CURRICULUM DESIGN

Same words, different stories: Transferring an Aboriginal health curriculum across disciplines

Associate Professor David Paul, Mr Craig Allen and Dr Paula Edgill, The University of Western Australia, Australia

Introduction

The development and implementation of a comprehensive Aboriginal medical curriculum presents its own unique collection of rewards and challenges. Within this context, medical students are taken on a journey through Aboriginal cultures and exposed to culturally safe/secure frameworks in order to produce a better clinical experience for Aboriginal clients. The comprehensive horizontally and vertically integrated curriculum we have implemented in the medical program at The University of Western Australia has resulted in significant shifts in student-reported preparedness to practise. Based on this success in medicine, we have implemented similar Aboriginal health curricula in the nursing, podiatry and dental programs at The University of Western Australia with the aim of better preparing the students in these programs to work more effectively within Aboriginal contexts.

Why was this program initiated?

Aboriginal peoples’ health and wellbeing depends in part on the quality of the health care services people have, or choose to have, access to. Although many factors influence the utilisation of health care services, one key factor that determines whether people access services is the acceptability of that service. Given the multidisciplinary nature of the health care workforce, it is important that all practitioners have the ability to better meet the health and health care needs of Aboriginal peoples and communities. The documented success of the comprehensive vertically and horizontally integrated curriculum that the Centre for Aboriginal Medical and Dental Health staff developed and implemented in the medical curriculum, and the presence of five other health disciplines within the Faculty of Medicine, Dentistry and Health Sciences, provided the opportunity to trial the applicability and relevance of a similar curriculum in those other disciplines.

Aims and objectives

1. To have a health workforce that is better prepared and better able to meet the health and health care needs of Aboriginal peoples and their families and communities.

2. To test the transferability of a comprehensive Aboriginal health curriculum developed for an undergraduate medical program into other health disciplines.
3. To identify the customisation required in a comprehensive Aboriginal health curriculum for it to be effective in other disciplines.

4. To determine if a common Aboriginal health curriculum is feasible for different health discipline courses.

**Approach to achieve aims and objectives**

The lessons learned within the medical school context provided a useful starting point to reflect on what is required to create shifts in the other health professional courses within the broader faculty. The introduction of two new health professional courses within the faculty, nursing science and podiatric medicine, provided the opportunity to embed Aboriginal health teaching and learning from the beginning. The existing curriculum that was mapped to year level and graduate outcomes in the medical course provided a template for the year and graduate outcomes for the new courses. Once there was agreement on how the template was to be implemented, it was possible to structure the Aboriginal health curriculum for each discipline, drawing on the content and approaches already successfully implemented in the medical course but customised for each. This customisation was particularly relevant given the different structure of each course, the differences in each student cohort and the cultures of each discipline.

**Challenges**

Evolving a curriculum in partnership with others within the medical course has led to the development of longer-term collaborative partnerships with colleagues who have developed a shared commitment and ownership of the Aboriginal health curriculum initiatives and their continuity. The development and implementation of similar curricula in each of the new courses has been different and raises questions of process and outcomes and how they impact on the quality of the experience for us as educators. Establishing and reinforcing the leadership role that Aboriginal health academics have in this field can, at times, challenge the hierarchical structures within academia, as well as the autonomy of unit co-ordinators. Negotiating the potential issues around territory, authority and expertise with new cohorts of colleagues is time consuming and can feel repetitious. Enthusiastic inclusion of content without the associated partnership and collaboration, and subsequent ownership, can result in an all-too-frequent and unsatisfactory guest lecture feeling. In other words, integral but not integrated – appearing slightly out of context and not perceived to be the main game by students.

Obvious challenges that needed to be negotiated as we engaged with academics new to Aboriginal health ranged from containing enthusiastic paternalism through to educating the naive. Content, and its ease of transferability, can be the least relevant issue to address when relationships and partnerships that we had taken as given in one course have to be negotiated, nurtured and built in new courses.

**Successes**

There are now nine years of end-of-course evaluation for the medical course but only two years for nursing and podiatry programs. Although we have a number of years of evaluation data for the dentistry program, we have not been able to implement a comprehensive across-the-course Aboriginal health curriculum.
By the end of 2011, seven cohorts of students who undertook a course-long Aboriginal health curriculum had graduated from the medical course and two cohorts of students had graduated from the podiatry and nursing courses.

The longer-term aim is to have a better-informed health workforce that respects Aboriginal knowledge and leadership, and is able to work in partnership with Aboriginal practitioners, patients and communities. Demonstrating that achievement, beyond the anecdotal, will require substantial further research looking at student and graduate preparedness to practise, as well as patient satisfaction and, in the longer term, shifts in patient outcomes.

What are the impacts?

In 2003 the Centre for Aboriginal Medical and Dental Health staff developed, in collaboration with the Faculty Education Centre, an Aboriginal health evaluation tool that was designed to assist with monitoring the effectiveness and utility of the Aboriginal health curriculum initiatives we were implementing. This tool has been validated and is now used across all the health courses that we teach into. We have done some early comparison of the evaluation data across the different disciplines but due to relative low numbers of students in some of the courses, as well as low participation rates in the evaluation process for some courses, we have not been able to complete a comparative analysis of the data yet. We hope to be able to do this over the next year. However, the nine years of data that we have, which evaluate final-year medical students, show a very substantial shift in student-reported preparedness in relation to Aboriginal health and health care. Table 1, from unpublished Year 6 Aboriginal Health Evaluation Reports from the Faculty of Medicine, Dentistry and Health Sciences, indicates this shift.

Table 1: Medical student perceptions of Aboriginal health preparedness to practise

<table>
<thead>
<tr>
<th>Skills in Aboriginal health</th>
<th>Yr 6 – 2003 Mean &amp; % agree</th>
<th>Yr 6 – 2004 Mean &amp; % agree</th>
<th>Yr 6 – 2005 Mean &amp; % agree</th>
<th>Yr 6 – 2006 Mean &amp; % agree</th>
<th>Yr 6 – 2009 Mean &amp; % agree</th>
<th>Yr 6 – 2010 Mean &amp; % agree</th>
<th>Yr 6 – 2011 Mean &amp; % agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communicate appropriately with Aboriginal people</td>
<td>3</td>
<td>29</td>
<td>3.61</td>
<td>58</td>
<td>3.65</td>
<td>56</td>
<td>3.75</td>
</tr>
<tr>
<td>Apply knowledge of Aboriginal Health to provide culturally secure health care</td>
<td><strong>2.65</strong></td>
<td><strong>14</strong></td>
<td>3.55</td>
<td>62</td>
<td>3.88</td>
<td>78</td>
<td>3.88</td>
</tr>
</tbody>
</table>

* Note, participation rates in 2007 and 2008 were too low to be reliable so are not included. Mean from a 5-point Likert scale.
How has the program developed Aboriginal leadership?

The Centre for Aboriginal Medical and Dental Health is Aboriginal led and the programs are developed and implemented by a team of Aboriginal and non-Aboriginal health academics. The Centre provides the opportunity for graduates to engage in and inform the academic realm and seeks to further build the capacity of the health and academic sectors.

What’s next? Program sustainability

Increasing teaching into more courses and more units within the respective courses is demanding in terms of time, energy and emotions. Ensuring that workloads do not increase beyond capacity is an ongoing issue that needs to be addressed. Although the framework of the Aboriginal health curriculum can be used to guide implementation in other disciplines, the particular cultures, expectations and contexts of each discipline mean that there is an ongoing challenge to customise content, expectations, and processes of delivery and assessment to reflect this.

For further information, contact:

**Associate Professor David Paul**  
Centre for Aboriginal Medical and Dental Health  
Faculty of Medicine, Dentistry and Health Sciences  
The University of Western Australia  
**E:** david.paul@uwa.edu.au