comprises a number of staff members, including heads of schools (from Indigenous health, rural health, and broader health sciences), senior lecturers, and an Indigenous student support officer. An internal review that addressed Indigenous health content was conducted, and the results forwarded to the committee. This process resulted in the identification of 'gaps' in teaching, facilitated the identification of 'out of date' or 'stereotypical' content and provided an assessment of a 'culturally safe' curriculum.

e.g. 2

Following a curriculum evaluation, case presentations replaced the submission of abstracts during weeks of discrete learning activities. This enabled students to share learning with the whole cohort. However, owing to poor attendance a reintroduction of the abstracts is currently under consideration. Field trips are dependent on local infrastructure and management, as well as staff support that may change from year to year. The small and limited numbers of organisations require support and engagement on an ongoing basis, and because of this a revised strategy is currently being designed.

Describe what evaluation measures of your Indigenous health curriculum content you undertake.

Type in here...

What are the contextual factors that influence your practice, including community partnerships, in the evaluation process (issues, difficulties, limitations, such as structural barriers, resource allocation, etc.)?

Type in here...

What would you like to achieve or what needs to be done (goals, objectives)?

Type in here...

How will you achieve your aims (strategies, plans, priorities, responsibilities, timeframe)?

Type in here...

7A. Indigenous students: Recruitment

Background/Questions

Background

The significant disparity in the health status between Aboriginal and Torres Strait Islander people and the general Australian population is widely acknowledged. The positive effect on the physical, emotional and cultural wellbeing of Indigenous people when treated by Indigenous doctors has been widely recognised. One way, therefore, that medical faculties/schools can address this health inequity is by the active recruitment of Indigenous students to both undergraduate and postgraduate courses. It is important that universities promote medicine as a viable career option for Indigenous students of all ages. This may be achieved through school visits, targeted information, career days, orientation days and workshops and by demonstrating that support is available for interested students.

Key Question

What does your faculty/school do to actively promote medicine as a career choice to prospective Indigenous students?

Reference:

HF 3.4, 4.2, 4.3, 4.3.1, 4.3.2, 4.3.3, and 4.4.1 / AMCG 7.1 and 7.2

Examples

e.g. 1

A university runs pre-med courses and has intensive summer courses available to prospective students. This is paired with orientation programs where students have the chance to meet with local community groups, visit the Indigenous Support Unit and familiarise themselves with staff available to assist them with housing, scholarships, the Indigenous Tutorial Assistance Scheme and other support. The university has found that key to the success of recruitment strategies is the close collaboration between the Indigenous Health Unit and the Indigenous Support Unit (co-location helps), and the existence of multiple pathways. This ensures that entry options are tailored to individual students' needs, (i.e. this is not just a school-to-university program). The university also targets regional career days, organises school visits and has close ties with relevant community groups.

e.g. 2

A medical school offers information sessions highlighting available support for Indigenous students in science and health-related courses. Medical students and recent graduates encourage potential students to consider medicine as a career. The course is advertised to prospective students through appropriate media such as *The Koori Mail*, the *National Indigenous Times* and on AIDA's website. The medical school approaches high school principals and career advisers to highlight medicine as a career option, outlining available support. It also holds orientation days and camps for potential Indigenous students. Information is distributed through the Aboriginal Medical Services. The university employs local Indigenous people to assist with the development of recruitment, retention, support and teaching strategies. Good community relationships and effective consultation have dramatically increased Indigenous student recruitment and retention.

Describe what your faculty/school does to actively promote medicine as a career choice to prospective Indigenous students.

Type in here...

What are the contextual factors that influence the promotion of medical studies among Indigenous students and their recruitment?

Type in here...

What would you like to achieve or what needs to be done (goals, objectives)?

Type in here...

How will you achieve your aims (strategies, plans, priorities, responsibilities, timeframe)?

Type in here...

7B. Indigenous students: Alternative entry schemes

Background/Questions

Background

While Indigenous students may attain a tertiary entry rank that will gain them a place in a medical course, many are not familiar with the university system, and may be hesitant to apply believing they would not achieve a place. At the same time there are many reasons (including structural disadvantage) why Indigenous students do not attain cut-off entry scores. It is desirable that universities have alternative entry schemes that ensure Indigenous students are accommodated within the medical faculty/school's overall student quota.

Key Question

What alternative entry schemes are available to Indigenous students?

Reference

HF 4.3.3, 4.5.1, 4.5.2 and 4.5.3 / AMCG 7.1 and 7.2

Examples

e.g. 2

A university has a designated number of places for Indigenous students. These places are part of the overall student quota and may not be re-allocated to non-Indigenous applicants. The university also has clearly articulated pathways into medicine for applicants who have a degree or vocational experience. It provides support for prospective applicants with bridging and pre-med courses, and offers tutorial assistance for the GAMSAT/UMAT. The GAMSAT/UMAT is a significant barrier to entry for Indigenous students. At this institution, only one out of twenty-four Indigenous students gained a place via the standard UMAT, UAI/TER, interview process, and only three achieved a 'competitive' UAI/TER.
(See 'Abbreviations' on p.2 for the complete spellings of the above acronyms.)

e.g. 3

A university has found that having alternative entry schemes enables the recruitment of students from a variety of backgrounds. This leads to greater Indigenous student enrolments, and fosters better and lasting relationships with the community.

Describe what alternative entry schemes are available to Indigenous students.

Type in here...

What are the contextual factors that influence the establishment of an alternative entry scheme (issues, difficulties, limitations, such as structural barriers, resource allocation, etc.)?

Type in here...

What would you like to achieve or what needs to be done (goals, objectives)?

Type in here...

How will you achieve your aims (strategies, plans, priorities, responsibilities, timeframe)?

Type in here...

7C. Indigenous students: Admission policy and selection

Background/Questions

Background

Support services and flexible tools are needed to facilitate the selection of appropriate Indigenous students. These selection tools should be developed with input from Indigenous communities and Indigenous student support units.

Key Questions

What are the selection tools and how are they weighted?

Are such tools the result of a consultative process?

Reference

HF 4.3.1, 4.3.3, 4.5.1 and 4.5.3 / AMCG 7.1 and 7.2

Examples

e.g. 1

A university uses GAMSAT/UMAT and has a flexible approach with interviews, which are often run off campus. The university has relevant Indigenous community members on interview and selection panels. It takes into account vocational experience when considering applications and offers support in preparation for GAMSAT/UMAT, and has a bridging/enabling course for applicants. The university has well-established contacts with the Australian Indigenous Doctors' Association for student support and mentoring programs, and supports its students financially to attend AIDA activities.

e.g. 2

A university relies on UAI/TER alone for selection. It has no Indigenous students and feedback from unsuccessful applicants is that entry is too competitive and narrow. The university is looking at expanding its selection tools for the next entrance round.

e.g. 3

A university does not use UMAT and relies on UAI/TER and a structured interview in its selection process. It offers a bridging course, and in some cases will suggest that applicants undertake a first year science degree in order to develop their knowledge base and demonstrate their commitment and capacity. The university will 'reserve' a place for them subject to successful completion of that year.

e.g. 4

A university found that flexible approaches to the selection of students maintained high standards of graduates and, as a by-product, a greater number of Indigenous students were retained throughout the medical courses. Students felt supported and had services to approach when they faced any difficulties. Flexible approaches to selection allowed for lasting relationships with communities to be developed and helped to set up networks, the recruitment of more students, liaison with Aboriginal Medical Services, and the development of better procedures around alternative entry schemes.

Please describe your selection tools and how are they weighted.

Type in here...

What are the contextual factors, including community consultation, which influence your practice (issues, difficulties, limitations, such as structural barriers, resource allocation, etc.)?

Type in here...

What would you like to achieve or what needs to be done (goals, objectives)?

Type in here...

How will you achieve your aims (strategies, plans, priorities, responsibilities, timeframe)?

Type in here...

7D. Indigenous students: Support, mentoring, networks and counselling

Background/Questions

Background

Medical students may encounter stressors that can affect their general health and wellbeing. It is desirable that universities are aware of the nature of the particular stressors faced by Indigenous students. Equally desirable is the provision by medical faculties/schools of a variety of culturally appropriate Indigenous student support services and processes that are linked to other support services. Indigenous student support should include: academic support, mentoring (from graduates of medicine or other health-related disciplines and other students), safe meeting places, networking and peer support, counselling, and physical, emotional, social, cultural and spiritual support.

Key Question

What support is in place for Indigenous students at faculty and university levels?

Reference

HF 4.3.1, 4.3.3, 4.3.4, 4.3.5 and 4.3.7 / AMCG 7.3

Examples

e.g. 1

University services ensure that extra support is available for those who are struggling emotionally and/or academically. This is provided through the Indigenous Health Unit and the Indigenous student support staff. The university has good links with the Australian Indigenous Doctors' Association for external support and mentoring programs. It provides safe meeting places and regular interfaculty meetings for Indigenous students to network. The university conducts cultural awareness training for staff to ensure culturally appropriate teaching and support is offered.

e.g. 2

A university has one Indigenous staff member responsible for curriculum development and teaching, student support and recruitment programs. It recognises that this staff member is often very busy—juggling student support, curriculum development and teaching—and that students have no one else to approach when difficulties arise and the one support staff is otherwise engaged. The university is looking at expanding its support services, which are much needed and should encompass a whole-of-school approach.

Please describe what support is in place for Indigenous students at faculty and university levels.

Type in here...

What are the contextual factors that influence your ability to provide support for Indigenous students?

Type in here...

What would you like to achieve or what needs to be done (goals, objectives)?

Type in here...

How will you achieve your aims (strategies, plans, priorities, responsibilities, timeframe)?

Type in here...

7E. Indigenous students: Financial support

Background/Questions

Background

AIDA's *Healthy Futures* report states that 86% of Indigenous medical graduates interviewed reported financial hardship as a significant impediment to study. When medical faculties/schools provide financial assistance to students, and guidance in the identification of scholarships, accommodation and other funding options, they have higher retention and graduation rates.

Many Indigenous students of all ages risk becoming overburdened in meeting commitments associated with study, work and family obligations. It is important that universities have support mechanisms in place to assist Indigenous students in securing accommodation, tuition and basic resources (such as for computers and travel costs) to avoid unnecessary withdrawal from the medical course.

Key Questions

What assistance is provided to students in terms of accessing scholarships, accommodation and other financial support?

What faculty/school scholarships are available to Indigenous students?

Reference

HF 4.6, 4.6.1, 4.6.2 and 4.6.3 / AMCG 7.3

Examples

e.g. 1

A university offers scholarships to Indigenous medical students covering fees for the duration of the course. Its Indigenous Student Support Unit (which is linked to the medical school student support) offers general support, and can arrange specific academic and tutorial assistance. The Unit has dedicated staff to source funding and safe accommodation. Students can access scholarship information and cadetship opportunities, and a student financial officer assists with budgeting and the provision of loans.

e.g. 2

A university has a financial support officer and includes links to such services on its website. It has had some student withdrawals, which students attribute to financial reasons. The university understands that assisting Indigenous students to identify scholarships, accommodation and other funding options results in higher retention and graduation rates.

With reference to the key questions in the preceding page, describe what financial support is available for Indigenous students.

Type in here...

What are the contextual factors that influence your ability to support Indigenous students (issues, difficulties, limitations, such as structural barriers, resource allocation, etc.)?

Type in here...

What would you like to achieve or what needs to be done (goals, objectives)?

Type in here...

How will you achieve your aims (strategies, plans, priorities, responsibilities, timeframe)?

Type in here...

7F. Indigenous students: Coordination of Indigenous student support

Background/Questions

Background

A well-coordinated relationship between faculty/school-based and university-wide Indigenous student support is of great benefit. This relationship, as well as the optimal use of the resources that underpin support services, is critical to the recruitment and retention of Indigenous students. The *Healthy Futures* report links such support to the graduation of Indigenous students.

Key Question

What is the relationship between faculty-based and university-wide Indigenous student support services?

Reference

HF 4.3.3 / AMCG 7.3

Examples

e.g. 1

A university has a well-established link between its faculty-based and its university-wide Indigenous support units. This collaboration has resulted in the successful recruitment and retention of Indigenous students. Working together has achieved much more than would have been possible if independent action had been pursued. While the faculty-based staff are able to assist in most circumstances, their capacity to do so is limited by the small size of the unit and its multiple commitments. The university-wide Indigenous support unit also has multiple demands placed upon it, but its larger size and the broader range of staff experience enhances its capacity to assist students.

e.g. 2

A university has an Indigenous health unit within its medical school, as well as a well-resourced university-wide unit. These two units operated in isolation while funding permitted. However, with a university restructure, funding for Indigenous student support was reduced. A negotiated agreement between the two units is currently being developed.

Please describe the relationship between faculty-based and university-wide Indigenous student support services.

Type in here...

What are the contextual factors that influence this relationship (issues, difficulties, limitations, such as structural barriers, resource allocation, etc.)?

Type in here...

What would you like to achieve or what needs to be done (goals, objectives)?

Type in here...

How will you achieve your aims (strategies, plans, priorities, responsibilities, timeframe)?

Type in here...

8A. Implementing the curriculum: Educational resources

Background/Questions

Background

Medicine can be taught in a way that enhances students' understanding of Indigenous experiences and worldviews. The best strategies facilitate an understanding of Indigenous health contexts, through teaching and interactions with Indigenous people during clinical placements. Sufficient resources need to be allocated to this end and collaborations with other universities are desirable. Cultural safety is an important consideration in all health settings.

Key Question

What opportunities exist for students to learn in Indigenous health settings?

Reference

CF 1, 2, 3, 4, 6, 7 and 10 / AMCG 1.4, 1.5, 1.6 and 8.3

Examples

e.g. 1

A medical school has few Indigenous health service placement opportunities in close proximity. It is currently planning to increase the number of experiential placements and electives for students in their clinical years. Funding opportunities are currently being sourced and partnerships fostered to support the plan. It is anticipated that this may take considerable time and effort but is worth working towards.

e.g. 2

A new medical school appreciated the importance of connecting with local, rural, and remote Aboriginal Medical Services, and their affiliate agencies, to develop a student placement strategy as part of its clinical skills curriculum. Partnerships were developed over time, which allowed careful consideration of opportunities and constraints within the potential placement services. This ensured the establishment of a realistic and sustainable framework. Cultural safety training formed part of the pre-placement strategy, and identification of placement-specific cultural mentors was considered integral to the process.

Please describe what opportunities exist for students to learn in Indigenous health settings.

Type in here...

What are the contextual factors that influence your practice (issues, difficulties, limitations, such as structural barriers, resource allocation, etc.)?

Type in here...

If there are currently no opportunities available, is there a plan for community engagement to facilitate student placement or experience, and what would you like to achieve (goals, objectives)?

Type in here...

How will you achieve your aims (strategies, plans, priorities, responsibilities, timeframe)?

Type in here...

Appendix 1

CDAMS Indigenous Health Curriculum Framework

Pedagogical Principles and Approach

There are ten key pedagogical principles that are most likely to contribute to successful curriculum design and delivery in the area of Indigenous health. The principles are listed here, along with strategies, examples and cautions for teaching and implementation approaches.

1) Educating medical students about the health of Aboriginal and Torres Strait Islanders is unique among teachings about the health of other Australians, and we can teach medicine in a way that enhances students' understanding of Indigenous experience and world-views.
2) Indigenous health is an integral part of medical education.
3) Teaching from a positive strengths-based model, rather than a deficit model, is more likely to encourage effective learning environments and attitudes.
4) Planning vertical and horizontal integration is important.
5) Indigenous staff are key curriculum developers and enhancers.
6) The attitudes of all teaching, clinical and administrative staff count towards effective learning.
7) In order to facilitate the most effective learning possible, partnerships with local Indigenous individuals, organisations and communities will need to be developed.
8) It is important to teach cultural safety/awareness separately from multicultural awareness.
9) Students can be important curriculum enhancers if effectively supported and encouraged, but they should not be expected or relied upon to perform this function.
10) Multi-disciplinary collaboration is likely to enhance learning outcomes.

This is an edited version taken from: G. Phillips 2004, *CDAMS Indigenous Health Curriculum Framework*, VicHealth Koori Health Research and Community Development Unit on behalf of the Committee of Deans of Australian Medical Schools, The University of Melbourne, Melbourne, pp. 13–22.

Appendix 2

Healthy Futures Report

Principle 1

All Australian medical schools and principal stakeholders have a social responsibility to articulate and implement their commitment to improving Indigenous health and education; and must

As a distinguished and respected profession known for both its objectivity and compassion, medicine is in a prominent position to lead Australia in its efforts to act on the crisis in Indigenous health and education. Medical organisations, schools and colleges across Australia know that Indigenous doctors provide a highly skilled, professional and unique contribution to the Australian medical workforce.

Actions

- Implement the Best Practice framework
- Implement the CDAMS Indigenous Health Curriculum Framework
- Provide a variety of financial incentives for Indigenous medical students
- Provide and protect identified medical places for Indigenous students
- Provide adequate resourcing for Indigenous health support units
- Record and evaluate achievements in improving medical education outcomes for Indigenous students

Principle 2

Make the recruitment and retention of Indigenous medical students a priority for all staff and students and show leadership to the wider university community

The Deans of medical schools and all their staff and students must demonstrate their commitment to Indigenous health and education by actively participating in Indigenous student recruitment and retention strategies and showing leadership to the wider university community. Indigenous staff and community members must be empowered to determine and lead these efforts and delegate responsibilities as needed.

Actions

- Value and encourage the contribution that Indigenous people bring to medicine
- Develop and maintain meaningful partnerships with Indigenous communities and health services under the guidance of Indigenous staff
- Support Indigenous applicants in preparing for and undertaking entry requirements in to medicine
- Develop and implement culturally appropriate promotional material to recruit indigenous students
- Provide administrative, academic and emotional support to Indigenous students
- Provide administrative, academic and emotional support to Indigenous staff and ensure they have time to pursue their own professional development
- Be positive role models and mentors for Indigenous students and staff

Principle 3

Ensure cultural safety and value and engage Indigenous people in medical school business

Medical school staff and students have a responsibility to examine and challenge their attitudes, beliefs and practices towards Indigenous Australians if they intend to work as health professionals. This will benefit all Australians both delivering and receiving health and education services.

Actions

- Establish cultural safety training for all staff and students
- Take affirmative action against racism and discrimination
- Establish an Indigenous advisory committee
- Employ adequate numbers of full time Indigenous staff and ensure they are well resourced and appropriately supported and represented in the management structure
- Engage local Indigenous people in recruitment, retention and teaching activities
- In partnership with Indigenous communities, provide practical and cultural learning opportunities and experiences

Principle 4

Adopt strategies, initiate and coordinate partnerships that open pathways to medicine from early childhood through to specialty practice

Flexible entry and articulation pathways need to be developed and promoted. Recruitment strategies should target and provide support to potential Indigenous medical students at different life stages including primary and secondary school and mature age.

Actions

- Establish and maintain strong working partnerships with local/regional schools, technical colleges, the Indigenous health workforce and other university disciplines to ensure that potential Indigenous medical students are identified and encouraged
- Undertake regular recruitment activities at local schools, communities, health services and other educational institutions
- Involve current medical students in Indigenous recruitment activities
- Encourage Indigenous medical students and graduates to act as role models and participate in mentoring programs
- Provide university orientation opportunities, summer camps, bridging and premedical programs that are targeted at a range of age groups and educational levels
- Tailor admissions and alternative entry requirements for Indigenous students and provide support for applicants through this process
- Provide financial support for Indigenous people to cover costs associated with applying for medicine

Principle 5

Ensure all strategies for Indigenous medical student recruitment and retention are comprehensive, long term, sustainable, well resourced, integrative and evaluated

The recruitment and retention of Indigenous medical students requires long-term commitment and strategic partnerships from Australian governments, medical schools and the wider community.

Actions

- Consistent with the Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework (2002) and taking account of this framework, develop and implement a comprehensive Indigenous recruitment and retention policy
- Establish Indigenous recruitment and retention plans and strategies
- Provide financial and human resources to ensure that recruitment and retention plans and strategies remain open and flexible
- Conduct ongoing evaluation of the Indigenous recruitment and retention plans and strategies

From: D. Minniecon & K. Kong 2005, *Healthy Futures: Defining Best Practice in the Recruitment and Retention of Indigenous Medical Students*, Australian Indigenous Doctors' Association, Manuka, ACT, pp. 52–4.

Appendix 3

Australian Medical Council's Guidelines

Part 2 Educational Standards Attributes of graduates

The goal of medical education is to develop junior doctors who possess attributes that will ensure that they are competent to practise safely and effectively as interns in Australia or New Zealand, and that they have an appropriate foundation for lifelong learning and for further training in any branch of medicine. Attributes should be developed to an appropriate level for the graduates' stage of training.

Specific attributes incorporating:

- knowledge and understanding
- skills and
- attitudes as they affect professional behaviour

are described in the list below.

Doctors must be able to care for individual patients by preventing and treating illness, assisting with the health education of the community, being judicious in the use of health resources, and working with a wide range of health professionals and other agents. They must be able to work effectively, competently and safely in a diversity of cultural environments, including a diversity of Indigenous health environments.

The quality of each medical school will ultimately be judged by the ability of its graduates to perform at a high level in the changing roles the community requires of its medical practitioners. This requires a flexibility of approach and a commitment to a lifetime of continuing medical education. Medical courses should produce graduates who are willing and able to develop further their knowledge and skills, beginning in the intern year and continuing throughout their professional careers. Graduates must possess a sufficient educational base to respond to evolving and changing health needs throughout their careers.

In Australia and New Zealand, inequalities remain in the health status of various social and cultural groups. Medical schools have a responsibility to select students who can reasonably be expected to respond to the needs and challenges of the whole community, including the health care of these groups. This may include selection of students who are members of such groups. The medical curriculum should also provide opportunities for cultural education programs, and opportunities for training and provision of service in under-serviced communities. A balance of rural, remote and urban area health needs should also be reflected in the curriculum.

Australia has special responsibilities to Aboriginal and Torres Strait Islander people, and New Zealand to Māori, and these responsibilities should be reflected throughout the medical education process.

Doctors work in a context in which the Indigenous peoples of Australia and New Zealand bear the burden of gross social, cultural and health inequity. Doctors must be aware of the impact of their own culture and cultural values on the delivery of services, historically and at present, and have knowledge of, respect for and sensitivity towards the cultural needs of Indigenous people. In this context, beginning doctors need to be able to relate the knowledge and understanding, skills, and

particularly attitudes set out below specifically to Indigenous peoples.

Knowledge and Understanding

Graduates completing basic medical education should have knowledge and understanding of:

1. Scientific method relevant to biological, behavioural and social sciences at a level adequate to provide a rational basis for present medical practice, and to acquire and incorporate the advances in knowledge that will occur over their working life.
2. The normal structure, function and development of the human body and mind at all stages of life, the factors that may disturb these, and the interactions between body and mind.
3. The aetiology, pathology, symptoms and signs, natural history, and prognosis of common mental and physical ailments in children, adolescents, adults and the aged.
4. Common diagnostic procedures, their uses and limitations.
5. Management of common conditions including pharmacological, physical, nutritional and psychological therapies. A more detailed knowledge of management is required for those conditions that require urgent assessment and treatment.
6. Normal pregnancy and childbirth, the more common obstetrical emergencies, the principles of antenatal and postnatal care, and medical aspects of family planning.
7. The principles of health education, disease prevention and screening.
8. The principles of amelioration of suffering and disability, rehabilitation and the care of the dying.
9. Factors affecting human relationships, the psychological, cultural and spiritual well-being of patients and their families, and the interactions between humans and their social and physical environment.
10. Systems of provision of health care in a culturally diverse society including their advantages and limitations, the principles of efficient and equitable allocation and use of finite resources, and recognition of local and national needs in health care and service delivery.
11. Indigenous health, including the history, cultural development and health of the Indigenous peoples of Australia or New Zealand.
12. The principles of ethics related to health care and the legal responsibilities of the medical profession.

Skills

Graduates completing basic medical education should have developed the following skills and abilities:

13. The ability to construct, in consultation with a patient, an accurate, organised and problem-focused medical history.
14. The ability to perform an accurate physical and mental state examination.
15. The ability to choose, from the repertoire of clinical skills, those that are appropriate and practical to apply in a given situation.
16. The ability to interpret and integrate the history and physical examination findings to arrive at an appropriate diagnosis or differential diagnosis.
17. The ability to select the most appropriate and cost effective diagnostic procedures.
18. The ability to interpret common diagnostic procedures.
19. The ability to formulate a management plan, and to plan management in concert with the patient.
20. Communication skills, including being able to listen and respond, as well as being able to convey information clearly, considerately and sensitively to patients and their families, doctors, nurses, other health professionals and the general public.
21. The skills needed to work safely as an intern, as outlined in the National Patient Safety Education

Framework developed by the Australian Council for Quality and Safety in Health Care.

22. The ability to counsel patients sensitively and effectively, and to provide information in a manner that ensures patients and families can be fully informed when consenting to any procedure.
23. The ability to recognise serious illness and to perform common emergency and life-saving procedures, including caring for the unconscious patient and cardiopulmonary resuscitation.
24. The ability to interpret medical evidence in a critical and scientific manner and an understanding of the epidemiology of disease in differing populations and geographic locations.
25. The ability to use information technology appropriately as an essential resource for modern medical practice.

Attitudes as they Affect Professional Behaviour

At the end of basic medical education, students should demonstrate the following professional attitudes that are fundamental to medical practice:

26. Recognition that the doctor's primary professional responsibilities are the health interests of the patient and the community.
27. Recognition that the doctor should have the necessary professional support, including a primary care physician, to ensure his or her own well-being.
28. Respect for every human being, including respect of sexual boundaries.
29. Respect for community values, including an appreciation of the diversity of human background and cultural values.
30. A commitment to ease pain and suffering.
31. A realisation that it is not always in the interests of patients or their families to do everything that is technically possible to make a precise diagnosis or to attempt to modify the course of an illness.
32. An appreciation of the complexity of ethical issues related to human life and death, including the allocation of scarce resources.
33. A realisation that doctors encounter clinical problems that exceed their knowledge and skills, and that, in these situations, they need to consult and/or refer the patient for help, in clinical, cultural, social and language related matters as appropriate.
34. An appreciation of the responsibility to maintain standards of medical practice at the highest possible level throughout a professional career.
35. An appreciation of the responsibility to contribute towards the generation of knowledge and the professional education of junior colleagues.
36. An appreciation of the systems approach to health care safety, and the need to adopt and practise health care that maximises patient safety including cultural safety.
37. A commitment to communicating with patients and their families, and to involving them fully in planning management.
38. A desire to achieve the optimal patient care for the least cost, with an awareness of the need for cost-effectiveness to allow maximum benefit from the available resources.
39. A preparedness to work effectively in a team with other health care professionals.
40. A realisation that one's personal, spiritual, cultural or religious beliefs should not prevent the provision of adequate and appropriate information to the patient and/or the patient's family, or the provision of appropriate management including referral to another practitioner.

From: Australian Medical Council (AMC) 2006, Replacement for Part 2 of the Australian Medical Council's Guidelines: *Assessment and Accreditation of Medical Schools: Standards and Procedures 2002*, AMC, Kingston, ACT, pp. 1–4.