The Australian Indigenous Doctors' Association
Yaga Bugaul Dungun

Medical Deans
AUSTRALIA AND NEW ZEALAND

Building Indigenous Medical Academic Leaders

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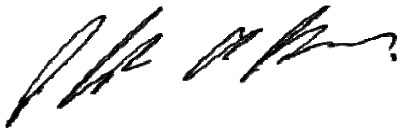
FOREWORD

On behalf of our respective organizations, we have much pleasure in presenting the Report of the Forum on Capacity Building for Indigenous Medical Academic Leadership, held in October, 2011.

The Report provides a comprehensive account of the key themes which emerged from the discussions over the two days of the Forum as well as specific recommendations to be considered and implemented over the next 3-5 years. The outcomes reflect the vast experiential knowledge and leadership background of the 70 Forum participants, from across the medical education continuum, and in many cases, broader health education sector. The outcomes therefore honestly reflect the many challenges to date to building capacity in the Indigenous medical academic sphere.

The Forum was held at a time when there is significant national reform occurring within both the education and health sectors, and with that the acknowledgement of the key role, and the need for proper resourcing of, Indigenous Health in medical training. Whilst there has been a very healthy increase in the number of Indigenous students enrolling in medicine in recent years, there is significant work still to be done to ensure that the majority of these students complete. This is critical to ensuring that there is the appropriate leadership capacity for the future and thus realizing the full value of the current and future investment in Indigenous Health, and of the existing significant contributions being made to medical schools by Indigenous staff.

We recognize that this report now throws the challenge to government, universities, research funding organizations, accreditation bodies, and of course, medical schools to plan their human and financial resources to address these outcomes. Importantly, our two organizations, which have been working formally in partnership since 2005, are committed to providing the necessary leadership to assist with the planning and structured implementation of strategies to realize the Report's outcomes.



Associate Professor Peter O'Mara
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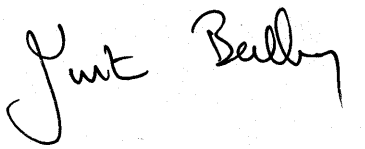

Professor Justin Beilby
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February 2012

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Medical Deans Australia and New Zealand Inc (Medical Deans) and the Australian Indigenous Doctors' Association (AIDA) wish to thank the Steering Committee for driving the progress of this initiative and guidance throughout the project period. The Steering Committee comprise Professor Helen Milroy (Co-Chair), Professor Richard Murray (Co-Chair), Professor Ngiare Brown, Dr Christine Clinch, Professor Paul Worley, Professor Della Yarnold and Professor John McCallum.

Both organisations acknowledge the work of Ms Giti Datt, Project Officer, Medical Deans, for her work during the early developmental stages of the project.

For his support, expert guidance and facilitation of the National Forum AIDA and Medical Deans would like to thank Mr Gregory Phillips.

Medical Deans and AIDA thank all participants for providing their time and expertise at the National Forum held on 13th and 14th October to help progress this significant initiative.

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EXECUTIVE SUMMARY

Experts convened in Sydney for a National Forum on 13th and 14th of October 2011, to brainstorm a series of strategies aimed at increasing the pool of Indigenous medical academic leaders. In breakout sessions participants, guided by a Stimulus Paper, considered the following topics:

- pipeline (pathway) issues
- curriculum differences across the country
- the dilemma of encouraging clinicians to undertake academic careers
- the capacity of research and teaching institutions
- ensuring culturally safe support networks
- the role of all organisations with a vested interest in building the Indigenous medical academic workforce
- strategies to support and fund initiatives identified within each of these categories

Discussion yielded four emergent themes, under which a series of specific strategies were identified:

1 The profile of academic careers is poor

- 1.1 A need to recognise that while ever we do not have enough Indigenous medical graduates we will not have enough Indigenous medical academics
- 1.2 Recognise the motivating factor for many Indigenous students is not pay but a desire to help their community
- 1.3 Cadetships offer a way to engage Indigenous medical students in research or education activities over the holidays or on a part time basis throughout their degree and have the benefit of providing them with financial support
- 1.4 Market academic careers to Indigenous students at an earlier stage
- 1.5 Encourage senior Indigenous medical students to be tutors to junior students and support this relationship with developmental courses for the tutors
- 1.6 Recognise the difference in an academic who is focused on medical education and excellence in teaching and one who is focused on excellence in research – develop the two streams

2 Training options for academic careers

- 2.1 Incorporate developmental opportunities earlier in medical education for example, research projects
- 2.2 Longitudinal options for training opportunities encompassing medical student studies through to post graduate vocational training as a registrar in a medical speciality
- 2.3 Further development of clinical/academic training programs similar to some Registrar training programs
- 2.4 Encourage Indigenous academics in all teaching/research endeavours and not only those specific to Indigenous health
- 2.5 Recognition of the cultural specific skills brought by Indigenous academics in the promotion profiles for academic levels

3 Remuneration is less for academics than clinicians

- 3.1 Scholarships to increase skills in medical education and/or research offered to Indigenous students and graduates
- 3.2 Quarantined funding to recruit and develop Indigenous academics

4 Support for Indigenous academics

- 4.1 Broaden the ownership base regarding Indigenous health in medical schools whilst not eroding dedicated Indigenous health teaching time or undermining the leadership role played by Indigenous staff
- 4.2 Indigenous and non-Indigenous mentors
- 4.3 Longitudinal learning opportunities provided in a flexible manner
- 4.4 Combined vocational training with academic training pathways through colleges
- 4.5 Provision of a culturally safe workplace
- 4.6 Adequate resources (human, financial and other) to achieve the outcomes
- 4.7 Ongoing developmental courses offered with sensitive supervision for the competing priorities experienced by many PhD candidates
- 4.8 Competitive achievement of “mainstream” awards encouraged and supported
- 4.9 Definition and recognition of the “hidden workload” many Indigenous academics carry – this is often not appreciated by supervisors nor articulated in their position description
- 4.10 Monitoring and accountability through quality management practices embodied in the accreditation processes undertaken by universities

Participants highlighted that much foundational work remains to be accomplished in the area of Indigenous medical student recruitment and retention, Indigenous Health curricula and overall support and promotion of Indigenous academics within the tertiary sector. A series of broader foundational recommendations were identified and whilst interconnected to the frameworks within which Indigenous medical academics operate are beyond the scope of this particular initiative. The strategies and recommendations specific to this initiative require that commitments made to foundational work are delivered.

Opportunities for action are identified for medical schools, research institutes and universities, medical specialist colleges, hospitals and health providers, Aboriginal Community Controlled Health Organisations and policy makers and funders. It is recommended that organisations review the opportunities for action and develop internal strategies that align with organisational plans for the next 3-5 years.

ACRONYMS

AIDA – Australian Indigenous Doctors' Association

ACCHS – Aboriginal Community Controlled Health Services (this includes previously termed Aboriginal Medical Services or AMS)

AMC – Australian Medical Council

AMSA – Australian Medical Students' Association

ARC – Australian Research Council

CPMC – Committee of Presidents of Medical Colleges

CPMEC – Confederation of Postgraduate Medical Education Councils

DEEWR - Department of Education, Employment and Workplace Relations

DIISR – Department of Innovation, Industry, Science and Research

DoHA – Department of Health and Ageing

DVC – Deputy Vice Chancellor

HDR – Higher degree by research

HWA – Health Workforce Australia

IDEAL – International Database for Enhanced Assessments and Learning (Consortium)

Medical Deans – Medical Deans Australia and New Zealand Inc (Formerly Committee of Deans of Australian Medical Schools (CDAMS))

MSOD – Medical Schools Outcomes Database and Longitudinal Tracking Project

NACCHO – National Aboriginal Community Controlled Health Organisation

NHMRC – National Health and Medical Research Council

PVC – Pro Vice Chancellor

RACGP – Royal Australian College of General Practitioners

RACS – Royal Australasian College of Surgeons

TEQSA – Tertiary Education Quality and Standards Agency

UA – Universities Australia

VC – Vice Chancellor

VET – Vocational Education and Training

1. BACKGROUND AND AIMS

The current Medical Deans and AIDA *Collaboration Agreement 2008-2011*[1] is the second such agreement between these two organisations. The *Collaboration Agreement* documents the commitment of Medical Deans and AIDA to working together with mutual respect and regard, inclusive consultation and cultural safety for all peoples in all spheres.

A key priority under the work plan of the *Collaboration Agreement* is to "*scope a project for building capacity for the next generation of Indigenous*[a] *medical academic leaders*," with the ultimate aim of establishing "*Chairs of Indigenous health in all jurisdictions within Australia*," some of whom may be Indigenous medical academic leaders.

Discussions since the work plan was first drafted led to the re-focus of this aim to one which more generally seeks to increase the pool of Indigenous medical academic leaders, without the emphasis at this stage solely on Chairs.

A national forum was organised over a day and a half on 13th and 14th October, to coordinate efforts to build this capacity. In order to maximise the utility of the forum a Stimulus Paper (Attachment A) was compiled to guide discussion in breakout groups.

The forum sought to determine how best to increase the pool of Indigenous medical academic leaders by creating pathways, opportunities and providing support. The following provides a summary of discussion and ideas raised at the forum from which a series of recommendations were drawn to form opportunities for action over the next three to five years.

[a] The term Indigenous, used throughout this report, refers to both Aboriginal and Torres Strait Islander peoples.

2. INTRODUCTION

Early findings of the Medical Deans - AIDA National Medical Education Review[b] indicate many Australian medical schools to still be in the developmental stages of implementing the Medical Deans (formerly Committee of Deans of Australian Medical Schools (CDAMS)) Indigenous Health Curriculum Framework[2] and Healthy Futures: Defining best practice in the recruitment and retention of Indigenous medical students[3]. Individual academic leaders and both Indigenous and non-Indigenous students are calling for Indigenous medical academics to be significantly involved in the development and implementation of curriculum and clinical guidance. This indicates there is still considerable work to be done and reinforces the need for greater numbers of Indigenous medical academics [4] highlighting the importance of this particular initiative in building capacity for Indigenous medical academic leadership.

A National Forum was held on 13th and 14th of October 2011, bringing together experts from across the country (Appendix 6.1) to brainstorm a series of strategies aimed at increasing the pool of Indigenous medical academic leaders. The program (Appendix 6.2) incorporated consideration of the following topics:

- pipeline (pathway) issues
- curriculum differences across the country
- the dilemma of encouraging clinicians to undertake academic careers
- the capacity of research and teaching institutions
- ensuring culturally safe support networks
- the role of all organisations with a vested interest in building the Indigenous medical academic workforce
- strategies to support and fund initiatives identified within each of these categories

There was strong support for further review and strengthening of a current surge in activity of foundational work relating to high school and university recruitment, retention and support. Participants at the National Forum acknowledged this work sits within the broader societal factors that influence Indigenous people in Australia, including geographic, economic, health and other social determinants. This contextual framework is also acknowledged in foundation documents including, but not limited to;

- Blueprint for Action[5]
- Healthy Futures: Defining best practice in the recruitment and retention of Indigenous medical students[6]
- Medical Deans (formerly CDAMS) Indigenous Health Curriculum Framework[7]
- National Indigenous Higher Education Workforce Strategy[8]
- Road Map II: A strategic framework for improving the health of Aboriginal and Torres Strait Islander people through research[9]
- National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework (2011 – 2015)[10]
- National Indigenous Higher Education Workforce Strategy[11]
- National Aboriginal and Torres Strait Islander Medical Specialist Framework for Action and Report[12]
- Collaborative works being conducted by the Leaders in Indigenous Medical Education (LIME) Network, including the Critical Reflection Tool[13].

[b] Medical Deans – AIDA National Medical Education Review: A review of the implementation of the Indigenous Health Curriculum Framework and the Healthy Futures Report within Australian Medical Schools (current initiative)

The National Forum output supports the progression of recommendations within these key publications. However, this report focuses on actions that the various sectors could undertake specifically build medical academic leadership capacity. These recommendations presume that foundational work is occurring, that is, they are built on the premise that key reports and strategies are being implemented, reviewed and continuously improved.

It is acknowledged that many of the key issues and recommendations identified in this report would be applicable to a wide range of Indigenous academic and health professionals involved in medical education; however this agenda has been driven with medically-qualified academics in mind. There is scope for these recommendations to be extended to other academics in medical education where applicable.

The following outlines the key issues discussed and specific recommendations to support current Indigenous medical academics whilst increasing the workforce.

3. EMERGENT THEMES

Breakout sessions were held, with each group facilitated by a member of the steering committee, where topics outlined in the previously circulated stimulus paper were considered and recommendations work-shopped. Analysis of the discussions yielded a series of themes and strategies aimed at overcoming barriers to successfully building capacity for Indigenous medical academic leadership. The following is a summary of the themes identified during discussion and corresponding strategies to address.

3.1 THE PROFILE OF ACADEMIC CAREERS IS POOR

3.1.1 A need to recognise that while ever we do not have enough Indigenous medical graduates we will not have enough[c] Indigenous medical academics

Concerns were raised regarding the overall low pool of Indigenous medical students from which all medical practitioners are drawn, including future Indigenous medical academics. A long term strategy that links the early stages of learning, through high school and university is needed. This strategy could commence with a review to determine what is needed for the pool of Indigenous medical graduates to reach levels that flow onto increased capacity for academic leadership. *Understanding the reasons behind high attrition figures was suggested as integral to the long term objectives of this initiative.* Culturally safe environments, an inclusive teaching approach and appropriate preparedness were all highlighted as possible factors influencing attrition. Participants acknowledged that data relating to pipeline and attrition issues needs to be improved. It was recommended that quantitative and qualitative data be collected extending beyond the Healthy Futures study with a focus on identifying best practice(s) for preparedness and retention.

Preparation and the needs around readiness to succeed is an under-represented and researched area. . *Tracking and evaluation of current successful initiatives is required to identify specific best-practice models of student support.* Participants recognised that the university experience plays a large role in retaining Indigenous medical students and this environment needs to be safe; this needs to be holistically tackled in order to succeed in building capacity along the entire pipeline. *Support is founded on three pillars - finance, the extent that living requirements are supported; academic, including preparation and tailoring the support; and cultural/personal, students need to see themselves in the curriculum, on campus and that they can deal with their personal issues.*

[c] In building a critical mass of Indigenous medical academics a specific target that would meet the needs of the medical academic profession has not been identified as part of this initiative. However many current reviews and reports, such as the recent National Indigenous Higher Education Workforce Strategy, utilize population parity as the target to constitute successful representation of Indigenous academics.

Pipeline entry points need improvement and enhanced flexibility. Pursuit of academic careers should be built into the pipeline and respected as a career option. *Opportunities should be built along the pipeline and multiple tracks of entry available*. Entry points into medicine for mature age students need review, as well as support mechanisms to address retention and completion issues. *Exit options should be built into the pipeline and this should be seen positively, not negatively. There should be options to pursue other health based careers based on experience and learning to date.*

Blueprint for Action[14] is the recommended source for strategies, targets and measures to improve university preparedness, build interest in medical and health careers and strengthen the pipeline for Indigenous secondary students. Institutional level strategies are being relied on to build the capacity of secondary students; the government needs to deliver on their commitment to Blueprint for Action. *This initiative, to increase the number of Indigenous medical academic leaders, requires that the foundational work occurs and is successful; this is not about going over work that has already been done.* Cohesiveness of national strategies requires consideration, currently strategies are being implemented by institutions, and departments within institutions, in an un-unified fashion. A national strategy on foundational capacity should holistically address all of the following:

i. Recognise that few Indigenous students finish year 12. If health is a national priority, then it needs to be competitive and well promoted. A leadership group of 25-30 Indigenous secondary students could be identified and brought together once a year to strengthen their leadership skills;
ii. Be regionally focused. Vocational Education and Training (VET), schools, families and communities need to be better connected at the local level. It is recognised that a lot is happening within institutions but there isn't a national approach;
iii. Be sustainable. Strong successful institutional programs should be maintained, not have funding sources removed as soon as they are getting positive results; and
iv. Be the combined responsibility of universities and government.

3.1.2 Recognise the motivating factor for many Indigenous students is not pay but a desire to help their community

It is widely acknowledged that Indigenous students get involved in healthcare because they want to make a difference to their communities and not because of prestige, monetary rewards or specialities. Whilst acknowledging that financial incentives may not be a motivating factor, remuneration is still important.

It was acknowledged that there will always be competing priorities for Indigenous graduates, however participants agreed that Indigenous doctors are needed everywhere, in clinical settings, universities and research. *Indigenous clinicians can only serve a small number of Indigenous patients on one day, but can potentially influence a whole generation of students.* Graduates should not however be penalised for not following Indigenous health paths but be given appropriate exposure to a wide range of career pathways and supported to choose for themselves.

Incentives to attract Indigenous graduates into academic careers need to be researched; the normal incentives of lifestyle, flexibility and prestige may not necessarily apply. Once identified, tailoring these incentives to attract and retain graduates is recommended as a mechanism to build Indigenous medical academic capacity. *Linked clinical and research appointments through academic titles is recommended.* Such appointments would acknowledge work across both domains, facilitate collaboration across institutions and enable Indigenous doctors to maintain links to the community.

3.1.3 Cadetships offer a way to engage Indigenous medical students in research or educational activities over holidays or on a part time basis throughout their degree and have the benefit of providing them with financial support

Summer time and vacation time employment is important. It was suggested that *improved flexibility within research institutes and teaching units would allow opportunities such as part-time or semester break experiences to be explored.*

A long term cadetship program is recommended. This cadetship could be linked to university studies, mentorships, and eventual academic positions. The program should present students with a list of the type of cadetships that are available from early on in their studies. Faculties and Indigenous Academic Support Units within each institution could be responsible for the cadetships with the potential for collaboration with Indigenous organisations such as the Leaders in Indigenous Medical Education (LIME) Network or AIDA.

Currently internships are inflexible and inconsistent with university semester and break structures, making them inaccessible to Indigenous students. For instance a typical university student is offered 4 to 5 weeks of holiday per year; however internships currently run on a 12 week basis over summer. One model of support is the John Flynn Cadetship which provides support to students throughout their medical degree in exchange for providing two years return of service after completing their internship. University funded cadetships were recommended, these could include the option for community based internships for Indigenous students.

It is recommended this project be investigated with the Universities' peak body, in collaboration with National Health and Medical Research Council (NHMRC), Australian Research Council (ARC) and AIDA.

3.1.4 Market academic careers to Indigenous students at an earlier stage

Current numbers may be an indication that academia is not considered an attractive career. This may be partially due to a perception of high workloads and relatively poor remuneration in comparison with clinical roles, but may also be due to a range of other factors, such as clear career pathways or a marketing deficit. Academic positions do not generally feature highly in the career aspirations of Indigenous people because career pathways offered by community controlled services, mainstream health services and speciality colleges are more clearly defined. There is also a pressure for Indigenous doctors to remain as clinicians; this creates a tension between staying out in the clinical system and working in an academic role. It was recommended that strategies be identified to manage the tensions between these two career pathways without compromising individual goals and ambitions. This is an issue that is relevant also to the broader issue of clinical and academic workforces. Academia is currently seen as a relatively unclear and poorly remunerated career path; the general recruitment of medical academics is difficult, and some vacancies go unfilled, in part reflecting the growth of the sector over the last decade. There can also be issues around how clinical teaching may be valued compared with research when it comes to recruitment, promotion and reward for prospective, full-time or part-time medical academics.

The challenge of building the medical academic workforce is therefore broader than Indigenous health; there are many issues and strategies in common for Indigenous and non-Indigenous medical academics. Pathways into teaching and research careers are generally poorly developed in comparison to expectations of medical internship or for training towards fellowship in a specialty college. Remuneration is generally not comparable with clinical work. Achievement of an academic post was not perceived to be a problem, but rather the general lack of acknowledgement and support of the particular stresses of developmental roles, and dealing with social factors such as prejudice within the culture of institutions.

Increasing the appeal of academia to Indigenous medical students requires a range of generally relevant strategies such as: marketing pathways into academic medicine that are responsive to student interests and capabilities; providing early access and opportunity to work with medical researchers and educators; developing opportunities to work with community groups on teaching or research projects; and building academic aspects of learning in the clinical context (for instance, teaching small groups, supervision and providing feedback). These are not the responsibility of medical schools only alone: universities more broadly, research institutes, funding providers, hospitals and community health organisations can work collaboratively with medical schools in these areas to make academic career paths better known and more attractive to students.

Learnings can be taken from parallel journeys as seen through rural health and frameworks can be built from these models and experiences. AIDA is also currently working at developing a training post in partnership with ACCHS and GPET that incorporates professional development across clinical, research and academic skill sets. Examples of the Latino student pathways in the United States and speciality tracks in Indigenous health at Washington University were cited as possible references for model development. These programs build skills in teaching, research and leadership into pathways for select medical students, which could be broadly applied to all medical students with an interest in academia.

3.1.5 Encourage senior Indigenous medical students to be tutors to junior students and support this relationship with developmental courses for the tutors

Early exposure to academic activity provides a potential mechanism to attract students to academia early on in their medical course. *Encouragement and providing the opportunity for Indigenous medical students to tutor more junior students and for Indigenous academics to tutor more junior staff is a strategy that could promote academic careers.* One successful example mentioned was of a Senior Medical Officer and part-time Medical Officer who guided students in exploring research opportunities; these students have now been successful in having their work published.

Participants acknowledged that while there is value in engaging Indigenous students in teaching and tutoring of others, this should not put their own academic performance at-risk. Such strategies always need to be contextualised for the individual student, their preferences and circumstances.

Developing interest and support in academia requires good experiences in academic life for students. Indigenous medical students need to feel safe within universities in order to be interested in returning to provide academic services within them. *Cultural safety and career attractiveness require attention in order to attract Indigenous medical students into academia. This is addressed further at 3.4.5.*

Students should be provided with opportunities to teach, encouraged to undertake mentoring and other support as appropriate. *Interested students could be identified and developed into cohorts that take specific extension studies.* Beyond graduation, junior doctors could be provided with opportunities to be tutors. Possible strategies include:

i. Mentoring and leadership development;
ii. Concurrent enrolment in postgraduate certificates; and
iii. A structured mechanism to encourage Indigenous graduates to go back into the community and the medical school as teachers, mentors and leaders. This would require connection, support and negotiation between medical schools and, for instance area health services.

3.1.6 Recognise the difference in an academic who is focused on medical education and excellence in teaching and one who is focused on excellence in research – develop the two streams

Participants highlighted the need to balance recognition of teaching with rewards for research achievement. Most full-time academics do both to a greater or lesser degree; many medically qualified academics have part-time roles that may have a greater focus on teaching only. Participants noted that academic promotions clearly require a combination of teaching and research, regardless of the intentions of the academic to pursue a prominently research or teaching focussed career. Concern was particularly raised that prolific publishers receive greater incentives than talented teachers. This emphasis on research promotion was seen to potentially direct teaching focussed academics towards more research based careers.

Participants acknowledged that some Indigenous doctors may not wish to focus more on teaching than research, so mechanisms to accommodate those pathways are necessary. *Increasing the availability of academic fellowships (salaried opportunities to pursue teaching and/or research interests for a defined period) is one mechanism proposed through which to improve academic pathways with a focus on one or both of teaching and research.*

It was recognised that a PhD and defined research interest are not necessary to achievement of excellence in teaching. Recognition of the distinction between teaching and research academic careers is in its infancy but universities have begun to support the pursuit of a teaching or research specific focus whilst maintaining the dual focus career pathways.

3.2 TRAINING OPTIONS FOR ACADEMIC CAREERS

3.2.1 Incorporate developmental opportunities earlier in medical education for example, research projects

Structured career progression with mentorship, authorship, and advice on achieving academic positions early on in the pipeline is highly recommended. Students should receive guidance on research and the education trajectory at the beginning of their studies rather than at the end. *Currently students are unaware of the importance of research and the efforts involved in getting work published; there needs to be emphasis and exposure early on for students.*

Capacity exchange is important in research development; it is still very much an apprenticeship style career. Although the membership of National Aboriginal Community Controlled Health Organisation (NACCHO) is quite diverse, all states have state based peak bodies incorporating an ethics council and there is often space for early career researchers. Winnunga is an example of an ACCHS and peak body providing community based experience and research opportunities for students. The research projects and students are supported by a part-time medical officer. *Winnunga is proud of the training it provides and believes it offers a great experience for the young doctors who will change the attitudes in hospitals and clinical settings.* Greater support to develop and enhance these state based peak bodies is recommended.

This recommendation also ties in with teaching opportunities throughout medical education, such as tutoring, which is detailed at 3.1.5.

3.2.2 Longitudinal options for training opportunities encompassing medical student studies through to post graduate vocational training as a registrar in a medical speciality

Participants noted the value of building an academic medicine option into each step of the medical training pathway from student to junior doctor and post-graduate trainee (registrar) with a specialist College., This will require funding and coordination with health services (particularly for junior doctors and registrars) as well as introductory research and teaching preparation programs in medical schools, for interns and in specialist training. Individual interests need to be supported, it was recommended that options be established along the pipeline of medical education and specialist training that allows those interested, to opt into an academic training stream. *Training programs should include teaching and research skill development and mentoring to increase interest in academia, enhance leadership skills and to better understand the efforts required to succeed within each.*

3.2.3 Further development of clinical/academic training programs similar to some Registrar training programs

Discussion on pipeline issues reiterated the importance of vocational training pathways and partnerships to ensure dual accomplishment of clinical and academic skills. One example discussed was the Australian General Practice Training (AGPT) 'academic registrar' program that meets the salaries of interested general practice registrars (who apply on a competitive basis) for 6 months full-time (12 months part-time) academic posts. This model was felt to be more broadly applicable. Participants particularly recognised the opportunities for partnerships with ACCHSs in the AGPT academic registrar program, particular as it allowed an Indigenous GP registrar to combine clinical training with research and teaching development in a community setting. *Currently, most specialist registrars have to pursue medical and academic training separately; remodelling this approach so that academic preparation can be concurrent with vocational training for Indigenous medical graduates (and others) was proposed.*

Participants highlighted that interest currently exists for teaching, however there were often few formal opportunities to convert this to a formal academic career path after graduation. *It was suggested that an extended skills development program be established through which interested medical graduates can teach at university level, without previous research experience and have this counted towards their specialist training.* It was recommended that funded programs based on the AGPT academic registrar model could be applicable across all specialties.

The importance of establishing networks and relationships nationally among Indigenous graduates who were interested in academic medicine were reiterated. *Collaborative training programs across institutions would help to overcome isolation.* State and/or national forums providing specialised medical education training were recommended. *Cross-institutional programs would assist to assuage costs and a national program would reduce repetition and enhance efficiencies.* Benefits of peer support and collegial networks would also be greatly fostered by cross-institutional national or state programs.

3.2.4 Encourage Indigenous academics in all teaching/research endeavours and not only those specific to Indigenous health

Growth in the number of Indigenous researchers outside of the field of Indigenous health was called for. Indigenous doctors, researchers, teachers and clinicians' pedagogical approach to medical education and Indigenous research methodologies should be respected and valued. *Indigenous medical students should be encouraged early on to seek out career paths of interest to themselves and that extend beyond the traditional Indigenous health field within the university setting.* Fostering pathways of the students' making requires a student-centric approach to recruitment. *General encouragement to undertaking postgraduate coursework qualifications that expand academic career opportunities, such as a Masters Degree in Public Health, was recommended.*

Participants affirmed the continued importance of Indigenous health research being undertaken by Indigenous researchers together with others. It was recommended that greater efforts be taken to nurture interest in Indigenous health teaching and research by all students, not just Indigenous graduates. In order to do so, research grants and the profile of Indigenous health needs to be raised, making teaching and research in this field prestigious.

3.2.5 Recognition of the cultural specific skills brought by Indigenous academics in the promotion profiles for academic levels

Indigenous epistemology is a relatively new concept in research and participants felt there would be benefit from further support for its development and articulation with more established traditions. Support for Indigenous teaching pedagogies, Indigenist research, and development of synergies in approaches between these and established methodologies was recommended. This recognises that investing in development of academic capacity of Indigenous peoples has benefits beyond the Indigenous community. *Indigenous academics have an immense richness to give to academia more broadly.*

Respect for the spectrum of Indigenous knowledges was acknowledged as important. *Participants highlighted that Deans of medicine, Executive/Faculty Deans, and University senior executive members need to promote the full spectrum of research methodologies that are relevant to Indigenous research – quantitative, qualitative and mixed-methods approaches as well as community-based and community-driven research.* It is important for developing Indigenous researchers to build a range of methodological capabilities. *A key principle in indigenous research is that Indigenous communities must have partnership of the research agenda and be encouraged to develop their own agenda.*

3.3 REMUNERATION IS LESS FOR ACADEMICS THAN CLINICIANS

3.3.1 Scholarships to increase skills in medical education and/or research offered to Indigenous students and graduates

Scholarships were highlighted by participants as a deficit in recruiting and retaining Indigenous medical graduates as academics. This includes scholarships for undergraduate coursework as well as post-graduate coursework and higher degrees by research. The current number and amount of scholarships provided and the mechanism for their delivery needs thorough evaluation. Recommendations included;

- holistic funding models that cover living expenses as well as tuition costs,
- institution funded scholarships as well as Government funded,
- HECS subsidies or exemptions,
- provision of a HECS free subject for academic skill development that students can elect to take and is counted towards the completion of their medical qualification, and
- central coordination of funding such as through Indigenous Health Units, or a national body to administer and deliver (recognizing administrative overheads).

The ARC currently has a pool of funding dedicated to supporting Indigenous researcher development. Further incentives could be provided to attract a greater cohort and keep them supported throughout their research. *Ongoing fellowships, rather than first year scholarships were supported.* A review of funding for research projects including scholarships and training is recommended to be undertaken by NHMRC and ARC. Concerns were raised around policy constraints of Australian Government Department of Health and Ageing (DoHA) to fund scholarships and support. It was recognised that Health Workforce Australia (HWA) has a primary role of supporting clinical placement management; however greater involvement in academic workforce development was called for.

Participants highlighted that scholarship support should not be provided in isolation but in conjunction with other support factors, including but not limited to cultural support and mentoring. Participants recognised the existence of successful cases in Australia and New Zealand in the provision of comprehensive student support schemes, primarily academically oriented, that include pastoral and financial support. There are learnings from national and international models for supporting Indigenous medical students and developing capacity along the pipeline, from entry, to exit and beyond.

Funding programs vary significantly across medical schools and specialty colleges. Some support is provided directly from the teaching institution, others receive Government based support. Universities need to take greater responsibility for the provision of initiatives that support medical students and developing graduates. The onus of funding and provision of initiatives to support capacity development is not however the sole responsibility of universities. *In developing the medical academic workforce, greater ownership needs to be taken by all institutions, Government bodies and community, given that this initiative is to train a qualified medical workforce that will give back to the community, provide research and teach the next generation of medical graduates.*

3.3.2 Quarantined funding to recruit and develop Indigenous academics

Participants discussed the funding implications of recruitment and development of Indigenous academics in the context of tight University budgets and competing pressures – particularly in research investment. Current systems and processes for the management of Indigenous academic development programs are ad hoc and diverse. *A simplified approach to the management of funding that demonstrates Government and organisational commitment is recommended. This may include special funding programs or negotiation of quarantined funds within budgets.*

3.4 SUPPORT FOR INDIGENOUS ACADEMICS

3.4.1 Broaden the ownership base regarding Indigenous health in medical schools whilst not eroding dedicated Indigenous health teaching time or undermining the leadership role played by Indigenous staff

A positive shift in non-Indigenous attitudes towards clinical medicine and teaching in Indigenous health was recognised by participants. Increased competition exists between non-Indigenous medical students to gain placement and roles with ACCHS; the benefit and necessity of all medical students to gain experiences within an Indigenous health or community setting, whether in ACCHS or elsewhere, was reiterated. Improved articulation of Indigenous knowledge in medical schools, particularly for non-Indigenous students, was seen to be important.

Instilling a better understanding of Indigenous health issues and Indigenous knowledge is essential to the medical education of all doctors. The delivery of Indigenous health within medical curricula should therefore be the responsibility of both Indigenous and non-Indigenous medical academics. *Further exposure to research and teaching within Indigenous Health Units and under the supervision of Indigenous academics for non-Indigenous medical students and graduates was proposed to develop interest, prestige and ownership of Indigenous Health curriculum delivery.* Concerns regarding the difficulty of teaching Indigenous health without having experience working in Indigenous health or limited clinical experience were highlighted. A cultural framework under which non-Indigenous academics could work within Indigenous health under the supervision, and with assistance from, Indigenous academics was supported. Currently the majority of teaching in Indigenous health is undertaken by non-Indigenous academics. *Development of role modelling partnerships between Indigenous and non-Indigenous medical academics working within Indigenous Health Units was recommended.* Greater collegiality between Indigenous and non-Indigenous academics was seen as a way to attune the academic system to Indigenous perspectives and thus strengthen accountability.

3.4.2 Indigenous and non-Indigenous mentors

Peer support for Indigenous students and establishment of mentoring programs were suggested. *Peer support can extend beyond Indigenous academics to include current PhD students or Indigenous people excelling in fields outside medicine or health.* The value of mentoring was a recurrent theme of the Forum and further development of such programs recommended. Mentoring extends from early schooling through to university. The implementation of a national mentoring scheme is recommended and should be further explored through preliminary analysis of existing mentoring programs, establishment of concrete mentoring objectives and inclusion of an evaluation mechanism.

Consultation with Medical Deans, the Confederation of Postgraduate Medical Education Councils (CPMEC), the Committee of Presidents of Medical Colleges (CPMC) and the Australian Medical Council (AMC) is recommended to determine the level of interest in the development of a national mentoring scheme. It was not anticipated that the scheme would be costly to create as frameworks already exist and structuring of current informal systems is recommended. Mentors could be drawn from a variety of disciplines. Mentors could potentially be drawn from various other fields outside medical and health and beyond the university. It was identified that the key mentor years include the first clinical year, the first year of university and the early residency period. A model has been developed to guide the development of a national mentoring framework - the Quadrant Mentoring Model incorporates individual, group, formal and informal components (Appendix 5.3). Structural elements that will require addressing include how mentors are selected and periodic evaluations of the mentor program.

Mentoring will allow commencing university students to more clearly understand their options. Mentoring has been seen to develop not just academic skills but broader life skills. University and medical school alumni provide a pool of potential mentors. A preliminary step could be a national audit and review of incumbent mentoring programs (for example, Group Training (NT)); the timeframe for which could be modeled from the current AIDA – Medical Deans Healthy Futures and Curriculum Framework Review project. Flexible solutions would be required to keep costs down and to best utilize existing resources.

3.4.3 Longitudinal learning opportunities provided in a flexible manner

Options for Indigenous clinicians to access academic roles in a flexible manner, depending on their availability were suggested. The ultimate aim is to establish vocational pathways to assist Indigenous doctors in achieving their career aspirations and the way in which a speciality organisation treats Indigenous academics comes into play. *The Royal Australasian College of Surgeons (RACS) for instance, is looking to promote a less prescriptive training pathway and more one that can be built based on personal interests and circumstances; the college then develops ways in which to support the trainee to follow their pathway of choice.* Rather than mapping out specific pathways for trainees, avenues should be sought to encourage and nurture trainees along pathways of their choosing. This will require a graduate centred focus and flexibility.

3.4.4 Combined vocational training with academic training pathways through colleges

A gap exists between training and pathways to be both a clinician an academic. Ideally, medical academics should not end up with several part-time contracts (as is increasingly the case); rather there should be opportunities for full-time comprehensive appointment as an academic clinician. Organisational and attitudinal shifts are needed to refine employment and training pathways.

Participants felt there were missed opportunities to formally pursue academic development while undertaking training with a specialist college. *Pathways that enable both academic and clinical work to be undertaken concurrently could be better explored and developed.* Joint positions are recommended that support clinical academic training and recognise that the teaching, in an Indigenous Health Unit for instance, is legitimate and often is an essential component of developing a patient centred approach to medicine.

3.4.5 Provision of a culturally safe workplace

Universities are responsible for provision of a safe environment for both staff and students. *All students should be graduating with an understanding of diverse views and normalising the fact that cultural understanding is essential to this broader understanding of world views needs to be reinforced; this should form part of the core business of medical schools.* Student experience in local Indigenous health centres encourages later engagement with Indigenous health and holds schools to account.

Content must be contextualised and localised recognising the similarities and differences between Indigenous peoples and recognising that Indigenous peoples are distinct. This may require other elements of the curriculum to be displaced to ensure all students graduate with an understanding of Indigenous cultural issues. The specifics of Aboriginal culture differ from those of Torres Strait Islanders; a lack of understanding of these cultural differences was highlighted, particularly in relation to issues of cultural safety. *Writing workshops with Indigenous people were suggested in order to structure a bank of knowledge from which all medical schools can draw on that utilises common language to address culturally safe issues.* Expertise in cultural writing and assessment item writing would be required and Indigenous writers should lead the development of any Indigenous curricula. A collaborative model that links with ACCHS and AIDA was recommended. The Royal Australian College of General Practitioners (RACGP) runs writing groups currently, and opportunities for universities to collaborate with colleges in this area could be explored. Assessment was identified by participants as an important area for consideration as assessment tends to drive learning. The variability in content, approach and quality – particularly in relation to assessment in Indigenous health – was discussed. Opportunities for reform, for instance through assessment collaborations such as the International Database for Enhanced Assessment and Learning (IDEAL) Consortium (http://www.idealmed.org) were identified. One of the benefits of an international approach through IDEAL would be the development of links with other First Nation experts in Canada, US and NZ. A roundtable discussion to develop this project was recommended.

Ensuring the safety of staff and students in medical schools needs to be a priority and relevant responsibility defined. A top down, leadership approach is required to create an environment where negative behaviour can be safely confronted and eventually eliminated. Access to de-briefing without repercussion and resilience training is recommended within institutions. The current models and commitment to implementation of cultural safety policies and strategies requires review and improvement. Creation of culturally safe environments requires leaders to be proactive so that in the future such measures will hopefully no longer be necessary once institutional culture is reformed.

Concerns were raised that hospitals are culturally unsafe environments and recommendations made to identify strategies to improve hospital and similarly unsafe clinical teaching environments. *Cultural training at the highest level, of opinion shapers and changers within the teaching hospitals needs to be implemented.* Like universities, teaching hospitals also require the establishment, monitoring and review of safe de-briefing environments. Unsafe behaviour needs to be deconstructed safely, mechanisms by which to best do this need further investigation.

Strategies to develop and recognise the contributions of Indigenous medical students, doctors and academics as well as the provision of incentives to organisations to support culturally safe support networks were discussed. *The creation of a professionalism award that rewards outstanding behaviour and leadership within the student and staff body was one suggestion.* Positive emphasis to foster change was stressed. Mechanisms that incentivise rather than punish organisations to establish strong models to challenge and manage inappropriate or discriminatory behaviour and build culturally safe environments were preferred, without negating the importance of accountability.

Cultural safety is often merged with the teaching of Indigenous health and while both are important and inter-related, they should also be distinct. There is a danger of confusing Indigenous health with cultural safety if these two components are combined. *Cultural safety is about being reflective in our practice whoever we are.* A stronger definition of cultural safety and a complete 360 degree evaluation and assessment of discrimination at the institutional and individual level was called for. A common definition of cultural safety would assist organisations in its implementation and management. The definition should be flexible enough to accommodate for localised differences. *Measurement of cultural safety should be extended to all teachers of medical curricula and environments where academics work and learn.* Review should extend to affiliate staff and external mentors. Areas to be considered in organisational reviews should include:

i. Preliminary research into successful measures to assess cultural safety and its incorporation into a framework;
ii. training and rehabilitation programs;
iii. mechanisms by which to provide safe reporting and debriefing around incidents;
iv. resilience training to help people confront and deal with unsafe behaviour and tackle the issues;
v. compulsory cultural safety training as currently this is mostly voluntary; and
vi. formalised accountability, potentially built into an accreditation framework.

If organisational reviews were consistent at the national level, this could provide a means for evaluating the effectiveness of the policies in place and draw a link between cultural safety training and actual practice. *A national report card could also provide an accountability mechanism for multiple aspects pertaining to Indigenous medical academic promotion and cultural safety as detailed at 3.4.10.* This should be about reflection and quality enhancement, not naming and shaming.

3.4.6 Adequate resources (human, financial and other) to achieve the outcomes

Specific, funded and resourced pathways for Indigenous graduates to become medical academics are essential. Support should address issues of poverty and access to mentors to guide students along the academic pathway. Resourcing and the access to resources should be reviewed. RACS has developed significant resources to increase the number of Indigenous surgeons and backed this with a suite of policy-supported initiatives. *In order to accomplish the goal of increasing academics, time and resources need to be suitably dedicated and this must be a deliberate process.*

Medical academics are often placed in positions of leadership for change and it can be a difficult responsibility to shoulder without preparation. For Indigenous doctors, this can lead to conflict within institutions and can be isolating when there is not a critical mass of Indigenous staff. National and state forum and networks are a mechanism to tackle isolation and should be extended to all Indigenous staff, not just academics. This forms part of the role of the LIME Network, to mentor and support Indigenous medical professionals, share case study information and create a safe space to exchange ideas.

Support for collaborative efforts should be further encouraged through increased funding, prioritising collaboration rather than competitiveness. Integration in training, sharing examination techniques, sharing placement of students, mentorship programs, training programs are potential areas for further collaboration; adjunct and conjoint positions across institutions could also be considered.

Easily accessible support tools, networking, and resources for students and staff should be developed or existing resources and supports enhanced. *Many toolkits and guidelines exist, however it was recommended the Guide to Managing Indigenous Researchers be extended to all academics.*

3.4.7 Ongoing developmental courses offered with sensitive supervision for the competing priorities experienced by many PhD candidates

The attrition rate for Indigenous students enrolled in PhDs is currently about 40%. Under conventional full-time models, PhD students generally face financial and other challenges and many Indigenous PhD students have additional burdens. Significant concerns were raised of instances when PhD students have encountered poor experiences or poor supervision. Support networks and stronger relationships are needed to address this. It was recognised there are pressures on medical PhD candidates to do everything, to be the researcher, the clinician and often the teacher. Participants highlighted the point that the current small pool of Indigenous research students needed to be supported and nurtured into careers as research leaders. It is important these students are supported to identify a research path of their choosing and gain the necessary experience. *It is important not to overburden potential leaders from the beginning* and particularly not to add to the already high responsibilities of Indigenous PhD candidates. Flexible entry pathways into higher degrees by research (HDR) or into postgraduate coursework that are sensitive to additional commitments were suggested.

The quality of supervision for HDR students is variable and concern was expressed regarding cases of poor supervision of Indigenous PhD students. *Participants recommended improvements in access for Indigenous PhD candidates to high quality supervisors and researchers*. Funding should be reinforced for this and support should be targeted and tailored for those students that require it. *Understanding of success factors and predictive factors for failure are required to best inform the development of tailored support.* Analysis of the impact of finance, academic preparedness, family and culture on students is needed. Mentoring and financial support were recommended as areas of focus to improve success for PhD candidates. Increasing cultural awareness training and effectiveness in medical schools and engagement of senior management in postgraduate studies departments were recommended to manage these issues.

Accredited research training and financial support for research students were recommended to increase the support and opportunities for PhD candidates. Interest levels in research overall need to be increased, with research, and particularly research in Indigenous health, making the field a respected pathway to undertake after graduation should be a priority. *Leadership training courses could be incorporated within programs to assist Indigenous medical graduates undertake and lead research.* Incentives to encourage the research pathways could include accommodation and transport, basic living costs and study subsidies. Students who demonstrate an interest in research should be provided with an opportunity to experience research and encouraged to make a career out of it.

3.4.8 Competitive achievement of "mainstream" awards encouraged and supported

Rewarding collaborative and good practice in Indigenous health is important however the teaching that Indigenous academics do spans further than Indigenous health. Concerns were raised that the recognition of excellence in teaching by Indigenous health academics is often reserved to Indigenous Health specific awards. It was agreed that this is having a negative impact on the perceptions of Indigenous Health awards as being a lesser or tokenistic award. Recognition of the achievements of Indigenous academics and staff through mainstream awards for excellence were called for to both acknowledge the teaching excellence of Indigenous Health academics and raise the value of Indigenous Health specific awards to the same level as mainstream awards.

3.4.9 Definition and recognition of the "hidden workload" many Indigenous academics carry – this is often not appreciated by supervisors nor articulated in their position description

Understanding the workload of academics is important, particularly the hidden workload of Indigenous staff, whether academic or professional. Indigenous people should not be expected to do everything from curriculum delivery to student care to cultural safety training to clinical work and more. *Alleviating teaching pressure and workloads of Indigenous academics was recommended to assist emerging academics pursue further developmental training*, such as specialisation, leadership programs and further clinical practice before returning to teach. *Institutional allowance to fulfil additional roles within the community and to other departments and organisations is required.* Accommodating Indigenous community and family obligations with work should be part of good management practice for universities employing Indigenous staff.

The value of undertaking further study to characterise the nature and quantum of culturally-specific community and family commitments for Indigenous academics was discussed. Potential methodologies could include academics diarising their work (both academic and community) over a period of time. This may be worth developing as a pilot study that could be extended more broadly.

3.4.10 Monitoring and accountability through quality management practices embodied in the accreditation processes undertaken by universities

Participants highlighted the gap between what is said, what is understood and what really happens around medical education. Four areas, some specific to Indigenous health, were identified where accountability and responsibility could be addressed:

1. *Partnerships are essential to good practice.* It is important for universities, health service providers and Indigenous individuals and community organisations to talk about how to do things together; 'have a yarn'. Increasing the understanding of the expectations of parties involved in collaborative activities and ensuring a shared understanding of the repercussions of mistakes is essential. *A policy framework is recommended to hold organisations accountable that empowers local Indigenous communities*. For instance, if a medical school comes to an understanding with an ACCHS around student placements and that understanding is not honoured, there should be tangible consequences. This is about building accountability and having conversations across organisations and partnerships. Clarity is needed around the purpose and outcomes all parties desire from collaborative activities. *A review of accreditation requirements and standards has been suggested to link these to quality teaching and culturally safe environments in hospitals and medical schools and establish formal accountability mechanisms.*

2. Accountability and responsibility around student intakes and completions should be better integrated into reporting frameworks for universities. *Attrition rates need to be addressed; support structures and readiness are the key factors that universities need to attend to and take responsibility for.* Flexibility in relation to attendance is important for Indigenous students so they can take part in leadership and other skill development programs, as well as recognise the commitment and obligation to community that Indigenous students have.

3. *Recognising Indigenous medical academics through appointment to leadership roles outside of Indigenous health received strong support from participants, such as appointment to the Chair of Selection Committees.* Appointment through adjunct or conjoint appointments of Elders was also suggested.

4. *Establishment of a national report card could provide a mechanism for reporting on cultural safety objectives and outcomes as detailed above at 3.4.5 whilst also reporting on the achievement of targets in the promotion and development of Indigenous medical academics.* It was suggested rankings be published however schools be de-identified for the full report. The report could include measures pertaining to teaching, learning outcomes and professional development. Measures could include efforts around increasing senior Indigenous representation on Faculty Executive and the number and impact of Indigenous academics reporting directly to the Dean.

4. OPPORTUNITIES FOR ACTION

The collective voice of forum attendees is encapsulated in the opportunities for action following. The Steering Committee acknowledges the work required to align these recommendations to organisational strategies and agenda and the importance of partnerships in progressing these opportunities. Out of respect for organisational specifics, the Steering Committee has elected to frame recommendations as opportunities and sees partnerships as essential in the formulation of specific project details, timelines and measures.

Recommendations from discussion at the forum were both specific to the agenda or in the broader context of Indigenous health and schooling. In acknowledging the wealth of experience and knowledge in attendance at the forum, it was decided that both sets of recommendations be included. Therefore specific opportunities are listed in category of organisational group first and broad opportunities including foundational work are listed second, at 4.2.

The good will of participants at the forum was well felt in presence and enthusiasm across the full day and a half. It is hoped that organisational representatives and individuals that attended or later read this report adopt the recommendations of this report and implement them with the same enthusiasm and good will experienced at the event.

It is recognised that the Forum is a direct outcome of the AIDA – Medical Deans' Collaboration Agreement 2008 – 2011. Many of the proposed recommendations detailed in this report will be the responsibility of Medical Deans and AIDA collectively to progress. It is hoped that specific recommendations of this report can be prioritised by the two organisations and built into a further Collaboration Agreement and work plan from 2012 onwards.

4.1 SPECIFIC OPPORTUNITIES

4.1.1 Opportunities for Medical Schools, Research Institutes and Universities

4.1.1.1 The Profile of Academic Careers is Poor

1. Explore the possibility of establishing a fast-tracked option for students with prior higher degrees into academic roles.
2. Examine incentives that attract Indigenous doctors to academia and develop a best practice framework for recruitment.
3. Develop part-time and vacation cadetship programs through research institutes and universities.
4. Ensure culturally safe experiences for Indigenous medical students throughout their studies to encourage their return to universities for post graduate studies and employment.
5. Provide opportunities for students to develop teaching and/or research interest/capabilities (e.g.: tutoring, research skills, projects)
6. Medical Schools develop a teaching subject or study that is available to Indigenous medical students (and that could be expanded to attract medical students generally into academic roles).
7. Review recruitment and promotion criteria to recognise the prior teaching experience of Indigenous doctors who are interested in undertaking teaching academic careers.
8. Establish teaching fellowships, specifically targeting potential Indigenous medical academics.
9. Develop national Indigenous medical educator job specifications that can be used as a resource for medical schools.

4.1.1.2 Training Options for Academic Careers

10. Establish mini research projects as part of medical qualification and in partnership with research institutes and ACCHSs to foster interest in research and academic research careers.
11. Increase awareness of the importance of research to academic careers and an understanding of efforts involved in having work published early on in medical education.
12. Build academic exposure and pathway options that students can opt into within the broader context of establishing a partnership to support students along their chosen pathway from medical school through to training in a specialist college. Such a program should incorporate mentoring through the research process and publishing of work.
13. Provide teaching training and academic practice throughout the continuum of medical education and training to increase interest in academic careers and leadership.

14. Continue to link clinical practice with research projects.
15. Establish academic study options that can be conducted alongside clinical aspects of vocational training with specialist colleges. It is particularly recommend that partnerships with ACCHS and specialist colleges such as AGPT be explored to facilitate this recommendation.
16. Establish or further develop national and state forums that provide specific medical education and research training for current and aspiring Indigenous medical academics.
17. Facilitate enrolment in postgraduate coursework studies (such as a Masters of Public Health), particularly studies that can be undertaken while practising as a junior doctor.
18. Encourage Indigenous researchers to undertake research in areas outside of the Indigenous health field.
19. Support development of the full range of research methodologies relevant to Indigenous communities and researchers, including Indigenous epistemologies.
20. Establish coursework on Indigenous knowledge that is Indigenous-led.

4.1.1.3 Remuneration is Less for Academics than Clinicians

21. Establish ongoing research fellowships as well as medical school scholarships.
22. Establish a sustainable funding stream to support the development of Indigenous medical academics.

4.1.1.4 Support for Indigenous Academics

23. Further recruit non-Indigenous clinicians and academics to teach within the Indigenous Health Units to alleviate the pressure on current Indigenous graduates to achieve their career goals.
24. Encourage mentoring relationships between senior academics and new Indigenous academics to assist them with understanding career pathways and performance expectations for promotion.
25. Provide support to non-Indigenous mentors who are supervising new Indigenous academics.
26. Engage with Indigenous medical students during their degree, to recruit students into pathways of their choosing that may include the option of an academic component.
27. Build partnerships between medical schools and specialist colleges to articulate academic career pathways that are relevant to the interests and career directions of Indigenous medical students, residents and registrars.
28. Establish tailored training and development programs that are attuned to the individual interests of Indigenous medical graduates that also develop Indigenous medical academic leadership capacity.
29. Enable interested Indigenous medical students and doctors to jointly pursue specialist training along with an academic career.

30. Establish supportive management environments that are culturally safe and cater for the needs of Indigenous medical academics, such as consideration of community leave within job specifications. Recruitment strategies should aim to recruit numbers of Indigenous staff so that individual Indigenous academics are less likely to feel isolated.
31. Establish mechanisms to deal with institutional racism, including the establishment of cultural safety training programs, safe reporting mechanisms and a top-down, leadership led approach. Resilience training should be extended to Indigenous medical academics
32. Normalize the importance of cultural understanding by graduating all medical students and specialists with an understanding of Indigenous cultural perspectives and health issues. Student experience in local Indigenous organisations such as ACCHSs, underpinned by authentic partnerships between schools and organisations, encourages later engagement with Indigenous health and holds schools to account.
33. Create a professionalism award that recognising outstanding behaviour and leadership within the student body.
34. Hold a roundtable discussion to consider a partnership with IDEAL Consortium to develop a bank of common assessment across medical schools for Indigenous health and cultural safety curriculum.
35. Develop and implement a measurement framework to assess teachers of medical curricula within all medical teaching settings.
36. Explore the capacity of Indigenous Health Units within universities to be further developed to support schemes specific to Indigenous medical academic capacity building, such as scholarship management, provision of research experience.
37. Establish university consortia and build a collaboration-based (rather than competitive) approach to recruiting and developing Indigenous doctors and academics.
38. Improve access to high quality supervisors and researchers for Indigenous HDR students.
39. Engage with postgraduate studies senior management with the issues around Indigenous student HDR support.
40. Review PhD retention strategies, with a focus on retaining Indigenous PhD students, including review of cultural safety
41. Provide accredited research training for Indigenous medical graduates.
42. Incorporate leadership training courses within PhD programs to assist doctoral Indigenous students undertake and eventually lead research.
43. Ensure that Indigenous academics are considered for general teaching excellence awards to whilst maintaining existing Indigenous-specific awards.
44. Undertake an evaluation of the hidden workload borne by Indigenous medical academics through further study. Establish a working group to develop methodologies for such work.

45. Recognise the further community and student support work undertaken by Indigenous medical academics within job specifications.
46. Take ownership and responsibility for high attrition rates of Indigenous medical students and establish appropriate, holistic support structures to manage this issue.
47. Engage with TEQSA, AMC and APHRA to establish accreditation standards around professional accreditation of university courses, medical schools and specialist college training that include Indigenous health and cultural safety in curriculum, development of Indigenous academics and partnerships with Indigenous organisations.
48. Undertake an evaluation of support required for clinical teaching settings and establish accountability frameworks to ensure culturally safe learning and working environments for medical students and Indigenous medical academics.
49. Establish purposeful partnerships predicated on increasing understanding of all parties and accepting accountability for results. Incorporate accountability frameworks and guidelines within partnership arrangements with local Indigenous communities that hold academic institutions and health organisations and leaders accountable to the local communities with whom they work. This could include the development of specific KPIs.

4.1.2 Opportunities for Medical Specialist Colleges

4.1.2.1 Training Options for Academic Careers

1. Develop/expand opportunities to undertake academic elective terms accredited for vocational training
2. Build academic exposure and pathway options that students can opt into that supports students along their chosen pathway from medical school through to vocational training in a specialist college. Such a program could incorporate mentoring through the research process and publishing of work along with development of teaching.
3. Provide teaching training and academic practice throughout specialist training program to increase interest in academic careers and enhance the role of the academic leader.
4. Explore the option of crediting teaching work to fellowship and specialist programs.

4.1.2.2 Support for Indigenous Academics

5. Engage with Indigenous medical students during their degree, to recruit students into specialties of their choosing and establish mentoring relationships to support students through their chosen pathway and develop interest in clinical academic careers.
6. Establish a partnership between medical schools and specialist colleges through which to clearly articulate learning programs specific to the interests and career direction of Indigenous medical students.
7. Establish tailored training and development programs that are attuned to the individual interests of medical graduates, whilst keeping in mind the importance of increasing medical academic leadership capacity.
8. Establishment of dual and multiple pathways. Training to become a specialist OR an academic OR both.
9. Establish supportive environments that are culturally safe and cater for the needs of Indigenous medical academics, such as inclusion of community leave within job specifications. Recruitment strategies should aim to recruit a capacity of Indigenous staff to support Indigenous medical academics and reduce isolation issues.
10. Establish mechanisms to deal with institutional racism, including the establishment of awareness programs, safe reporting mechanisms and a top-down, leadership led approach. Resilience training should be extended to Indigenous medical academics
11. Normalise the importance of cultural understanding by graduating all medical students and specialists with an understanding of Indigenous culture. Student experience in local Indigenous health centres encourages later engagement with Indigenous health and holds schools to account.
12. Develop and implement a measurement framework to assess teachers of medical curricula within all medical teaching settings.

13. Engage with the AMC (and its Specialist Education Accreditation Committee) and APHRA to establish accreditation standards around professional accreditation in Indigenous health, including support of Indigenous registrars, cultural safety, Indigenous health curriculum and development of Indigenous fellows as medical academic.
14. Undertake an evaluation of support required for clinical teaching settings and establish accountability frameworks to ensure culturally safe learning and working environments for Indigenous residents and registrars and Indigenous medical academics.
15. Establish purposeful partnerships predicated on increasing understanding of all parties and accepting accountability for results. Incorporate accountability frameworks and guidelines within partnership arrangements with local Indigenous communities that hold organisations and leaders to accountable to the local communities with whom they work. This could include the development of specific KPIs.

4.1.3 Opportunities for Hospitals and Health Service Providers

4.1.3.1 The Profile of Academic Careers is Poor

1. Facilitate participation of junior doctors and registrars in tutoring, teaching and research activities (e.g. rostered release from clinical duties, mixed academic/service roles)

4.1.3.2 Training Options for Academic Careers

2. Facilitate junior doctor and clinician undertaking of research projects, higher degrees by research and relevant post-graduate coursework degrees.

4.1.3.3 Support for Indigenous Academics

3. Provide flexibility in clinical practice to allow Indigenous doctors to undertake further education or training relevant to academic development whilst practising clinically
4. Establish supportive environments that are culturally safe and cater for the needs of Indigenous medical academics, such as inclusion of community leave within job specifications.
5. Promote recruitment strategies which aim to recruit a critical mass of Indigenous staff to support Indigenous medical academics and reduce isolation issues.
6. Establish mechanisms to deal with institutional discrimination, including the establishment of awareness programs, safe reporting mechanisms and a top-down, leadership led approach. Resilience training should be extended to Indigenous medical academics.
7. Develop and implement a measurement framework to assess teachers of medical curricula within all medical teaching settings.
8. Establish partnerships with research institutes, medical schools and universities to create localized joint appointments that enable Indigenous doctors to work as clinicians and teach concurrently.
9. Undertake an evaluation of support required for clinical teaching settings and establish accountability frameworks to ensure culturally safe learning and working environments for medical students and Indigenous medical academics.
10. Establish purposeful partnerships predicated on increasing understanding of all parties and accepting accountability for results. Incorporate accountability frameworks and guidelines within partnership arrangements with local Indigenous communities that hold organisations and leaders to accountable to the local communities with whom they work. This could include the development of specific KPIs.

4.1.4 Opportunities for Aboriginal Community Controlled Health Organisations

4.1.4.1 The Profile of Academic Careers is Poor

1. Establish research and teaching opportunities through sponsored cadetships and internships for Indigenous medical students.

4.1.4.2 Training Options for Academic Careers

2. Partner with Universities/ medical schools/ research institutes to establish mini research projects to foster interest in research and academia for medical students.
3. Partner with local research institutes and universities to provide research projects and teaching opportunities linked to clinical practice for Indigenous doctors.
4. Partner with Universities/ medical schools/ research institutes to develop vocational academic study programs.

4.1.4.3 Support for Indigenous Academics

5. Establish purposeful partnerships predicated on increasing understanding of all parties and accepting accountability for results. Incorporate accountability frameworks and guidelines within partnership arrangements with local Indigenous communities that hold organisations and leaders to accountable to the local communities with whom they work. This could include the development of specific KPIs.

4.1.5 Opportunities for Policy Makers and Funders

4.1.5.1 The Profile of Academic Careers is Poor

1. Support capacity development within the pipeline through incentive schemes that reward institutions achieving successful outcomes in graduating Indigenous medical students, such as a completion bonus for Medical Schools.
2. Follow through with commitments to Blueprint for Action to develop and monitor foundational capacity within the pipeline.
3. Fund research and framework development into Indigenous medical academic recruitment.
4. Increase academic career incentives to encourage graduates to undertake research and teaching positions.
5. Fund programs that provide exposure to academia.
6. Fund a teaching unit during medical qualification for Indigenous students free of charge (for instance, through HECS exemption) that could be extended more broadly to attract medical students into academia.
7. Recognise the value of teaching academic pathways by making teaching more prestigious and support with incentive funding. Review reward systems to raise the profile of academic teaching to that of academic research.
8. Fund the establishment and support of teaching fellowships for Indigenous medical academics.
9. Review the existing clinical loading schemes that currently recognise the remuneration deficit incurred by clinicians that take on teaching positions but withhold the same loading for those academics that pursue a solely teaching career thereby becoming ineligible for clinical loading.

4.1.5.2 Training Options for Academic Careers

10. Establish incentives for leaders within their fields to mentor and provide teaching to Indigenous students interested in research and publishing.
11. Fund Fellowships for mid-career clinicians to engage in research part-time (e.g.: PHCRED Fellowships model)
12. Fund the establishment of collaborative academic skills development programs that can be accredited towards specialist/vocational training.
13. Fund state and national forum that bring together Indigenous medical academics, and those in training, to develop skills in medical education.

4.1.5.3 Remuneration is Less for Academics than Clinicians

14. Establish a partnership between Health and Education ministries of Government to identify core priorities in the area of Indigenous medical academic leadership promotion.
15. Establish a sustainable funding stream to support the development of Indigenous medical academics.

4.1.5.4 Support for Indigenous Academics

16. Fund the establishment of a national mentoring scheme from secondary through to post-vocational qualification to develop capacity within the medical academic pipeline and promote academic career paths.
17. Fund the establishment of dual academic/specialist training pathways (for instance, based on the AGPT model).
18. Continue to fund networks such as LIME and AIDA to bring together Indigenous academics and doctors nationally to overcome isolation and provide structured support networks.
19. Recognise that support needs extend to cultural not just financial and develop support mechanisms that incorporate accountability for both financial and cultural support.
20. Fund a study of the hidden workload of Indigenous medical academics.
21. Incentivize medical schools to focus on sustainable support for Indigenous medical students through retention promoting funding models.
22. Fund the evaluation of clinical teaching settings and development of accountability frameworks.
23. Establish purposeful partnerships predicated on increasing understanding of all parties and accepting accountability for results. Incorporate accountability frameworks and guidelines within partnership arrangements with local Indigenous communities that hold organisations and leaders to accountable to the local communities with whom they work. This could include the development of specific KPIs.

4.2 BROAD RECOMMENDATIONS

4.2.1 Evidence Based Toolkit on Pipeline

Participants recommended the undertaking of a research project to build an evidence based toolkit around pipeline issues. Three elements should be considered: preparedness, admission and retention rates, particularly with a focus on understanding high attrition rates. The study should explore all phases of the pipeline, starting with secondary schooling, to admission, to graduation. The aim of this project would be to highlight what works, what doesn't work and what is most effective.

4.2.2 Input to Indigenous Cultural Changes Review

Compacts are approachable; it is recommended that individuals and organisations take the initiative to provide input into the Indigenous Cultural Changes Review. Engagement with Compacts (the funding agreement that every university signs with the Federal Government) was recommended as these contain agreed targets and statements. It was an overarching, university-wide review so would need further clarification to the medical department.

4.2.3 Reconciliation Plan

All medical schools should have an established plan regarding how they will address issues of cultural safety, enforcement and accountability which is well communicated and implemented.

4.2.4 College of Indigenous Health

A method of validating Indigenous knowledge would be the establishment of Indigenous Health as a discipline, such as Cardiology and Paediatrics. Building the discipline will require dedicated resources to establish a larger bank of knowledge. Partnerships are required to undertake further research and should include political representatives, national bodies, advocacy organisations and networks such as LIME. The long term objective of such an initiative would be the establishment of the College of Indigenous Health which could be a 5-10yr project. The first stage would require a signal of intent to follow through with this recommendation and determining the level of support from existing specialist colleges.

4.2.5 Accreditation Review & Strengthening

Meetings between CPMEC, CPMC, AMC, TEQSA, Medical Deans, AIDA and specialist colleges regarding accredited standards and Indigenous health to discuss the following topics was recommended:

i. Accreditation of medical colleges - Is there a measurement around Indigenous health and teaching?
ii. Clarification on the setting of graduate/trainee outcomes.
iii. Potential for collaboration between colleges to improve their Indigenous curriculum.
iv. Inclusion of Aboriginal or Torres Strait Islander assessors in AMC accreditation teams.

4.2.6 KPIs – Universities, Colleges and Hospitals

It is recommended that accountability be improved by shifting focus to completion rates of Indigenous students, which would assist the acculturation process. Completion rates, teaching quality and cultural safety in teaching environments needs review. Concerns were raised regarding medical schools pushing up numbers without providing support, with little or no regard to modifications to the curriculum and without establishing partnerships with Indigenous agencies. It is recommended that targets, in terms of numbers, be set in conjunction with incentives provided for completion rates for universities and medical schools. It was suggested that the teaching of Indigenous Health curriculum be linked to completion rates through a general framework. It was recommended that the colleges be included in such a review as many registrars also teach.

Engagement with TEQSA to define a teaching quality framework was recommended. There is a need to identify what is required to support clinical teaching in clinical settings that keeps students engaged in culturally safe practices. An inquiry is proposed with possible recommendations and support into clinical teaching, as this is outside the academic environment that can be controlled through policy.

It is recommended that incentives be established to better evaluate the system. Long term indicators could be modeled from the rural health outcomes to assist with establishing a pattern for the future of hospital accountability frameworks. These structures are already in place but require realignment which could be achieved. Consultation with the new national authority is recommended as a first step.

4.2.7 National funding and accountability project

It is recommended that a strategy and model for funding and accountability be developed collaboratively by Australian Government Department of Education, Employment and Workplace Relations (DEEWR), Department of Innovation, Industry, Science and Research (DIISR), Universities Australia (UA), Medical Deans, and VCs. Recommended factors for inclusion are:

i. Incentives and rewards for sustainability and excellence. Extra incentives for completion rates, not enrolments rates should be provided to universities and colleges; financial rewards and incentives for institutions that exhibit excellence in terms of Indigenous Health; and a central administrative and monitoring agent for financial support (such as Commonwealth Scholarships).
ii. More stringent accountability for AMC accreditation requirements.
iii. Flexible Student Financial Support: Flexible financial support (scholarships, bursaries, etc) is recommended to directly pay for costs associated with activities or items such as textbooks, HECS fees and housing of Aboriginal and Torres Strait Islander medical students.
iv. Funding incentives on completion not at enrolment of Indigenous medical students or potentially a sustainable scheme of incentives provided at each year of study.

4.2.8 Indigenous representatives at Australian Medical Students' Association

There is a perception that Indigenous students and Indigenous issues are poorly represented within the Australian Medical Students' Association (AMSA). It was recommended that AMSA review their commitment to their Indigenous portfolio and the framework under which it resides as presently it sits within the rural portfolio. Development of a closer more respectful relationship between AMSA, Indigenous students and AIDA was suggested.

4.2.9 Immersion Experience Programs Review & Improvement

It is recommended that university immersion experiences be analysed to quantify current practices and experiences. Funding for such engagement programs should be included in the review. The ultimate goal would be the establishment of immersion experiences across all medical schools, such as camps and mini-medical schools for students and their families. Secondary school students could spend time on campus to give them the opportunity to experience university. Students could stay overnight in a college for example.

4.2.10 Seamless Integration of Indigenous health

Indigenous health could be incorporated as a standing item for meetings, such as Faculty Executive, University Senior Executive and Medical School level, for transparency, similar to Occupational Health and Safety.

4.2.11 Clinical Learning Outcomes Review and Best Practice Program Development Project

Participants recommended the pooling of existing university resources and national funding to establish a national clinical placement program into ACCHS. This should be coordinated collaboratively with AIDA, Medical Deans, ACCHS, NACCHO and Universities and HWA approached for funds. The capacity of ACCHS, which varies on a case by case basis, was identified as a limiting factor. A preliminary burden assessment, audit and analysis were viewed as essential components to be incorporated into the program development, responsibility for which should be determined before commencing the project.

5. APPENDICES

5.1 DELEGATES LIST

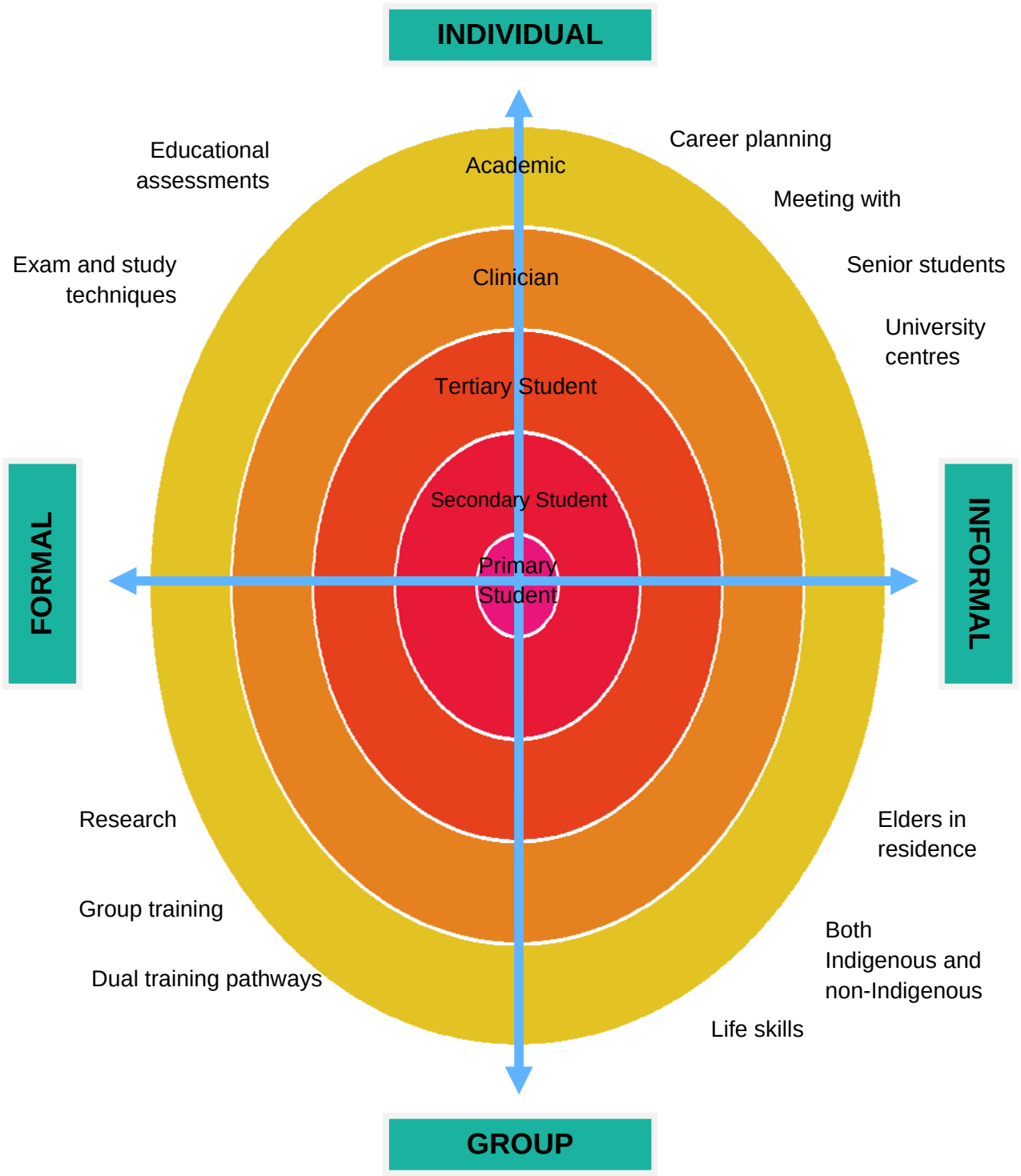
Surname	First Name	Organisation	Position/Role
Alldridge	Louise	Griffith University	Academic Lead Selections & Equity
Andersen	Clair	University of Tasmania	Director
Armstrong	Benjamin	Australian Indigenous Doctors Association, University of Wollongong	AIDA Student Representative
Bandler	Lilon	University of Sydney	Senior Lecturer in Indigenous Health
Barnard	Amanda	Rural Clinical School, Australian National University	Associate Dean, Head, Rural Clinical School
Beilby	Justin	Adelaide University & President of Medical Deans Australia and New Zealand	Executive Dean
Brown	Ngiare	Australian Indigenous Doctors Association	Medical Officer
Burdett	Denise	Workforce Information Policy Officer	NACCHO
Carapetis	Jonathan	Menzies School of Health Research	Director
Carriage	Christine	University of Western Sydney	Indigenous Project Officer
Cavanagh	Joe	Medical Deans Australia and New Zealand	Project Manager: Medical Deans - AIDA National Medical Education Review
Cavanagh	Miriam	School of Medicine, Sydney, The University of Notre Dame	Lecturer
Clinch	Christine	Centre for Aboriginal Medical and Dental Health, University of Western Australia	Lecturer
Collins	Margo	Leaders in Indigenous Medical Education	Program Manager
Crampton	Peter	University of Otago	Pro-Vice-Chancellor, Health Sciences Division
Crengle	Sue	University of Auckland, Te ORA	Senior Lecturer Medical Chair, Te ORA
D'Antoine	Heather	Menzies School of Health Research	Associate Director of Aboriginal Programs
De Carvalho	David	Department of Education, Employment and Workplace Relations	Group Manager, Higher Education
DeWitt	Dawn	Rural Health Academic Centre, The University of Melbourne	Chair of the Rural Health Academic Centre
Dodd	Zell	Aboriginal and Torres Strait Islander Workforce, Health Workforce Australia	Acting Program Manager
Doolan	Gaye	Australian National University	Indigenous Health Project Officer
Drysdale	Marlene	Monash University	Head, Indigenous Health Unit
Greenhill	Jennene	Rural Clinical School, Flinders University	Associate Dean & Director
Harr	Murray	University of New South Wales	AIDA Student Representative
Harris	Judy	Winnunga Nimmityjah Aboriginal Health Service	Chairperson
Haynes	Timothy	University of Wollongong	Project Officer
Hays	Richard	Bond University	Dean
Høj	Peter	Universities Australia	Vice Chancellor & President
Hudson	Nicky	The University of Wollongong	Academic Leader: Community Based Health Education
Jackson-Pulver	Lisa	Muru Marri Indigenous Health Unit, The University of New South Wales	Director
Jennings	Garry	Baker IDI Heart and Diabetes Institute	Director
Jones	Alison	University of Wollongong	Dean, Graduate School of Medicine

Surname	First Name	Organisation	Position/Role
Kidd	Michael	Flinders University	Executive Dean, Faculty of Health Sciences
Kimpton	Tammy	General Practice Education and Training	GPET Representative
Kong	Kelvin	Hunter ENT	Otolaryngology, Head & Neck Surgeon
Lee	Peter	Universities Australia	Vice Chancellor
Lyle	David	University of Sydney	Head of Department, Broken Hill UDRH
Marles	Elizabeth	General Practice Education and Training Ltd	GPET Board Director
McCallum	John	National Health and Medical Research Council	Head of Research Translation Group
McConnell	Jennifer	University Of Notre Dame Fremantle	Associate Dean (Indigenous Health)
McDermott	Dennis	Flinders University	Assoc. Head of Faculty, ATSI Health
Milroy	Helen	Centre for Aboriginal Medical and Dental Health, University of Western Australia	Director, CAMDH
Mokak	Romlie	Australian Indigenous Doctors Association	Chief Executive Officer
Mudge	Peter	The Royal Australian College of General Practitioners	Patron of the RACGP Foundation
Murray	Richard	School of Medicine and Dentistry, James Cook University	Dean and Head of School
Newbury	Jonathan	Spencer Gulf Rural Health School	Head of School
O'Mara	Peter	Australian Indigenous Doctors Association	President
Phillips	Greg		Facilitator
Puddey	Ian	University of Western Australia	Dean
Reid	Papaarangi	University of Auckland	Head of Department
Rossiter	Graeme	Commonwealth Government Department of Health and Ageing	Director
Sim	Moira	Edith Cowan University	Head of School
Singh	Jagdishwar	Confederation of Postgraduate Medical Education Councils Ltd	General Manager
Skinner	Timothy	Rural Clinical School, University of Tasmania	Director
Slape	Dana	University of Western Sydney	AIDA Student Representative
Solomon	Mary	Medical Deans Australia and New Zealand	Executive Officer
Strasser	Sarah	Flinders University	Associate Dean, Flinders NT
Symonds	Ian	The University of Newcastle	Dean of Medicine - Joint Medical Program
The Nguyen	Hung	National Faculty of Aboriginal and Torres Strait Islander Health, Royal Australian College of General Practitioners	Board member
Thiedeman	Melanie	Royal Australasian College of Surgeons	Indigenous and Rural Health Project Officer
Tongs	Julie	Winnunga Nimmityjah Aboriginal Health Service	Chief Executive Officer
Walker	Judi	Federation of Rural Australian Medical Educators	National Chair
Walters	Theanne	Australian Medical Council	Deputy Chief Executive Officer
Wood	Angela	University of Western Sydney	AIDA Student Representative
Yarnold	Della	Flinders University	Chair, Poche Centre for Indigenous Health
Zimitat	Craig	University of Tasmania	Director, Medical Education

5.2 PROGRAM

DAY 1	Thursday, 13th October 2011
Venue	Marriott Hotel, 36 College St, Sydney Ibis Room 2
10.00 am	*REGISTRATION*
10.30 am	WELCOME
10.50am	Medical Deans – AIDA National Medical Education Review *Preliminary Findings*
11.00 am	**SESSION 1** **Breakout Session** Topic 1: Pipeline issues Topic 2: Embracing content specifics Topic 3: Bringing clinicians in **Feedback and Recommendations**
1.00 pm	*LUNCH*
2.00 pm	**SESSION 2** **Breakout Session** Topic 4: Research and teaching capacity Topic 5: Culturally safe support networks Topic 6: The role of research institutions, teaching hospital, universities and Aboriginal Community Controlled Health Organisations **Feedback and Recommendations**
4.00 pm	*AFTERNOON TEA*
4.15 pm	**PRELIMINARY RECOMMENDATIONS**
5.15 pm	CLOSE
7.00 pm	DINNER Marriott Hotel: Waterview Restaurant *Speaker: Professor Papaarangi Reid*
DAY 2	**Friday, 14th October 2011**
Venue	Marriott Hotel, 36 College St, Sydney Ibis Room 2
8.30 am	REGISTRATION
9.00 am	WELCOME
9.15 am	**REVIEW & REFLECTION OF DAY ONE**
9.45 am	**SESSION 3** **Breakout Session** Topic 7: Funding and resource requirements *Developing the detail and determining responsibility*
10.30 am	**FINAL RECOMMENDATIONS & CONCLUSIONS**
12.15 pm	CLOSE

5.3 QUADRANT MODEL OF MENTORING



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www.aida.org.au

www.medicaldeans.org.au