Presentation Abstracts

LIME Connection II

Prof. Ian Anderson Professor, Indigenous Health Director Centre for Health & Society and Onemda VicHealth Koori Health Unit, University of Melbourne Research Director CRC for Aboriginal Health	Examining the Medical Workforce Over the last decade there has been an increasing focus nationally on the development of a workforce that is better equipped to deliver quality and effective health services to Indigenous Australians and contribute to the development of strategies as well as an engagement across a number of health disciplines. Here I want to focus on medical workforce development and provide a context for work that is currently being developed under the auspices of the Medical Deans of Australia and New Zealand. In particular I want to focus on the development of the Leaders in Indigenous Medical Education Network and the development of the quality agenda in medical education in relation to Indigenous health.
Mr. James Andrew Aboriginal Programs Coordinator, Faculty of Medicine, University of British Columbia	Increasing the number of Aboriginal Physicians through facilitated Admissions & Preadmissions Programs Why we did the work: To meet the needs of the Aboriginal communities. What we did: Developed and implemented an admissions policy for Indigenous students into medical school in 2001, and an Indigenous preadmissions program to help facilitate the policy in 2002. The faculty has committed 5% of its annual complimented seats to qualified Indigenous applicants. The admissions policy has been supported by our university senate. Aboriginal preadmissions program accommodates up to 20 students each year. What we found and what we learned: Our enrolment has increased significantly over a 5 year period. Went from 2 students to 21 students. Learned to respond to our critics. How was the Aboriginal community involved? Consulted the Aboriginal community to assist in the development of the policy and the preadmissions program. The faculty also has its own Aboriginal admissions selection committee to assist with its Aboriginal selections. How will this information be used to inform policy and practice? It will help to provide other medical schools the tools and lessons learned to implement their own policy and programs.

	Implications for stakeholders and future directions: Will help to increase the number of Indigenous physicians in Aboriginal communities. Other Canadian medical schools are using us as a model.
Ms. Petah Atkinson Koori Health Project Officer, Koori Health Team, School of Rural Health, University of Melbourne	Cultural Safety Workshop Why we did the work: Cultural safety requires health professionals to acknowledge their position of power, reflect on their judgements and communication styles, and be proactive about providing a safe service. What we did: Developed a one day interactive workshop that explores Cultural Safety issues with medical students. What we found and what we learned: That Medical Students generally had very little knowledge of cultural safety and/or Aboriginal Health. Many had rarely met an Aboriginal person/patient. How was the Aboriginal community involved? The Aboriginal community has been involved in the initial development and in the current provision of the Cultural Safety Workshop. How will this information be used to inform policy and practice? It is being used to further develop Aboriginal health into the medical curriculum. Implications for stakeholders and future directions: This is an area of curriculum that is deficient and requires further development and resources in order to integrate Cultural Safety into the general curriculum. Co-Author: Michael Tynan, School of Rural Health, The University of Melbourne, Strategic Planning & Policy Unit, Shepparton, Australia
A/Prof. Amanda Barnard Assoc. Dean, School of General Practice, Rural and Indigenous Health, Australia. National Univeristy	Partnerships and Placements – Vertical Integration in Clinical Learning Why we did the work: Establishment of the Australian National University Medical School with its emphasis on incorporating all elements of the Indigenous Health Framework into its curriculum, and its focus on a community based clinical experience in year 3, combined with the fact that ANUMS holds the contract for GP registrar education in the region, and established good relationships with Winnunga Nimmityjah, provided an opportunity for the organisations to work in partnership. What we did: A committee representing all stakeholders involved in delivering Indigenous health training and clinical placements for medical students

	and GP registrars in the ACT and SENSW was convened. Meetings were held at Winnunga Nimmityjah. Issues, challenges and 'dreams; were all discussed, and collaborative decisions on optimal training and clinical placements were made. What we found and what we learned: • That we shared common goals, and that there was enormous goodwill shared. The challenge lies in sustaining this. • That a variety of clinical placements needed to be established according to all stakeholder needs and capacity • ANUMS infrastructure support of long term placement in year at Winnunga, was critical, and that students and staff valued the longer term attachments. • Student interest and enthusiasm could be supported, without unduly stretching resources or capacity • Integration of distance academic support for students and was possible but one of the most challenging issues How was the Aboriginal community involved? The Aboriginal community are the key stakeholders, and all planning meetings held at Winnunga with representation from the organisations. Aboriginal health workers are involved in teaching of students. How will this information be used to inform policy and practice? The structure and support of clinical placements for medical students and GP registrars is based on this information, and reviewed through regular meetings. Implications for stakeholders and future directions: There should be further work in clarifying roles and relationships, possibly in the form of an MoU, and ensuring ongoing strength of partnerships. Co-Authors: Jennifer Thomson & Peter Pinnington, School of General Practice, Rural and Indigenous Health, Australian National University
Ms. Johanna Barton Rural Eye Manager, Dept. of Opthalmology, Prince of Wales Hospital	Rural Culture is One Why we did the work: In recognition that Registrars who work in Aboriginal rural communities require to work in a safe cultural practice. What we did: Contact Ms Louise Brown at Bourke Hospital to arrange suitable program. Louise has a package/ video for staff. What we found and what we learned: Specialist outreach services have been developed to compensate for the lack of specialists practicing in rural and remote areas. Sustainability depends on an adequate specialist base, integration with remote communities

How was the Aboriginal community involved?
Involvement of the local Aboriginal community was identified immediately as crucial to the success of the service. Ms Louise Brown works at the Bourke Hospital. Part of this position is to deliver understanding of Indigenous culture.

How will this information be used to inform policy and practice?
Working with policy makers from the ground up will ensure that the implementation of a service is the one most suited to the community.

Implications for stakeholders and future directions:
In rural and remote communities outreach, sustainable specialist's services are essential and need to be an accepted part of normal practice. With a greater understanding let us strive to improve holistic outcomes for the Aboriginal population.

Co-Authors:
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A/Prof. John Broughton

Snr. Academic,
Dunedin School of Medicine,
University of Otago

Ka pai tena: Maori health in the Undergraduate Medical & Dental Curricula. Experiences from Otago Univeristy

Why we did the work:
To incorporate a hauora Maori (Maori health) component into the undergraduate Medical and dental curricula.

What we did:
The Maori health component of the undergraduate curriculum was developed following a review in 1988 which recommended the establishment of a lecturer in Maori health.

What we found and what we learned:
The experiences of Maori health teaching had a variety of responses from good to unfortunately, bad. A number of strategies were developed to overcome what negativity there was such that now, two decades later, hauora Maori is a naturally accepted part of the curriculum.

How was the Aboriginal community involved?
Maori were part of the 1988 review Board and were actively involved in the development, content and delivery of the Maori health curriculum.

How will this information be used to inform policy and practice?
The experiences are considered in the development of the new undergraduate Medical and dental curricula.

Implications for stakeholders and future directions:
Shared experiences of the past provide a means of ensuring that future development and delivery of Indigenous health beliefs and practices can be achieved in a non-threatening and all-embracing environment.

Mr. Tom Calma Acting Race Discrimination Commissioner ATSI Social Justice Commissioner & Human Rights and Equal Opportunty Commission	The Indigenous Health Curriculum in Australian Medical Schools Indigenous peoples' health status in Australia is significantly poorer than that of the non- Indigenous population; of note, there is a 17-year gap in life expectation between the two groups. In his 2005 Social Justice Report, Commissioner Calma recommended that the governments of Australia commit to achieving equality of health status and life expectation between Indigenous and non-Indigenous Australians within 25 years. In order to achieve this goal, governments need to commit to Indigenous peoples' achieving equal access to primary health care and health infrastructure within 10 years; and to fund programs based on need. Training a health workforce to work in primary health care – a workforce that understands Indigenous health problems and is comfortable working with Indigenous peoples – is a vital part of this plan. In 2004, the Medical Deans of Australia and New Zealand with Gregory Phillips finalised an Indigenous health curriculum framework for Australian medical schools, and the Australian Medical Council linked the accreditation of Australian medical schools to their implementation of the curriculum. Commissioner Calma surveys the implementation of the curriculum noting the wide variance in its adoption between Australian medical schools. He proposes the adoption of targets and deadlines to ensure its adoption by all Australian medical schools as soon as possible.
A/Prof. Marlene Drysdale Head Indigenous Health Unit, Dept. of Rural & Indigenous Health, Monash University	Telling them 'You Can Do It': Recruiting and Retaining an Indigenous Health Workforce
A/Prof. Jacinta Elston Assistant Dean Indigenous Health, Faculty of Medicine, Health & Mocular Sciences, James Cook University	Strong Murri Medical Students – the James Cook Univeristy Experience With our move to establish a new Medicial School in the late 1990's we articulated our intention to establish a program which activitely seeks to engage and retain Aboriginal and Torres Strait Islander students in our program. Almost a decade on, we reflect on our performance and experience, unpacking the enablers and barriers to successfully recruiting and retaining Aboriginal and Torres Strait Islander people in our program. Our experiences may provide opportunities for colleagues and stakeholders to strengthen their own capacities in this area, and from our collective experiences and knowledge new policy imperatives could develop. Co-Authors: Val Alberts, Yvette Roe & Richard Murray, James Cook University
Ms. Sally Farrington Acting Head & Coordinator of Support,Faculty of Health Sciences, Yooroang Garang	Facilitating Access, Retention and Success for Indigenous Students in Health Sciences Why we did the work?

Whilst the number of Aboriginal and Torres Strait Islander students in higher education in Australia has improved in recent years, their attainment and participation continues to be lower than that of other Australians (AIHW, 2005). We felt there was a real need to get behind these statistics at a local level and explore the factors that influence progression and retention of Indigenous health sciences students.

What we did:
We completed a qualitative study of students' experiences during their studies at the Faculty of Health Sciences.

What we found and what we learned:
The research findings highlighted the factors which facilitated or challenged Indigenous student access, success and retention at the Faculty of health sciences.

How was the Aboriginal community involved?
In this research the community was defined as the staff and students of Yooroang Garang and the research arose from staff concerns about student success and retention.

How will this information be used to inform policy and practice?
The findings of this study have informed policy, curriculum and program changes in programs which support Indigenous students at the faculty of health sciences.

Implications for stakeholders and future directions:

Co-Author:
Susan Page, Faculty of Health Sciences, Yooroang Garang

Dr. Eleanor Flynn

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Medical Education Unit,
University of Melbourne

Working with Indigenous Simulated Patients in Extended Communication Skills Workshops

Why we did the work:
We wanted to help senior medical students understand the important issues for urban Indigenous patients with a chronic disease, in particular how to work with patients who are unhappy with the health service. These sessions occur at the beginning of a 6-week rotation covering chronic disease and community services including teaching sessions on communicating bad news and illness trajectories.

What we did:
We worked with Indigenous and non-Indigenous staff (academic and professional), and Indigenous actors to develop the scenario and the issues covered in the tutorials. We then trained several Indigenous actors and other persons to be the "patient" in a communication skills tutorial where a patient is concerned about the conflicting information he or she had obtained about his/her diabetes and about the problems attending all the "necessary" clinics.

What we found and what we learned:
When the Indigenous simulated patients were "on song" the session went very well with the students being challenged to work with the

patient to come up with practical responses to the problems. When the patient was not comfortable, or was late, or the facilitator was too dogmatic then the students did not engage well and did not learn anything about the extra problems that urban Indigenous people might face in managing chronic disease.

How was the Aboriginal community involved?
The Aboriginal community was involved by helping to develop the story and issues for the patient and all the simulated patients for this teaching session are Aboriginal.

How will this information be used to inform policy and practice?
By continuing to develop the material in the teaching session, by working more directly with the Aboriginal community to discover and train more simulated patients for the teaching sessions and by developing assessments to match the teaching, working with Indigenous persons to be part of the assessment.

Implications for stakeholders and future directions:
Involvement of Aboriginal community members both in curriculum development and in direct teaching of medical students.

Co-Authors:
Shaun Ewen & Jenny Schwarz, University of Melbourne

Ms. Maggie Grant

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Teaching Best Practice in Indigenous Helath – Culturally and Technically Safe Practice

Why we did the work:
A primary concern of medical schools is that there is a culturally safe environment for Indigenous students and staff. Another concern is encouraging non-Indigenous students' knowledge of and interest in Indigenous health and this often involves facilitating exploration of their own personal beliefs. In practice, there may be considerable tension between these two concerns.

What we did:
We have been increasing the amount of Indigenous health teaching in medicine and other professional programs. As a result the volume of classroom discussion on Indigenous health has increased. We have explored ways of creating an environment in which issues can be openly explored and myths de-bunked, while at the same time creating a culturally safe environment for Indigenous students.

What we found and what we learned:
Managing classroom dynamics requires considerable organisational commitment and skilled teachers. Some teaching methods seem to be associated with better outcomes. However Indigenous staff may require considerable collegial support in these settings. Other staff need greater training in understanding Indigenous issues in general, to increase their knowledge of best practice medicine in Indigenous settings and to manage classroom dynamics.

How was the Aboriginal community involved?
This has been a teaching methods issue for staff and has involved intense discussion led by JCU's Indigenous Health Unit.

How will this information be used to inform policy and practice?
Through exchange of ideas through publication and conferences and as a part of staff development processes at JCU.

Implications for stakeholders and future directions:
With potentially increased enrolments of Indigenous students, stakeholders need greater awareness of the tension between allowing all students opportunities to explore attitudes in depth and cultural safety for Indigenous students.

Co-Author:
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Dr. Lisa Jackson Pulver

Associate Professor,
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Presentation 2: Barawul Yana: Better Strategies for the Recruitment, Retention and Support of Indigenous Medical Students – a UNSW Project

Why we did the work:
The University of New South Wales, as part of a research consortium with Monash University and James Cook University, undertook a project to look at opportunities for and barriers to Indigenous student entry to medical education. The UNSW project component identified the high school years as an important window of opportunity for encouraging and supporting the retention of Indigenous students through to tertiary education in medicine and other health programs.

What we did:
A core component of the UNSW research was to examine the role of university based health career residential programs in facilitating the entry of high school students into higher degrees and to understand what factors impact on student choices. This was achieved through face-to-face and telephone interviews with a number of key stakeholders and informants.

What we found and what we learned:
We found eight broad thematic areas raised by the research including, the multiple pathways students use to enter university; the influence of positive Indigenous role models; the tension experienced between being both academic and Indigenous; widespread concerns with perceptions of a stigma attached to Indigenous or special entry status; the importance of both a supportive family and culturally safe encounters with educational environments to career progression; the importance of career advisor and teacher expertise in dealing with Indigenous students and their life contexts; and the importance of encouraging Indigenous ‘visibility’ with a culture of success and achievement. What we learned was that Indigenous specific residential health career programs are a highly successful strategy for encouraging recruitment and support for higher education careers in health.

How was the Aboriginal community involved?
The Muru Marri Indigenous Health Unit and the Nura Gili Indigenous Programs at the UNSW, together with the Rural Clinical School as part of the investigating team, provided the important contacts with students and other community members. Appropriate ethical approvals were sought and gained.

How will this information be used to inform policy and practice?
The Indigenous specific residential program model that is described in this research, we believe, constitutes ‘best practice’ in Indigenous

student recruitment and support for careers in medicine and health. It is recommended that the university sector nation-wide endorse, develop, and where necessary, adapt this model of Indigenous student recruitment and support for promoting careers in medicine and other health professions.

Implications for stakeholders and future directions:
We are proposing that a partnership be established between Indigenous, educational and university sector stakeholders to address barriers to the successful promotion of health careers to Indigenous students. Some future directions include piloting of career advisor and teacher training – within a health status framework. Further, more cooperative work is needed around student attainment of the core skills needed to develop an appropriate academic/science language base for degrees in higher education, in particular, the health sciences.

Co-Authors:
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Embedding Indigenous Health Within a New Medicine Program

Why we did the work:
In 2004, the UNSW Faculty of Medicine introduced a major change in the pedagogy and structure of its curriculum, becoming one that is outcomes-based with a strong alignment between eight graduate capabilities and the curriculum's learning activities and assessments. Learning in Indigenous health is addressed throughout the program and is particularly represented in the capability: Social and Cultural Aspects of Health and Disease.

What we did:
Learning in the new program is based around health scenarios which aim to provide a broad context for students to understand the biomedical, psychosocial and clinical features of health and disease. Examples of scenarios which provide a context for students to learn about Indigenous health will be shown.

What we found and what we learned:
Students report a high level of satisfaction with learning in health scenarios. Assessment methods including individual assignments, group projects and written examinations demonstrate that students acquire an awareness and appreciation of Indigenous health from different perspectives.

How was the Aboriginal community involved?
The Indigenous Health Unit within the School of Public Health & Community Medicine contributed significantly to the development of health scenarios. Members of the local Aboriginal community have also contributed directly through presentations to students.

How will this information be used to inform policy and practice?
Continuous evaluations provide feedback for ongoing improvement in curriculum delivery.

Implications for stakeholders and future directions:
It is expected that this approach to learning will enhance students' appreciation of Indigenous health and influence their clinical practice.

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Dr. Martina Kamaka

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Cultural Competency Training: Efforts at the University of Hawaii John A. Burns School of Medicine (JABSOM)

Why we did the work:
Native Hawaiians suffer the worst health disparities in Hawaii. Efforts at the Department of Native Hawaiian Health (DNHH) at JABSOM have focused on recruitment and retention of Native Hawaiian students as well as the development of a cultural competency curriculum incorporating lecture, workshops, PBL cases and cultural immersion. The latter efforts were also encouraged by the school as a result of curricular changes and federal requirements.

What we did:
The DNHH has done the following:

- assisted in developing a Native Hawaiian family stream throughout first year PBL units.
- designed lectures and workshops on culture and medicine.
- developed cultural immersion weekends for first year medical students and family practice residents.
- developed first and fourth year electives in Native Hawaiian Health.
- held focus groups with Native Hawaiian (NH) patients, students and physicians to discuss medical training.
- developed a retention program for 1st and 2nd year Native Hawaiian and Imi Hoola students.
- addressed increasing recruitment of NH physicians through the Imi Hoola post baccalaureate program.

What we found and what we learned:
Data from focus groups was used to develop components of the immersion weekend, workshop and the PBL case revision. Retention efforts have resulted in improved national exam pass rates.

How was the Aboriginal community involved?
The department has actively worked with Native Hawaiian community groups, institutional review boards, health care systems/centers and traditional healers and cultural practitioners in our research and educational endeavors. (Cultural training initiatives were requested by community).

How will this information be used to inform policy and practice?
Evaluation results of curricular components will be used to improve and modify the curriculum. Institutionalisation of components (ex: the immersion weekend is currently grant funded), will be dependent on results showing efficacy.

	Implications for stakeholders and future directions: More NH physicians as well as an effective “cultural competency” curriculum in the medical school should help decrease health disparities.
Dr. Ursula King Population Health Scientist, Coordinator Indigenous Health Strategy, Graduate School of Medicine, University of Wollongong	All Together Now: The Central Importance of Developing Cultural Competency Why we did the work: Recognised that, as a new regional medical school, there was an opportunity to develop cultural competency of all staff (academic and general) at inception. This was based on the premise that only a whole of school approach, starting with a self-reflective and supportive process of engaging with Indigeneity and Indigenous health issues, would enable a strong foundation on which to build an Indigenous health program within and across all of the Graduate School of Medicine’s (GSM’s) activities. What we did: In partnership with UoW Indigenous academics and local AMS networks, developed an introductory Indigenous health and cultural safety staff development workshop for all GSM staff. The GSM Executive supported compulsory attendance, and incorporation of this workshop into the Faculty Development Program as a formal learning module to ensure its continuation. What we found and what we learned: Leadership from the GSM Executive was critical to ensuring that GSM staff were aware of the central importance of ‘being on the same page’ regarding an understanding of Indigenous issues. A partnership approach to preparing and delivering the workshop established important links with local Indigenous knowledge and experience, and demonstrated the benefits of an open and collaborative process. How was the Aboriginal community involved? Through a partnership process as described above. How will this information be used to inform policy and practice? By acknowledging the vital importance of supporting the development of a culturally competent mind set amongst those with the responsibility for developing, delivering and evaluating medical school curriculum. Implications for stakeholders and future directions: Strategic importance of a partnership approach through early and ongoing engagement with local Indigenous networks, and working with this to develop strategies that ‘maintain the momentum’ Co-Authors: Miriam Cavanagh, Graduate School of Medicine, University of Wollongong

Dr. Kelvin Kong

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Ms. Lousie Lawler

Lecturer,
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Growing Our Own – Nurturing Indigenous School Students into the Health Professions

Why we did the work:
Remote and rural Australia is in the grips of a health workforce crisis that will predictably deteriorate over coming years. To combat this, initiatives have been undertaken to encourage rural youth into health professions. Yet Indigenous students are less inclined to take advantage of these opportunities than their non-Indigenous counterparts. Simultaneously, universities actively seek Indigenous students for all health courses. This study has uncovered some reasons for these discrepancies.

What we did:
A research program, under the auspices of the Rowan Nicks Russell Drysdale Fellowship, through Sydney Universities Faculty of Medicine, has been exploring issues that disengage Indigenous students from school. An unintended consequence of this program had discovered many junior high school students with desires to pursue professional careers, but who have no one to motivate and direct them through their secondary school years. Subsequently many become caught up in the social distractions of late adolescence and lose sight of their goals. These children are now being identified and linked to staff in the School of Rural Health and other health professionals in modified and informal mentorships.

What we found and what we learned:
The study found that for many Indigenous students school can be an alien environment and fails to connect them to the future world of work. Another frequent disadvantage is the lack of knowledge and experience of the professional working world, which denies them access to parental or other family experience. The study found that by linking students to a professional a relationship can develop that not only provides the information regarding health professions but provides the student with encouragement and motivation when distractions arise. The program has only been running for 2 years so no definitive results are available however there is some evidence to suggest that the mentor relationships are having a stabilizing and motivating effect on most students.

How was the Aboriginal community involved?
The program has an Indigenous advisory board and works closely with local Indigenous agencies such as the Aboriginal Medical services and Employment Strategy. Parental and family support is crucial to the success of the program. In 2007, Federal funding has been attracted for a regional roll-out via the Indigenous Coordinating Council and an Aboriginal Coordinator has been employed to work exclusively with the students.

How will this information be used to inform policy and practice?
This program outlines a strategy that health professionals can personally utilise to attract and nurture Indigenous people into the health professions.

	Implications for stakeholders and future directions: In order to ensure Indigenous students are available to enroll into health courses including medicine, work has to commence at a community level in the early years of secondary school if not before. This program is now funded to expand across western NSW which will enable students from many schools the opportunity to grow under the nurturing care of a health professional.
Dr. Helen Milroy Associate Professor and Director, Centre of Aboriginal Medical and Dental Health (CAMDH), University of Western Australia	Presentation 1: Indigenising Medical Schools Presentation 2: Examining Culture & the Medical School Experience The Centre for Aboriginal Medical and Dental Health at the University of Western Australia has been working over the past 11 years implementing recruitment, retention and support programs for Indigenous medical students as well as developing and teaching a 6 year integrated curriculum in Indigenous health within the Faculty of Medicine, Dentistry and Health Sciences. So often the student feedback indicates that teaching such a holistic model of health and wellbeing is 'good medicine' for everyone yet there remains significant resistance to adequately resourcing and expanding our programs. Recruiting and graduating Indigenous medical students also contributes to a cultural shift within the medical school environment and offers a unique source of feedback for both general and Indigenous health curriculum. Many lessons have been learned along the way and this paper will reflect on the success and difficulties in maintaining the focus and continuing to build the profile of Indigenous issues within the Faculty. Potential strategies for building on success whilst maintaining the cultural grounding and security of our programs will be discussed.
Ms. Lin Oke Chair, Koori Occupational Therapy Scheme	The Koori Occupational Therapy Scheme (KOTS) – First Steps Towards Devleoping and Indigenuos Occupational Therapy Workforce Why we did the work: Occupational therapy is concerned with the promotion of health, wellbeing and participation in everyday life. It aims to address barriers to individuals and communities participating in daily activities, as a result of experiencing illness, disability or disadvantage. It has been shown that Indigenous health services are best controlled and delivered by Indigenous health professionals (AIDA, 2005). However, less than 0.1% of the occupational therapy workforce identify as Indigenous Australians (Lowe & O'Kane, 2004). Additionally, anecdotal information suggests that availability of occupational therapy services within Aboriginal controlled health services is limited. What we did: A group of Victorian occupational therapists have formed the Koori Occupational Therapy Scheme (KOTS). This group aims to increase understanding and competence within the occupational therapy practitioner and academic ranks regarding Indigenous health and to advocate for increased support for Indigenous students to complete occupational therapy training. What we found and what we learned: KOTS has been meeting for 18 months and has representatives from occupational therapy academics, managers and practitioners. The group has undertaken a number of key activities so far. These include the production of an information pack for occupational therapists regarding Indigenous health issues; promoting OT to Indigenous high school students at career events; liaison with Indigenous high

	school students to arrange work experience placements; and fundraising activities with a view to providing scholarships for Indigenous students in the future. How was the Aboriginal community involved? KOTS was established, and operates, with guidance from colleagues at the Victorian Aboriginal Community Controlled Health Organisation and other Indigenous health professionals. How will this information be used to inform policy and practice? It is anticipated that the activities of KOTS will influence policy and practice within the occupational therapy profession at both academic and practitioner levels. Implications for stakeholders and future directions: Future directions include the establishment of a scholarship providing both academic and financial support; exploring the Indigenous health content of occupational therapy curricula; and the development of culturally relevant and appropriate resources for occupational therapy faculties, practitioners and for potential Indigenous students. Co-Authors: Tamar Paluch & Naomi Priest, KOTS; Glenda Thorpe, VACCHO
Prof. Papaarangi Reid Associate Professor, Faculty of Medical and Health Sciences, University of Auckland	Presentation 1: Indigenous Health is Every Doctor's Business Presentation 2: Super Maori or Super Doc – the Indigenous Medical Graduate of the future Presentation 1: Indigenous health intersects the business of medical training in numerous places and levels and yet some institutions, communities, staff and student bodies are still challenged to progress Indigenous health beyond lip service. What if things were different? What would it take? What barriers stand in the path of Indigenous health rights being met and who must take initiative and responsibility to address these issues? Seven simple steps to progress Indigenous health are discussed as well as seven serious challenges for the future. Presentation 2: A survey of Maori doctors in 2000 noted that many wanted to strengthen skills in Maori language and participation in cultural activities and that providing training and support in this area was seen as a priority. There is a need to contextualise this finding as subsequent opportunities for support have had variable levels of engagement. However, a tension has developed as to whether Indigenous doctors need to be cultural experts as well as competent medical graduates. This tension is teased out in an attempt to describe the ideal Indigenous medical graduate of the future.
Ms. Bhavini Patel Director of Pharmacy, Royal Darwin Hospital	Sharing the True Stories. Work with NT Clinical School Sharing the true stories is a project, which has focused on identifying and addressing barriers to effective communication between Aboriginal client groups and health staff in renal and hospital services in the Top End of the Northern Territory (NT). Stage 1 of the study, conducted in 2001, found that lack of shared understanding and miscommunication between health staff and Yolngu patients, a subset of Aboriginal patients accessing renal and hospital services in Darwin, seriously limited the patients' capacity to make informed

choices about their health care and limited the ability of the health professionals to deliver effective services. From the outset Yolngu co-researchers insisted upon a model of communication, which asserted that the effective use of interpreters entailed creating shared understanding of biomedical and Yolngu concepts to be achieved outside of and prior to the clinical encounter.

Stage 2 of the action research project conducted between 2002 and 2005, implemented and evaluated strategies to improve communication between health staff and Indigenous clients in renal and hospital services in Darwin, and in a number of remote communities in Arnhem Land. One of key focus areas for stage 2 of the project was to improve communication practices of both health staff and patients and promote the use of interpreters within the health system. This paper will discuss the focused and on-going work undertaken with the NT Clinical School (part of Flinders University) and the Charles Darwin University Pharmacy curriculum development committee to integrate concepts of cultural safety and develop the knowledge, skills and attitudes for undergraduate health students to facilitate transcultural practice.

Dr. David Paul

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Making a Difference: Changing the Health Workforce

Presentation 1: Making a Difference: Changing the Health Workforce

Why we did the work:
Acceptability is a key factor that determines access to health care services. In developing and implementing a comprehensive, vertically and horizontally integrated curriculum our aim has been to contribute to: the creation of a culturally secure health workforce; developing a safer learning environment; and, increasing the number of Aboriginal people in the health workforce.

What we did:
From 2000 we have progressively implemented an Aboriginal health curriculum across the six year medical course. This has included developing curriculum content; year and graduate outcomes; and, developing an evaluation tool to assess the impact of the changes. The Aboriginal health content in Medicine has increased from less than 3 hours over six years to core content of 40 hours for every graduate and up to 150 hours if students take all the option units offered. We have also developed an Aboriginal health specialisation within the MBBS program for those students who undertake a required number of learning opportunities in Aboriginal health additional to the core curriculum content.

What we found and what we learned:
That an integrated, stepwise, course long, Aboriginal health curriculum can produce substantial shifts in knowledge, attitudes and skills based on a self reported evaluation of students. However it is an intensive process that requires adequate resourcing, experienced staff and a collaborative partnership with the Aboriginal support unit on campus and with other academics within the faculty.

How was the Aboriginal community involved?
The majority of the staff of the Centre are Aboriginal and the curriculum has been developed by those staff members in collaboration with staff of the School of Indigenous Studies. The majority of the teaching is done by Aboriginal staff and Aboriginal community members.

How will this information be used to inform policy and practice?
This work shows what can be achieved given basic resources, the right content and context, staff and effective partnerships. Based on this experience we have begun to implement a similar curriculum in the Dental School at UWA and commenced the process for Health

Science and Podiatry. We have also shared our evaluation tool with a health course at another university. Implications for stakeholders and future directions: Sustainable success is dependent on appropriate resourcing, strong partnerships and adequate staffing levels.

Co-Authors:
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Mr. Peter Pinnington

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Australian National University Medical School (ANUMS) Indigenous Health Curriculum Implementation

Why we did the work:
The ANUMS has had a commitment to include Indigenous health curriculum since its inception in 2004.

What we did:
The ANUMS established the Aboriginal Health Medical Education Training Committee (Committee) in 2004 of stakeholders in Indigenous Health from across the ACT. Employment of an Indigenous Health academic, Peter Pinnington, who in 2005 integrated the eight subject areas of the Medical Deans of Australia and New Zealand Indigenous Health Curriculum Framework (2004) across all years and disciplines.

What we found and what we learned:
The ANUMS curriculum structure readily accommodated integration of the Framework. There were differences in incorporation of the Framework into lecture, PBL work in the first two years as distinct to the clinical years. The commitment and enthusiasm from the Dean and school wide staff has been integral to the successful implementation of Framework. The Dean at the inaugural lecture in May 2005 made the comment of endorsement that, “the Indigenous curriculum is core and assessable”.

How was the Aboriginal community involved?
The involvement of the Indigenous health sector, includes the medical staff and Indigenous health workers from the Aboriginal Medical; Service Winnunga Nimmityjah and allied health services in the delivery of lectures, seminars and PBL’s across all years as well as research activities.

How will this information be used to inform policy and practice?
To inform any evaluation of the curriculum and policy development of Indigenous health at the ANUMS.

Implications for stakeholders and future directions:
The implications for the future direction of the Indigenous health curriculum for the ANUMS are to build upon what has already been developed and delivered and reflecting upon any evaluation taken and developing strategies to address any issues which arise in such evaluations.

Co-Authors:
Amanda Barnard & Jenny Thomson, Australian National University Medical School

Ms. Suzanne Pitama Maori Health Lecturer & Director, Maori/Indigenous Health Institute, University of Otago	Supporting the Whanau abd he Cousins as Well: A Tale of Cultural Safety Within the Indigenous Medical Curriculum The genesis of Cultural Safety introduced Indigenous Health as a curriculum topic first into nursing and then into medicine. This session is aimed at discussing the University of Otago, Christchurch, as a case study for how cultural safety has influenced and impacted teaching Indigenous curriculum. It highlights strengths and opportunities of development that have occurred within the last 6 years.
Dr. Jennifer Reath GP Manager Aboriginal and Torres Strait Islander Health Unit Royal Australian College of General Practitioners	Assessing the Curriculum What we did: We convened a workshop including representation from NACCHO and the Australian Indigenous Doctors' Association in 2005 to draft questions for the FRACGP examination and to advise on process issues for the delivery of those questions. A clinical scenario was tested in the October 2006 FRACGP examinations. A further workshop to review examiner feedback and candidate results related to this scenario and to refine the processes and develop new questions will be convened in September 2007. What we found and what we learned: We found that Aboriginal health workers and community members were very enthusiastic to assist in role playing for the FRACGP examination and that RACGP State Faculties and Aboriginal Community Controlled Health Services worked well together to recruit and support the role players. We learned that there may be a greater awareness among some candidates of the cultural safety issues than the clinical issues being tested and that further review of the processes is required including provision of training and information for non-Aboriginal examiners and consideration of extending the role of the Aboriginal role players to that of coexaminers. How was the Aboriginal community involved? Aboriginal Community Controlled Health Services and NACCHO State Affiliates were involved in recruiting Aboriginal people to role play patients for the examination. NACCHO continues to be involved in the workshop to review the results of these endeavours and to develop new examination questions. How will this information be used to inform policy and practice? National processes will be recommended for support and training of Aboriginal people and non- Aboriginal examiners involved in the FRACGP examination. Implications for stakeholders and future directions: These recommendations are likely to be of relevance for assessment of medical school Aboriginal health curricula and those of other specialist colleges.
Dr. Craig Richards Snr. Lecturer, University of Newcastle	Indigenous Medical Education – Achieving Quality and Quantity Why we did the work: To identify ways in which we can both successfully provide improved geographical access and an increased number of places to prospective Indigenous medical students, whilst still meeting our responsibility to adequately support both Indigenous students and staff.

What we did:
Based on the combined experiences of the authors, we identified generic challenges faced by all Australian medical schools in the provision of Indigenous medical education via alternative entry pathways and proposed possible structural solutions.

What we found and what we learned:
Challenges common to all Universities centre around two issues. Firstly, small numbers of Indigenous students at any one campus, leading to difficulties meeting the complex support needs of these students and limiting the capacity of institutions to evaluate the success of their selection and support programs. Secondly, recruiting Indigenous doctors as academics and having often only a single academic responsible for all things Indigenous, in the absence of senior Indigenous academics to provide mentoring. We propose that a truly collaborative national approach is required whereby a structure is developed to allow all Disciplines of Indigenous Health and general support staff across Australia to function as a single unit. The benefits and challenges of achieving such a structure will be discussed.

How was the Aboriginal community involved?
By sharing with us over many years their experiences as Indigenous doctors, academics, students and general support staff.

How will this information be used to inform policy and practice?
This synthesis identifies issues which need to be addressed via policy and practice by all medical schools seeking Indigenous students and proposes collaborative means of achieving this.

Implications for stakeholders and future directions:
Medical schools need to consider a radical rethink in the way they do business if they are to successfully deliver Indigenous medical education via alternative entry pathways across 17 medical schools.

Co-Authors:
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Conversion Through Immersion?

Why we did the work:
To make use of a traditional Maori context (i.e. the marae) as a venue for clinically focused teaching. It was recognised that by using this venue, incidental learning would help increase students' understanding and ability to engage with Maori. A primary focus was increasing their ability to work safely with Maori patients and whanau.

What we did:
We engaged in a process of design, implementation and evaluation of a Marae based teaching block (3days/2nights). It was emphasised that this was not a cultural visit, but rather the marae was being used as a teaching venue. Sessions involved explicit use of students' marae experiences in relation to the clinically focus teaching.

What we found and what we learned:
Students' behaviour and feedback suggested positive engagement with core Maori processes. The proximity of their experience helped them to engage more deeply with the material being presented and learning exercises being undertaken.

How was the Maori community involved?
Local community members who hosted us ensured appropriate processes were followed, as well as sharing their history with the students. A number of Maori health workers from the community have contributed to the teaching on the course.

How will this information be used to inform policy and practice?
This block has been part of a process of Hauora Maori curriculum development, seeking to provide a consistent teaching experience across the University of Otago Medical School's three campuses.

Implications for stakeholders and future directions:
The marae based teaching block provided a solid foundation for the subsequent teaching of Hauora Maori and curriculum development.

Co-Authors:
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Rethinking Teaching Students in Health Science Disciplines About How to Work WIth Clients from Diverese Social and Cultural Backgrounds

What we did:
A literature review, followed by an exploration of the key ideas that help improve the quality of interactions.

What we found and what we learned:
1. Some of doctors' mistakes are due to 'thinking' and 'feeling' errors from the occasional failure of the shortcuts in thinking used by all practitioners.

2. Social cognition research about racial bias in communication shows that all health care providers hold stereotypes about client race, gender, class, and other characteristics influencing their interpretations of client behaviours and symptoms, and their clinical decisions, applying these stereotypes frequently occurs outside conscious awareness, and providers interact less effectively with minority than with white patients. Approaches to reducing 'thinking' and 'feeling' errors include: metacognition (thinking about diagnostic thinking), cognitive forcing strategies (specific approaches to predictable errors), simulation training, and checking for misunderstanding of probabilities.

With implicit stereotypes in provider communications: enhancing internal motivation and avoiding external pressure to reduce bias, enhancing understanding of the psychological basis of bias, enhancing providers' confidence in their ability to successfully interact with socially dissimilar patients, enhancing emotional regulation skills specific to promoting positive emotions, increasing perspective taking and affective empathy, and improving the ability to build partnerships with patients.

How was the Aboriginal community involved?
The community was not actively involved in the literature review. However, years of experience of working as a doctor, in AMS settings, and ongoing discussions with Indigenous colleagues have informed the analysis.

How will this information be used to inform policy and practice?
The studies referred to in the review can be used to inform practice and teaching about cross cultural communication.

Implications for stakeholders and future directions:
Teaching should be aimed at encouraging students in health sciences to take the client's perspective, work with clients in equal partnerships, make fewer thinking and feeling errors, and work with imagination, curiosity and humility, and an openness to clients' experiences.

Co-Author: Shaun Ewen, Onemda VicHealth Koori Health Unit

Prof. Peter Smith

Dean,
Faculty of Medicine,
University of New South Wales

A Faculty Wide Statement and the UNSW Journey to Turn Around the Stats

Why we did the work:
UNSW has been actively recruiting Aboriginal students into its medicine programme since 1993. We knew that the solution to graduating doctors was beyond simple recruitment methods, and that an overall, holistic approach was needed.

What we did:
Since 2003 we have developed a number of strategies designed to strengthen our retention to graduation of Aboriginal students entering medicine. These included reforming the Indigenous pre-medicine programme; the support of a series of scholarships, both monetary and residential; the creation and implementation of a faculty wide statement of intent for Aboriginal health; and inculcation of Indigenous health throughout the curriculum.

What we found and what we learned:
The use of these strategies in the context of an undergraduate medical program has provided a template for action that has seen our retention rate go from poor to very good. We will examine these measures and present our thoughts on the pathway we took, and the steps we need to take to continue to build on these early successes.

How was the Aboriginal community involved?
Indigenous staff at both Faculty and University level, along with core non-Indigenous staff, have worked with organisations, communities, families and prospective students around Australia.

How will this information be used to inform policy and practice?
This strategy confirms our policy of dedicated, non-quota entry programmes, to this University. The next steps are to evaluate the pre-medicine programme and the impact of the various scholarship programs on recipients' retention.

	Implications for stakeholders and future directions: The UNSW is undergoing constant evaluation and ongoing improvement. Co-Author: Lisa Jackson-Pulver, Muru Marri Indigenous Health Unit, University of New South Wales
Prof. John Stuart Cojoint Associate Professor & Snr. Staff Paediatrician University of Newcastle & Hunter New England Health	The Death of an Aboriginal Baby, an Instructive Case for Medical Students In 1968 a five month old Aboriginal baby was admitted to hospital in Cunnamulla with gastroenteritis. Two days after admission, the baby died. This would not be a particularly unusual event except that some three months later when a sibling of the deceased child was admitted to the same hospital, the mother was arrested and charged with manslaughter on the grounds of an alleged failure to provide the baby with adequate food or to seek medical attention. After 3 months in jail for failure to raise bail the mother was found guilty by an all white, all male jury and sentenced to 3 years hard labour. An appeal was heard and dismissed by the Queensland Supreme Court and it wasn't until a further two months later that the Court reversed its decision following a public outcry and she was released one month before she would have been eligible for parole. This case raises many issues concerning Aboriginal people living in remote communities and has been used as an instructive case to demonstrate to medical students the difficulties an Aboriginal person may encounter in dealing with the medical and criminal justice systems. Students are asked initially to review the medical details of the case. It becomes apparent that the baby was malnourished at the time of admission which may have contributed to her death. However the medical care was substandard and the medical officer on call at the hospital was not called to see the baby on the night of admission. Subsequent treatment included tube feeding and a subcutaneous drip, neither of which were recommended for severe dehydration even in 1968. Eventually intravenous fluids were started but soon after, the baby died from "bronchopneumonia" weighing 6 ozs (approx 200g) less than her admission weight 48 hours earlier. Students are next asked to review the living conditions of the mother, her approximate income and what the baby was fed on prior to admission. It soon becomes clear that the $6 a week that she received was completely inadequate and explained why the baby was fed mainly on "Sunshine" milk. Further avenues for study include the medical evidence provided at the trial and subsequent appeals, the reasons for the arrest and charges and an assessment of whether racism played any part in the proceedings. The presentation will detail some aspects of the case, suggest learning goals for the students and provide the reading materials and references.
Dr. John Taylor Deputy Director & Snr. Fellow, Centre for Aboriginal Economic	Applied Demography and Indigenous Population Health Perspectives on What's Possible and Where We Go From Here

Policy Research, Australian National University	The structural circumstances facing Indigenous populations are increasingly diverse and locationally dispersed leading to variable outcomes and implications in terms of population health. In this presentation I explore key aspects of this diversity by bringing together the findings of recent regional and community demographic studies. The aim is to provide some sense of population scale and composition within which deliberations on population health policy might be considered. I do this by highlighting what, for want of a better term, might be described as emerging demographic hotspots in the sense that particular Indigenous population dynamics in particular locations and regions are giving rise to particular issues of public policy concern.
Dr. Janelle Trees Doctor, Port Kembla Hospital	"Big Name, No Blanket" – Opening Indigenous Discussion About Internship Trauma, suffering, self-annihilation, bullying, perfectionism, self-actualisation, prosperity, pride in achievement, experiencing oneself as the catalyst for healing, the privilege and daunting responsibility of intense intimacy with strangers (emotionally and physically); becoming part of the workforce in a respected but often exploited role, experiencing brilliant camaraderie and its flipside, petty nastiness; frustration with bureaucracy and waste in the face of suffering. All of these overwhelm the intern, working under conditions which would test any personality. Indigenous people are very familiar with the concept of initiation through trial and struggle but the conditions of medical internship are determined by market forces as much as by social need and culture. After many years of solid commitment to study and all the sacrifice that entails, the new doctor's first year in medicine is exciting and empowering. It is also, more often than not, a threat to the mental and physical health of the new doctor (as well as that of his or her patients). In this presentation we will consider some of the ideas and conflicts which arise in the course of internship. Much responsibility with limited power and often inadequate training sets new doctors up for difficulty. As Indigenous doctors, internship can be harder in some ways and easier in others. Let's open discussion of our strengths in coping with difficult conditions, including our storytelling, which by articulating, externalizing and generalizing experience, is a source of resilience and learning.
Ms. Leah Walker Associate Director, Division of Aboriginal People's Health, University of British Colombia	Essential Elements to Creating and Sustaining an Interprofessional Aboriginal Health Elective in Aboriginal Communities Why we did the work: There is an expressed need for Aboriginal health curriculum and interprofessional teamwork in UBC's medical school. Aboriginal people have also expressed a need for health care providers able to work respectfully with them. What we did: We developed and improved upon an innovative one-month interprofessional health elective course in Aboriginal communities. A first at UBC and in Canada, this course is a clinical and experiential primer in Aboriginal health taught by Aboriginal community partners. What we found and what we learned: We found that strong community engagement principles and course adjustments improved outcomes for students, the university partners

	and the communities involved. Students rated the course highly and are more likely to choose careers working with Aboriginal people. Community partners strengthened their teaching capacity and have taken ownership of the course. How was the Aboriginal community involved? Course content and instruction was community based. Community knowledge was respected and honored through clinical appointments and other forms of acknowledgement. How will this information be used to inform policy and practice? Course process, principles and content will be used in developing future curriculum locally, nationally and internationally. Implications for stakeholders and future directions: We have a built a solid foundation for expanding this course into more Aboriginal communities as well as for developing and creating new projects. Co-Author: Andrew James, Division of Aboriginal People's Health, University of British Colombia, Vancouver, Canada
Ms. Karina Walters	Without Reservation Indigenzing the Academy
Conjoint Prof. Ken Wyatt AM Director of Aboriginal Health for the Dept. of Health for Western Australia	Rethinking Our Workforce Needs – Not for Today but Tomorrow Currently we have been forced to acknowledge the reality of the dilemma of workforce shortages within the Health sector, which directly impact upon the level of skilled staff working within Rural and Remote communities. Can the emergent problem be fixed through the rethinking of the curriculum or is it about planning for a new and different workforce and are Medical Schools stuck in the historic practice of the past? Can innovation and being creative around developing a new workforce take account of the training the traditional workforce whilst exploring opportunities to provide a new style of worker who is multi skilled and can be a new multi skilled hybrid workforce. The implications for the rethinking of the Medical and Health School Culture and the Curriculum is challenging. Being creative and gaining change has enabled societies to advance – can Universities set the reform agenda for a new direction for a new and different worker to today's current workforce member.
Prof. Neville Yeomans Dean of Medicine, University of Western Sydney	Admission of Indigenous Medical Students: Experiences of a New School Why we did the work: The University of Western Sydney medical course commenced in 2007. Particularly because of the University's location, in proximity to two of the largest Indigenous Australian populations in the country, the School was keen to include some Indigenous students in the first cohort, while doing its best to not set students with insufficient relevant educational background up to fail.

What we did:
We considered each application case by case – gathering as much educational and relevant social information as we could. The dean had a preliminary conversation with most applicants soon after they identified a wish to apply, to describe the admission process we would use. Each applicant was then interviewed by a panel of two School members and two external Indigenous academics, to assess the above parameters, as well as gauge the applicant's understanding of important issues in Indigenous health and their motivation to do Medicine.

What we found and what we learned:
There was some pent-up demand in our region. Eleven applied and 5 were eventually enrolled. Two are mature students with degrees; both had either taught at or been staff at UWS previously. Two have incomplete degrees, another who has completed a nongraded certificate in a health area has been offered a deferred place if one year of a health science degree is completed successfully; only one has come straight from year 12. About half the students enrolled are having some academic difficulty at the end of semester 1 and will receive more intense assistance for the remainder of this year.

How was the Aboriginal community involved?
By certifying Aboriginality of applicants, and by helping interview the applicants.

How will this information be used to inform policy and practice?
We may be a little more cautious about relevant scientific background, as we decide whether to offer a place. We will also consider mounting a bridging course in the future.

Implications for stakeholders and future directions:
As we get better at this process, the School aspires to be a major educator of Indigenous doctors in the future.