



The Australian Indigenous Doctors' Association
Yaga Bugaul Dungun



Medical Deans

A U S T R A L I A A N D N E W Z E A L A N D

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

February 2012

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First published February, 2012.

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ACKNOWLEDGEMENTS

This Review was funded by the Australian Government Department of Health and Ageing.

Medical Deans Australia and New Zealand and the Australian Indigenous Doctors' Association acknowledge the Review Steering Committee, Chaired by Professor Ian Puddey and Doctor Tammy Kimpton, for their leadership and direction. Both organisations also acknowledge the Review Technical Reference Group, Chaired by Professor Richard Murray, and Mr Gregory Phillips for their expert guidance and advice throughout the duration of this Review.

Particular thanks go to the Leaders of Indigenous Medical Education (LIME) Network Project Team and many of the LIME Reference Group members for participating and sharing their wealth of knowledge and expertise in the field of Indigenous medical education.

Additionally, special thanks go to all the participants who volunteered their time to participate in this Review. The Deans, faculty managers and staff within all Australian medical schools, as well as the many medical students, including the AIDA and AMSA student representatives, all deserve special thanks for their significant individual and collective contributions to this Review.

Definition: In this document the term 'Indigenous' is used to refer to Aboriginal and Torres Strait Islander People of Australia. The terms 'Aboriginal', 'Aboriginal and Torres Strait Islander peoples' and 'Indigenous' are used interchangeably with reference to the Australian context.

ABBREVIATIONS

AHS	Aboriginal Health Service
AIDA	Australian Indigenous Doctors' Association
AMC	Australian Medical Council
AMS	Aboriginal Medical Service
AMSA	Australian Medical Students' Association
CBL	Case Based Learning
CDAMS	Committee of Deans of Australian Medical Schools (now Medical Deans Australia and New Zealand Inc.)
CPMEC	Confederation of Postgraduate Medical Education Councils
DoHA	Australian Government Department of Health and Ageing
ERC	Extended Rural Cohort
GAMSAT	Graduate Australian Medical Schools Admission Test
HWA	Health Workforce Australia
IEU	Indigenous Education Unit
IHU	Indigenous Health Unit
LIME Network	Leaders in Indigenous Medical Education Network
Medical Deans	Medical Deans Australia and New Zealand Inc.
MMI	Multiple Mini Interview
MSOD	Medical Schools Outcome Database and Longitudinal Tracking Project
NACCHO	National Aboriginal Community Controlled Health Organisation
PBL	Problem Based Learning
RCS	Rural Clinical School
UMAT	Undergraduate Medicine and Health Services Test

1. EXECUTIVE SUMMARY

This review of the implementation of the CDAMS (henceforth Medical Deans) Indigenous Health Curriculum Framework (*Curriculum Framework*) and the Australian Indigenous Doctors' Association's Healthy Futures Report (*Healthy Futures*) arose out of the Medical Deans – AIDA 2008 Collaboration Agreement. The review commenced in September 2010. A Steering Committee and Technical Reference Group were established and qualitative and quantitative research and data collection was undertaken in all Australian medical schools from January – September, 2011. The principal instruments used in the collection of data were semi-structured interviews, student focus group discussions and written responses to two audit proformas. The final report was submitted to the Australian Government Department of Health and Ageing (DoHA) in February 2012.

Implementation of the Curriculum Framework

All Australian medical schools report the incorporation of Indigenous health content, and all report significantly more Indigenous health content is integrated in their curricula than was reported in the 2004 National Audits and Consultations Report. The implementation of the *Curriculum Framework* has not only resulted in the development of more relevant Indigenous health content but has also stimulated a number of highly effective and more culturally appropriate pedagogical approaches in some schools. The significant work of the Indigenous and non-Indigenous staff that make up the Leaders of Indigenous Medical Education (LIME) Network in this area is acknowledged.

The most effective implementation initiatives consistently reported in Australian medical schools include:

- experience based learning activities such as clinical placements in Rural Clinical Schools and Aboriginal Medical Services
- the establishment and support of formal internal collaborative working partnerships and groups
- the integration of clinical science/medicine and Indigenous health content, and
- cultural immersion and some cultural awareness programs, and reflective learning activities

Despite the progress achieved, the comprehensiveness and effectiveness of implementation varies considerably between the different medical schools and significant gaps and areas for improvement were identified in all medical schools. Commonly reported weaknesses in the implementation of the *Curriculum Framework* include:

- the *Curriculum Framework* itself was too broad, unsubstantial and lacked specific technical content
- insufficient time available and/or dedicated within the medical program to effectively implement Indigenous health content
- the absence of compulsory and assessable content

- limited vertical integration and continuity of Indigenous health content and the limited current capacity of schools and clinical providers to provide quality Indigenous Health learning in clinical contexts
- issues arising out of a lack of understanding of intercultural sensitivities and their implications, and
- insufficient leadership and prioritization provided to effectively develop and integrate the overarching *Curriculum Framework*.

While the amount of content has increased and the LIME Network continues to do good work in developing existing resources, in many medical schools the limited staffing resources and time dedicated to, and/or currently available for, integrating the *Curriculum Framework* means quality and sustainability of curriculum content cannot be guaranteed. These areas may well require strengthened recognition within the AMC's Assessment and Accreditation Standards and Procedures.

Implementation of the *Healthy Futures*

Since the publication of the Healthy Futures Report in 2005 there have been significant increases in the numbers and percentage of Indigenous students in Australian medical schools. In 2011 the proportion of new Indigenous enrolments in Australian medical schools was 2.5%, which is equivalent to the proportion of Indigenous people in the Australian population. Some of the increase in Indigenous student enrolments can be attributed to the strategies recommended in *Healthy Futures*.

Particularly effective Indigenous student recruitment and retention strategies currently implemented in some Australian medical schools include:

- offering preparation for medicine and bridging programs
- the application of appropriate alternative entry requirements
- establishing Indigenous Health Units (IHUs) and appointing Indigenous support staff
- the development and maintenance of effective partnerships, both internal and external, and
- the development of effective mentoring programs

Despite the progress that has been achieved, there is considerable variation in the adoption and effective implementation of the strategies recommended in *Healthy Futures*. Only a small number of schools have committed resources to implement a range of Indigenous student recruitment and support strategies identified within the *Healthy Futures*. These schools are in the main responsible for the bulk of Aboriginal and Torres Strait Islander student recruitments and graduations.

Aside from the significant variability in medical schools' adoption of Indigenous student recruitment and support strategies, this review identified several common issues and gaps impacting on effective implementation. These include:

- specific Indigenous student support processes such as mentoring programs and academic support were not provided in the majority of schools

- in several schools IHUs were not present or insufficiently resourced to develop and implement comprehensive recruitment and student support strategies
- internal processes such as working partnerships were often based on individual personalities and their commitment to supporting and recruiting Indigenous students rather than embedded as core medical school procedure, and
- the persistent presence of institutional, covert and overt racism

There is documented and anecdotal evidence indicating that medical schools may not be graduating Indigenous students at a rate appropriate to enrolments. A more accurate picture of enrolment to graduation analysis will be possible in the coming years as expected timeframes for graduates are completed. However, the quality and sustainability of recruitment and retention programs requires considerable attention within the majority of medical schools.

Within Australian medical schools there is widespread support for both the *Curriculum Framework* and *Healthy Futures* initiatives and general agreement that both the initiatives, and the content within them, are fundamentally sound. As indicated above medical schools have made considerable progress in implementing Indigenous health content and Indigenous student recruitment and retention strategies since the publication of the *Curriculum Framework* and *Healthy Futures*. Progress has been achieved through the hard work and dedication of many individuals within Australian medical schools. Such work has been reinforced through the vision, collaboration and commitment of both Medical Deans and AIDA, the AMC's inclusion of both initiatives in accreditation standards and the LIME Network's dedication to building capacity for quality and effectiveness of teaching and learning in Indigenous health in medical education, as well as best practice in the recruitment and retention of Indigenous medical students.

Whilst considerable developments have occurred, medical schools have a continuing responsibility to resource these initiatives. Though the establishment of Indigenous Health Units (IHUs) and the appointment of Indigenous staff are recognized as having been fundamental to productive change, not all medical schools/faculties have IHUs and in several schools the numbers of Indigenous and non-Indigenous staff employed to implement the initiatives are clearly insufficient. While the LIME Network continues to develop existing staff and capacity, the further development of quality and sustainability in this sector will require additional resources in the same way the rural health training schemes have allowed the consolidation of the place of Rural Health in medical schools. Furthermore both initiatives require dedicated senior leaders and pathways, financial and staffing resources, as well as significant internal and external coordination and collaboration in order to deliver quality outcomes and become embedded as core medical school business.

2. RECOMMENDATIONS

The following recommendations present opportunities for Australian medical schools, Medical Deans, AIDA and relevant stakeholders to strengthen the identified areas of weakness in the implementation of both the Medical Deans Indigenous Health Curriculum Framework and AIDA's Healthy Futures Indigenous student recruitment and retention initiatives

Recommendation 1

That every medical school/faculty has an established Indigenous Health Unit with appropriate staffing and resourcing to improve and sustain implementation of the *Curriculum Framework* and *Healthy Futures*, and that implementation is ideally led by a suitably qualified Indigenous academic in the role of Associate Dean (Indigenous Health) or equivalent.

Timeframe: By 2014

Recommendation 2

That every medical school develops specific professional development pathways for Indigenous staff to raise their professional profile and allow them to assume senior leadership roles within the medical school.

Timeframe: By 2014

Recommendation 3

That every medical school invest in the development of a range of specific entry pathways, enabler courses, culturally appropriate alternative entry requirements, mentoring programs and other support strategies for the recruitment and graduation of Indigenous students.

Timeframe: By 2014

Recommendation 4

The *Curriculum Framework* recognizes Indigenous Health as an integral part of the medical curriculum and advises the teaching of discrete, compulsory and assessable units on Indigenous history, cultures, societies, experiences and interactions with health systems and policies, complemented with Indigenous examples and content throughout the medical program. It is recommended that Medical Deans, AIDA and the LIME Network jointly commission the writing of a comprehensive set of national resources and study guides, building upon existing good practice to ensure all schools have the opportunity to increase their implementation of both discrete and integrated assessable Indigenous Health content.

Timeframe: Commissioned by 2013 – Available for implementation by 2015

Recommendation 5

That Medical Deans and AIDA conduct a detailed analysis of Indigenous medical student retention rates with an emphasis on the factors and reasons for temporary and permanent withdrawal from the program.

Timeframe: By 2014

Recommendation 6

That all Australian medical schools establish links with local Indigenous communities for both strategic and operational advice on the school's implementation of the *Curriculum Framework* and *Healthy Futures* through the establishment of an Aboriginal and Torres Strait Islander Liaison Committee or similar.

Timeframe: By 2013

Recommendation 7

That Medical Deans and AIDA commit to ensuring the development of locally relevant cultural awareness and orientation programs for all staff and students.

Timeframe: By 2014

Recommendation 8

That the AMC, in collaboration with Medical Deans, AIDA and the LIME Network, ensure all medical school accreditation teams include a member with genuine Indigenous Health expertise, ideally an Aboriginal and/or Torres Strait Islander and/or Maori person, and that the AMC consider further how to assess implementation of the *Curriculum Framework* and *Healthy Futures*.

Timeframe: By 2014

Recommendation 9

While medical schools have a continuing responsibility to adequately resource both the *Curriculum Framework* and *Healthy Futures* initiatives as part of their core business, and the LIME Network continue to develop existing staff and capacity, the development of quality and sustainability in this sector will require additional resources in the same way the rural health training schemes have allowed the consolidation of the place of Rural Health in medical schools. It is recommended that Medical Deans, AIDA and the Commonwealth investigate the development of a Commonwealth funded national Indigenous Health Clinical Training Scheme.

Timeframe: Commencing 2012 -Ongoing

Recommendation 10

A critical factor in the implementation of the *Curriculum Framework* is the provision of quality immersion learning experiences through practicum placements in an Indigenous health context. Currently this would likely require additional resources for the sector. It is recommended that Medical Deans, AIDA, NACCHO, the LIME Network, HWA and other relevant Indigenous stakeholders work closely to develop further and strengthen two-way capacity building partnerships between medical schools and AMSs.

Timeframe: Commencing 2012 –Ongoing.

3. REVIEW BACKGROUND

This review is an outcome of the 2008 Collaboration Agreement between Medical Deans Australia and New Zealand (Medical Deans) and the Australian Indigenous Doctors' Association (AIDA), which committed both parties to support several priorities including:

- Implementing the Medical Deans' Indigenous Health Curriculum Framework (*Curriculum Framework*)
- Increasing the recruitment, support, retention and graduation rates of Aboriginal and Torres Strait Islander medical students
- Enhancing pathways into medicine for Aboriginal and Torres Strait Islander peoples (Medical Deans – AIDA, 2008)

The *Curriculum Framework* is a set of guidelines for developing and delivering Indigenous health content in core medical education in Australian medical schools. Published in 2004, it recognizes the significant health disparity between Indigenous and non-Indigenous Australians and the need to provide *all* Australian medical students with the knowledge, skills and cultural competence to work effectively with Indigenous people and reduce the gap in health outcomes between Indigenous and non-Indigenous Australians. It serves as a resource for medical educators by articulating the basic components of a functional and effective curriculum for all Australian medical students about the causes, nature and appropriate responses to Indigenous health issues, without perpetuating stereotypes or teaching from the deficit model (Phillips 2004a).

The Healthy Futures Report (*Healthy Futures*) provides key strategies and a best practice framework for improving the recruitment and retention of Indigenous medical students in Australian Universities. Published in 2005, *Healthy Futures* recognizes the severe shortage of Indigenous doctors in Australia and the considerable contributions that Indigenous doctors can make to improve Indigenous people's physical, cultural and emotional wellbeing (Minniecon and Kong 2005).

The Australian Medical Council (AMC) endorsed the *Curriculum Framework* in 2006 and incorporated it within its medical school assessment and accreditation standards and procedures. This is highly significant as the Framework is the only curriculum framework the AMC has fully endorsed and incorporated within the medical school accreditation standards. The AMC also recognizes *Healthy Futures* within its accreditation standards and regards it as a key resource to assist schools in meeting the standard to develop specific admission and recruitment policies for Aboriginal and Torres Strait Islander students. The *Healthy Futures* objectives are also clearly reflected in the accreditation standard referring to student support, which states that medical schools must offer appropriate student support and cater for a student's social, cultural and personal needs (AMC 2011: 26-28).

4. REVIEW AIMS AND OBJECTIVES

4.1 AIMS

The aims of the Review were to:

- review the implementation of the *Curriculum Framework* in the medical school curricula currently taught in Australian Universities
- review the implementation of *Healthy Futures*’ recruitment and retention strategies for Australian Indigenous medical students; and
- provide recommendations based upon the findings of these reviews

4.2 OBJECTIVES

The specific objectives of the Review were to:

1. document the implementation of the *Curriculum Framework* and assess the effectiveness of its implementation
2. identify examples of best practice in the implementation of the *Curriculum Framework*
3. identify issues impacting on effective implementation of the *Curriculum Framework*
4. document the development of pathways into medicine and retention strategies for Aboriginal and Torres Strait Islander students through the application of such strategies as:
 - a) Offering preparation for medicine and bridging programs
 - b) Establishing alternative entry requirements and processes
 - c) Facilitating University and school visits
 - d) Fostering a ‘personal contact’ approach
 - e) Providing mentoring support
 - f) Fostering cultural safety
 - g) Involving Indigenous Health Units and Indigenous staff
 - h) Developing partnerships
5. To make recommendations based on the findings

5. METHODOLOGY

5.1 OVERVIEW

The Review commenced in September 2010 and was completed in January 2012. Both quantitative and qualitative data was collected in all 19 Australian medical schools between January and July 2011 (see Appendix 1 – two campuses of the University of Notre Dame Australia included). The quantitative data collected provides insight into *what* Australian medical schools implement in relation to the *Curriculum Framework* and the *Healthy Futures*. The qualitative data collected provides insight into *how* Australian medical schools implement the *Curriculum Framework* and the *Healthy Futures*.

5.2 DEVELOPMENT OF GOVERNANCE STRUCTURE

The Review was governed by a Steering Committee (SC) and a Technical Reference Group (TRG) (See Appendices 2 and 3). The SC provided guidance on the purpose and plan of the review, as well as the final report and recommendations. The TRG provided guidance on technical aspects of the research including the ethics processes, methodology and analysis of data and reports. This governance structure ensured the engagement of key stakeholders and was vital in guiding the Review process to ensure that an informed, accurate and inclusive research took place.

5.3 ETHICS

Ethics approval for the Review was sought and granted by the University of Sydney's Human Research Ethics Committee (HREC) on 23 November, 2010 on the basis that Medical Deans' staff are employed by the University of Sydney. This approval paved the way for ethics ratification processes to take place within all other Australian medical schools.

5.4 REVIEW OF RELEVANT REPORTS AND PUBLICATIONS

An analysis of relevant reports and publications was conducted prior to data collection. A collection of these were reviewed and are presented in Appendix 4.

5.5 CONCEPTUAL FRAMEWORK

A conceptual framework was developed to inform the agenda for the data collection and analysis process. The key concepts in this framework were:

- Contextual relevance
- Integration and collaboration
- Cultural safety
- Capacity and sustainability

These key concepts form what the relevant literature and discourse suggest are vital themes relating to effectively implementing Indigenous health content and Indigenous student recruitment and retention initiatives. For a diagrammatic representation and detailed discussion of the framework see Appendix 5.

5.6 DATA COLLECTION

Data for the Review was collected using three instruments:

- Semi-structured interviews with medical school staff
- Student focus groups
- Audit proformas

5.6.1 SEMI-STRUCTURED INTERVIEWS

A minimum of three semi-structured interviews were conducted in each of the 19 medical schools. The first interview sought information on the provision of leadership, funding and resourcing of both the *Curriculum Framework* and *Healthy Futures*. The second interview sought information on the implementation of the *Curriculum Framework*. The third interview sought information on the implementation of the *Healthy Futures* strategies. The Dean of each school, usually accompanied by the school's Faculty Manager, participated in interview one. A range of relevant staff involved in the development and delivery of both initiatives participated in interviews two and three. A total of 133 staff across all medical schools participated in these interviews. Unless participants objected, all interviews were recorded and transcribed for analysis.

5.6.2 STUDENT FOCUS GROUPS

Student focus group sessions involving between three and eight medical students were conducted in 12 of the 19 Australian medical schools. Separate focus groups were conducted for Indigenous and non-Indigenous students. Focus group sessions were not conducted in all medical schools due to the logistics involved in organizing students to participate during the specific time of data collection. In those schools where focus groups were conducted, AIDA and Australian Medical Students' Association (AMSA) student representatives assisted in gathering participants. Additionally two larger focus group sessions were conducted at the AIDA and the AMSA student representative meetings during the Review period. A total of 142 medical students participated in focus group discussions. A graph of all student and staff participants is provided in Appendix 6.

5.6.3 AUDIT PROFORMAS

Each medical school was asked to complete two audit proformas. The first audit proforma sought information on the incorporation of Indigenous health content within the medical program. The second proforma sought information on the adoption of *Healthy Futures* strategies.

The proformas were distributed to individuals designated as lead for implementing either or both initiatives. Each proforma was intended to be completed in collaboration with key staff members. 15 of the 19 medical schools returned both proformas for review and analysis. Two schools completed only one audit proforma for analysis and two schools did not complete either audit proforma.

5.7 METHOD OF ANALYSIS

A thematic analysis was conducted on the data gathered for this Review. All data was transcribed and coded by the project manager. Interview and focus group summaries were sent back to participants for feedback and accuracy checks. A sample of five medical school transcriptions were coded, de-identified and confirmed for consistency and validity during a face to face meeting with the Technical Reference Group, after which all remaining school interviews were transcribed and coded for analysis. Each medical school was then provided with a discrete separate report containing information regarding its own implementation of the *Curriculum Framework* and *Healthy Futures*. The common overarching themes, developed during data analysis, are used in presenting the findings of this report.

5.8 LIMITATIONS

There were several limitations to this research.

Limited time span for data collection

There was a limited time span for the collection of data, which took place between January and July 2011. In several medical schools it was indicated that additional developments in relation to the implementation of both initiatives would occur soon after the data collection period. As this is not a longitudinal study these developments were not included for analysis. Additionally, the time period for data collection within each school was generally two-three days. Due to this restriction, a small number of staff invited for interview could not be present. All medical schools were given adequate notice of the visits however, and arrangements were often altered to ensure maximum active participation.

Student selection process

Student participants were not selected randomly but participated on a voluntary basis. Selection bias could be inferred as generally this resulted in student participants being those who have an interest in the field of Indigenous health. However this approach allowed for a more comprehensive account of the implementation of Indigenous health within medical schools. These students were more likely to enroll in Indigenous health electives and Indigenous health setting placements, and therefore were generally more aware of where and how Indigenous Health was integrated within their course.

Inter-medical school diversity

Australian medical schools present a particularly diverse field of research. Nine Australian medical schools offer graduate entry courses, seven offer an undergraduate entry course and three offer a dual entry course. Significantly, between 2004 and 2009 eight new Australian medical schools were established. Other variables include the size of the student population and intake number, and the

varying values and missions of each school. This level of diversity complicates comparisons and creates difficulties in the development of national recommendations or a *one size fits all approach*. A table highlighting many of these variables is included as Appendix 1 and the recommendations of this review have been formulated with this diversity in mind.

Intra-medical school diversity and time constraints

While interviews and audits were intended to be conducted and completed in collaboration, in a small number of schools this ideal was not realized due to issues such as conflicting views, internal politics and participant's time constraints. Additionally, in several schools only one staff member was dedicated to, and had sufficient knowledge of the implementation of the initiatives. These issues, particularly staff time constraints and schools which had limited staff members able to contribute, made for difficulties in data collection and accuracy. To avoid major inaccuracies resulting from these issues, all schools were provided with several opportunities to provide additional feedback.

6. FINDINGS – *CURRICULUM FRAMEWORK*

This chapter presents the Review findings in relation to the *Curriculum Framework* Review objectives by:

1. documenting the implementation of the *Curriculum Framework*
2. identifying examples of best practice in the implementation of the *Curriculum Framework*
3. identifying issues impacting on effective implementation

6.1 IMPLEMENTATION OF THE *CURRICULUM FRAMEWORK*

All medical schools in Australia implement aspects of the *Curriculum Framework*. The audit undertaken as part of this review revealed that in 2011 the vast majority of Australian medical schools appear to implement significantly more Indigenous health content than that of the medical schools audited in 2004 (Phillips 2004).

Indigenous health content is delivered within lectures, Case Based Learning (CBL), Problem Based Learning (PBL), workshops, tutorials, self-directed learning activities and clinical placements. It is delivered by both non-Indigenous and Indigenous staff and content is almost always developed in consultation with Indigenous people and agencies, which supports best practice literature, and is referred to in the pedagogical principles within the *Curriculum Framework* (Phillips 2004a: 17) (Hays 2002) (Garvey & Atkinson 1999).

The audit findings also revealed that Indigenous health content within Australian medical education covers a wide range of topics. The main topic areas covered include rural Indigenous health, cultural awareness and cultural implications for health, Indigenous history, communication, clinical presentations of disease, population health and social determinants of health. The audit also indicated that generally, Indigenous health content is not taught discretely but as integrated components of broader subject areas.

Importantly, a comparative analysis of the audit undertaken for this review and the audit results of the 2004 *National Audits and Consultations Report* indicates that in 2011 Australian medical schools implement significantly more Indigenous health content than in 2003.

Although these findings indicate progress, the audits, interviews and focus groups revealed that there is considerable variability in the comprehensiveness and effectiveness of medical schools' implementation of the *Curriculum Framework* and only a small number of schools could be considered as following *best practice*.

6.2 BEST PRACTICE IN THE IMPLEMENTATION OF THE *CURRICULUM FRAMEWORK*

The interviews and focus groups indicated several processes and pedagogies which may be considered as best practice in the implementation of the *Curriculum Framework*. These have been developed through years of experience and trial and error, and are supported by the relevant literature (Hays 2002) (Minniecon & Kong 2005) (Phillips 2004) (Phillips 2004a) (Ewen, Pitama, Robertson & Kamaka 2011) (Paul, Allen & Edgill 2011) (Myer, Jackson-Pulver & Fitzpatrick 2009) (The Leaders in Indigenous Medical Education Network 2012).

6.2.1 APPOINTING INDIGENOUS STAFF, THE FORMATION OF INDIGENOUS HEALTH UNITS (IHUs) AND LEADERSHIP

The data consistently highlighted the importance of IHUs and Indigenous staff as being fundamental to developing and delivering appropriate course content and providing pastoral care to students. In particular, Indigenous doctors and academics working within medical schools were regarded by staff and students as highly important curriculum developers and deliverers, as well as role models and providers of pastoral care and academic guidance for Indigenous students.

This important example of best practice is employed within most medical schools.

Though numbers of Indigenous staff have improved over the past 10 years, total numbers remain quite low and vary from no staff to a maximum of four within individual medical schools. While 14 of the 19 Australian medical schools have IHUs, in August 2011 there were approximately 33 full time equivalent Indigenous staff employed in all Australian medical schools. Of these 33 Indigenous employees, only 18.1 FTEs are employed as academic staff, of which approximately five are medical practitioners, and not all assume full time posts within their medical school. See Appendix 7 for a school by school breakdown of Indigenous staff.

Several schools have ensured Indigenous staff sit on relevant committees to promote the implementation requirements of the *Curriculum Framework*. However, in only five medical schools do Indigenous staff hold senior leadership positions (Associate Dean, Professor (Level E) or equivalent). It was suggested in schools that were guided by an Indigenous staff member in a senior leadership position, that this appointment was instrumental in allowing the school/faculty executives and advisory councils to engage with, and endorse, the implementation requirements of the *Curriculum Framework* and facilitated positive institutional change.

6.2.2 ESTABLISHING EFFECTIVE COLLABORATIVE INTERNAL PARTNERSHIPS

In several schools the development and maintenance of formal collaborative internal partnerships greatly contributed to effective implementation of the *Curriculum Framework*. These effective partnerships were generally formed between Indigenous Health Unit staff or relevant staff implementing the initiative and:

- the Dean of Medicine
- discipline and/or domain heads
- the central University Indigenous Education Unit
- several medical school and University staff to form an Indigenous health governance group

All these partnerships were effective in building capacity for implementation. They were also effective in facilitating the collaboration required within the medical school to implement the overarching *Curriculum Framework* across the continuum of the medical course.

Additionally, a small number of Deans have taken the initiative to receive guidance and advice through formal partnerships with Indigenous Elders in residence and Indigenous staff within other schools of the University.

6.2.3 EXPERIENCE BASED LEARNING ACTIVITIES AND OPPORTUNITIES

Experience based learning, including clinical placements in rural settings and AMSs, and some Case and Problem Based Learnings (CBLs and PBLs), were clearly regarded as examples of best practice. General feedback from students and staff on acquiring skills to work with Indigenous patients in this way was highly positive.

It gives students a chance to see the interface between culture and clinical staff and settings.

The majority of schools have developed partnerships with AMSs to provide students with relevant experience based learning; however the capacity of AMSs to provide meaningful experiences for all students was often presented as a limitation. A small number of medical schools demonstrated initiatives in working with AMSs, including developing Memorandums of Understanding and collectively building capacity for student placements (an example of this type of initiative is outlined in the LIME good practice case study provided in Appendix 8). However it was widely acknowledged that additional consideration should be given to how medical schools can resource these learning opportunities more effectively.

A small number of schools developed additional experience based learning activities through employing local Indigenous actors and patients to facilitate CBLs within the medical school. These initiatives were also regarded as highly productive, especially when students were assessed on their competency and the school was able to foster a culturally safe and welcoming environment for the actors and patients to work in.

6.2.4 THE INTEGRATION OF CLINICAL SCIENCE/MEDICINE AND INDIGENOUS HEALTH CONTENT

In several schools, integrating clinical and Indigenous health content within lectures was a productive strategy which had a positive impact on student attitudes towards the place Indigenous health has in medicine. This approach required close collaboration between individuals experienced in Indigenous health settings, including Indigenous and non-Indigenous health workers, and clinicians teaching specialized components of the course.

If you show that you can't manage rheumatic fever medically, unless you understand what socially determines it, unless you can interact effectively with people, unless you see that role as a collaboration between partners, you can't do good technical medicine. Once I cottoned onto this, and it took a while, I now find students are soaking it up. (Academic staff member)

A nephrologist here had a lecture on kidney disease and part of it was on Indigenous health and was quite positive as he mentioned different modes of service delivery and doing kidney disease in the bush. It was not a special 'Indigenous' thing...It was integrated. (Medical student)

We do the Rheumatic Heart Disease lectures with the pediatrician, who is a Non-Indigenous doctor who has a lot of experience working with Indigenous people and we also lecture with a Non Indigenous cardiologist and we talk about the Indigenous health components and link it all in...you need the support of other lecturers and clinicians...Indigenous health is often seen by the 'hardcore students' as a bit of a soft thing, around the edges, and when we incorporate it like this it becomes part of the hardcore of medicine. (Academic staff member)

6.2.5 CULTURAL IMMERSION AND AWARENESS PROGRAMS

Several schools use cultural immersion and awareness programs to introduce students to aspects of Indigenous culture and history and the associated implications for health and health care. One example of this approach provided students with a week long experience within an Indigenous health service and with local community members. Feedback from staff involved in the program was that students unanimously valued this experience, which allowed many to use reflective thinking and analyse their own preconceptions about the course and their future careers. Another example of this approach involved students visiting a massacre site guided by local Aboriginal community members. It was reported that this experience also promoted attitudinal changes in regards to Indigenous

history and health. A key component to the success of these programs was the development and maintenance of Indigenous professional and community partnerships.

One school identified its staff cultural awareness program as a highly successful initiative. This program engaged all tutors working within the medical program in a two hour workshop. Presenters of the workshop included Indigenous staff, general practitioners with experience in Indigenous health settings, Indigenous medical students to highlight their experiences as students within the program, a member of the Department of Health and Ageing (DoHA) and staff from the University's central Indigenous Education Unit. The workshop resulted in very positive feedback from participants, particularly in relation to developing their understanding of Indigenous medical student's experience of the medical school and program.

Successful cultural immersion and awareness programs commonly involved the development of strong working partnerships between Indigenous community members and Indigenous and/or non-Indigenous staff members of the medical school. Additionally, student cultural awareness programs which were developed with specific relevance to the practice of medicine and the context of their placements were considered to be successful. As in the example above, relevance to the context of the medical school and medical education is important in the development of successful staff cultural awareness programs.

6.2.6 REFLECTIVE LEARNING ACTIVITIES

Several schools have developed Indigenous health content and activities which encourage student reflection. These reflective learning activities included:

- Students logging records of their interactions with Indigenous patients and presenting a theme relating to Indigenous health care for class discussion and reflection, before finally writing a report which is compulsory and assessed.
- Online reflective learning packages to ensure students continue learning Indigenous health specific content while in the important clinical years: The reflective 'wikis', which students create, are compulsory and assessed. This process provides one avenue which may overcome the potential for students to learn adverse skills in treating Indigenous patients from their supervisors within clinical settings, who may not practice in a culturally competent manner. For a more detailed description of this initiative see Appendix 9.

6.3 ISSUES IMPACTING ON EFFECTIVE IMPLEMENTATION

Despite the progress outlined above, the student focus group sessions and staff interviews repeatedly raised significant issues about the effectiveness of the implementation of the *Curriculum Framework*.

6.3.1 CURRICULUM FRAMEWORK LACKING IN TECHNICALLY SPECIFIC AND RELEVANT CONTENT

Several staff suggested that the *Curriculum Framework* was too broad and lacked technically specific and relevant content.

...the specification of technical content, other than cultural methods for teaching, it is very thin...more detailed information on the treatment and management of Indigenous patients is required.

Similarly, there were consistent student comments referring to Indigenous health learning and content as often not clearly connected to the practice of being a doctor, and that there was a need for much more experience based learning in Indigenous health.

We need more experience based learning, even if it is just talking in groups about experiences...that coalface experience gets the message across.

The reason why we feel less confident is the barriers are never tied into the reality of us working in our office or in the hospital. We don't know how our management is going to differ. We are ill equipped to manage this differently.

Additionally, many students indicated that contextually relevant Indigenous health content and learning, which recognizes urban contexts and the contextual diversity of Indigenous Australia, was not prominent, or potentially inappropriate and counterproductive.

It has to be relevant. Time and time again we get the stereotype of the Aboriginal in the Northern Territory. It's not relevant to where I will work... It would be good to have something relevant, for example the demographic population issues around Sydney to know the issues in communities...We really aren't taught about how they

engage what their life is like...nor are the similarities emphasised. They talked about the communication skills, like you should build a rapport with the Indigenous patient, ask where they are from etc. But in reality in the clinical setting where you have 10 minutes with doctor and patient and you have to get the whole history done? There is such a disconnect between the reality of being a doctor in an urban or hospital setting where you have to see x number of patients...

Its complex, (for example) you might come across patients who won't want to be asked where they're from - "what do you mean where I'm from? Down the road!"

If anything I'm afraid that next year I might have a patient that I do not know how to deal with and that I might come across rude and arrogant

6.3.2 INDIGENOUS HEALTH CONTENT INTEGRATED SUPERFICIALLY

In many schools staff participants referred to the difficulties involved with developing collaborative partnerships to effectively integrate Indigenous health content within the curriculum.

You have the domain head saying 'we own this' and then us saying 'hang on we have the overarching Curriculum Framework, you also have to fit with us'. And then what you end up with is not collaboration but a power play...

Some staff and subject area people don't see the relevance of Indigenous health.

In focus group discussions students consistently stated that Indigenous health content was integrated superficially and that there was minimal content within the program.

I feel like (this school) has a very tick box approach to the implementation of this. I read this (the Curriculum Framework) and I feel like I could highlight sentences that were thrown into a lecture. It doesn't feel integral but an additive and we can tick this box and move on.

Only one lecture (on Indigenous health) in first year, and one in third year. So even if the lectures are good we don't learn.

Furthermore, the vertical integration of Indigenous health content into the clinical years and the capacity of clinical providers to develop, deliver and provide Indigenous Health learning and experiences were viewed as significant issues for implementation in the majority of Australian medical programs.

In the clinical years the teaching of the Curriculum Framework fizzles. The idea is that the doctors in their bedside teaching will include (Indigenous Health) in their teaching. For example, if they look at lung cancer they will look at the epidemiology of tobacco smoking. This just doesn't happen, it's the clinic...The added problem is the students are no longer close (to the medical school) when they're in their clinical schools.

6.3.3 TIME CONSTRAINTS

Some of the above issues stem from the time pressures within all medical courses, and particularly in graduate entry schools. Time constraints are compounded by the need for establishing and maintaining internal and external collaborations to effectively integrate and deliver Indigenous health content. Many staff members noted that there was only time for minimal content within the program and that this directly affected the quality of teaching and learning.

The downfall is the time we are allowed in med to get what we need done...to challenge the attitudes of students. We don't have this in medicine. We have two half day workshops and other teaching here or there. So there is no ongoing relationships with students to challenge them...they need time and exposure and this doesn't happen with some scattered PBLs.

6.3.4 CULTURAL SENSITIVITIES AND THEIR IMPLICATIONS

Many medical school staff and students highlighted the difficulties of delivering content fraught with the potential for arousing racist views, tensions and emotional responses. This has also been identified in the LIME Good Practice Case Study provided as Appendix 10. Staff and students consistently identified cultural sensitivities and their implications as a significant issue in integrating Indigenous perspectives into established medical curricula.

Because we were emphasising Indigenous issues a lot, it meant there was a higher danger for Indigenous students and staff to come into contact with discriminatory issues. It happened...one of the reasons this was causing a lot of grief for our Indigenous and supporting white staff is that if you had a racist take control of a class or make racist comments we spent a lot of time answering that and that meant racist ideas which were brought up started to dominate and what we understood from our collaborations with Indigenous staff that there is in fact different groups in the class, a very small number of racists, most indifferent in the middle and a small but not insignificant number of allies and what we needed to do was shift the focus of the class to the allies and shift the focus to moving those in the middle to allies and once we did this it made an incredible difference to the staff and the way they ran classes and to the negative impact that might be on staff and students if racist things might be said. I think the impact was quite profound.

Many student participants complained that negative stereotyping of Aboriginal and Torres Strait Islander people was fostered by teaching Indigenous health content through a deficit model.

There is a big focus on the barriers in Indigenous health...it seems to be a very negative view of the way (Indigenous people) do or don't access health without any real strategies to help us in the day to day format.

There is not much given in the way of 'these are the strengths of a community that you can use.' Like identifying elders, gaining their respect. Things like this are not emphasised as they could be.

Many student participants also complained of a confrontational dogmatic pedagogical approach taken by some Indigenous health lecturers and by some guest lecturers.

(In the cultural awareness session) there were preconceived ideas about what we were thinking and it was very aggressive. It was meant to be an open forum for discussion but the way the lecturer presented, and (with) this attitude, there was a brick wall there.

I think the stuff about culture is quite fear driven, don't do this, don't do that, don't. So when I went on my placement... I was scared. But I found (Aboriginal and/or Torres Strait Islander people) understood that I'm not perfect and make mistakes.

While these common experiences indicate that some Indigenous staff and guest lecturers will need to adjust their pedagogical approach, they also indicate that, given the sensitive context of Australian history and Indigenous health, medical students will require better preparation for understanding and learning from complex social and intercultural interactions to develop skills which will inevitably better their professional care of Indigenous patients.

From the teaching perspective, many staff were wary of preconceived views and attitudes of both Indigenous and non-Indigenous students as well as the impact of the lack of knowledge of some staff and students, which can create potential minefields in the tutorial rooms and lecture halls.

Because it is such a strong agenda some staff will want to put in a case study about an Indigenous patient. But they don't realise this could potentially put an Indigenous student in a bad situation or create hassles for Indigenous staff. For example, the staff member is delivering the session and the Indigenous student thinks it is a very deficit model and then all of a sudden that student is at war with the tutor and other students in her class while they (the other students) all think it is reverse racism. So this requires us (Indigenous staff) to support the educators.

I'm worried about the preconceived racist opinions within students, not as though they are widespread but you have to be prepared to get a curly question from a student that is aimed to unseat you and you need to know how to deal with this, you can't get involved with this battle, it is deep seated within the students upbringing often.

We have a spectrum of students ranging from those who really get it (the Indigenous health agenda) straight away, to those who are hostile.

6.3.5 SENIOR LEADERSHIP

Senior leadership was a further issue consistently suggested in staff interviews as impacting on implementation. A common concern identified by staff was that if those leading implementation did not hold a senior position within the medical school then implementation was a constant battle.

Unless you have support and engagement of the Dean and the identified leaders within a faculty, then this kind of change doesn't occur. You have mice running around at ground level and you never get the real traction. We have had real support and without that the initiatives wouldn't happen and wouldn't be sustainable

The schools which appeared most effective in integrating the *Curriculum Framework* were those where a senior staff member was formally assigned to lead implementation.

While all Deans of Medicine emphasized their support for implementing the *Curriculum Framework*, only a small number were able to be actively involved. However, in nine schools, an Associate Dean or equivalent was formally involved in leading implementation and five of these had Indigenous staff in the senior role. These appointments were viewed as instrumental in allowing the school/faculty executive to engage with and endorse the implementation requirements of the *Curriculum Framework*. Indigenous and non-Indigenous staff emphasised that this arrangement facilitated the engagement of discipline heads in collaborating to integrate the overarching *Curriculum Framework*.

6.3.6 INDIGENOUS HEALTH CONTENT AND ASSESSMENT NOT EMBEDDED WITHIN THE MEDICAL PROGRAM

An important issue which appears to be impacting on the effectiveness and quality of the implementation of the *Curriculum Framework*, revealed within the interviews and focus group discussions, is that assessment of Indigenous health content is apparently not yet embedded within the majority of medical programs in Australia. Students and staff also *consistently* expressed the view that Indigenous health content was not a compulsory or valued aspect of the medical course.

To me most of it (Indigenous health content) is quite separate and usually the assessment of it is very lax and this gives it lower status. (medical student comment)

There was an elective called Indigenous Health which sits outside the main course so not viewed as integral to the medical course, you get the idea that if you have an interest in Indigenous Health then you can take it while the rest of us can get on with the serious business of Western medicine.

Many staff indicated the absence of compulsory content and assessment as a significant factor devaluing Indigenous health content within the course.

My biggest battle is with the staff because the staff have the power to say 'this is compulsory, if you want a degree at (school) you have to do this as part of your course' ... it's (Indigenous health content) not valued...one of the biggest barriers is the non-assessment...the other barrier is the weighting of the assessment, if they put 1-2%, then the students don't care. So there are institutionalised barriers which are very, very difficult to penetrate and to change. Indigenous health is not valued in the same way

The following quote of a medical dean highlights further key issues in integrating Indigenous health content effectively.

Obstetrics and Gynecology is a six month course...so, easy to align it with assessment, with teaching and student expectations etc. Now Indigenous health doesn't have that and I don't think it should because it needs to be embedded as a stream throughout. But it does make it quite difficult to have a coherent map of the content objectives and assessment, particularly of those capabilities. So I introduced summative, as opposed to formative (assessment) for the assessment of student attitudes towards women in Aboriginal health care in the Obstetrics and Gynecology attachment. However, it is still possible that if a student does poorly in this (they can) still pass the course. And there are several other points in the program where they have assessments (on Indigenous health) and they count, but they are not the majority of the course. So a student could perform poorly consistently in the discipline of Indigenous health but pass the program because they can make it up in other areas. So quite difficult as opposed to if we had three months where it would be concentrated on Indigenous health issues, they could fail and would have to re-sit each time until they passed. So this is a challenge and one of the things we will be looking at in the new program is moving less around students having to meet learning objectives and moving more to a clinical competency framework where students must demonstrate competency across a range of competencies before they graduate. And one of these will be around cultural awareness and Indigenous health care.

Integrating Indigenous health content as discrete units and within existing subject areas, particularly within clinical science/medical content, is considered best practice. The comment above suggests there are fundamental problems with an approach that relies exclusively on integrating Indigenous health content within existing medical units. The time constraints within medical schools and the curriculum are consistently cited as making it difficult to incorporate Indigenous health content in a meaningful way.

Moreover the integration and assessment of Indigenous health content into major existing units is clearly limited, potentially allowing students with ignorant attitudes towards the health and wellbeing of Aboriginal and Torres Strait Islander people to retain those attitudes and still become doctors.

These issues and those outlined earlier all impact on the quality of implementation. To address these issues it is necessary to support and encourage medical schools, as is suggested in the *Curriculum Framework*, to take an approach that allows comprehensive discrete compulsory units of work on Indigenous health which is complimented with integrated content.

In our experience, it is important to provide a foundation for Indigenous health by teaching discrete, compulsory subjects/lectures/PBLs about Indigenous history, cultures, societies, experiences and interactions with health systems and policies. This can be effectively complemented with Indigenous examples and content appropriately placed throughout the curriculum. (Phillips 2004a: pg 14)

6.3.7 RESOURCING AND SUSTAINABILITY ISSUES

Underpinning many of the issues raised above are significant resourcing issues. Currently many Australian medical schools have not been able to fund, or recruit and develop adequate staffing resources to implement the *Curriculum Framework* effectively.

In an ideal world we would have enough appropriately qualified Indigenous people who could act as tutors, trainers etc. to meet all our needs in a Rolls Royce program where aspects of Indigenous health, with appropriate assessment was embedded across the program but in reality we have to pull back from this because we don't have enough people to do it. I would say this is the major structural barrier at the moment (Dean of Medicine).

In many schools concerns were raised about the sustainability of implementing the initiatives.

Employment of staff provides us with the capacity to implement the curriculum. One thing that concerns me is with succession planning. There aren't a lot of people around who have the capacity to do what (staff member implementing Curriculum Framework and Healthy Futures) does...there's just a shortage...this is critical it's not as though we have a deputy to (staff member), no one to take over (Dean of Medicine).

In several schools key staffing positions for implementing the *Curriculum Framework* were unfilled for long periods of time due to difficulties recruiting staff. To address these issues medical schools will require encouragement and support to both recruit and professionally develop staff.

7. FINDINGS – *HEALTHY FUTURES*

This chapter presents the Review findings with reference to the *Healthy Futures* Review objectives. In particular, the chapter focuses on the recruitment and retention strategies that have been adopted by schools to address the *Headline Target of Healthy Futures* - that by 2010 Australian medical schools would have established pathways into medicine for Indigenous Australians and would have enrolled 350 extra Indigenous students. Based on the recruitment and retention strategies outlined in *Healthy Futures*, the following approaches adopted by medical schools have been identified and analysed:

1. Offering preparation for medicine and bridging programs
2. Establishing alternative entry requirements and processes
3. Facilitating University and school visits
4. Fostering a 'personal contact' approach
5. Providing mentoring support
6. Fostering cultural safety
7. Involving Indigenous Health Units and Indigenous staff
8. Developing partnerships

It will come as little surprise to Deans of medicine and those working towards recruiting Indigenous medical students within medical schools that only six of the 19 Australian medical schools can be identified as implementing several of the *Healthy Futures* recruitment and retention strategies. This raises the importance of documenting and assessing the comprehensiveness and effectiveness of the strategies Australian medical schools employ to both recruit and retain Indigenous medical students.

7.1 RECRUITMENT

Though current enrolments still fall short of the *Healthy Futures* target of 350 *extra* Indigenous enrolments, strategies such as those above appear to have contributed to an increase in the numbers and percentage of Indigenous medical student recruitments since 2005. As can be seen in the following table, new Indigenous student enrolments in medical schools throughout Australia in 2011 were 2.5% of the total enrolments, which is approximately the same as the proportion of Aboriginal people in the total national population (ABS 2009).

Aboriginal and Torres Strait Islander Medical Students - enrolments as a percentage of total domestic students, 2004-2011				
Year	Total new enrolments	Total enrolled	% of total domestic new enrolments	% of total domestic enrolled
2004	24	90	0.8%	1.2%
2005	17	94	0.9%	1.2%
2006	33	109	1.5%	1.2%
2007	41	125	1.6%	1.3%
2008	44	129	1.5%	1.2%
2009	38	137	1.3%	1.1%
2010	50	161	1.7%	1.2%
2011	80	218	2.5%	1.6%
Source: Medical Deans				

7.1.1 OFFERING PREPARATION FOR MEDICINE AND BRIDGING PROGRAMS

Three medical schools have established an alternative entry pathway via preparation for medicine (premed) programs for Indigenous students. These intensive programs generally involve students covering a series of medical subject areas in a small amount of time (three-four weeks), with an assessment upon completion. They not only provide an alternative entry pathway, but also the opportunity for students to personally assess their readiness and desire to study medicine, and for staff to assess the capabilities of potential students. They therefore contribute to improved retention rates and they are considered highly successful within the schools which have established them. In 2011, the three schools offering premed programs were responsible for 34 of the total 80 Indigenous student first year enrolments Australia wide.

The premed program in one school was seen as successful not only in its preparation of students for the medical program but in fostering 'whole-of-school' support for recruiting and supporting Indigenous students. In this program many academic staff are involved in the preparation and delivery of the program. An internal review of the program found that positive relationships were fostered between medical school staff and future Indigenous students, effectively providing a support network within the school of medicine for those students who successfully completed the course.

Four schools had established enabling and/or bridging programs. These programs provide Indigenous students with the opportunity to develop their knowledge through spending time in what the medical school considers a relevant or related degree. These programs were considered successful when they did not require students to study an extended period of time to obtain their medical degree. For example, one program that was considered successful provided an automatic pathway

into the graduate entry medical course after the successful completion of the first two years of a degree in health science, science or arts. In 2011, the four schools offering enabling and/or bridging programs were responsible for 35 of the total 80 Indigenous student first year enrolments Australia wide.

In 2011 the six schools which indicated they offered premed and/or enabling/bridging programs were responsible for enrolling 60 of the total 80 Indigenous student first year enrolments Australia wide.

See Appendix 11 for a LIME Good Practice Case Study on providing bridging and premed programs.

7.1.2 ESTABLISHING ALTERNATIVE ENTRY REQUIREMENTS AND PROCESSES

All schools provide the opportunity for any applicant, Indigenous and non-Indigenous, to gain entry into medicine by sitting the Undergraduate Medicine and Health Services Admission Test (UMAT) or the Graduate Australian Medical Schools Admission Test (GAMSAT) exams and an interview. However, it was suggested by many staff participants that this process is not currently culturally appropriate for many potential Indigenous students and that it does not adequately assess their potential for completing the program, or recognise the current agenda to overcome the severe shortage of Indigenous doctors in Australia.

Several schools have adopted more culturally appropriate interview processes for potential Indigenous students such as including Indigenous staff on interview panels and ensuring that Indigenous staff members assist in developing interview questions and, in some cases, the interview process.

A small number of schools have taken the initiative to also apply more appropriate interview processes to non-Indigenous students to help ensure that non-Indigenous students' attitudes towards the Indigenous health agenda are considered and assessed prior to their entry into the course.

Only a few schools indicated the provision of a variety of alternative entry processes which were sufficiently flexible to be able to assess the particular qualities of individual students. These processes included waiving the UMAT and GAMSAT exams, providing interviews within the IHU rather than the School of Medicine, providing provisional entry pathways, providing study skills programs to prepare for entry and assessing previous experience of applicants.

7.1.3 FACILITATING UNIVERSITY AND SCHOOL VISITS

The majority of medical schools, generally through their IHUs or through the University's central Indigenous Education Unit (IEU), conduct or connect with high school visits and outreach programs to promote medicine to Indigenous students. Several schools have developed posters and brochures for advertising a degree in medicine to potential Indigenous students, which are distributed to high

schools and careers advisors. Most schools also have staff attend relevant Indigenous career fairs and events to promote their course to prospective Indigenous students.

Several schools also invite Indigenous high school students into the school for programs which introduce students to the medical school and to 'hands on' activities conducted by health professionals.

A small number of medical schools have developed specific partnerships with high schools that have been identified with high Indigenous student populations. In a small number of medical schools IHUs have identified interested Indigenous school students and provide mentoring and support for these students. See Appendix 12 for a LIME Good Practice Case Study on facilitating University and School visits.

There is only limited evidence of any clear success from these activities and some staff noted that this strategy is resource intensive and does not acknowledge the low pool of potential Indigenous students.

In Victoria 160 (Indigenous) kids finished year 12 in 2008, 80 of them had scores that get them into University and that is across the board. So doing simple recruitment and marketing isn't going to do it. It's not just about telling kids they might want a career in med and sending out pamphlets and having a recruitment officer. If that's all we're going to do then we are going to be waiting a god zillion years for the programs to work. What we need to be doing is to be building a particular capacity to increase the school pipeline, this is probably a broader University issue... the problem is that high schools are focused on the underperforming students but there is no one picking up the Indigenous students who are going well and giving them the support to do well enough to get into University. And the other problem is that few of these kids are doing sciences. So you got a big problem in health sciences in terms of secondary school pipeline.

You have to invest in an articulation, what is the enabler course that someone does from a health profession to get into the (graduate entry) program? ... (This) requires a resource that is bigger than simple marketing and recruitment strategies.

Factors contributing to the low pool of potential Indigenous students were cited as:

- tertiary entry requirements
- the relatively small Indigenous student population
- science performance and the capacity of high schools to support Indigenous students who perform well, but below the level required to gain entry into medicine, and
- the lack of medical schools development of a clear enabling or bridging program

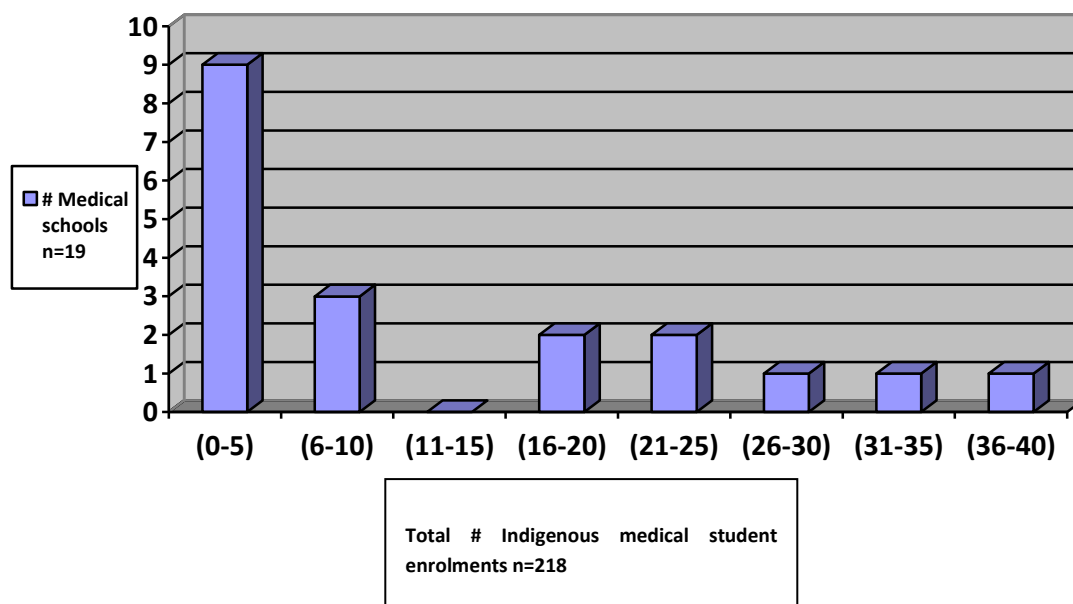
While clearer articulation for entry into medicine appears necessary, facilitating school and University visits raises awareness of career opportunities in medicine. These programs have also had some success in recruiting Indigenous students into other health related disciplines. Additionally they provide an opportunity for high school students to be exposed to Aboriginal and Torres Strait Islander professional role models and help promote long term attitudinal change.

7.1.4 RESOURCING AND IMPLEMENTING A RANGE OF ALTERNATIVE ENTRY PROCESSES

No recruitment process alone guarantees success and the majority of medical schools, including those with relatively high Indigenous student enrolments, indicated that ongoing commitment and resources are required to develop and sustainably implement effective Indigenous student recruitment processes. However, it is clear that the six schools that have committed resources to developing and implementing a range of alternative entry processes are, in the main, responsible for the improvement in Indigenous student enrolments in recent years. Of the total 218 Indigenous medical students enrolled in 2011, 140 were enrolled within the six schools which had established premed and/or bridging programs as well as other alternative entry processes.

The following graph indicates this skewed distribution of Indigenous student enrolments across the 19 Australian medical schools.

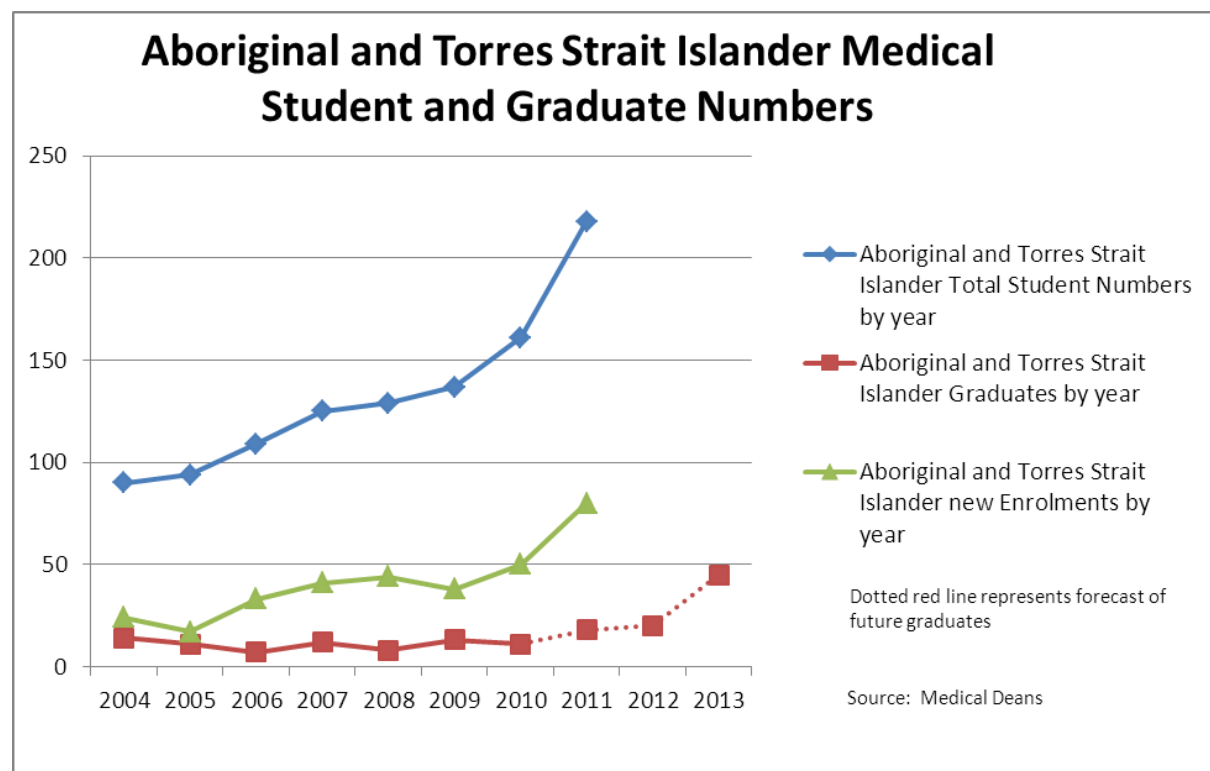
Total Aboriginal and Torres Strait Islander student enrolment numbers within Australian medical schools (2011)



In 2011 the six schools which indicated they offered premed and/or enabling/bridging programs were responsible for enrolling 60 of the total 80 Indigenous student first year enrolments Australia wide.

7.2 RETENTION

The graph below illustrates both the recruitment and retention of Indigenous medical students.



While this graph indicates that Indigenous student graduations may continue to rise in the coming years, anecdotal evidence from Deans, medical staff, Indigenous students, relevant literature and data from the Medical Schools Outcomes Database and Longitudinal Tracking (MSOD) Project suggests Indigenous students, especially during their second and third year of study, may have significantly higher withdrawal rates than non-Indigenous students (Garvey, Rolfe, Pearson & Treloar 2009) (Drysdale, Faulkner & Chesters 2006) (MSOD 2007-2010).

7.2.1 FOSTERING A 'PERSONAL CONTACT' APPROACH

15 of the 16 schools which completed the *Healthy Futures* audit profomas indicated that they adopted a 'personal contact' approach to student recruitment. However only a small number of schools clearly offer individual assistance to potential Indigenous students by having a staff member, generally Indigenous, provide guidance through the application process and welcome and introduce potential students to the school and staff members.

A few schools attempt to maintain personal contact as a strategy for retaining students. As reported in one school, having Indigenous and non-Indigenous staff "*available for students throughout their journey into medicine and throughout their degree*" begins at

the first point of contact...via phone with an Indigenous staff member who talks with students about the program. Then potential students will be welcomed into the school by an Indigenous doctor and are given the opportunity to discuss the course further with someone who has been through the course. After this there is continual contact and support available if needed.

The success of this 'personal contact' strategy is dependent on collaborative relationships and understanding between support staff and academic staff, as the fine balance between maintaining academic standards and offering appropriate support to Indigenous students is not easily reconciled. Additionally Indigenous students are often confronted with personal, family and community matters that may impact on their academic performance and not be fully recognised or understood by academic staff. Academic staff on the other hand, are concerned that academic standards be maintained. Reconciling these different views is difficult and requires a collaborative and understanding approach.

There is one other thing, the issue of advocacy and being able to have someone from the IHU being able to go and argue the toss with faculty for the students rather than let the students sink or swim based on their ability or inability to argue for themselves, or for the faculty to feel kind or generous or otherwise. So here, we have very good relationships with the faculty support processes and the faculty Associate Dean or manager of student affairs and the Dean. This means we can actually go and talk with them, 'Ok there's something going wrong here', and sort it out. It also means we go to every board of examiners meeting that is had so that if one of our students come up in terms of poor marks we are able to present an argument of context to explain what is going wrong and sometimes this gives the student a conceded pass if they are on 49 or something. Whereas if this doesn't happen students can get kicked out because there wouldn't be the knowledge within the faculty about what is going wrong with those students. We don't go and 'share dirty linen', but we go in a confidential and respectful way to advocate for the students' position without telling everything. And I think this is vital, it is also formalised. We are at the point now in the board of examiners where they will ask if this is an Indigenous student. They are now ready for it. Because we have personal relationships with community and students, we often know what is going on. They respect what we tell them.

Despite the potential problems associated with adopting *a personal contact approach* to recruitment and retention strategies, the feedback from Indigenous students was that this was critical to success and the *Healthy Futures* strongly emphasizes the importance of this approach in recruiting and graduating Indigenous medical students.

The importance of maintaining personal contact, building trust and developing supportive relationships, partnerships and networks was identified by all Indigenous student support workers as the most important strategy for attracting Indigenous students to medicine and retaining them (Minniecon & Kong 2005: 22).

7.2.2 PROVIDING MENTORING SUPPORT

In the Healthy Futures Report 43% of surveyed Indigenous medical students indicated that mentoring was the form of support they would like during their degrees (Minniecon & Kong 2005: pg 27), and, in the course of this review, student participants *consistently* indicated they required more support within medical schools. However, only a small number of schools are currently offering specific targeted mentoring programs for Indigenous students.

One example of a mentoring program, adopted in two schools, which was developed through the guidance of one of the University's Indigenous Education Units and their health faculty IHU, involved the provision of social and academic support and professional guidance from experienced clinicians. This support is offered formally in group sessions twice a semester and each student is linked with a clinician they can contact at any time. The clinician mentors involved in the program have made themselves available to advocate on behalf of individual students with medical school staff. They also provide students with opportunities to sit in and observe their clinical consultations. Additionally these mentors help introduce the students to professional networks. The success of this particular program was indicated by the positive praise of students involved and the fact that some of these students regarded the mentors as *akin to Elders*.

Mentoring support of this kind is particularly relevant for Indigenous students during their clinical training as a significant gap was identified in student support during these years.

The first few years I thought were quite good but...I felt there was a significant gap in the level of support for that switch and integration into the hospital environment from the University environment. I fell through this because there wasn't that level of support...you didn't have people there who you could run scenarios past that related specifically to Indigenous patients and their treatment...I feel it would have been extremely beneficial to have a good level of support there.

7.2.3 FOSTERING CULTURAL SAFETY

In a medical school context, the concept of cultural safety has been referred to as embracing diversity and promoting learning environments in which all students and staff are comfortable within their identity and are not subjected to racism or discrimination (Phillips 2005).

In 2005 the Healthy Futures Report suggested that cultural safety was not well established within most medical schools. The report found that 66% of Indigenous medical students experienced racism and discrimination from other students, residents, professors or physicians during their course and 64% felt they were not supported adequately by their medical school (Minniecon & Kong 2005: 29). The research undertaken for this report found that some medical schools appeared to have developed more culturally safe environments where mutual respect and understanding was evident, and where students had *“never heard a bad word from staff”* or experienced discrimination or racism.

Unfortunately, student focus groups discussions and staff interviews indicated that overt and covert racism and discrimination remain a significant issue in the majority of Australian medical schools. In these schools Aboriginal and Torres Strait Islander students reported that their identity has been challenged through comments such as *“you’re not even black”*. Many students also reported feeling uncomfortable within the medical school and reported hurtful, derogatory or insensitive comments from both other students and staff.

I remember lecturers making inappropriate comments. I walked out crying after one lecture where the lecturer made narrow judgmental comments about Indigenous health. International students found it funny. International students are not sure what Aboriginal people have gone through and their history and these students often stay in the country and practice.

One (female medical student) said Indigenous students are novelties.

When I got leave to go to a conference, I got permission to go, but (a medical school staff member) said ‘now you know if you have funerals and stuff you can’t go.’ I didn’t know what to say, like, ‘so I’ll let my uncles and aunties know this?’

Furthermore a considerable number of student participants, both Indigenous and non-Indigenous, identified the clinical environment as a setting where culturally inappropriate practices and learning may occur.

Especially in the clinical years your main exposure to Indigenous health issues is through your consultant. They tend to offer negative impressions. All you get is Indigenous people are non-compliant, don't understand, aren't grateful etc.

The majority of schools are implementing strategies, engaging in events and establishing protocols in an attempt to address this issue. This includes developing and delivering cultural awareness programs, providing welcome to country ceremonies, acknowledgement of country and attending events such as NAIDOC Week, Sorry Day and Reconciliation Week. But these strategies and events were not often viewed as effective and are generally targeted towards students rather than staff. In only a minority of schools are cultural awareness programs encouraged and provided for staff, though several are in the process of developing such programs. Moreover the attendance of these programs is often voluntary, and often viewed by staff and students as tokenistic and counterproductive.

(The cultural awareness programs are) fairly superficial...we have an afternoon for everyone. Most students seem happy to be over with it. (Indigenous student)

Some of the cultural awareness training we had has made some more negative towards Indigenous health. (Non-Indigenous student)

There are cultural awareness programs for staff...It's the one day workshop, quick fix, tick - 'yes we did it'. (Academic staff)

We would be pushing it uphill to get our clinical staff to attend these workshops. Many have done it, ticked that box... (It) has to be the right person teaching it and there has to be an identified need. If they come in to something which they don't think is relevant then you've lost them (Dean of Medicine).

Within a small number of schools staff reported examples of quite effective cultural awareness programs which were referred to in section 6.2.5 of this report. Though clearly there is a need to develop a more strategic approach to the implementation of such programs so as to foster culturally safe environments across all medical schools.

7.3 RECRUITMENT AND RETENTION

Several of the *Healthy Futures* Review objectives facilitate both the recruitment and retention of Indigenous medical students.

7.3.1 INVOLVING INDIGENOUS HEALTH UNITS AND INDIGENOUS STAFF

During the data collection period Indigenous Health Units (IHUs) were established within 14 of the 19 Australian medical schools/faculties and approximately 34 full time equivalent positions were occupied by Indigenous people in Australian medical schools. See Appendix 7 for Indigenous staff numbers within medical schools. Notably, of the 218 Indigenous students enrolled in medicine in 2011, 211 were enrolled within the 14 schools with established IHUs.

IHUs varied significantly in staff numbers, resources and responsibilities. Staff numbers varied from one to five and the majority of IHUs have only one or two staff. Staff members within all IHUs were directly involved in recruiting and supporting Indigenous medical students and also in implementing the *Curriculum Framework*. In several Universities, IHUs were responsible for Indigenous student recruitment and retention and implementing Indigenous health content across the entire health faculty, which effectively reduced their capacity to develop initiatives specific to medicine.

The IHUs and Indigenous staff are consistently viewed within medical schools as being fundamental to:

- developing, integrating and delivering appropriate curriculum content
- developing and implementing initiatives to promote medical degrees and recruit Indigenous medical students
- providing cultural and academic support for Indigenous medical students
- forming and sustaining partnerships with key Indigenous organizations and individuals, and
- And developing and delivering cultural awareness programs and fostering a more culturally safe environment within medical schools.

IHUs and Indigenous academics and clinicians working within medical schools were consistently regarded by staff and students as highly important to appropriate curriculum development and delivery, as well as role models and providers of support for Indigenous students.

Despite their crucial role, Indigenous and non-Indigenous staff in IHUs consistently reported being understaffed, poorly resourced and overburdened with the significant tasks outlined above as well as the culturally sensitive, relatively new and complex field of education in which they work. Additionally IHU staff consistently stated that there was a lack of support and recognition of the time and resources required to sustain the numerous internal and external partnerships required to develop, integrate and deliver an overarching curriculum framework and Indigenous student recruitment and retention strategies.

If we are going to have healthy relationships with Indigenous community...this takes time. A lot of people might say you are just going out yarning. Well you're not. What you are doing is going out and having proper liaison, Aboriginal way. And that's not recognised in the work model either... 'Yes we want Aboriginal staff, so let's just go get them and put them in a position.' But the additional supports required, the additional time that is required, the additional development that is required is not resourced enough.

It was repeatedly suggested that the required processes and collaboration to effectively implement recruitment and retention initiatives within the medical school and/or faculty were based on 'personalities' rather than embedded in school/faculty processes or policy. Strong leadership was referred to as a key factor required to ensure IHUs were not overburdened with "everything Indigenous" and that the significant task of integrating and embedding recruitment and retention initiatives was recognized and supported by all medical school staff. Notably 10 of the 14 IHUs did not have a staff member who was in the senior position of Associate Dean or equivalent.

It is clear that in order to sustain the progress that has been made by IHUs and their Indigenous and non-Indigenous staff, additional staffing resources, as well as the support and engagement of leadership and staff outside of the IHUs is required in the majority of Australian medical schools.

7.3.2 DEVELOPING PARTNERSHIPS

Internal Partnerships

The majority of schools demonstrate some evidence of informal partnerships between their IHU (or Indigenous health governance group or relevant staff implementing the initiatives) and medical school, faculty and other University staff. In particular these partnerships involve relationships of varying depth and formality with:

- Deans of Medicine
- domain/discipline heads
- year and theme leaders
- admission staff
- the central Indigenous education units
- Rural Clinical Schools

However in most schools the importance of these relationships was not widely recognized or formally embedded within school practices. Though there were variations within and between

schools there was a widespread perception that most internal partnerships were tenuous and dependent on the commitment of individuals rather than embedded as core school practice.

I think there is a lot of interest and good will but it's not a particularly formalised process.

I think we have varying degrees of engagement. From struggling to come to terms with the need for it (Indigenous student recruitment and support) - to being supportive and engaging - to being supportive and engaging (but) with degrees of ignorance asking for (IHU) people to come in and 'just do it for them'.

If I were to leave (the school) you would need someone in my role that is supportive of letting Indigenous students in the course (admission staff member).

The tenuous nature of many required internal partnerships contributed to a strong and consistent perception amongst students and staff of widespread ignorance about relevant Indigenous issues relating to the recruitment and retention of Indigenous medical students.

The tutors and teaching staff just don't get it. You know the value of it, 'we are doing Indigenous health, we won't worry about that too much we are doing anatomy afterwards.'...There is a whole lot of push from those within the faculty... who don't see Indigenous health as being core...And this is a constant battle.

The medical school doesn't seem to be flexible with Indigenous issues...students must go to a hospital in first year (but) for me that same week I had to visit my two aunties in hospital. I emailed the coordinator to tell about my grandmother too and it was actually the last time I saw her. I got a long email stating this was not professional and that it would impact my career...and there can be people failed if the word unprofessional is used. I was pretty devastated by it. Makes me just want to get out of the place.

Another issue, in those schools where there was not a well-resourced or established IHU, was the capacity of central Indigenous Education Units (IEUs) to fully support the implementation of *Healthy Futures* recruitment and retention strategies. However, the capacity for recruiting and supporting

Indigenous medical students was greatly increased in those schools where there was both an IHU and a central IEU that had established an effective working partnership with each other.

External Partnerships

The importance of “*building trust, developing supportive relationships, partnerships and networks*” was identified in *Healthy Futures* as “*the most important strategy for attracting Indigenous students into medicine and retaining them*” (Minniecon and Kong: 2005: 22). All medical schools are connected with the LIME Network and most schools have developed other external partnerships with organizations and individuals such as with:

- Aboriginal Medical Services
- Aboriginal Health Workers
- High schools
- Indigenous individuals, community groups and organizations
- Professional organizations and networks such as AIDA
- Indigenous health professionals, and
- Other professionals specializing in Indigenous health

These partnerships were often highlighted as time consuming to establish and maintain, as well as complicated by the capacity of host agencies and individuals to offer their support to medical schools and students. Even so, it is important for medical schools to continue to foster these partnerships as they provide a strong foundation for curriculum development, student support and research partnerships. Further, they are valuable networking opportunities and raise awareness of medical schools’ initiative to recruit and support Indigenous medical students. They also allow the sharing of practical and professional knowledge of best practice and help reinforce aspects of the *Curriculum Framework* for many medical students (Indigenous and non-Indigenous). The partnerships that a small number of schools have developed with local Indigenous individuals and community groups have also contributed to the development of more culturally appropriate recruitment and support strategies.

8. DISCUSSION

This review of the implementation of the *Medical Deans Indigenous Health Curriculum Framework* and the *AIDA's Healthy Futures Report* finds that in 2011, Australian medical schools have made important and significant developments towards the implementation of both initiatives. Australian medical schools implement considerably more Indigenous health content in 2011 than in 2004, and the percentage of first year Indigenous Australian medical student enrolments has steadily increased since 2004.

However, this review also finds that in 2011 there is considerable variation in the implementation of both initiatives across Australian medical schools. The majority of Australian medical schools are not yet comprehensively implementing the *Curriculum Framework* and the *Healthy Futures*, and most face similar implementation issues as reported in the *Audit and Consultations Report* in 2004 and the *Healthy Futures* in 2005.

In regards to implementation of the *Curriculum Framework*, the majority of schools indicated there was little time dedicated within the medical program to implement a sufficient amount of discrete and integrated Indigenous health content, and that compulsory and assessable content needs to be increased in order to achieve the intended student outcomes of the *Curriculum Framework*. Additionally, the need to further develop technically specific and relevant Indigenous health content was clearly expressed in the majority of Australian medical schools. Finally, assigning senior level leadership, adequate staffing and financial resources, and appropriate methods for reducing the impact of cultural sensitivities on quality education present as key areas to be addressed in most medical schools.

In regards to the *Healthy Futures* implementation, only a small number of schools provide a range of the 'best practice' recruitment and retention strategies identified within the *Healthy Futures Report*. Most schools indicated that their current financial and staffing resources are insufficient for developing and establishing significant recruitment and retention strategies for Indigenous medical students. The findings also indicate that currently many medical schools are recruiting Indigenous medical students without having established sufficient and relevant support processes. Finally, the majority of schools indicated a clear need to continue working towards fostering increased internal awareness, capacity building and engagement to appropriately recruit, support and graduate Indigenous medical students and to develop more culturally appropriate environments within medical schools.

The development, and subsequent endorsement, of the *Curriculum Framework* and *Healthy Futures* has provided Australian medical schools with important resources for implementing Indigenous health curricula and Indigenous student recruitment and retention initiatives. The LIME Network has played an important role in developing and supporting existing capacity and a small number of schools have managed to dedicate sufficient internal funds and access external funding for resourcing the implementation of both initiatives.

However, the existing resources and funding dedicated to the initiatives within most Australian medical schools has facilitated what appears to be only superficial incorporation of Indigenous health content and Indigenous student recruitment and retention initiatives.

The current issues which impact on the quality and sustainability of implementation clearly indicate that many medical schools require further support in developing appropriate and adequate Indigenous health curricula and student recruitment and retention programs and strategies. The existing resources in many schools are inadequate to fully maximize return of investment and to address the need to build capacity to the next level. For the important developments achieved thus far to be sustained and improvements to become a reality, a funding partnership between medical schools and the Commonwealth will be required. At the same time this does not mean medical schools should expect special funding as both initiatives and their contribution to the national Indigenous health agenda should be considered core business.

While medical schools have a continuing responsibility to resource these initiatives, and the LIME Network continues to do well in developing existing staff and capacity, the further development of quality and sustainability in this sector will require additional resources in the same way the rural health training schemes have allowed the consolidation of the place of Rural Health in medical schools. Furthermore both initiatives require dedicated senior leaders, financial and staffing resources, as well as significant internal and external coordination and collaboration in order to deliver quality outcomes and become embedded as core medical school business.

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10. APPENDICES

APPENDIX 1: MEDICAL DEANS BENCHMARKING PROJECT – AUSTRALIAN MEDICAL SCHOOL MATRIX

University	Go8	Entry type	Interview	Age of Med School	Location	Length of Degree	Public/Private	Rural Focus	Intake number
Adelaide	Y	School leaver	Oral assessment	125 years	Capital City	6 years	Public	RCS	179
ANU	Y	Graduate	Structured interview	6 years	Capital City	4 years	Public	RCS	94
Bond		School leaver	Structured interview	4 years	Satellite City	4 years and 8 months	Private	No RCS	91
Deakin		Graduate	MMI	2 years	Satellite City	4 years	Public	RCS	136
Flinders		Graduate	Structured interview	36 years	Capital City	4 years	Public	RCS	144
Griffith		Graduate	Structured interview	5 years	Satellite City	4 years	Public	No RCS	156
James Cook		School leaver	Structured interview	10 years	Satellite City	6 years	Public	All rural	180
Melbourne	Y	Graduate	MMI	148 years	Capital City	4.5 years grad entry	Public	RCS and ERC	85 in 2009 but 330 typically
Monash	Y	Dual	MMI	49 years for school leaver	Capital City	5 years school leaver and 4 years grad entry	Public	RCS and ERC	301 school leaver and 73 grad entry

				intake, 2 years for grad intake					
Newcastle		School leaver	Structured interview	32 years	Satellite City	5 years	Public	RCS	196
New South Wales	Y	School leaver	Structured interview	49 years	Capital City	6 years	Public	RCS	277
Notre Dame Fremantle		Graduate	Structured interview	5 years	Capital City	4 years	Private	RCS with UWA	109
Notre Dame Sydney		Graduate	Structured interview	2 years	Capital City	4 years	Private	RCS	113
Queensland	Y	Graduate	No interview	?	Capital City	4 years and 2+4 years for accelerated pathway	Public	RCS	429
Sydney	Y	Graduate	MMI	127 years	Capital City	4 years	Public	RCS	299
Tasmania		School leaver	No interview	45 years	Capital City	5 years	Public	RCS	124
UWA	Y	Dual	Structured interview	54 years	Capital City	6 years school leavers and 4 years plus bridging for grad entry	Public	RCS	64 grad entry and 173 school leaver
Western Sydney		School leaver	MMI	3 years	Capital City	5 years	Public	RCS	133
Wollongong		Graduate	MMI	3 years	Satellite City	4 years	Public	No RCS	86

APPENDIX 2: MEDICAL DEANS – AIDA NATIONAL MEDICAL EDUCATION REVIEW: STEERING COMMITTEE

Membership

Name	Organisation
Doctor Tammy Kimpton (Co-Chair)	AIDA
Professor Ian Puddey (Co-Chair)	Medical Deans
Ms Margo Collins	LIME Network
Ms Colleen Gibbs	DoHA
Professor Lisa Jackson-Pulver	LIME Network
Professor Alison Jones	Medical Deans
Mr Trent Little	AMSA
Professor Iain Martin	Medical Deans
Ms Odette Mazel	LIME Network
Mr Pat Maher	HWA
Mr Romlie Mokak	AIDA
Mr Graeme Rossiter	DoHA
Doctor Jag Singh	CPMEC
Professor Tim Usherwood	AMC

**APPENDIX 3: MEDICAL DEANS – AIDA NATIONAL MEDICAL EDUCATION REVIEW:
TECHNICAL REFERENCE GROUP**

Membership

Name	Organisation
Professor Richard Murray (Chair)	Medical Deans
Ms Cris Carriage	LIME Network
Ms Mary Guthrie	AIDA
Associate Professor David Paul	LIME Network
Ms Leila Smith	AIDA
Ms Elaine Terry	Medical Deans' Faculty Managers
Professor Della Yarnold	AIDA
Associate Professor Craig Zimitat	LIME Network

APPENDIX 4: SUMMARY OF RELEVANT REPORTS AND PUBLICATIONS

The Medical Deans – AIDA National Medical Education Review is focused on the implementation of the *Curriculum Framework* and the Healthy Futures, two initiatives that are specific to the Australian medical education context. Therefore the following summary of relevant reports and publications specifically identifies Australian medical school initiatives relating to the implementation of both initiatives. To date there is a significant lack of documentation relating to the implementation of both initiatives within Australia.

It is important to note however that there are numerous reports and publications which refer to certain aspects associated with implementing both initiatives such as developing Indigenous simulated patient programs and establishing a culturally safe environment. It is also important to note that significant achievements relating to the implementation of Indigenous health content and Indigenous student recruitment and retention strategies have been made and documented in comparable countries with Indigenous populations such as Canada, New Zealand and the USA. The LIME Network website houses a significant resource database which contains many of the above associated reports and publications.

Additionally several initiatives have been developed within Australian medical schools but are yet to be documented. Many of these initiatives are outlined in the results section of this report.

Indigenous simulated patients: an initiative in “closing the gap” (Ewen, Collins, Schwarz and Flynn: 2009)

This brief article outlines the use of Indigenous educational expertise in the Indigenous Simulated Patient Program, which was developed in 2002 and conducted within the University of Melbourne. The program involves utilizing Indigenous actors and meets several of the goals within the Medical Deans Indigenous Health Curriculum Framework such as incorporating the educational experience of Indigenous people and exposing students to Indigenous peoples’ lived experiences and world views.

The main objective of the program is to make students aware that Indigenous and non-Indigenous patients will have the same and different issues. The program is delivered during the early and late stages of the medical course. During the early stage, students are encouraged to practice their developing communication and patient-interviewing skills within a tutorial session where the students discover the “patient” is Indigenous. In the later stage of the medical course the simulated patient scenario becomes more complicated and requires the student to demonstrate they are able to problem solve issues such as family responsibilities and living arrangements that may arise with Indigenous patients.

The article concludes by highlighting that both the Indigenous actors’ and the students’ experiences of the program can be very positive and rewarding.

Reform in Australian medical schools: a collaborative approach to realising Indigenous health potential (Mackean, Mokak, Carmichael, Phillips, Prideaux and Walters: 2007)

This article provides an overview of the Australian Medical Council's *Assessment and accreditation of medical schools: standards and procedures (2006)*, the *Medical Deans Indigenous Health Curriculum Framework (2004)* and the Australian Indigenous Doctors' Association's *Healthy Futures: defining best practice in the recruitment and retention of Indigenous medical students (2005)*.

The article states that there is more to achieving the shared goal of developing a better trained medical workforce and more Indigenous doctors in Australia than developing guidelines for success in curriculum, recruitment and retention reform. What is required within medical schools is organizational reform that will require ongoing, strategically planned and implemented work to ensure productive outcomes rather than tokenistic gestures. Examples of this work, which the article highlights is within the AIDA, AMC and Medical Deans documents, will include "relationship building (within and external to the medical school), capacity building, staff development and training in cultural safety, the identification and commitment of realistic resources, and the ability of a medical school to reach out and form partnerships with local Indigenous communities, organizations and individuals" (Mackean et al: 2007, p5).

The article concludes with an affirmation of the AMC's, AIDA's and Medical Deans' commitment to continuing their collaborative work to help achieve the goal of training a better medical workforce in Indigenous health and more Aboriginal and Torres Strait Islander Doctors.

CDAMS (now Medical Deans) Indigenous Health Curriculum Development Project: National Audit and Consultations Report (Phillips: 2004)

This report, published in 2004, provided a national overview of the then 12 Australian medical school's implementation of Indigenous health related content. The data gathered from the national audit and consultations was utilized to inform the development of the *Medical Deans Curriculum Framework*.

For each medical school, Indigenous health content within the medical curriculum is outlined in an audit table, which also includes; the mode of delivery; the number of hours/units dedicated to delivery; whether the content is part of the core medical curriculum or an elective; and who the content is delivered by. From these tables it is clear that across the nation there was a wide variety of Indigenous health related content being delivered, mainly through lectures, tutorials, PBL's and placements in Indigenous health settings. It is also clear that there was a large discrepancy in relation to the amount of Indigenous health content delivered within Australian medical schools. Some schools appeared to implement minimal content within their program, while some others appeared to provide a comprehensive education on Indigenous health. Nationally the majority of the content was included as non compulsory/non-core training, or as a minor component of a core module. The proportion of content delivered by Indigenous and non-Indigenous staff appeared to be approximately equal.

In the consultations results, the report highlights that all schools expressed “a general commitment towards the principles of Indigenous health, though the level of commitment and awareness of issues regarding Indigenous peoples in general and Indigenous health in particular varied greatly” (Phillip 2004: 11). For example, some schools grounded their commitment through developing Indigenous health strategic plans, curriculum maps and disciplines of Indigenous health, while others did not.

Approaches to implementation were also quite varied. Schools that had developed partnerships with Indigenous individuals and organizations both within the University and externally to facilitate curriculum development found the process rewarding. Some schools however, were unaware of how or where to establish such partnerships. Most schools were aiming to integrate Indigenous health content across disciplines, while some schools taught Indigenous health as a discrete subject area/discipline. A small number of schools taught Indigenous health both in a discrete and in an integrated fashion. Additionally, experiential learning experiences with Indigenous people was viewed by many as positive however it was cautioned that these forms of learning must be appropriately coordinated to ensure they were contextualized and relationships were built on intercultural understanding. While implementation strategies varied across the country, the report found that “there was a consistent belief and attitude across all schools that Indigenous health should be taught alongside rural health content” (Phillips 2004: 13).

The report clearly highlights that, apart from an expressed commitment to the ‘Indigenous health’ agenda, there is a lack of consistency in regards to medical schools’ implementation of Indigenous health content. Most schools suggested that limited coordination, continuity and quality of content, along with funding, teaching capacity and personnel were the major barriers to successful implementation of Indigenous health content within most schools.

Making a difference: The early impact of an Aboriginal health undergraduate medical curriculum (Paul, Carr and Milroy: 2006)

This journal article describes the implementation of an integrated Aboriginal health curriculum into the undergraduate medical course at the University of Western Australia (UWA), as well as the effect this curriculum has had on students’ perceptions of their knowledge and ability in the field of Aboriginal health. The curriculum, which was progressively introduced from 2000, included a minimum of 37 hours of direct teaching in Indigenous health within the core medical program. Some students have received over 150 hours of tuition, depending on the amount of Aboriginal health options they chose.

The article highlights two main strategies that were central to the implementation of the new curriculum. The first was the establishment of the Centre for Aboriginal Medical and Dental Health (CAMDH) in 1996. One of CAMDH’s specific roles was to develop Aboriginal health teaching within the faculty. The second strategy was the articulation of learning outcomes that focused on developing students’ knowledge, skills and attitudes for each year level was viewed as central to the implementation of the integrated Aboriginal health curriculum (see below).

Year-level learning outcomes for the Aboriginal health curriculum at the (UWA)	
<u>Year</u>	<u>Learning outcomes</u>
1	Explain the impact of historical, cultural and social factors on Aboriginal and Torres Strait Islander peoples' health and health care
2	Describe and discuss health and health care issues for Aboriginal and Torres Strait Islander peoples today
3	Discuss the special health care needs of Aboriginal and Torres Strait Islander peoples and demonstrate appropriate strategies to meet these needs
4	Demonstrate, through discussion, the ability to work in partnership with Aboriginal and Torres Strait Islander peoples, acknowledging the meaning that they attach to health and illness, including the cultural and other origins of that meaning, and taking into account their coping strategies
5.1	Illustrate, with examples, health and health care for Aboriginal and Torres Strait Islander peoples today
5.2	Apply knowledge of the sociocultural context of health for Aboriginal and Torres Strait Islander peoples
5.3	Plan and describe how to provide comprehensive, multidisciplinary health care and health services for Aboriginal and Torres Strait Islander peoples
Graduate	- Demonstrate a working knowledge of the sociocultural context of health care of Aboriginal and Torres Strait Islander peoples and an ability to plan and provide comprehensive, multidisciplinary culturally secure care (Paul et al 2006: 524)

The impact of the implementation of the new curriculum was assessed on two groups of final year medical students in 2003 and 2004. The research participants included 181 students from the first and second cohorts to run through the new curriculum. The findings of the research suggested that with "targeted and structured teaching and learning in Aboriginal health, significant shifts in students' self perceived levels of knowledge, skills and attitudes are possible" (Paul et al 2006: 522)

Training Indigenous doctors for Australia: shooting for goal (Lawson, Armstrong and Van Der Weyden: 2007)

This journal article identifies the lack of Indigenous doctors within Australia and provides an overview of the achievements, strategies and future plans of three medical schools that have had significant success in the recruitment and retention of Indigenous medical students. Key representatives were interviewed within the participating medical schools, which were from the University of Newcastle, the University of Western Australia, and the James Cook University.

The development of the Indigenous entry program within the University of Newcastle medical school was made possible through three main factors. Firstly the foundation Dean, David Maddison, was said to have created a 'receptive environment' for an Indigenous entry program. He had helped develop a medical school that had a strong focus on community, equity and engagement. Secondly, Robert Sanson-Fisher, an individual with experience within Indigenous health settings had the

passion to push the agenda within the medical school. And thirdly, John Hamilton, the Dean during the early 1980's, supported the initiative for the school to explore and work through the barriers to Indigenous entry and retention within the medical school.

At the University of Western Australia the Centre for Aboriginal Medical and Dental Health (CAMDH) was founded in 1996. CAMDH's goal was to improve Indigenous student recruitment and retention as well as to assist with the teaching of Aboriginal health and improving links with Aboriginal organizations. Apart from CAMDH's work, Helen Milroy from the Palyku people, attributes the significant improvements in Indigenous student recruitment and retention to the CAMDH's collocation with the Universities pre-existing Centre for Aboriginal Programmes (now the School of Indigenous Studies), which provided support and alternative entry schemes for students in other programs.

At the James Cook University medical school, Jacinta Elston (Associate Dean – Indigenous Health) from the Kalkadoon people, states that their success was achieved because producing Indigenous doctors was integral to the school's rationale and accreditation in 1999. The school was developed with rural and remote health, Indigenous health and tropical medicine as its focus. Additionally, under Jacinta's leadership, an Indigenous Health Unit was created in 2003 to improve Indigenous student recruitment and retention across the faculty of Medicine, Health and molecular Sciences.

All three schools have developed programs which are based on alternative entry schemes which assess a students' ability through a wide range of criteria, rather than an academic score. The programs include various combinations of recruitment strategies along with "premedical preparation, academic, social and personal support during the course, and flexible pathways." All schools additionally have determined quotas for Indigenous students, which are suggested to lower the need for advocating student entry on a case by case basis.

All three medical schools illustrated the importance of:

- selection processes need to be rigorous to ensure students will successfully complete the course
- preparation programs are defined and varied to ensure there are many and clear pathways into medicine
- medical schools organize strategies to provide both academic and social support to Indigenous students
- and recruitment initiatives are developed with long term strategies that connect to both Indigenous school students and Indigenous communities

Footprints Forwards: Better strategies for the recruitment, retention and support of Indigenous medical students (Drysdale, Faulkner, Chesters: 2006)

The Footprints Forwards project identified opportunities for and barriers to the recruitment and retention of Indigenous medical students. The project also identified reasons why Indigenous students leave medicine and provided eight recommendations to facilitate the recruitment and retention of Indigenous students into medicine.

The significant barriers identified within the report included:

- the inadequate preparation of teachers in the school system to work with social and culturally diverse students and the consequent 'performance gap' between Indigenous and non-Indigenous students in the Australian schooling system
- a significant proportion of high school careers advisors and counselors surveyed were unaware of the various pathways into medicine available to potential Indigenous students
- the lack of a consistent sustainable national approach to recruitment and the considerable variation of Indigenous student recruitment strategies within Australian medical schools

The major opportunities identified included:

- information sessions delivered by Indigenous health professionals for high school students
- the provision of support for high school students in the areas of mathematics and science
- the identification of potential students and the provision of specific mentoring support from university students/programs
- and mechanisms to support students with lifestyle associated issues such as finances and accommodation

The main reasons identified within the report as to why Indigenous students defer or withdraw from their medical course were:

- Financial reasons
- Relationship/family problems
- Couldn't cope
- and cultural isolation

Withdrawn students also provided advice which they would suggest for Indigenous students enrolling or contemplating enrolling in medicine. The most prominent form of advice provided was 'get all possible support'.

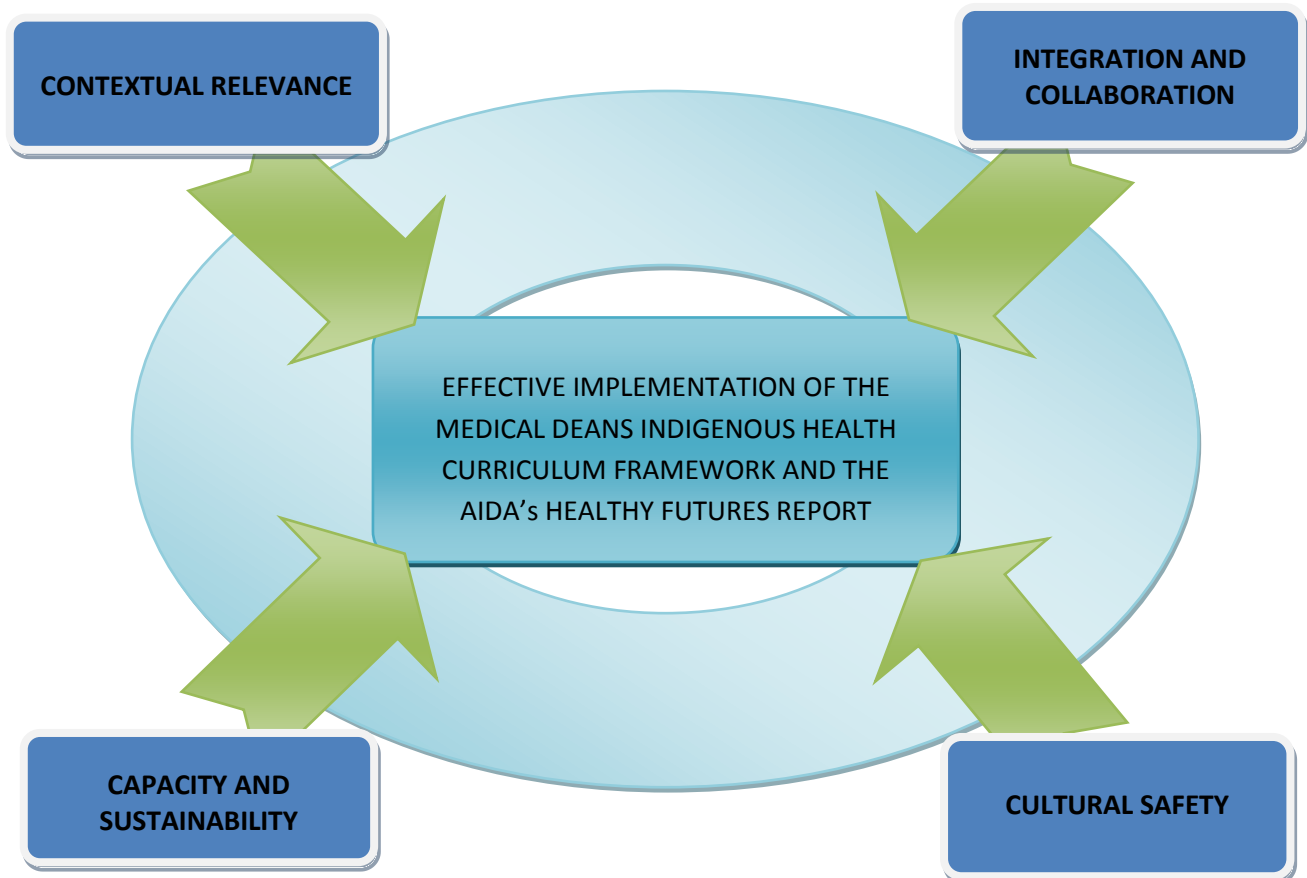
The report's final recommendations were:

- A nationally coordinated and collaborative approach
- A focus on secondary school students – including personal contact and promotion
- Career development support – supporting career development practitioners to provide more appropriate and comprehensive advice
- Support from universities for existing recommendations – including the recommendations set out by *Medical Deans Curriculum Framework* and AIDA's Healthy Futures Report
- Indigenous support mechanisms in universities

- Existing approaches in universities – including the review of existing approaches within medical schools and the development of improved strategies for recruitment and retention
 - Further research
 - Mature age Indigenous medical students – investigating to improve the potential for medical schools to recruit mature age Indigenous students
-

APPENDIX 5: CONCEPTUAL FRAMEWORK

The diagram below provides a visual illustration of the conceptual framework.



Integration and Collaboration

Integration and collaboration refers to how the Curriculum Framework is horizontally and vertically integrated into Australian medical schools' core curricula and how the Healthy Futures recruitment and retention strategies are integrated into medical school recruitment processes and admission procedures. These processes also encompass how medical school staff work together and collaborate with external partners to achieve the effective implementation of the Curriculum Framework and Healthy Futures. This concept has been utilized to assess issues such as:

- whether Indigenous health and or medical support units are present and integrated within the medical school;
- whether processes are in place to facilitate effective collaborative partnerships;
- whether Indigenous health content is integrated vertically and horizontally across core medical curricula;
- how Indigenous health content is developed, delivered and integrated into core medical curricula;
- whether a whole of school approach to developing and delivering Indigenous health content and student recruitment and retention initiatives is evident; and

- the obstacles and issues that make it difficult to develop collaborative and integrative approaches to the implementation of the Curriculum Framework and the Healthy Futures Initiatives.

Cultural Safety

For the purpose of this review, cultural safety refers broadly to the fostering of mutual respect and understanding of Indigenous cultural values and to the appropriate development and delivery of the Curriculum Framework and Healthy Futures initiatives. Therefore, in this review the concept of cultural safety has been utilized to assess issues such as:

- whether Indigenous culture and its diversity is recognized and reflected within medical school curricula;
- whether Indigenous culture and its diversity is recognized and reflected within medical school recruitment and admissions procedures; and
- whether there are processes in place, such as relevant cultural awareness training, which facilitate mutual understanding and respect between Indigenous and non-Indigenous students and staff;

Contextual Relevance

Within this review the concept of contextual relevance refers to how medical schools connect to and identify with local Indigenous contexts to facilitate the implementation of the Curriculum Framework and the Healthy Futures initiatives. Therefore, in this review the concept of contextual relevance has been utilized to identify:

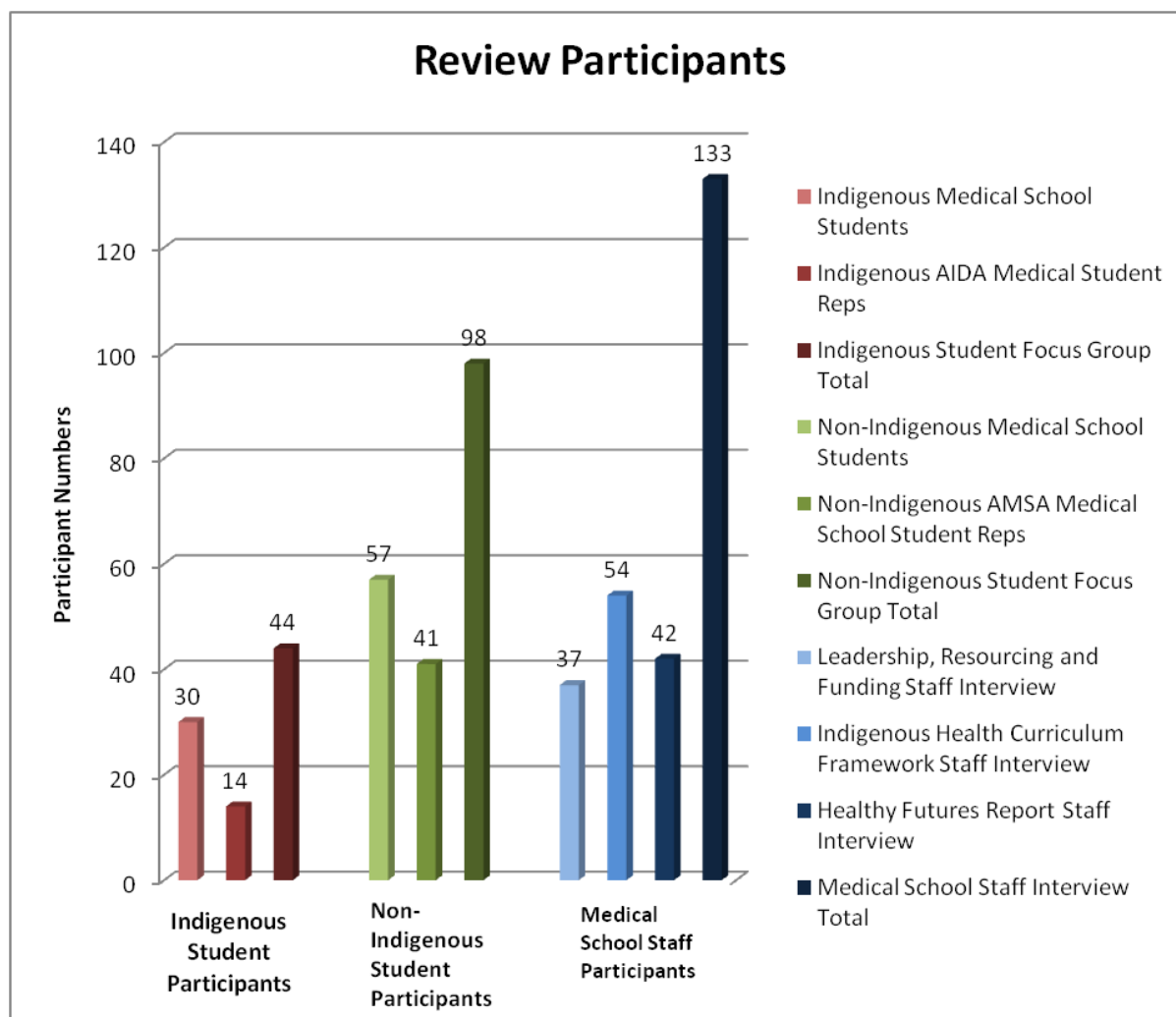
- how medical schools develop relationships and partnerships with local Indigenous individuals, communities and organisations to contribute to developing student recruitment and retention strategies and Indigenous related health content;
- whether medical school staff and students are educated about local Indigenous contexts and associated protocols; and
- the barriers and issues that make it difficult to connect to and identify with local Indigenous contexts

Capacity and Sustainability

Within this review the concepts of capacity and sustainability refer to how medical schools have allocated and utilized resources that contribute to the effective and ongoing implementation of the Curriculum Framework and Healthy Futures initiatives. Therefore, in this review the concepts of capacity and sustainability have been utilized to assess issues such as:

- specific and ongoing funding geared towards implementing the Curriculum Framework and Healthy Futures;
- specific resources that effectively progress the implementation of the Curriculum Framework and Healthy Futures within medical schools;
- successful initiatives that have increased capacity and sustainability in terms of effective implementation of the Curriculum Framework and Healthy Futures;
- the barriers and issues that make it difficult to build capacity and sustainability in this area

APPENDIX 6: REVIEW PARTICIPANTS



APPENDIX 7: AUSTRALIAN INDIGENOUS ACADEMIC AND PROFESSIONAL STAFF

Indigenous Academic and professional staff in Australian medical schools		
Medical School	Indigenous staff (FTE - academic and professional)	Indigenous staff (FTE - academic only - estimate)
MS1	4	2
MS2	1	0
MS3	1	0
MS4	0	0
MS5	3	2
MS6	0.5	0
MS7	2	2
MS8	0.4	0
MS9	1	0
MS10	2	2
MS11	3.5	1.5
MS12	3	1
MS13	2	2
MS14	2	2
MS15	2	1
MS16	2	0
MS17	0	0
MS18	1	1
MS19	2.6	1.6
Total	33	18.1
Source: Review participants		

THEME: COMMUNITY ENGAGEMENT

The Community Responsiveness & Engagement through Streamed Clinical Education and Training (CRESCENT) project

Ms Shawana Andrews, The University of Melbourne, Australia

Introduction

The Faculty of Medicine, Dentistry and Health Sciences at The University of Melbourne is developing a new community-based clinical education and training model for health science students, to complement its current hospital-based model. The Community Responsiveness & Engagement through Streamed Clinical Education and Training (CRESCENT) project seeks to develop an innovative approach to clinical education that better links students with the communities in which they learn and to whom they will provide services. This model is reliant on engaging existing health services, including Indigenous health services, in the Northern and Western suburbs of Melbourne, Victoria, to contribute to and participate in community-based clinical education. The CRESCENT Aboriginal Community Engagement Project is a component of this broader program, which undertook a service and mapping consultation with Indigenous health service providers in the region.

Why was this project/program initiated?

The CRESCENT project envisions that:

the health needs of people in Melbourne's Northern and Western suburbs are met by a diverse, well-trained workforce that understands and responds to the community it serves, and is equipped to work in the health system of the future.

In 2008, the Council of Australian Governments (COAG) agreed to a National Partnership Agreement (NPA) on Closing the Gap in Indigenous Health Outcomes. The NPA Implementation Plan¹ states:

The limited availability of a culturally competent workforce to provide health care to Aboriginal and Torres Strait Islander people is the single biggest risk to achievement of the objectives of the reforms under the NPA. (p.6)

1 Commonwealth Government of Australia (n.d.), National Partnership Agreement on Closing the Gap in Indigenous health Outcomes: Implementation Plan. Accessed on 2 November 2011 at <<http://www.health.gov.au/internet/main/publishing.nsf/Content/closinggap-tacklingchronicdisease>>.

Therefore, identifying the best ways in which to develop Indigenous health teaching and learning within a community-based model in Melbourne's Northern and Western suburbs, was considered an important element of the model.

Aims and objectives

The Aboriginal Community Engagement project began in March 2010 and aims to engage with Aboriginal services and organisations in the region, and those mainstream organisations that service a significant number of Aboriginal people, with the following objectives:

- to develop a planned and inter-professional approach to student placements in Aboriginal health
- to provide opportunities for students to experience an Aboriginal health clinical environment after appropriate cultural awareness training
- to develop a best-practice model of engagement for health science students in Aboriginal health services
- to inform and reform the faculty's curricula with regard to community clinical placements in Aboriginal health.

Approach to achieve aims and objectives

We wanted to identify relevant services, organisations and groups, so we undertook a mapping exercise. This was followed by an initial consultation; we hit the road between April and July 2010 and met with six Aboriginal organisations, four hospital-based Aboriginal Liaison Officer/support programs for Aboriginal patients, three community health centres, two city councils, two University Indigenous Student Units, one Aboriginal Reference group and a welfare service.

Challenges

The outcomes of the community consultations highlighted the uncertainties and complexities that will need to be addressed and overcome, particularly in considering the expectations placed on resource-poor Aboriginal organisations and services to contribute to the clinical training of students.

What is clear from this consultation is that one model of clinical training won't fit all, nor will a successful model in one year necessarily suit the same service the following year. Flexibility, coordination and ongoing communication between the University and the organisations are paramount.

The process of moving from mapping to agreement among stakeholders highlighted the challenges faced by Aboriginal organisations to be able to commit to providing clinical training due to funding issues, infrastructure limitations and time-poor or limited number of clinicians. Through this process we were able to negotiate a 3-year student placement agreement with three Aboriginal organisations through a successful application for a federal clinical training infrastructure grant led by the Department of General Practice. This has secured a number of clinical training placements in Aboriginal health for both medical and social science students.

As there are numerous Aboriginal organisations that are unable to make an ongoing commitment but which are able to provide placements occasionally or opportunistically, the recommendation from the consultation that provided for an Aboriginal Clinical Training and Engagement Officer, beyond the life of the current project, is being progressed. Such a position allows for the maintenance of ongoing relationships between the University and relevant Aboriginal organisations, which will maximise the opportunities available to students within these services.

Successes

The recommendations that were developed by the Aboriginal community throughout this consultation reflect a general recognition that preparing a future health workforce to contribute to Aboriginal health and wellbeing whilst they are students, is beneficial. The community consultations resulted in the identification of seven main considerations and issues associated with clinical training in an Aboriginal community setting, including twelve recommendations.

What are the impacts?

The outcomes of the consultations highlighted many challenges, but also demonstrated the great potential within the Aboriginal community primary health care sector for interdisciplinary clinical training for health students from a small but highly-skilled Aboriginal health workforce. The consultations also highlighted and acknowledged the importance of the role of the Aboriginal health sector in contributing to the education of a culturally competent future health workforce.

How has the project developed Indigenous leadership?

The position of Project Officer – CRESCENT Aboriginal Engagement Project, was identified for Indigenous applicants only, which created an opportunity to develop the skills of the appointed Project Officer. By having Indigenous community members and organisations central to the process, their expertise, knowledge and recommendations will inform the entire project. The mapping exercise has ensured that the University works in partnership with the Indigenous community. Recommendations include ensuring that there is 'appropriate comprehensive training for staff involved in supervising students' and that a mechanism is set up 'that facilitates community input to the development of the clinical training curricula'. These recommendations ensure that Indigenous leadership is embedded in the model.

Program sustainability

By undertaking a comprehensive mapping and consultation process with the Aboriginal community, we envisage that we can develop a clinical placement program for Health Science students that takes into account the needs of the health services, Aboriginal community and the University. The consultation process identified sustainability as one key area for consideration. It was clear throughout the consultation that any model of clinical training for health students in the Aboriginal community would require a great degree of coordination and ongoing building and maintenance of relationships between the University and the relevant organisations. As the community-oriented clinical training model develops and evolves so, too, will the partnerships between the University and the community.

Through this project it has been recognised that not all medical and allied health students will have the opportunity to undertake a clinical placement in an Aboriginal organisation, therefore highlighting the importance of an integrated Aboriginal curriculum across courses.

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THEME: TEACHING AND LEARNING

ReALTiME for Aboriginal Health

Professor Evelyne de Leeuw and Mr Gerard Finnigan, Deakin University, Australia

Introduction

ReALTiME is the abbreviated name given to the teaching and learning approach called Reflective Asynchronous Learning 'Technologies' in Medical Education. It provides 3rd and 4th year medical students with the knowledge and skills training to treat and care for Aboriginal patients with cultural awareness, understanding and respect. The approach was designed by the staff from the 'Doctors, Peoples, Cultures and Institutions' theme at Deakin University Medical School, with technical assistance from the Deakin Knowledge Media Division.

Why was this project/program initiated?

Typically in 3rd and 4th year the responsibility for guiding and supporting student learning in Aboriginal and community health falls to clinical supervisors in hospitals, who are not always best placed or experienced enough to guide this learning. Similarly, most medical students at Deakin University undertake their 3rd and 4th year clinical rotations at great distance from the University, typically between 100–300kms away.

To overcome these challenges, ReALTiME was created and implemented to deliver a comprehensive learning package and assessment program. The content was informed by work with the local Aboriginal community and delivered with the wisdom and knowledge of Aboriginal Elders and Aboriginal Health Workers. The design enables students to progressively study the program at the time most convenient and clinically aligned with their experiences throughout 18 months of their two-year rotation, irrespective of where their student clinical placement exists.

Aims and objectives

- To deliver an education and assessment program that engages 3rd and 4th year medical students on Aboriginal health at an expert and scholarly level.
- To deliver the experience, knowledge and expertise of Aboriginal Elders and Aboriginal Health Workers to all students irrespective of the location of their clinical rotation.
- To provide flexibility for students to undertake the study when best aligned with clinical experience with Aboriginal patients.

- To provide deeper understanding and second order learning opportunities for students to appreciate essential dimensions of Aboriginal health and practice.
- To teach students the skill of dynamic reflective practice to improve their understanding, approach and clinical skills in managing Aboriginal people. (Reflection-In-Action, Reflection-On-Action and Reflection-For-Action).
- Provide repetition of reflective practice tasks to improve the skill and build confidence.

Approach to achieve aims and objectives

ReALTIME Learning Packages were created for an on-line format and consist of a suite of streamed structured video conversations ('Learning Packages') with Aboriginal Elders and health practitioners. The 30–50 minute conversations are delivered in a number of 3–7 minute clips. During the streaming of the clips key learning messages appear in a side panel and each clip is concluded with literature readings (pdf format) and access to internet resources. The total conversation ends with a downloadable 'prompts list'. Students apply the list to a case, issue, or event which they will describe and reflect on (guided by a Reflection Manual) using WikiMedia technology. This allows for constant and dynamic updates and feedback. There are three different Aboriginal health learning packages:

- The Aboriginal Hospital Liaison Officer
- Didari: Narrative Medicine (Aboriginal diabetes)
- Indigenous Men's Health (not available in 2010).

All students are required to work through every package and apply the material to real life clinical examples from their placement. Students must submit a 1000 word reflection for each package that applies the prompts, supports contentions with peer-reviewed literature and other sources and answers the question, 'what will I do next time to improve the way I care for or manage an Aboriginal person?' These submissions are part of the student's formal assessment and are graded.

Challenges

There were (and remain) some human resource challenges, in particular, if the program attempts to provide continuous student feedback on the development and progress of their reflective writing pieces. We have dealt with that through student expectation management. Another challenge was that, although there is a belief that all students are 'Gen Y' (and fully Twitter and Facebook connected), in fact many students feel overwhelmed with information and communications technology and needed encouragement to engage. We dealt with this through briefing sessions (face-to-face, on-line, and through audio and video recording). The final challenge was that many students appeared unable to engage, either intellectually or emotionally, with the task of reflection. We dealt with this by introducing reflective practice and action in Years 1 and 2 and across the curriculum, supported by a hands-on practical guidance manual.

Successes

In the first cohort completing the program in 2010, all 109 students successfully applied the skills and >80% identified ways to improve the medical management of Aboriginal people in their clinical

settings. Of the 131 students commencing in the second cohort of 2011, 87 students have completed the packages and all (100%) have identified or implemented personal actions to improve their communication, care and demonstration of cultural respect for, or on the next occasion, of treating an Aboriginal patient.

From a qualitative perspective, the feedback from the first cohort of students was overwhelmingly positive and included comments that the program contributed to their emotional and intellectual growth and they feel they would be better doctors.

What are the impacts?

While a formal evaluation of the first cohort of students is currently underway, preliminary analysis shows the program is successful at enabling students to identify ways of personally improving their communication and care of Aboriginal patients. However initial reviews of responses from those students who have completed the program from the second cohort (n=87) suggest the program shifts students to think beyond their individual practice. Over 30% of these students have individually committed to actively working within their clinical environment to either advocate and/or educate others across the health system for more culturally appropriate responses to Aboriginal people. Similarly 63% sought to actively engage with and consult Aboriginal health professionals, not only to improve the care of their patients, but out of a desire to gain greater insight and understanding themselves.

How has the project developed Indigenous leadership?

This program did not specifically aim to develop Indigenous leadership. The Aboriginal Elders and health professionals who developed the learning packages are highly regarded and respected as leaders throughout the community and sector.

Program sustainability

There is a funding commitment by Deakin University to sustain ReALTime. We would like to partner with out-of-state stakeholders and agencies to strengthen that element of our approach.

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THEME: CURRICULUM DESIGN

Managing a diverse student discomfort with an Indigenous health curriculum

Professor Dennis McDermott and Mr Dave Sjoberg, Flinders University, Australia

Introduction

Indigenous health staff members run two, half day Cultural Safety Workshops (CSW) in the first year of our medical course at Flinders University. The CSW are part of the Health Professions and Society stream.

Why was this project/program initiated?

Evaluations of our Indigenous health teaching within Medicine, Nursing, Allied Health and professional development contexts – over an 8-year period – showed that there is a spectrum of responses to Indigenous health teaching. Some students/participants were accepting and keen, while at the other end of the spectrum, some students were hostile and rejecting. We also found that inappropriate racialised comments were often made by students during Indigenous health teaching sessions, with teaching staff not feeling equipped to manage those occurrences. We decided to redevelop a cultural awareness day into Cultural Safety Workshops – separated by a month and augmented by mandatory reading responses – with the view to addressing these issues.

Aims and objectives

Our overarching aim is to create a cultural shift in the entire Faculty, to create an environment where both Indigenous students and staff feel culturally safe. The aim of the workshop is to provide a forum to unpack preconceived ideas, stereotypes and myths about Aboriginal and Torres Strait Islander peoples, in particular with regard to culture and health determinants. We hope this workshop then provides a strong foundation for subsequent teaching and learning in Indigenous health throughout the course, where racialised comments are deconstructed and Indigenous students are not expected to be experts in all things Indigenous.

Approach to achieve aims and objectives

Students come along to the workshop expecting to hear stories and learn something about Indigenous Australians. However, we have developed an approach whereby the gaze is redirected to an exploration of one's own position in the discussion of cultural identity and power balance/imbalance. The workshops are designed to engage with student resistance, by requiring students to

interrogate their resistance and confront it. Such challenging content means that teaching staff have to be skilled in managing student disquiet. We have had, therefore, to develop teaching strategies that encompass this. Workshop facilitators have a mentor, with whom they can review challenges that arose in previous workshops and devise ways in which to facilitate difficult material in a more effective manner.

Challenges

A particular resistance to these workshops arises from some students, who tend to categorise non-biomedical components of the curriculum as simply 'filler' and 'irrelevant'. This is within a context where some students also do not appreciate the necessity of an Indigenous Entry Stream, despite being seemingly accepting of other alternative entry criteria such as that for rural students.

Successes

Despite the spectrum of varying response by students, the workshops have been powerful, and we have seen shifts in students' perceptions over time, especially noticeable after they have an opportunity to apply what they learn in the workshops. For example, at the end of a semester, one student stated:

I thought it was rubbish at the time, but I now realise it's changed the way I'll be operating as a parent, with friends and family, and the way I'll practice as a clinician.

The workshops have also been the catalyst for the creation of two student groups; a 'Health and Human Rights Group' and a 'Cultural Safety Group'.

What are the impacts?

In acknowledging the existence of a spectrum of student response to Indigenous health teaching, we have developed strategies to work with resistance, rather than try to eradicate it. This has resulted in a robust teaching model that includes both Indigenous and non-Indigenous staff involvement in the workshops. We have found this model teases out the discussion from different perspectives in the same educational space. We therefore deliberately structure our speaker panels to include both Indigenous and non-Indigenous speakers. Some students have reported that adding non-Indigenous presenters allowed them to be more open, and to ask questions without fear of being inadvertently offensive.

Each year between 130–150 students participate in the workshop. Student evaluation is conducted annually, but to date student attitudinal change has not been measured. A small grant has just been won by the team so in 2012 we will explore the extent of attitudinal change that does occur as a result of participating in this workshop.

How has the project developed Indigenous leadership?

Indigenous leadership is integral to the success of this workshop, both in its development and its delivery. By inviting Aboriginal and Torres Strait Islander guests to talk with the students, as members of a panel, students get to break down their preconceived ideas and stereotypes. Following the

workshops, one student commented that, 'I never knew there were Indigenous doctors until today'. Such experiences give Indigenous people a voice to tell their own story and experiences, so they can participate in teaching the Indigenous health curriculum.

Program sustainability

Because of its challenging nature, both for students and teaching staff, the workshop is constantly being revised and changes made to improve it, taking both student and staff feedback into account. With a move to a Doctor of Medicine program pending, we are aware that new challenges may arise – advanced studies/Indigenous health research streams may require further criticality of students, who yet bring varying degrees of prior exposure to critical thinking. We are developing strategies to proactively engage with diversity through a tailored pacing of curriculum, and team innovation in pedagogy, to build both a culturally-safe teaching and Faculty environment.

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THEME: RECRUITMENT AND RETENTION

All or nothing? The value of a complete package – Indigenous recruitment and retention

Dr David Paul, The University of Western Australia, Australia

Introduction

At the University of Western Australia (UWA), the Faculty of Medicine, Dentistry and Health Sciences, via its Centre for Aboriginal Medical and Dental Health (CAMDH), has implemented a comprehensive Indigenous health strategy, one component of which is aimed at the recruitment and retention of Aboriginal and Torres Strait Islander students into the medical course.

Why was this project/program initiated?

Before CAMDH was established in 1996, there were only four Aboriginal and Torres Strait Islander students studying medicine at UWA and there only had been two earlier medical graduates, one in 1983 and the other in 1985. CAMDH staff recognised that there needed to be effective strategies implemented that would both increase the number of Aboriginal and Torres Strait Islander students entering into the medical course, and ensure students were adequately supported to successfully graduate.

Aims and objectives

CAMDH was established with three main interests: increasing the number of Aboriginal and Torres Strait Islander people in the health workforce; ensuring that all graduating practitioners are better informed and skilled so that they can work in a culturally safer manner; and, facilitating inclusive research in the area of Aboriginal and Torres Strait Islander health.

Approach to achieve aims and objectives

Recruiting, retaining and successfully graduating Aboriginal and Torres Strait Islander medical practitioners has been a key strategy to help to address the representational inequity within the health workforce. The high success in student retention and successful completion has been made possible by the preparatory pathways that students undergo to ensure that they have adequate background knowledge to succeed in the medical course. For example, the preparatory pathways are tailored to each student's particular needs and prior experience. They include utilising Open Learning orientation programs (full time bridging programs run by the School of Indigenous Studies), Pre-Medicine/Pre-Dentistry program (summer school), and enrolling in a Bachelor of Health

Science or Bachelor of Science for one or two years. In addition there is an extensive secondary schools program run in collaboration with the School of Indigenous Studies that encourages school students to consider university study and professional courses leading to a health career. This program involves school visits and three intensive careers camps at Year 8, 10 and 12, one of which is specifically focused on health careers.

Challenges

Only nine of the 71 Aboriginal and Torres Strait Islander students who entered medicine since the establishment of CAMDH had successfully completed the Tertiary Entrance Examination (renamed the Western Australian Certificate of Education in 2010) at the end of Year 12 and, of them, only four gained a place in Medicine via mainstream entry pathways. This highlights the importance of having comprehensive ways in which to support Indigenous students to prepare for entry into medical school, in addition to alternative entry options for Aboriginal and Torres Strait Islander students.

Another challenge has been to ensure students are adequately supported once they start medical school. Once students enter Medicine, CAMDH staff members provide substantial support for academic, material and personal issues. This comprehensive support is supplemented with efforts by staff from the School of Indigenous Studies.

Successes

In 2011 there were 26 Aboriginal and Torres Strait Islander students studying Medicine at UWA. There have been 21 medical graduates, along with one dental graduate, another two students studying Dentistry and 12 studying Health Science.

We have found that the strong collaboration between CAMDH and the School of Indigenous Studies, including being co-located, means that students have a much larger cohort of staff members to access for support. In addition, having a central location where all the Aboriginal programs are based on campus means that medical students are in close contact with all the other Aboriginal students on campus, which helps to ensure a more culturally secure and supportive environment for students. Integral to the successes achieved by CAMDH is the close collaboration and partnership with the School of Indigenous Studies at UWA.

What are the impacts?

The significant increase in student numbers enrolled in Medicine and the increase in graduates is one thing. Of equal importance is the excellent retention rates that CAMDH has been able to achieve for the students who have entered Medicine. In the 16 years since CAMDH was established there have been 71 Aboriginal and Torres Strait Islander students enter the medical program. 21 students have graduated, 26 students are currently enrolled, nine transferred to alternative study (Health Science), six transferred to other medical schools, four are on leave for family and other reasons and six students have left study. In other words, CAMDH has been able to achieve over 91% retention rates in the tertiary health sector for Aboriginal and Torres Strait Islander students entering the medical program.

How has the project developed Indigenous leadership?

The initiatives that CAMDH has successfully implemented have been recognised nationally and internationally via the:

- Inaugural LIMELight award for Leading Innovation in Indigenous Student Recruitment, Support and Graduation, 2007
- Premier's Award for Excellence in Public Sector Management – People and Communities: Education and Skills Development, 2005.

Program sustainability

The university's decision to move to a solely postgraduate professional degree structure has meant that CAMDH has had to reconsider its recruitment pathway strategies. As a part of this, guaranteed entry into Medicine from first year undergraduate entry has been approved for Aboriginal and Torres Strait Islander students. Alternative entry requirements have also been approved and CAMDH staff members are in the process of developing an Advanced Diploma program for students who do not have a Bachelors degree but have some relevant prior education and experience.

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APPENDIX 12: LIME GOOD PRACTICE CASE STUDY

THEME: RECRUITMENT AND RETENTION

Aspire Realise Achieve

Dr Louise Alldridge and Ms Teleah Lindenberg, Griffith University, Australia

Introduction

The full name of this project is 'Developing close relationships with local schools to increase the aspiration and confidence of Indigenous students to pursue careers in Medicine and Dentistry. Aspire Realise Achieve'. It aims to inspire local Indigenous students to consider careers in Medicine and Dentistry by bringing together Indigenous community leaders, local schools and Australian Indigenous Doctors' Association (AIDA)/Indigenous Dentists' Association of Australia (IDAA) to seed and nurture aspirations of young Indigenous people and their families.

The main objectives are to:

- establish networks and role models
- raise aspirations and confidence in Indigenous secondary school students
- raise educational outcomes for Indigenous secondary school students
- increase the uptake of Indigenous students to the Medicine and Dentistry programs.

Project Leaders:

- Dr Louise Alldridge (Senior Lecturer in Medical Education. Academic Lead in Selection and Equity, Griffith University School of Medicine)
- Mr Graham Dillon (Senior Elder in Residence, Gold Coast)
- Ms Suzanne Wilkinson (Student Equity Services)
- Mr Graham Coghill (GUMURRII Student Support Unit)
- Prof Ratilal Laloo (Professor of Rural, Remote and Indigenous Oral Health, Griffith University School of Dentistry and Oral Health)
- Dr Jane Evans (Senior Lecturer, Griffith University School of Dentistry and Oral Health).

Project Stakeholders:

- Education Queensland (Project Funders)
- Gold Coast, Logan, Beaudesert and Redlands state schools
- Community representatives: Uncle Graham Dillon, Senior Elder of the Kombumerri people

- GUMMURRI Student Support Unit
- Griffith University Medical Students and Dental Students Associations
- Student services (Student Equity Services)
- Aboriginal and Torres Strait Islander students
- External Relations, Griffith University
- AIDA
- IDAA
- HOPE4HEALTH
- Rural, remote and Indigenous oral health clinical placements.

Why was this project/program initiated?

This project was initiated due to the low participation of Indigenous students at Griffith University Schools of Medicine and Dentistry and Oral Health along with the consequential lack of Indigenous doctors and dentists in Australia. Griffith University has graduated one Indigenous doctor and currently has one Indigenous medical student. Records show there are currently 153 Indigenous doctors and 161 Indigenous medical students in Australia. This data is valid as at October 2010. Source: Medical Deans Australia and New Zealand Inc., 2010.

Aims and objectives

- To establish links with state schools in the Gold Coast, Logan, Beaudesert and Redland areas that have significant cohorts of Indigenous students, through outreach activities.
- To consult with Elders, Education Queensland, parents/carers, AIDA/IDAA and students in order to 'sow the seed' of realistic aspirations to encourage Indigenous people to consider a career in Medicine and Dentistry.
- To establish a bi-annual activities day for local Indigenous pupils and their families.
- To establish a significant presence of Indigenous medical and dentistry students along with the GUMMURRI student support unit at our official Open Day and careers markets.
- To contribute to the creation of educational opportunities for the local Kombumerri people in the spirit of their (generous) Deed of Agreement with Griffith University relating to the Smith Street lands – southern precinct, Gold Coast campus.
- Long-term goal: Improved Indigenous health and wellbeing through increased participation in Medicine and Dentistry.

Approach to achieve aims and objectives

The main strategy involves the employment of an Indigenous Outreach Officer to make contact and build relationships with schools, Indigenous students, their families and community members. In addition, we hold activities days in the Centre for Medicine and Oral Health, attend careers

markets and take part in National Aborigines and Islanders Day Observance Committee (NAIDOC) celebrations. We have identified realistic role models within the Schools of Medicine and Dentistry and Oral Health.

Challenges

The main and most important challenge is to achieve sustainability, which naturally requires continued long term funding. It is also important to ensure that addressing our social responsibility remains a priority for the University and Education Queensland. Both Griffith University and Education Queensland have strategic priorities in relation to improved educational outcomes for Indigenous students.

Further challenges involve developing strategies for engaging with 'busy' school staff and schedules to ensure access to Indigenous students and devising ways of monitoring outcomes.

Successes

Over 40 local secondary schools have been visited so far – reaching over 250 individual school students.

Critical contact has been made with over 80 school teachers, principals, guidance officers, Indigenous workers and community Elders. Close associations have now been established with 11 community groups including: Deadly Solutions, General Practice Gold Coast, Kalwun Health and Black and Deadly.

Three on-campus activities days have been held with 13 local schools participating. These days focussed on hands-on engagement and University demystification, where the students dressed up in scrubs (with masks, hats, and shoe covers) and then did a circuit of activities including baby 'resus', plastering arms, an anatomy quiz with anatomy models, dental activities with phantom heads and a simulated shark attack with 'sim man' with lots of fake blood. This is all topped off with a barbeque at our Indigenous support service.

In addition four Indigenous careers expos have been attended, each with at least 3000 Indigenous school pupils taking part. We also took part in local NAIDOC celebrations. We have recently secured top up funding of AUD \$15,000 from Education Queensland which funds the Indigenous Outreach Worker and the activities day.

What are the impacts?

We have received several testimonials from schools which have stated with enthusiasm that the activities and visits have had a positive impact on their students within the project and broadly back in the school classroom.

From Indigenous Support Coordinators commenting on the Activities Day:

The students received so much information that will guide them in making decisions for their immediate schooling as well as their future.

A fun and informative day that left a lasting memory with our students, opening their minds...

And, from a Year 10 pupil, Beenleigh State High School:

I never thought about being a doctor. I never thought I was smart enough. Now I do...

We are currently tracking some student participants and hope to continue this onto higher education. The purpose of the tracking is to determine whether students' school work improves following the activities day and also whether they go on to university. The project also has an impact on all the members of staff and students that take part. The Griffith Graduate Attributes include ensuring our graduates are 'Socially responsible and engaged with their communities' and have 'Awareness and respect for the values and knowledges of Australian Aboriginal and Torres Strait Islander First Peoples'. This project contributes to developing these attributes.

Due to the nature of targeting students early, the true success will not be evident for around three to six years when we would hope to see an increase in participation of Indigenous students in Medicine and Dentistry programs at Griffith University.

How has the project developed Indigenous leadership?

The project promotes and supports increased Indigenous leadership in academic achievement and eventually in Medicine and Dentistry. The project was developed in close association with Uncle Graham Dillon (Senior Elder in Residence), GUMURRII Student Support Unit and consulting with the Indigenous community. We continuously seek direction from Uncle Graham Dillon and GUMURRII. The project also employs an Indigenous Outreach Officer.

Program sustainability

We have recently gained further top up funding for this particular project from Education Queensland, however this pilot has inspired the Griffith University Health Group to invest in a similar project scaled up to cover the University's Health Group more broadly. The project leader and Indigenous Outreach Officer will be key participants in a working group to develop this proposal.

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