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Having the Hard Conversations: *Strengthening pedagogical effectiveness by working with student and institutional resistance to Indigenous health curriculum*

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<http://www.flinders.edu.au/medicine/sites/poche.adelaide/cultural-safety.cfm>

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List of acronyms used

AIDA	Australian Indigenous Doctors Association
AMC	Australian Medical Council
ANMAC	Australian Nursing and Midwifery Accreditation Council
CATSINaM	Congress of Aboriginal and Torres Strait Islander Nurses and Midwives
DoH	Department of Health
HDR	Higher Degree by Research
IAHA	Indigenous Allied Health Australia
IFNTF	International Federation of National Teaching Fellows
NATSIHP	The National Aboriginal and Torres Strait Islander Health Plan
OLT	Australian Government Office for Learning and Teaching
PIHN	Poche Indigenous Health Network
RFDS	Royal Flying Doctor Service
RHD	Research Higher Degree
SDoH	Social Determinants of Health
UQ	The University of Queensland

Executive summary

‘Closing the Gap’ in Indigenous/non-Indigenous health outcomes is a bipartisan national priority (Australian Government, 2014, p. 1). The National Aboriginal and Torres Strait Islander Health Plan 2013–2023 (NATSIHP) recognised, however, that new approaches were necessary to achieve equity in health by 2031. The Australian Government Minister for Indigenous Health at the time called for ‘bold’ approaches, that there were ‘new agendas to embed’ to achieve the plan’s vision of a health system ‘free of racism and inequality’, one where ‘all Aboriginal and Torres Strait Islander people have access to health services that are effective, high quality, appropriate and affordable’ (Australian Government 2013, pp. 3–7). Developing an appropriately skilled and culturally safe health workforce is central to this task. When students enrolled in health professional training courses respond to challenges arising from Indigenous health curricula with resistance—and in particular with disengagement—then teaching and learning can fail (McDermott & Sjoberg 2012). Institutions can also resist. Where a commitment to incorporate Indigenous-preferred pedagogy is not seen as central to developing an effective health practitioner, it can not only dilute the comprehensiveness of Indigenous health subjects and jeopardise their ‘core’ status, but also undermine the rationale for faculty support for measures to facilitate a student journey through difficult terrain.

This fellowship proposed a coherent program of activities, developed in partnership with existing national and international collaborators, to clarify and work through these barriers. The fellowship generated and refined a framework of educational strategies to aid the emergence of self-reflective, culturally safe practitioners. ‘Closing the Gap’ requires health professionals not only able to embrace the complexity inherent within Australian Indigenous health presentations, but with the capability, further, to respond successfully and to work well with Aboriginal and Torres Strait Islander peoples. Dissemination measures, including a major symposium and roundtable, a national series of workshops, and the production and release of a range of online resources, aimed to weave good practice through the national pedagogical repertoire. In this fellowship we wanted to go further. We wanted to ensure dissemination activities and briefings informed a wider health system and community discourse and, where possible, were also targeted to major health professional course accreditation bodies. It was considered important to conduct this secondary set of tasks collaboratively with Indigenous health professional bodies, building on strong, existing relationships. Engaging regulatory audiences was seen as a profound way to embed the outcomes of this fellowship within the education system responsible for training the health workforce, as well as the health care delivery system itself. As such, generating and embedding strategies for institutional change—within both systems—was seen to be a major, desired outcome of this fellowship, one critical to ensuring effective course content, culturally safe faculty or health care environments, and locked-in institutional support.

Apart from a range of appendices, which include specific resource outcomes of the fellowship, along with an external evaluator’s report, the body of this report is organised into five chapters. These establish the rationale for the fellowship, move through the evidence-gathering stage to begin the process of identifying, and assembling, good practice, develop and refine initial frameworks into a coherent Guide to Good Practice, outline the range of subsequent dissemination activities, and describe the resources produced and their future utilisation.

Chapter One provides the background to this National Senior Teaching Fellowship. It describes the context in which this fellowship emerged, the need to engage in ‘hard conversations’, and details the aims of the fellowship.

Chapter Two identifies leading-edge Australian and international pedagogical practice in resolving resistance to challenging material. It examines our approach to the existing national and international literature, discusses constraining and enabling factors, introduces and analyses the notion of resistance, explicates the outcomes of the literature review and their implications for the work of the fellowship, and initiates the developmental process for the good practice framework.

Chapter Three describes the peer-consultative process of introducing the findings of the literature review, and a range of interviews with key informants, into a two-day consultative forum, ‘Having the Hard Conversations’ Symposium and Roundtable. The resultant presentation of the draft framework, along with its refinement and extension, then provided the impetus for subsequent dissemination, consultation, resource production and scholarly publication activity.

In **Chapter Four** we report on a comprehensive, multi-tier, suite of dissemination activities that were conducted at a range of locations, nationally and internationally. We note a specifically tailored set of practical workshops aimed at those delivering Indigenous health curricula. These were conducted in four capital city locations. We also note the need to go further than mere presentations in an attempt to shift the discourse (both academic and public), as well as discuss some shortcomings in expected briefings or other engagement with accreditation bodies—and some, unexpected, avenues of engagement with other key stakeholders.

We also report here on the impact of conference presentations, seminars/webinars, and other fora, including social media, as modalities of dissemination.

Chapter Five introduces the two kinds of resources resulting from the fellowship: a Guide to Good Practice and a set of educational video resources, with accompanying facilitator guides. Both sets of resources are freely available for download.

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Chapter 1: About the fellowship

1.1 Why do we need ‘hard conversations’?

Non-Indigenous health professionals deliver the majority of health interventions to Aboriginal and Torres Strait Islander Australians. Their work is pivotal to improving Indigenous health outcomes, the worst of any population group in the nation (Australian Bureau of Statistics 2013). Any shortfall in the efficacy of Indigenous health pre-registration education, or practitioner professional development, compromises the emergence of effective, culturally safe practitioners and severely jeopardises the success of measures to ‘Close the Gap’. Yet many students and health professionals struggle to engage fully with Indigenous health curricula. We teachers of Indigenous health are asking students to enter an emotionally charged zone; one that requires them to feel safe enough to open up to difficult questions, one premised not only on *cognitive* learning, but also *affective* learning. Where that involves tapping into deeply held feelings, beliefs and prejudice, engagement may prove too confronting (Gabb & McDermott 2008; Rasmussen et al. 1996).

The North American medical education literature identifies class as a mediator of a documented student resistance to the role of the social determinants of health (SDoH) in shaping patient presentations. One recommendation from that literature is to move from the individual depictions favoured by narrative medicine to sociopolitical analyses of the way the SDoH operate (Wear & Aultman 2005). This fellowship responds to a deeper reading. In an Australian context of a widespread denial of troubling elements of our shared national history, analysis of colonisation-related determinants can be sufficiently disquieting to threaten student engagement with the subject under study (McDermott 2004). The praxis of cultural safety is premised on the need to reverse the professional ‘gaze’. It requires students to eschew a primary focus on all there is to know about the culture of the client or patient but, rather, to explore the cultural underpinnings that they, themselves, bring to the health encounter. Where students prefer ‘concrete’ modes of thinking, where such are linked to clinical competence, and where Indigenous health and cultural safety are seen as peripheral to core clinical business, the impetus for engagement withers (Rasmussen 2001). By contrast, becoming a thinking, culturally safe practitioner is also the prerequisite for emerging as a clinically safe one (McDermott 2012). Successful Indigenous health pedagogy, then, aims to develop a critical stance and a reflective practice. Systematically exploring issues such as power imbalances in health settings, the contemporary consequences of colonisation and the pervasiveness of racism—and the profundity of their effects—however, may fundamentally challenge those participating on personal, professional, organisational and political levels.

There is a great need for more research producing higher quality evidence on both the mechanisms at play here, and appropriate pedagogical responses. In the absence of an acknowledged evidentiary base, the centre I lead at Flinders University (Flinders University) has developed a working praxis drawn from both anonymous, university-mandated student evaluations of teaching (SETs) and external workshop evaluations. These have been augmented by de-identified student critical reflections, classroom and student observations and other forms of direct feedback. Our model—now based on over 1600 reflections or evaluations from both university health professional courses (nursing, midwifery, medicine, public health and allied health) and practitioner (including general practitioners, psychiatrists, psychologists and

counsellors) professional development training—suggests a spectrum of response, along which are a number of identifiable groupings. We posit four, elastic, cohorts of participants, self-arranged along a positive to negative array. At one end of the spectrum are participants that are **‘accepting/open/keen for more’**; at the other are participants who are actively **‘hostile/rejecting’**—even overtly racist. In between are cohorts whose response to the material they encounter could be described best as ranging from **‘moved, yet uncertain/conflicted’** to **‘disturbed/flummoxed’** (McDermott & Sjöberg 2012) (see *Figure 1* below).

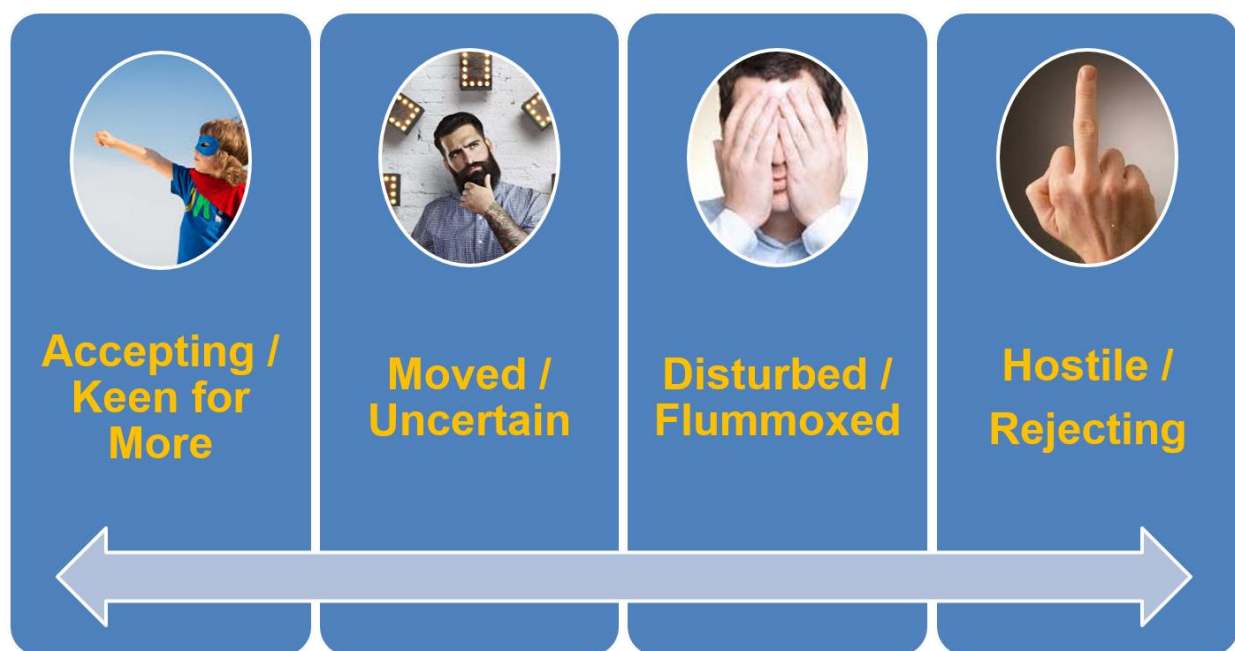


Figure 1. Spectrum of response

In the service of enhancing learning, this fellowship aimed to positively address the disquiet that Indigenous health teaching can cause students and institutions alike. In health professional education, Indigenous health and cultural safety are stones thrown into water. The disturbance is not confined to students, nor the classroom. The ripple effects can rock Indigenous staff and students and test school and faculty smooth functioning and goodwill. This subject area is challenging to teach and at times markedly stressful to tutors/facilitators. Openness to Indigenous-led curriculum and Indigenous pedagogical perspectives is threatened by unfamiliarity and academic discomfort (Coombe, Lee, & Baker 2013). In the name of an ‘integrated’ curriculum, content is easily fragmented, then parcelled out to be delivered by unprepared staff. Where stereotypical, or racist, attitudes persist within staff members holding key positions—particularly high-ranking ones—the necessary apportioning of curriculum approval and status, teaching time, funding, staff and administrative support, are all subject to ‘gate-keeping’. Curriculum gains—and their potential for graduating practitioners with a deep and nuanced understanding of Indigenous health, who are capable of working effectively in Indigenous settings—are easily lost where the social determinants of Indigenous health, along with the development of practitioner cultural safety, are deemed marginal to the ‘real’ work of medicine, nursing, allied or public health. Without a critical mass of school or faculty support, the rationale behind Indigenous-preferred pedagogical strategies is deemed trivial and the core or mandatory status of demonstrably effective academic subjects or topics is too-readily dismantled (Coombe, Lee, & Baker 2013).

This fellowship drew on the experience of collaborators at the University of Hong Kong in particular. Lessons learned there in successfully introducing medical humanities to students, along with disquieting curriculum and pedagogy to the institution—combined with our pedagogical experience at Flinders University—point to some practical strategies that can form the basis of further work. We posited, for example, that developing as a culturally safe practitioner involves a transformative ‘unlearning’—one that may need to begin with discomfort, a ‘turning towards’ dissonance (Chen, Salter, & Chan 2010; Ryder et al. 2013; Ryder, Yarnold, & Prideaux 2011). Our work suggests, as an over-arching strategy, the utility of developing structures to support a ‘manageable disquiet’, to make the uncomfortable, comfortable enough through sensitive facilitation, and to foster a spirit of ‘coming along with us’ on a journey of mutual discovery. What would particularly assist would be a framework, a guide for integrating current knowledge and good practice to best effect. This fellowship will further a national and international collaborative scholarship on ways to work *with* and *through* resistance—to develop modes of respect and mutual safety that successfully allow hard, but necessary, conversations to occur—rather than a counterproductive hardening of attitudes.

1.2 Aims of the fellowship

This fellowship aimed to refine, disseminate and embed measures to resolve a complex ‘sleeping issue’ in Australian educational praxis. To do this by going beyond a simple description of other ways of teaching, to a deeper investigation of the way we think about the pitfalls and promise attached to Indigenous health education, along with its companion issue of cultural safety, then how we might go about fostering the educational outcomes we believe are necessary to engender. In addressing resistance and engagement in relation to the successful teaching of Indigenous health it focuses on barriers to, and enablers of, student progress along a necessary, but often disquieting educational journey. As a program of activities aiming for more student-responsive curricula and a more-effective pedagogy, with potential to produce more efficacious graduates, it resonates with the aim of the (former) Office of Learning and Teaching to ‘enhance student learning’ (Australian Government 2014). Its program of activities and desired outcomes are particularly relevant to a call in the recent National Aboriginal and Torres Strait Islander Health Plan (NATSIHP) for an ‘Australian health system ... free of racism and inequality and ... health services that are effective, high quality, [and] appropriate’ (Australian Government 2013, p. 7). Additionally, this fellowship speaks directly to Recommendation 18 of the Behrendt Review:

***That universities** develop and implement an Aboriginal and Torres Strait Islander teaching and learning strategy applicable across a range of curriculums, focused on standards of excellence as applied to other curriculum content and feeding into descriptions of graduate attributes, with an initial focus on priority disciplines to close the gap such as teaching and health professions.*

This fellowship stressed the central role of institutional support to maintain a culturally safe environment for all staff involved in Indigenous health education. As such, it echoes the call within Recommendation 29 of the Behrendt Review for the development of institutional ‘strategies ... to ... support and retain Aboriginal and Torres Strait Islander staff’ (Behrendt et al. 2012, pp. xxii, xxiv).

Chapter Two: Identifying leading-edge Australian and international pedagogical practice in resolving resistance to challenging material

2.1 Approach

To gain a deeper understanding of ‘what works’ in Indigenous cultural training we have drawn on the principles of realist evaluation, a theory-based approach that seeks not only description but also explanation. A realist approach asks the questions, what works (or fails), for whom and in what circumstances, in what respects and how? (Pawson et al. 2005). It ‘is intended to reveal the inner mechanisms by which a program operates’ (Salter & Kothari 2014). A realist review seeks to uncover the *program theory(ies)* underpinning cross-cultural training programs. This directs our attention to the interaction of *context*, *mechanisms* and *outcomes*. Context includes factors such as the organisational setting, the policy environment and resources available. The mechanisms are the ways in which changes are brought about. Outcomes include both the intended and unintended consequences.

A realist approach draws on a range of data sources in a ‘pragmatic and reflexive manner’ (Greenhalgh et al. 2009) to build a picture of how and why a program is thought to work.

2.2 Method

We undertook a rapid evidence assessment using guidelines developed by the Civil Service of the United Kingdom Government (2014). These include limiting the search by using less-extensive search strings, a focus on finding reviews wherever possible, using ‘grey’ sources minimally

A key word search was undertaken using electronic databases (Medline, PubMed, Scopus and CINAHL). Three groups of words were used to search the databases and are shown below. The first group of key words reflects variations in the terminology of the topic being reviewed, as well as the different paradigms that underpin some of these terms. For example, cultural competence is a favoured term in the US and reflects a paradigm based on multiculturalism; whereas the term cultural safety was first developed in New Zealand and reflects bi-racial and post-colonial contexts (DeSouza 2008). Terminology is inconsistent, however, with different terms and definitions in use and often used interchangeably. The second group of key words was included to ensure that the focus was on health professions students, training strategies and effectiveness. Finally, the third group of key words allowed the researchers to focus the literature primarily regarding Indigenous populations.

Program theories are not necessarily made explicit in journal articles or evaluations. In many cases, however, an implicit program theory can be gleaned from program descriptions: ‘the reviewer must enter the literature with the explicit purpose of searching it for the theories, the hunches, the expectations, the rationales and the rationalisations for why the intervention might work’ (Pawson et al. 2005, p. S1:26). Information was extracted on: *model and assumptions; context; mechanisms, strategies and activities; short-term and longer term outcomes; evaluation* and any discussion of *challenges and student resistance*.

These components form part of a causal chain and each will have a theory regarding how it is supposed to work and how it relates to other components. The process of theory mapping also reveals potential mechanisms for resisting the intervention. The extent to which an intervention runs to plan, along with the extent and nature of resistance met, shapes the success or failure of the intervention. Figure 2 gives a graphic representation of the process.

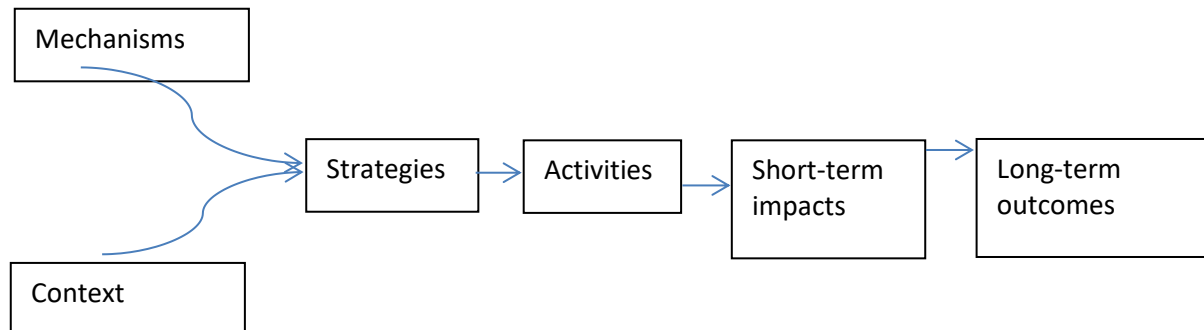


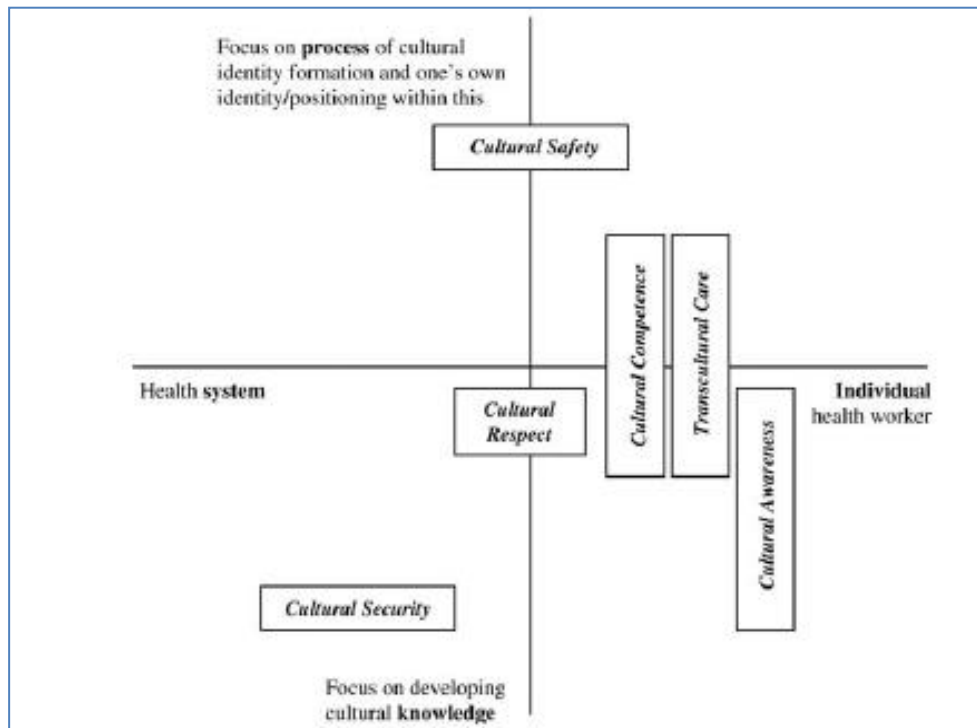
Figure 2. Mechanisms, resistance and intervention

As well as papers describing interventions, other papers provided descriptions and critiques of conceptual models that underpin Indigenous cultural training, or explorations of student and faculty perspectives on training, as well as discussion of enablers and including the notion of resistance.

As Pawson et al. (2005) warn, a realist review does not promise simple answers but can provide a ‘rich, detailed and highly practical understanding of complex social interventions’ (p. S1:21). In 2015, approval was granted by Flinders University Social and Behavioural Research Ethics Committee to conduct two sets of interviews. The first was designed to generate practice-based evidence from a range of Australian and New Zealand academics with current responsibilities for both preparing and delivering Indigenous health curriculum. Its preliminary findings were used to supplement the synthesis of the literature in the preparation of the draft good practice framework that was put to the fellowship’s 2015 symposium and refined through the accompanying roundtable process. A second set of interviews focused on key authors (as identified by content experts at Poche Adelaide as acknowledged experts in the field), who were invited contributors to that symposium and roundtable. In total, transcripts of six video-taped interviews of 60 to 90 minutes duration, two group phone interviews and an additional three individual phone interviews, were coded, analysed, and integrated with the range of different program theories identified through the literature review process, to extend, challenge and refine the draft good practice framework we desired to develop.

A review undertaken by Downing, Kowal and Paradies (2011) identified six models through which cultural training can be conceptualised; ‘cultural competence, transcultural care, cultural safety, cultural awareness, cultural security and cultural respect’. These can be located on two continuums: individual to systemic change, and understanding of own culture and processes of identity versus understanding the culture of others (see Figure 3).

This type of examination of models can help uncover both the explicit and the unstated assumptions that are embedded in interventions. For example, Is the ‘problem’ lack of cultural knowledge? Or lack of understanding of processes of culture and identity including a focus on power and relationships? Or both? Differing understandings are embedded in the different models.



Source: Downing et al. 2011, p. 249

Figure 3. A comparison of theoretical models underlying Indigenous cultural training

Cultural humility has been presented as both a process and outcome and provides another model that encompasses a lifelong process of self-reflection and self-critique. It has been described as a

process that requires humility as individuals continually engage in self-reflection and self-critique as lifelong learners and reflective practitioners, it requires humility in how physicians bring into check the power imbalances that exist in the dynamics of physician-patient communication by using patient-focused interviewing and care, and it is a process that requires humility to develop and maintain mutually respectful and dynamic partnerships with communities on behalf of individual patients and communities in the context of community-based clinical and training models. (Tervalon & Murray-Garcia 1998, p. 118)

Cultural humility requires practitioners to give reflexive attention to their assumptions and beliefs to develop a respectful partnership with each client, rather than identifying the cultural traits of clients.

Some programs draw on more than one of these models, seeing them as building one on the other or as complementary. For example, De Souza (2008) argues that a 'triangulation of approaches is required that addresses not only the theory and practice demands of the nursing profession but also the social and ethical imperatives that can rectify the unfair burden of health inequalities' (p. 125). Coffin (2007) suggests cultural security is about the meeting of Western and Aboriginal approaches in health, and sees cultural security being built on both cultural awareness and cultural safety, with the two approaches linking understanding with action.

In terms of program theory, we would expect to see empirical evidence of differences in the models in terms of the strategies chosen, the way they are implemented and the outcomes they seek to bring about. As Paul, Carr and Milroy (2006) put it, 'An approach designed to understand a static other will be different from an approach designed to facilitate students' awareness of, and ability to respond to, disparity in health care outcomes' (p. 753). It appears, however, that this is not always the case. In examining examples of Australian Indigenous cultural training, Downing et al. (2011) note that despite significant differences espoused by the models, those differences are not necessarily evident in the operationalisation of the concepts and 'indigenous cultural training in the Australian context have generally not progressed beyond a cultural awareness model' (p. 250).

2.3 Mechanisms

Mechanisms have been described as 'ideas about how change will be achieved in an intervention' (Greenhalgh et al. 2009, p. 396). Pawson and Tilley (2004) have likened mechanisms to the workings of a clock that cannot necessarily be seen but drive the movements of the hands. Mechanisms, thus, offer a way to both apprehend and utilise an unseen, but core, driving logic. How an intervention strategy is implemented and received by subjects constitutes the 'mechanism' and uncovering these potential processes is the starting point for realist evaluation.

At least eight broad and inter-related mechanisms were identified in the programs described, namely to:

- impart knowledge regarding health inequities as a foundation for cross-cultural training
- impart knowledge about cultural groups
- provide cultural encounters
- encourage reflection on individual and societal attitudes, practices and culture
- teach cross-cultural skills
- challenge beliefs
- invoke empathy
- address organisational/institutional factors.

The mechanisms were made explicit in some accounts and were implicit in the strategies and activities described in others. The success or otherwise of the mechanisms in bringing about the desired changes is influenced by enabling and constraining contextual factors, some of which were explicitly identified.

A range of strategies were employed singly or in combination across the mechanisms. Examples of strategies include:

- *Didactic*: online presentations, audiovisual presentations, lectures; tutorials
- *Interactive*: brainstorming, discussion, online fora, case scenarios, role-playing; simulated patient sessions
- *Reflective*: journals, cultural autobiography, discussion, narratives
- *Engagement*: community service, outreach, field trip, hearing from community members, interviewing community members, cultural mentorship, cultural immersion.

Strategies that actively engage the audience were seen as more successful than more didactic activities (Macdonald, Carnevale & Razack 2007; Pedersen, Walker & Wise 2005).

A strategy may be employed in the service of, or trigger, various mechanisms. For example, an

audiovisual presentation may impart knowledge regarding health inequities, or encourage reflection, or both.

In **Appendix B**, as part of the fuller version of the processes we undertook to frame, then refine, our Guide to Good Practice, and ensuing resources, we take each of the mechanisms noted above in turn, presenting a detailed summary of each of the theorised mechanisms and a discussion of key enabling and constraining factors that make it more or less likely that either favourable outcomes will be achieved or resistance will be met. In the body of this report we highlight a few key points, from each mechanism, to assist an understanding of how each bears on the final strategies we outline as good practice.

Mechanism 1: Impart knowledge regarding health inequities as a foundation for cross-cultural training

Much of the discussion regarding the need for cultural training is grounded in the evidence regarding health inequities. Thackrah and Thompson (2013) suggest there is now widespread inclusion of compulsory content on Indigenous health in Australia as a response to ‘recognition that a culturally informed workforce can contribute towards reducing health inequities’ (p. 113). Some authors linked this to a human rights or social justice perspective and others noted that it is also required as a pragmatic public health strategy (Pedersen & Barlow 2008). Paul, Ewen and Jones (2014) argue that simply knowing more about the ‘other’ will do little to address disparities and that strategies are needed to develop self-reflexivity, promote an understanding of the historical and social context that constructs cultural identity and develop communication skills. This points to the necessary interaction of mechanisms that may be required to produce desired results.

While imparting knowledge regarding health inequalities and their social determinants is a key mechanism for many programs there is evidence that this will be met with denial by at least some students. Browne, Pitner and Freedman (2013) examined online comments about media stories highlighting health inequities research projects in the US. They found that many respondents did not believe that health disparities were real. This points to a need for pedagogical strategies ‘to unpack the reality of health disparities and their underlying causes’ Browne et al. 2013, p. 226) but also points to possible areas of student resistance. Wear and Aultman (2005) cite the work of Titus (2000) who suggests that denial is a strategy resistance that is linked to victim-blaming—individual deficiencies rather than structural factors are seen as the root of problems.

Mechanism 2: Impart knowledge about cultural groups

As discussed above, imparting cultural knowledge in the form of cultural awareness programs appears to remain a dominant strategy in Australia. Downing et al. (2011) suggest the underlying assumption is that such knowledge will promote tolerance and prompt people to change their practices.

There is significant critique of this approach, particularly when used in isolation as it has been implicated in perpetuating stereotyping, oversimplifying complex issues and homogenising difference. For example, Clear (2008) warns against reductionist approaches that reduce people to characteristics and categories. Others point to the risk of stereotypes being incorporated in case presentations (Jacklin, Strasser & Peltier 2014), or generic approaches leading to failures in individual care (Williamson & Harrison 2010).

It seems this mechanism has at times been employed as an end in itself (e.g. providing cultural checklists) but has also been used as a complementary mechanism or one that facilitates other mechanisms, for example, informing critical reflection. Indigenous stakeholders themselves have suggested some specific cultural knowledge should be an important component of training (Abbott et al. 2014; Kamaka 2010). Wain et al. (2012) suggest that the critique of knowledge-based curricula focusing on the characteristics of cultural groups and the emergence of patient-centred care and narrative-based medicine means that attention is shifting to transformational pedagogical approaches.

Figure 4 below presents a graphic representation of possible pathways to both unwanted and desired educational outcomes.

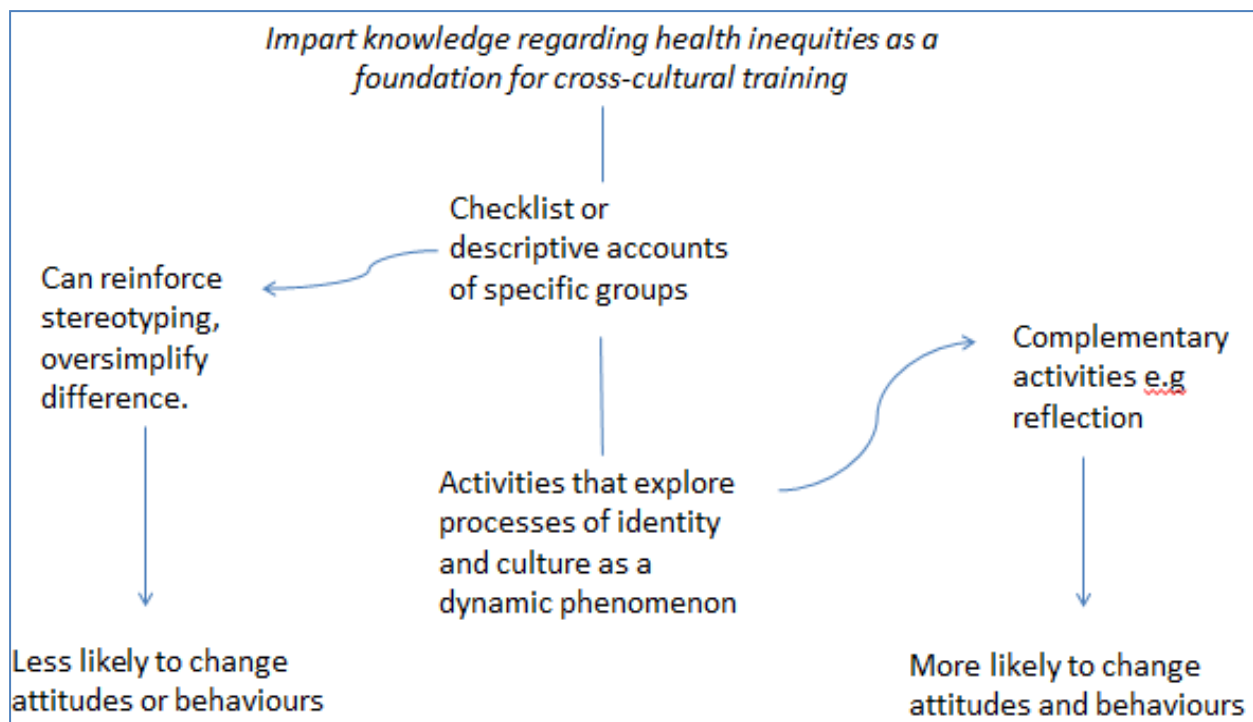


Figure 4. Imparting knowledge

Mechanism 3: Providing cultural encounters

Interaction with individuals and communities from specific cultural groups is promoted as a means for students to become more aware of cultural issues, to develop cultural sensitivity and skills. Activities providing cultural encounters were included in several of the curricula described and include patient–provider interactions, community outreach services, interviewing community members—sometimes paralleled by direct (community) informant video podcasts—and cultural immersion.

Like the provision of cultural knowledge, exposure to other cultural groups does not necessarily directly facilitate culturally competent care. It is in combination with strategies that encourage reflexivity that positive outcomes are more likely (Durey 2010). The number, type and duration of cultural encounters may mediate the effectiveness of this mechanism with a risk that generalisations may be made from a small number of encounters (Campinha-Bacote 2002). Pedersen et al. (2005) warn that while positive results of intergroup contact to decrease racism have been documented, intergroup contact alone may do more harm than good.

Mechanism 4: Encourage reflection on own attitudes and practices and culture

Encouraging reflection on one's own attitudes and practices was a widely employed mechanism to bring to the surface, and challenge, judgemental and racist attitudes, as well as to make visible the influence of one's own culture on interactions and understandings. Promotion of reflection and self-awareness is seen as critical in health professionals acknowledging the ways in which belief systems and cultural values shape patient encounters (Anderson, Ewen & Knoche 2009) and is also seen as a means to enhance empathy (Wear & Aultman 2005). Others suggest that reflection can change behaviour and improve practice (Cooney 1999, cited in Cultural Safety Research Group 2006). Self-reflection formed an important part of the interventions that cited cultural humility as an underpinning concept.

Critical self-reflection encompasses examination of wider societal influences and the dominant discourses that produce and reproduce inequities. Analysis of discourse draws attention to the socially constructed nature of self, culture and race. Whiteness studies are an area of study that critically examines the role of dominant white culture. Race is understood as a social construction and dominant cultural groups are encouraged to reflect on their own values and practices when working with Indigenous or minority populations (Durey 2010).

One of the consequences of incorporating reflective practices in the curriculum was the creation of a level of discomfort for students and faculty. Acknowledgement of privilege, power imbalances, racialising discourses and marginalising practices were seen as significant sources of discomfort. Several authors pointed out that such reflection requires openness to views and experiences of others and the ability to consider different beliefs and perspectives with empathy. Difficulties were reported for students and educators alike, particularly those from Western backgrounds (Kickett, Hoffman & Flavell 2014). Non-Indigenous teaching and clinical colleagues may be unaware of, or unable to acknowledge neither the workings of their white privilege, nor that their life notions reflect, and are ultimately derived from, their status as inheritors of the outcomes of colonisation (Jackson et al. 2013, p.105).

Many authors presented the promotion of reflection in the curriculum as necessary and perhaps necessarily uncomfortable. Disengagement, hostility, guilt, defensiveness, grief and anger were among the reactions noted. These reactions were often referred to as examples of resistance, which will be discussed further in Section 2. The discomfort experienced may be an example of cognitive dissonance—psychological discomfort stemming from a perceived incompatibility of beliefs—which has been found to be a means of reducing racism and prejudice (Pedersen et al. 2005). Dissonance may be stimulated by recognition that one holds contradictory beliefs or ideas or the introduction of new information that conflicts with one's existing beliefs or ideas.

Mechanism 5: Teach cross-cultural skills

The teaching of cross-cultural skills was suggested in a number of papers (see for example, Abbot et al. 2014; Campinha-Bacote 2002; Lacey et al. 2011) and included communication and consultation skills. Abbott et al. (2014) note that many of the skills required for cross-cultural consultations are those required for any effective consultation 'respect and management of the patient as an individual in their sociocultural context' (p. 60). Skills specific to consultations with Indigenous people included sensitivity to language used regarding Aboriginality and culture, avoidance of oversimplification of language, building trust and rapport over time, strategies to manage complex consultations and multi-morbidities, and application of knowledge regarding Aboriginal history and lived experience.

Pedersen et al. (2005) suggest that a focus on changing attitudes is often based on the assumption that changes in attitudes will lead to changes in behaviour. They note, however, that there is evidence to show that changes in behaviour can lead to changes in attitudes and that a focus on behaviour change may be more useful than a focus on attitudes. Teaching and learning of non-racist, respectful behaviours may be an effective means of bringing about change. This was affirmed by interviewees with experience in teaching the Hui Process and Meihana model (Lacey et al. 2011). Students learned behaviours and skills that had immediate application and therefore high currency for the student. Through applying these behaviours they engaged in more positive and rewarding interactions with Maori patients, which influenced their thoughts and attitudes.

Mechanism 6: Challenge beliefs

Many of the interventions challenged beliefs as an integral part of the program. The assumption here is that false and unhelpful beliefs need to be challenged not only to enable transformation to be achieved but, also, for it to be ethically sound' (Briscoe 2013). Challenging beliefs is closely aligned to processes of reflection. Several authors noted that educators needed to allow often racist assumptions and beliefs to surface in a safe environment. Again, the experience of distress and discomfort on the part of both students and educators was noted.

Pedersen and Barlow (2008) cite evidence from Batterham (2001) that found challenging false beliefs significantly reduced the acceptance of them and that participants whose false beliefs were challenged scored significantly lower on a prejudice measure compared with a control group. Pedersen and Barlow (2008) also note that the notion of 'false' beliefs fails to adequately capture a key characteristic of modern prejudice—the objection to 'special treatment' for Aboriginal Australians and other marginalised groups. Here there is a failure to appreciate the need for additional support to redress historical and social factors that have created and reproduced disadvantage. They suggest that 'in any anti-prejudice strategy, equal opportunity issues and the redressing of social disadvantage should be made clear' (Pedersen & Barlow 2008, p. 150).

Mechanism 7: Invoke empathy

A number of the interventions described noted that the strategies employed were designed to invoke or enhance empathy as a basis for reducing racism. Use of various narratives or storytelling strategies were recounted, linking with the tradition of storytelling within Indigenous cultures. The assumption regarding change was that these stories acted as the basis for collective discussions uncovering unconscious bias at the individual and societal level and

encouraged self-reflection on assumptions, values and social justice (Wain et al. 2012).

Wear and Aultman (2005) raise questions about the efficacy of reflective exercises in generalising to other experiences—does the empathetic response ‘follow them out of the classroom door?’ While a student may empathise with an individual character or person, it may not lead to reflection on the broader structural issues or their role in these. They draw on Boler’s ‘pedagogy of discomfort’ (1999) to suggest there is a need to move beyond passive empathy, sympathetically connecting with another, to understanding one’s social position and power which implicates oneself in the issues raised in the text. This would suggest a role for critical reflection and challenging of beliefs in the curriculum.

Mechanism 8: Address organisational/institutional factors

Common to many of the programs described was a general observation that success was contingent on a supportive institutional environment. A commitment to social accountability and community engagement were seen as important factors in the sustainability of a program in Aboriginal health at the Northern Ontario School of Medicine (Jacklin et al. 2014).

Although the role of organisational and institutional factors was often acknowledged there was little written on interventions specifically addressing these factors. One example is the Critical Reflective Tool (CRT), which uses the notion of the ‘hidden’ curriculum to uncover ways in which institutions undermine or support the ‘formal’ curriculum (Ewen et al. 2012; Paul et al. 2014). As well as the formal, officially endorsed curriculum, the unscripted interpersonal teaching and learning interactions form an influential informal curriculum. Organisational practices, structures and processes contribute to the hidden curriculum which influences ‘what is learned at medical school rather than what is taught’ (Ewen et al. 2012, p. 200).

They describe a trial of the tool in which 12 of 20 possible medical schools participated. They used the tool to examine four domains: institutional policies, evaluation activities, resource allocation, and institutional ‘slang’. Overall feedback regarding the tool was positive, but the utility of the tool was contingent on the process of implementation with executive-led and whole-school approaches yielding the most positive feedback. This reinforces the fact that how institutions and leadership engage with and value Indigenous health is critical in the success of the programs.

Overall

Examination of the mechanisms employed in Indigenous cross-cultural training has revealed that there is no simple recipe or toolkit to follow. There is value in employing multiple mechanisms and strategies, which can provide differing pathways to positive outcomes. Different mechanisms work in different ways in different contexts and different students will respond to mechanisms in different ways.

2.4 Constraining and enabling factors

While the act of bringing underlying, or implicit, program theories to the surface provides a useful starting point for analysing the programs, it is also important to pay attention to the many possible constraining and enabling factors. For each mechanism, there are factors that shape the outcomes and some of these have been identified in the summary of the mechanism.

Other factors were suggested as having contributed to successful programs and interventions overall and these are summarised below. The summary also draws on factors found to characterise successful programs relating to improving Indigenous outcomes and ‘closing the gap’ in terms of the key social determinants of health (Osborne, Baum & Brown 2013) and suggestions for improving anti-racism strategies (Pedersen et al. 2005).

- Programs are underpinned by a nuanced understanding of culture that accounts for broader social, political, historical factors such as the legacy of colonisation, social position, education and socioeconomic status.
- Indigenous peoples are involved in program planning, development and delivery.
- Organisational contexts are supportive, including provision of appropriate resources.
- Indigenous knowledge and cultural beliefs and practices are explicitly valued.
- There is high-level, committed leadership for programs, initiatives and interventions within schools and faculty.
- Indigenous staff are employed within a safe, supportive environment.
- A whole-of-school (or organisation) approach is adopted.
- There is a commitment to research and evaluation to inform program development and contribute to the knowledge base regarding Indigenous cultural training.

The emphasis on the broader institutional context fits with a realist approach to understanding how interventions work.

2.5 Resistance

In the first section we were concerned with uncovering how programs were thought to bring about change. In this section we turn our attention to instances of where the mechanisms brought about resistance, rather than the desired changes. Once more, we are seeking explanation rather than just description.

There appears to be a spectrum of responses to Indigenous cultural training. Students’ receptivity to content ranges from positive, supportive responses, an open disposition to feeling ‘moved, sorrowful, ashamed of our nation but not feeling personally blamed; uncertain, distressed, resentful, betrayed; and angry, rejecting’ (McDermott & Gabb 2010; Thackrah & Thompson 2013).

Resistance has been defined as ‘an unwillingness to consider research or theories that contradict one’s sense of social order’ (Moore 1997, p.128). Wear & Aultman (2005) note that, in particular, resistance can manifest as challenges to course material and teaching staff when presenting dimensions of inequality as issues of structural inequality or power differentials. For them, there are discernible modes of resistant student behaviour that can range from physical absence, or other forms of dis-engagement, to challenges to the very legitimacy or need for the course at all.

Student resistance can be expressed in many ways: non-engagement, discounting the authenticity of an Indigenous experience, prejudices and blatant racism. Students may fail to see the relevance of the curricula and resent it (Durey et al. 2008; Ewen et al. 2012; Johnstone & Kanitsaki 2008). Ward, Daniels and Branch (2014) use the term the ‘groan zone’ to characterise student resistance to decolonising pedagogy. As noted earlier, significant discomfort can arise when encountering alternative worldviews, uncovering taken-for-granted

prejudices and learning history from Aboriginal perspective. We have also previously noted, however, that discomfort and dissonance may also be pathways to desired changes. Thus, managing resistance implies a balancing act for educators—provoking levels of discomfort and dissonance that facilitates change without students rejecting or retreating from the material all together. Maintaining ‘safety’ for those who do engage was seen as important as pedagogical strategies that draw attention to personal processes and practices (Browne et al. 2009, p. 173). One strategy suggested was the development of a safe space in which students can engage with challenging curriculum (Thackrah & Thompson 2013). Components of a safe place or space might include establishing ground rules that support trust, suspension of judgement and censorship, and active listening. Inclusion of non-Indigenous presenters may encourage more openness and encourage questioning (McDermott & Sjoberg 2012).

Wear and Aultman (2005) apply a typology of resistance that suggests students may express resistance through denial, discounting or distancing. We have already noted that when imparting knowledge about health inequities it is possible that at least some students will deny the evidence and question the motivations involved in presenting the evidence (Browne et al. 2013). Students may reject evidence as it contradicts their own beliefs about inequities. Leach, Iyer and Pedersen (2007) draw on research demonstrating that many of the structurally advantaged non-Aboriginal majority believe that the Aboriginal people unfairly benefit from government handouts. Thus, despite evidence to the contrary, they may position themselves as deprived relative to Aborigine who they perceive as unfairly advantaged by government benefits.

Johnstone and Kanitsaki (2008) describe educators ‘appealing to various moral, legal, professional, and/or economic arguments to “make their case” and to “sell their ideas”’ (p. 147). These included arguments reminding participants of patient rights, their own legal obligations and organisational requirements. The efficacy of these approaches has not been evaluated.

Students may express resistance through discounting, dismissing the content as irrelevant to medicine (or other profession). Medical students have described non-biomedical components of the curriculum as ‘filler’ (McDermott & Sjoberg 2012). Where educators were able to communicate relevance, students appear more likely to engage. Reflecting on student reactions to various strategies, educators found that students seeming to ‘wake up’ from their unengaged stance when a case narrative demonstrated the benefits using a ‘Culture of Medicine’ model (Macdonald et al. 2007). Kamaka (2010) undertook focus groups with stakeholder groups to inform program design in Hawaii. Medical students felt that for cultural issues to be taken seriously they needed to be ‘high yield’; that is, involve content that would be assessed in exams.

The third strategy of resistance is distancing whereby students believe that ‘big picture’ changes, changes in social structures or institutions, are beyond their influence. As pointed out by experienced educators during interview, it is true that students are often in positions of limited power to challenge structures or processes and that concentrating on areas in which they have more agency—for example, the clinical encounter—is more productive. McDermott and Sjoberg (2012, p.26) describe a workshop specifically designed to engage with student resistance which ‘unpacks preconceived ideas, stereotypes and myths about Aboriginal and Torres Strait Islander peoples’. One of the outcomes of these workshops has been the creation of two student groups; a ‘Health and Human Rights Group’ and a ‘Cultural Safety Group’ suggesting given appropriate structures students can engage in structural issues.

While these strategies focus on student resistance, a number of authors focus on the role of institutions and the interaction of student culture, medical culture and organisational culture.

Roberts et al. (2010) explored the views of second-year students in two medical schools regarding cultural diversity training. They found that despite differing pedagogies the students' views were remarkably similar. Three coexisting, conflicting discourses were identified. Firstly, students claimed that although the training was important the schools marginalised its teaching. A second discourse suggested medical school was an 'inappropriate setting' as the subject matter was not relevant to biomedicine. Thirdly, it was felt that that cultural diversity experience should occur in the workplace and socially with their peers. The authors used Bourdieu's (1977) concept of habitus to explore the findings of potentially conflicting discourses. They suggest within the social structures of the medical school conformity raises the chances of success. 'Medical school' and 'student culture' are inextricably linked, each influencing the other. Failure of learning may be attributed to 'resistance' on the part of students, rather than institutional failure in validating the learning.

Hafferty's taxonomy (1998, cited in Ewen et al. 2012) of formal, informal and hidden curricula provides a useful framework to examine often invisible but powerful influences on the teaching and learning of students. The informal curriculum comprises interpersonal interactions between teachers and students, corridor conversations, and the broader societal values, norms and popular culture discourses that influence what and how, students learn. Policies, resource allocation, evaluation and institutional slang provide insights into the hidden curriculum (Paul et al. 2014). Students may respond to curricula with resistance because it is not supported by the dominant values, beliefs and practices that are communicated to them via the informal and hidden curricula. For example, in the Roberts et al. (2010) study cited above, they found that students believed medical schools marginalised and failed to adequately support effective teaching in the area of cultural diversity. This provides a powerful influence on how students react to the formal curriculum. Ewen et al. (2012) posit that the 'greatest barrier... remains an essential part of the hidden curriculum, which is how institutions and the leadership within those institutions engage and value Indigenous health' (p. 204).

A fundamental challenge to Indigenous cross-cultural curricula may be made regarding its place in the medical curriculum. Pointing to the need for system change Jacklin et al. (2014) suggest 'negotiation of space will continue to be a problem for Aboriginal health curricula at all medical schools until there is greater acceptance of Aboriginal ways of knowing and Aboriginal health is given more prominence in the Medical Council of Canada Qualifying Examination and accreditation standards' (p. 149). Claims have been made that such content is unnecessary as culture issues are not a major problem in clinical practice (Macdonald et al. 2007). Johnstone and Kanitsaki (2009) point to 'the healthcare illusion of non-racism', the belief that racism no longer exists or does not exist in this space. Others report faculty questioning its relevance and concerns raised about an already full curriculum (Roberts et al. 2010).

Another framework, developed by Essed (1991), was used to examine both personal and institutional resistance in a study of workplace training and identifies three areas of conflict: (1) norms and values, (2) societal resources, (3) definitions of the social world (Johnstone &

Kanitsaki 2008). Again, findings point to ways in which organisations and leadership can compromise the effectiveness of training. In particular, the authors point to the political nature of such training and suggest the politics of cultural diversity education and the 'politics of resistance' to such programs need to be better recognised and understood.

2.6 Outcomes

There seems broad agreement that the 'big picture' goal of Indigenous cultural training is an improvement in health equity. Achievement of this goal is predicated on outcomes that have been variously described as a culturally informed workforce, culturally competent professional or cultural humility.

What constitutes 'cultural competence', for example, remains contested and difficult to measure. Kumas-Tan et al. (2007) undertook a systematic review of frequently used cultural competence measures and in examining the 10 most widely used measure identified six 'problematic, unexamined' assumptions embedded in the measures:

1. Culture is equated with ethnicity and race.
2. Culture is possessed by the 'Other'; dominant groups are not seen as having a culture.
3. Cultural incompetence stems from lack of familiarity with the Other.
4. Cultural incompetence stems from practitioners' discriminatory attitudes to the Other.
5. Cross-cultural care is about Caucasian practitioners working with the Other.
6. Cultural competencies about being comfortable with oneself and with others.

Many evaluations consider short-term outcomes such as student reactions, changes in knowledge, attitudes, intention to change, but fewer examine actual changes in practice, patient experiences of practice or other outcomes such as increased equity of access. Short-term and intermediate outcomes are important to detail and link, they are a critical part of the causal pathway that explains how the program is supposed to work.

Dwyer, Silburn and Wilson (2004, p. 12) outline the causal pathway in this way:

... a theoretical causal pathway where desired outcomes such as improved health status and wellbeing are premised on the generation of certain impacts, such as changes in modifiable risk and protective factors operating in individuals and environments. These impacts are premised on changes in processes and/or structures such as improved capacity and higher quality or better coordination of services and programs. In turn, the implementation of new processes and structures requires a range of inputs or activities such as supporting policy directions, workforce development and funding. These chains of inputs and effects take place in a wider social and political context that mediates the effectiveness of all elements.

and make clear the relationship of such a model to evaluation:

... if empirical evidence of change can be seen for each of the points along the continuum, then it can be reasonably predicted that the outcomes are at least in part attributable to the program.

2.7 Generating a draft framework from which to develop a Guide to Good Practice resource

The purpose of this work was to inform discussion about 'good practice' and development of a good practice model. What then does this exercise contribute to our understanding of what works, for whom, and in what circumstances?

Firstly, and predictably, the review, analysis of the interviews, and subsequent roundtable discussion and refining demonstrate that design and implementation of what has previously been encapsulated under Indigenous cross-cultural training is not a straightforward or easy task. Different programs have different starting points - they draw on different conceptions of culture and may draw on a range of evidence and theories. There is a growing consensus that underpinning notions of culture need to move away from a focus on knowledge of beliefs, customs and traditions towards a more critical approach that engages with processes of identity formation, power relationships and resource distribution and the role of historical and social factors in producing these.

A range of possible mechanisms for change have been identified and each of these is influenced by layers of context and a multitude of constraining and enabling factors. A number of the programs included in the review implemented multiple strategies and activities. These encompassed a range of mechanisms and hence possible pathways for change. While it is likely that there may be debate regarding the identified mechanisms which are often 'hard to nail' (Greenhalgh et al. 2009), they provide a starting point for educators and evaluators to uncover program theory, consider the relationships between mechanisms and explicate the expected outcomes.

Chapter Three: ‘Having the Hard Conversations’ symposium and roundtable

In April 2015, a two-day symposium and roundtable: *Having the Hard Conversations: Good practice in working with resistance to Indigenous health and cultural safety*, was held at Flinders University in Adelaide. The event attracted 42 national and international participants, with expertise in the field, who contributed to the further development, or refining, of issues, approaches and good practice strategies.

The symposium and roundtable sought ways to ‘have the hard conversations’. In particular, it aimed to address a number of specific questions:

- How do we turn disengagement into continuing engagement with Aboriginal health/cultural safety training?
- What would diminish resistance/make the conversation easier?
- What would it take to turn services, systems or organisations into culturally safe ones?

3.1 Pre-symposium video interviews

Over two days prior to, and during the symposium, eight presenters—recognised as key national and international scholars in this field—were individually interviewed to draw out their responses to several major issues identified in the literature review. Each interview took between 60 and 90 minutes. All interviews were subsequently transcribed to provide further data for analysis in the service of refining the good practice framework. With permission, the full videos were professionally edited into six three-minute video resources that aim to provide concise, highly pertinent, but practical assistance to educators. Each of the six resources addressed a topic of particular relevance that included: challenges, cultural safety, power imbalances, self-reflection, listening, and mechanisms of change. Along with a 13-minute video, designed for use in organisational change contexts, they were initially made available for free download from the Poche Adelaide website at:

<http://www.flinders.edu.au/medicine/sites/poche.adelaide/cultural-safety.cfm>

and will also be available from the Lime Network’s Resources Hub at:

<https://www.limenetwork.net.au/resources-lime-publications/resources-hub/>.

Learning objectives and questions/prompts for facilitators were subsequently developed after trialling of the video resources in a variety of educational contexts, including professional development workshops, conference workshops, educational staff development workshops and health professional lectures and tutorials. These are also available for download, to accompany each video. The full videos (and transcripts) were retained for any subsequent resource production.

3.2 Development and refinement of the Guide to Good Practice

The work of the symposium and roundtable was informed by an early outline of the Guide to Good Practice resource (the guide), describing and drawing on the work of the literature review and initial interviews, then presented in the form of a ‘Having the Hard Conversations Discussion Paper’. This discussion paper brought together insights arising from both the literature and

expert informants to further explore the issues, strategies and outcomes of cross-cultural training approaches with a focus on Indigenous health and cultures.

The work undertaken on day one (Symposium) of the two-day program featured a number of individual presentations and panel discussions within sessions that explored specific areas of interest, as listed in Table 1, below.

Table 1. Symposium day one

Session One	How do students and health practitioners respond to indigenous health and cultural safety curriculum?	Individual presentations
Session Two	Institutional resistance and the challenge of fostering institutional change	Individual presentations
Session Three	Working with resistance at both the individual and the institutional level	Panel of scholars publishing in this area
Session Four	Embedding change in curriculum and securing institutional change: the potency, and politics, of accreditation	Panel of three Indigenous health peak bodies and two accreditation bodies
Session Five	Introduction of discussion paper: <i>Towards a good practice framework to address individual and institutional resistance</i>	Individual presentation

Day two (Roundtable) began with a summary of what had emerged from day one, before attendees split into three groups to work on specific issues, before reporting back to a final plenary session. The full symposium/roundtable program is attached as **Appendix C**.

Chapter Four: Conducting a comprehensive, multi-tier, suite of dissemination activities at a range of locations.

4.1 Conducting practical workshops for those delivering Indigenous health curricula

Four, specifically tailored **dissemination workshops** were held across a number of states in 2015 and 2016. The workshops provided opportunity for educators and other stakeholders to engage with the issues, and strategies-in-response, arising from the fellowship's literature review, interviews, and other elements of its program of work. After the video resources were developed and trialled in on-campus teaching and staff workshops, they were introduced into the workshops. Elements of the Guide to Good Practice were progressively introduced, as strategies, as they emerged from the process of refinement. The guide was not released, nor distributed in (stand-alone) draft form at the workshops, as a decision was made to make use of the workshops and related fora to provide end-user feedback into the final version. The locations and partnering institutions for each workshop are listed in Table 2, below. Numbers of participants at each site ranged from 45 to 70)

Table 2. Dissemination workshops

DATE	LOCATION	PARTNER INSTITUTION
12.6.15	Melbourne	The University of Melbourne
6.11.15	Perth	National Aboriginal & Torres Strait Islander Higher Education Consortium (NATSIHEC)
17.11.15	Sydney	University of New South Wales
11.3.16	Canberra	Office of Learning and Teaching (OLT)

At the Perth workshop, involving participants from NATSIHEC, Professor David Paul—a collaborator on this fellowship—mapped the varied issues worked through, and strategies explored by, participants.

His schematic representation (see Figure 5) captures many of the major curricular, pedagogical and organisational challenges arising from the fellowship's program of work and provides a visual guide to a range of the complex processes involved.

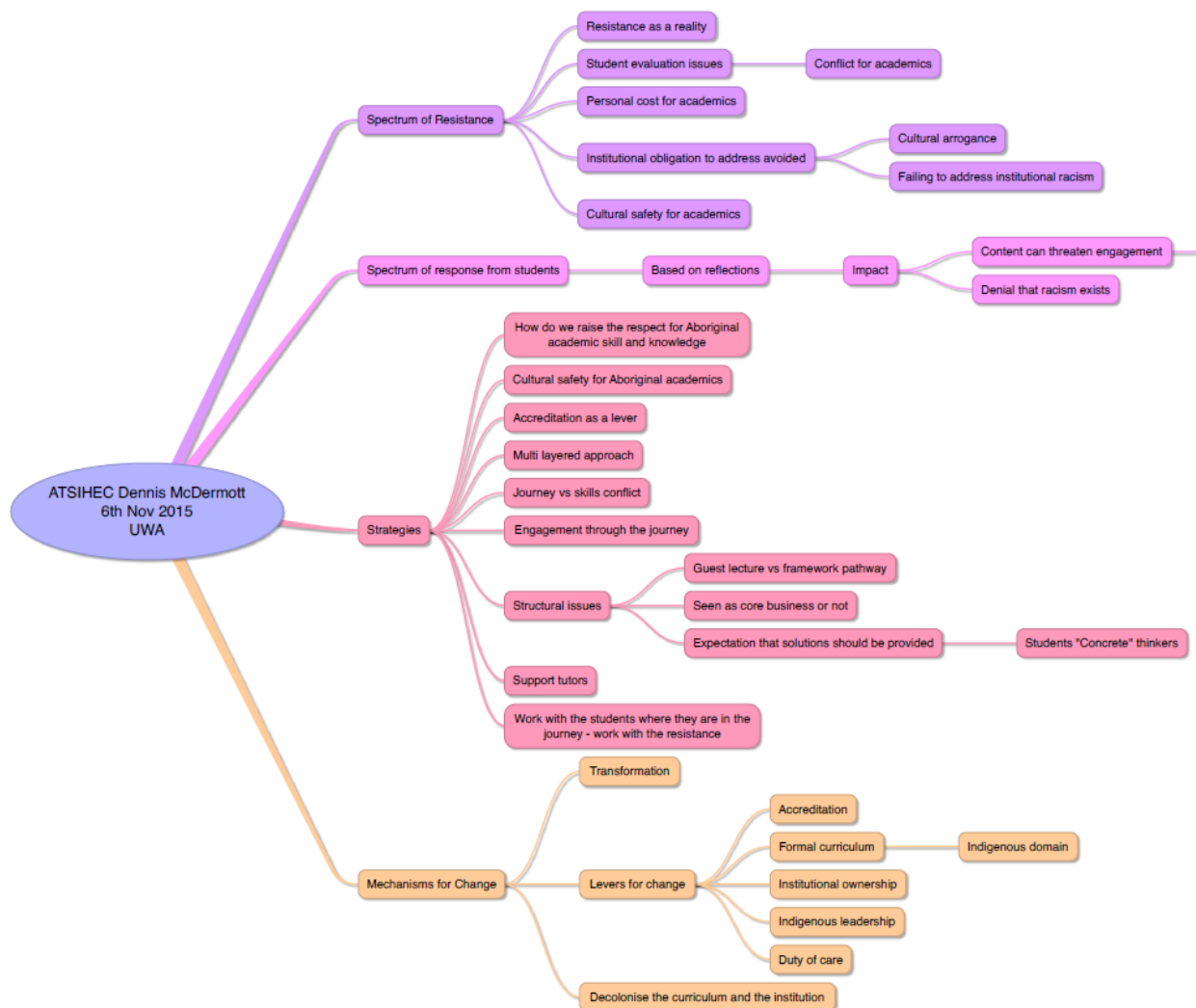


Figure 5. Major curricular, pedagogical and organisational challenges

4.2 Providing briefings on program outcomes to key stakeholders

The 2015 symposium and roundtable provided an initial opportunity to engage with two of the major health discipline accreditation bodies—The Australian Medical Council (AMC) and the Australian Nursing and Midwifery Accreditation Council (ANMAC)—in conjunction with key Indigenous health peak bodies—Australian Indigenous Doctors Association (AIDA), Indigenous Allied Health Australia (IAHA) and the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM)—around the implications for health professional course accreditation related to issues of concern, and strategic responses to identified concerns, arising from the fellowship’s program of work. A panel discussion on day one, involving these five organisations, focused on raising and clarifying the ramifications for accreditation requirements, and for reviewing processes, of such issues as student resistance and organisational ‘gate-keeping’. The fellowship had hoped to engage more deeply with all relevant accreditation bodies to pursue concrete changes to accreditation practice. The scale of the process—of evidencing the need for change, researching best practice accreditation processes and pursuing these to course-specific outcomes—proved too great for this fellowship alone.

Three less-encompassing modes of stakeholder engagement, that still form part of the jigsaw of change, however, should be noted. The first was the mutually productive relationship

developed between the fellowship host centre, Poche Adelaide, and CATSINaM. This collaboration deepened as the fellowship progressed and the interaction of the fellowship's desire—to ensure that the developing good practice framework was as relevant to stakeholder needs, as well as fit-for-purpose in responding to those needs, as possible—aligned with CATSINaM's central aim to embed cultural safety into all nursing and midwifery education, and health care delivery to Indigenous Australians. Joint activities, including co-convened seminars, invited conference addresses, partnering on a national Indigenous health curriculum adaption and co-developed resources advanced both the fellowship's and CATSINaM's agenda.

The second opportunity to effect change, through bringing elements of fellowship work to bear on a major stakeholder's agenda, arose with an invitation to join a small group reviewing the NATSIHP (2013–2023). As the body responsible for the embedding in training and health care delivery of a groundbreaking, but ambitious new approach—one requiring key attention to the role of culture and the social determinants of health, including racism—the Australian Government's Department of Health (DoH) requested input from the fellowship. A presentation was requested, along with participation in planning, as the DoH set about preparing an implementation plan capable of operationalising these previously under-addressed elements.

A third strand of stakeholder engagement was a product of a collaboration with the Royal Flying Doctor Service (RFDS), through its CEO, Mr Martin Lavery, and the Patron of the Poche Indigenous Health Network (PIHN), Professor Tom Calma. The collaboration coalesced around a mutual desire to contribute, including through the findings of the fellowship, to a well-evidenced, but bolder national discourse on embedding cultural safety in expected standards for both health professional training and health care delivery. The collaboration resulted in a journal article (Lavery, McDermott & Calma 2017), published in the *Medical Journal of Australia* that was designed to advance the national discourse on the issue and a first step in building momentum for a change in quality assurance standards; one that would provide a real impetus for overcoming fellowship-identified barriers to better outcomes.

4.3 Conference presentations, seminars, webinars and other modes of dissemination

Once the learnings of the symposium and roundtable had been digested, and in parallel with the specifically-targeted workshops addressed in 4.1 (above), a range of academic and more-general other fora, through which to disseminate elements of the good practice framework, were pursued. A comprehensive listing is available in **Appendix D**. Keynote conference presentations, invited plenary presentations and invited public seminars, provided particular platforms for engaging with diverse audiences. An example of dissemination to an important academic audience was the keynote address at the *Australian and New Zealand Association of Health Professional Educators (ANZAHPE) Conference*, Adelaide Convention Centre, 12 July 2017, on 'The power of "holding", the dilemma of de-othering: eliciting individual and institutional transformation within Indigenous cultural safety education'. In contrast, a public lecture platform was offered by a period as *Scholar in Residence* at Sydney Nursing School, 9 November 2017, on the topic of 'Having the Hard Conversations: how do we work with resistance, and yet maintain student engagement, to graduate culturally safe health professionals?' Yet, even concurrent conference session presentations offered scope to extend the fellowship's engagement with academic discourse in the field. One example is the session delivered to the *International Federation of National Teaching Fellows (IFNTF) World Summit*, in

Halifax, Canada, on 5 May 2018 on the topic of ‘The power of ‘holding’: Eliciting individual and institutional transformation within Indigenous cultural safety education’.

Specific webinar opportunities were pursued in Australia, with the Australian Psychological Society’s webinar series on the role of the SDoH in psychological practice and in Canada, with the San’Yas Indigenous Cultural Safety webinar series—one particularly addressing responses to indigenous-specific racism—reaching a wide audience. Often, fellowship-derived participation in a seminar would also provide a webinar audience, along with the frequent possibility of incorporation within a permanent video-recording of the event providing a freely accessible web resource. A particular example of this was this fellowship’s association with the OLT National Teaching Fellowship of Dr Chelsea Bond. Dennis McDermott and Dave Sjoberg’s inclusion in both the Sydney and Melbourne iterations of Dr Bond’s final dissemination seminar, *Teaching While Black*, yielded both extended web coverage and permanent resource production. This event was also one of a range of dissemination activities—involving particular conference presentations (including, notably, the May 2018 National Speech Pathology Australia Conference) as well as other seminars and a Poche Key Thinkers Forum (‘Outing’ Unconscious Bias, August 2018) that gave rise to documented, strong social media activity, particularly through Twitter—that enabled audiences access to fellowship’s issues and responses that they might not have otherwise had.

Chapter Five: Resources produced—Guide to Good Practice and video resources

5.1 Guide to Good Practice

The full guide is attached as **Appendix B**. It is available for free download, initially through the Poche Adelaide website, at:

<http://www.flinders.edu.au/medicine/sites/poche.adelaide/cultural-safety.cfm>

but will also be available through the Leaders in Medical Education (LIME) Network's Resources Hub at:

<https://www.limenetwork.net.au/resources-lime-publications/resources-hub/>.

A summary contents page is reproduced below.

Table 3. Summary contents page for the Guide to Good Practice

Having the Hard Conversations	
<i>A guide to good practice in Indigenous health and cultural safety education</i>	
• About this project	Section 3
• Acknowledgements	<i>Building the scaffold/setting the stage/organisational change</i>
	1. Organisational readiness/support
	2. Leadership
	3. Well-Being and resilience of educators/emotional labour
	4. Partnerships and networks
Section 1	<i>In the classroom/building the curriculum/refining pedagogy</i>
1. What is <i>Having the Hard Conversations</i> ?	1. Creating a safe space
2. Why do we need a guide?	2. Invoking empathy
3. How has the guide been developed?	3. Dealing with culture
4. Some notes on terminology	4. Learning to listen
Section 2	5. Building critical reflection
1. Indigenous health inequities	6. Decolonising educational institutions and health care organisations
2. Racism and health	7. Addressing power and privilege
3. Our duty of care: professionals and stewardship	8. Evaluating our practice
4. Building on Indigenous foundations: Embedding Indigenous knowledge, values and processes	

5.2 Video resources

As noted in 3.1 (above), a range of professionally developed video resources are available for educator use. Each of six three-minute videos address a topic of particular relevance including: challenges, cultural safety, power imbalances, self-reflection, listening; and mechanisms of change. Along with a 13-minute video, designed for use in organisational change contexts, they are available for free download from the Poche Adelaide and will also be available from the Lime Network's Resources Hub at the web addresses given above.

Accompanying learning objectives and questions/prompts for facilitators are also available for download.

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Appendix A

Certification by Deputy Vice-Chancellor (or equivalent)

I certify that all parts of the final report for this OLT grant/fellowship provide an accurate representation of the implementation, impact and findings of the project, and that the report is of publishable quality.

Name: Professor Clare Pollock

Signature:



Date:

30-1-19

Professor Clare Pollock
Deputy Vice-Chancellor (Students)
Flinders University
30th January 2019

Appendix B

Guide to Good Practice

Having the Hard Conversations: *A guide to good practice in Indigenous health and cultural safety education*

About this project

This 'Guide to Good Practice' (the guide), is one of the major educational resources arising from a National Senior Teaching Fellowship awarded to Professor Dennis McDermott in 2014 by the (then) Australian Government Office of Learning and Teaching (OLT). The programme of work, *Having the Hard Conversations: Strengthening pedagogical effectiveness by working with student and institutional resistance to Indigenous health curriculum*, involved a team of national and international scholars in the field of Indigenous health and cultural safety education. Over a four-year period, they collaborated to develop, refine and disseminate a framework for conceiving of, and delivering, effective strategies to meet student and institutional resistance to the personal, professional, and political challenges encountered by many in curriculum material and teaching processes alike.

The guide aims to be well-evidenced, accessible and practical in application. It is designed to be used in tandem with a suite of video resources that are directly applicable to a range of health professional educational settings (whether university courses or professional development workshops). In particular, six three-minute video resources, drawn from interviews with key national and international scholars in this field, aim to assist educators looking to keep students and practising health professionals engaged and successfully traversing a journey of change, despite any cognitive dissonance or emotional discomfort. Titles available include: Challenges; Cultural Safety; Power Imbalances; Self-Reflection; Listening; and Mechanisms of Change. A thirteen-minute video, suitable for use in organisational change contexts is also available, as are other downloadable video recordings of seminars, webinars and other presentations aimed at supporting educator comprehension and pedagogical success.

All video resources, and accompanying facilitator material, are available for free download at the Poche Adelaide website at:

<http://www.flinders.edu.au/medicine/sites/poche.adelaide/cultural-safety.cfm>

and will also be available from the Lime Network's Resources Hub at:

<https://www.limenetwork.net.au/resources-lime-publications/resources-hub/>.

Acknowledgements

Although, as noted, this work represents the outcome of a formal, four-year collaboration, it had its genesis in informal projects-in-common - and a generous sharing of scholarship, experience and insights - over a much longer period. Valued input has been provided by core team-members of Flinders University's Poche Centre for Indigenous Health and Well-Being, Adelaide, along with Professor David Paul (University of Notre Dame), Dr Tamara Mackean (Flinders University), Ms Cheryl Ward (Provincial Health Services Authority of British Columbia, San'yas), Ms Laurie Harding (Provincial Health Services Authority of British Columbia, San'yas), Dr Barry Lavalley (University of Manitoba), Dr Melanie Tervalon (Children's Hospital Oakland, California), Dr Rhys Jones (University of Auckland), Dr Chelsea Bond (University of Queensland), Dr Suzanne Pitama (University of Otago), Dr Martina Kamaka (University of Hawai'i), and Professor Joseph Keawe'aimoku Kaholokula (University of Hawai'i).

Special thanks, for extensive contributions - over and above - go to Mr Dave Sjoberg, Dr Angela Lawless and Ms Liz Larkin.

Section 1

1.1 What do we mean by ‘Having the Hard Conversations’?

Non-Indigenous health professionals deliver the majority of interventions and programmes to Aboriginal and Torres Strait Islander Australians. Their work is pivotal to improving a range of Indigenous health outcomes, which for many indicators are the worst of any population group in the nation.ⁱ Yet many, thoroughly competent, professionals report uncertainty regarding how to engage with Indigenous health issues, cultures, clients and communities. Many cite a personal lack of social relations with Aboriginal and Torres Strait Islander peoples, particularly evident where encounters with Indigenous Australians pass unrecognised in the wake of inaccurate views of what diverse Indigenous Australia looks like, and where it resides. When ranged alongside a still-existent inadequacy in health professional training in Indigenous health, in the contemporary consequences of colonisation, and in the provision of culturally-safe care, for a number of practitioners the response to the possibility of such a professional encounter is unease, even fear (McDermott, 2016).

To provide services that Indigenous Australians would want to engage with, it is crucial for service providers to be aware of their own assumptions, attitudes, beliefs, and values. This requires not only fostering health professional reflection on their own culture in relation to a professional’s therapeutic interactions but, also, the re-positioning of such reflective practice as the default setting for effective cross-cultural work - i.e. as *core* clinical, health promotional, and organisational business. One exemplar approach which encapsulates the need for the mitigation of power differentials, for the development and embedding of self-reflective practice, and for treating clients ‘regard-ful’, rather than regardless, of difference - is the above-mentioned one of cultural safety.

The same precepts of recognising and reducing power differentials, self-reflexivity, and conscious avoidance of a conflation of equity and sameness of treatment (often expressed as ‘I just treat everyone the same’) are central to a number of other approaches that are of similar pertinence to Indigenous health education - and utility to a future practitioner’s clinical, or health promotional, effectiveness. These include: cultural humility (Tervalon & Garcia, 1998); the more-nuanced and flexible models of cultural competence offered by Weaver (1999) (a model from a Native American perspective) and Goode and colleagues at the (US) National Center for Cultural Competence (Goode, 2014); as well as the Australian-developed Integrated Model of Gabb and McDermott (2008). These approaches inform our comprehension of the minimum good practice requirements for effective cross-cultural service provision, yet their implementation holds major ramifications for individual practitioner training, organisational quality assurance, and overall service configuration.

The very content of Indigenous health and cultural safety training, along with the potentially-disquieting degree of critical analysis involved, challenges many students and health professionals on personal, professional, organisational and political levels. Where students or practitioners respond with resistance - and, in particular, with disengagement - teaching and learning can fail. The development of a workforce that is genuinely effective in Indigenous health settings is jeopardised. Institutions, such as universities, hospitals or government departments, can also resist. The comprehensiveness of Indigenous health subjects may be diluted, Indigenous perspectives can be discounted and core subject status dismantled.

Student resistance can be expressed in many ways: non-engagement, discounting the authenticity of an Indigenous experience, prejudices and blatant racism. Students may fail to see the relevance of the curricula and resent it (Downey, Ward, Daniels et al (2014 use the term the “groan zone” to characterise student resistance to decolonising pedagogy. As noted above, significant discomfort can arise when encountering alternative worldviews, uncovering taken for granted prejudices and learning history from Aboriginal and Torres Strait Islander perspectives. Significantly, however, discomfort and dissonance may also be pathways to desired changes. Thus, managing resistance implies a balancing act for educators - provoking levels of discomfort and dissonance that facilitate change without students rejecting or retreating from the material all-together.

Students tell us that they come to health professional education ill-informed by schooling and upbringing, as well as ill-informed by a pervasive stereotyping in sections of print, electronic and social media. We know that those who deal in ‘shock-jock’ tactics, whatever their medium, deploy negative stereotyping as a means for putting a complex topic beyond cool examination. In doing so, they also reinforce a widespread misunderstanding of crucial elements of both a shared national history and the nuance of, and sophistication within, Indigenous knowledge systems. In turn, such disinformation can diminish the willingness of students and practitioners to engage with Indigenous health and cultural safety education whenever the dissonance with existing knowledge and value systems becomes too great.

One lesson arising, then, from the widespread colonial legacy of the demeaning, even demonising, of Aboriginal and Torres Strait Islander culture, knowledge and perspectives might be for an educator to *expect* to meet some discomfort, even some desire for disengagement, from students. The substantial body of work of the University of Hong Kong’s Professor LC Chan, in seeking to embed medical humanities into medical student training - in the service of creating healers rather than mere medical technicians - is premised on a foundational strategy of ‘turning *towards* dissonance’, rather than away, whenever it is encountered (Chen, Salter & Chan, 2010). We need a pedagogy that assists us to work *with* student discomfort, to make any disquiet manageable, to create a sufficiently-safe space to have the ‘hard’ conversations.

1.2 Why do we need a guide?

Although the models referred to above have been developed to better prepare the health workforce to be more effective, there is little evidence that, across the range of approaches, cultural training for health professionals can produce better health outcomes for patients or clients. It is even difficult to clarify whether, or not, specific elements of health professional training can be shown to influence the future behaviour of a practitioner. One of the events central to developing the framework upon which this guide is based, 2015’s Poche Key Thinkers Forum, FINDING COMMON GROUND - AVOIDING THE TERMINOLOGY TRAP: *Identifying and applying the critical elements of Cultural Competence/Humility/Safety for effective cross-cultural work*, suggested that we have little evidence that, whatever the model, health care systems have been able to successfully operationalise them for incorporation into the work practices of a service. In fact, evaluation of system-wide programmes from a New South Wales health region (Hunter New England Health) and a Canadian province (Provincial Health Services Authority of British Columbia) point to very real difficulties in embedding culturally respectful/competent/safe ways of working as the system’s normative practice. We do know, though, many of the conceptual and training approaches through which we have been attempting to develop more-effective practitioners have not been working. In the development of the framework, and subsequent guide, we needed firstly, then, to jettison what’s been shown to be unhelpful. A second response was to develop a shared understanding of the domains of greatest promise for further scholarship and better training. A major recognition arising from the 2015 forum (whose contribution to the strategies discussed in this guide are dealt with in more detail in Section 1.4, below) was that, in the search for better health outcomes, there is an imperative to deal with any ‘terminology trap’: the issues are beyond semantics or any need to come up with the one, ‘right’ model.

In the search for which dimensions may be key, this forum set out to examine the workings of the different models: what sets them up for effectiveness? It became clear, however, that there were also pre-conditions to examine:

- Firstly, what are the **contexts** in which patient or client lives are lived? This requires close attention to the historical and contemporary circumstances of a particular community, or wider population group - this forum particularly addressed Indigenous Australians, Canadians and New Zealanders, along with African-Americans. On the positive side, what strengths or resilience (including cultural resilience) need to be factored-in? On the negative, what’s the role of ‘white’ or ‘settler’ privilege, colonisation and racism?

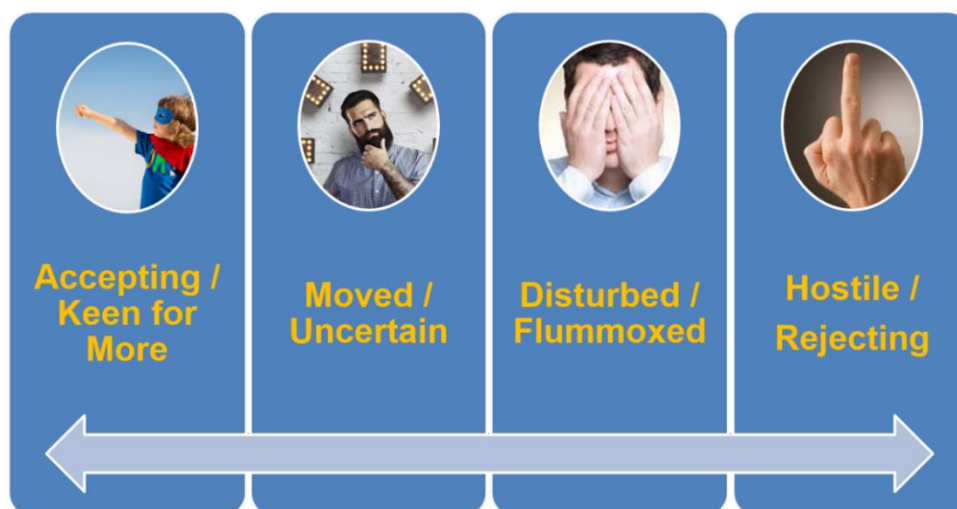
- Secondly, what are the **mechanisms** by which a model can bring about change in a health professional, or health organisation? Does it involve imparting foundational knowledge about health inequities, as much as building necessary knowledge about a specific cultural group? Is it important for its working to provide cultural encounters- and what kind? Does the model seek to teach skills, challenge beliefs or invoke empathy - or some combination of such particular mechanisms?

Beyond descriptive terminology, we need a deep comprehension of the dynamics at play when a particular model is applied to practice if we wish to improve practice through strengthened training. It's possible that our terminology referring to working across cultural divides is, in itself, problematic. There may be an inherent 'Othering' in focussing too strongly on being more effective 'cross-culturally': "Every clinical encounter you come up against is a cross-cultural encounter" (Dr Rhys Jones, Finding Common Ground). Until a more-accurate term emerges, 'cross-cultural' should, perhaps, be bookended by scare quotes. If, indeed, "culture has many axes that describe who we are" (Dr Melanie Tervalon, Finding Common Ground), then that mandates a caution in approach - a perceptual humility - that actively avoids a too-simple characterisation of the patient or client. If relational humility is essential to working well with the unique person presenting for health care, then there is a tension here between health systems that demand competence of practitioners - especially in doing no harm - and the need for those practitioners to acknowledge a very real 'not knowing'. No level of practitioner skill guarantees a real comprehension of how the person they're working with actually experiences the world, nor how they might wish to proceed right now.

1.3 How has the guide been developed?

As noted, above, the Guide offers a comprehensive suite of responses to the dilemma of how best to maximise the continuing engagement of a student or health professional with Indigenous health and cultural safety education, despite a range of reported challenges thrown up by the nature of curriculum material and pedagogical approaches. The need for a comprehensive response to resistance and disengagement initially arose in the delivery, by Diane Gabb and Dennis McDermott - over a ten-year period, in NSW and Victoria - of a sequence of Indigenous and multicultural mental health workshops. Evaluations over this period gave evidence of the issue of emotional responses from participants, to challenging material, as a constraint on the effectiveness of the educational process. This was bolstered by subsequent evaluations of undergraduate and postgraduate health professional Topics (course subjects) over a seven-year period, at Flinders University, yielding similar findings.

Figure One - SPECTRUM OF RESPONSE



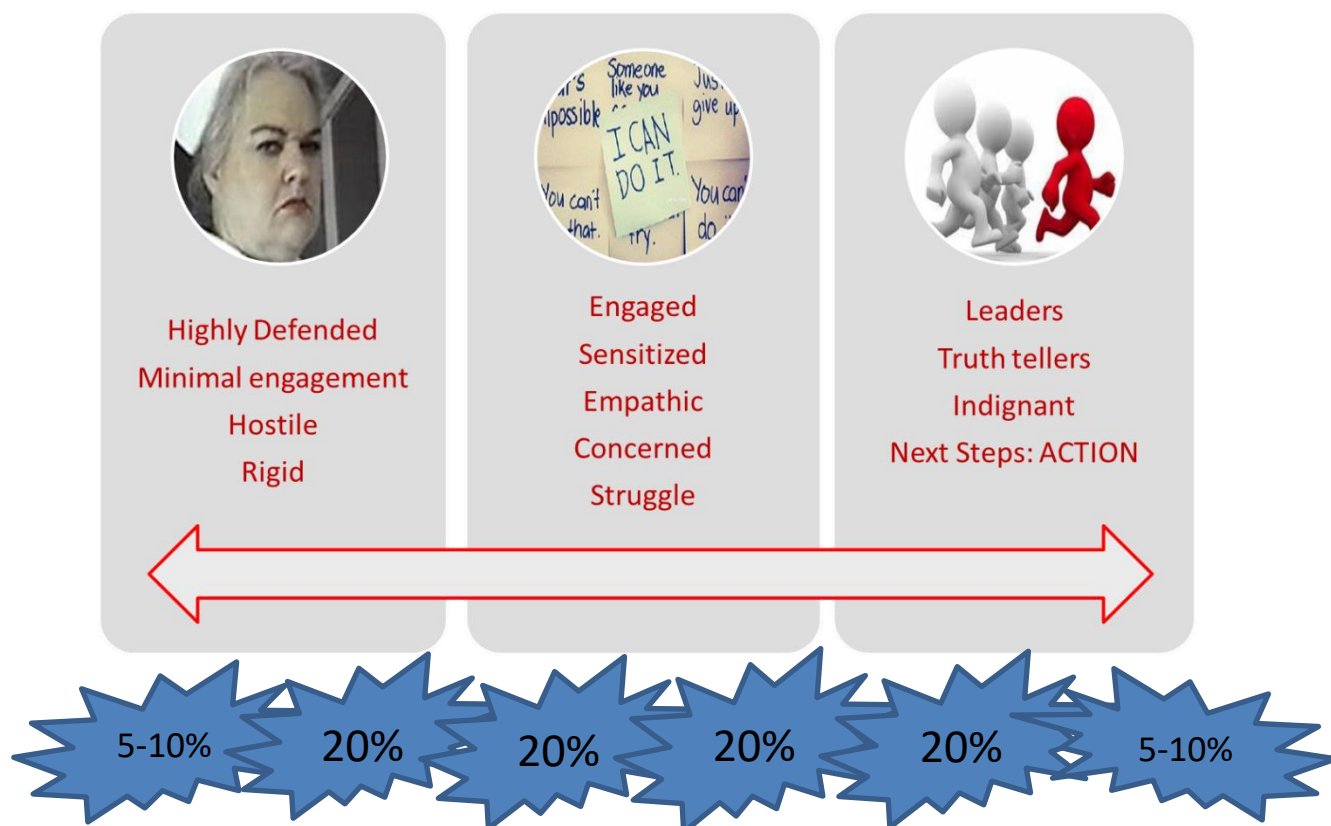
Our findings have been paralleled by large scale evaluation data reported from a province-wide, sophisticated on-line cultural safety training delivered in British Columbia (Daniels & Ward 2015). In both the Australian and Canadian jurisdictions, we note the emergence of distinctive modes of responding to

the challenging material that many students are meeting, in a comprehensive way, for the first time.

Both sets of responses ranged from very negative to very positive. Students and practising professionals alike showed evidence of at least four response styles, merging one into the next along a spectrum. The first, which we have dubbed 'Accepting/Keen for more' (in the Canadian context 'Truth-tellers/Champions' (Daniels & Ward 2015)), could be characterised by its openness and willingness to engage, together with a desire to know and learn, no matter the difficulty of some of the material (McDermott 2016). In the second mode, 'Moved/Uncertain', there was often a sense of sorrow around the events and consequences of colonisation; a perception of a national shame, but no indication of feeling personally blamed. The third discernible grouping, 'Disturbed/Flummoxed', responded to challenging material with evident distress, a number of participants believing that they were being judged, and found guilty. To many within this group, the material was a source of major dissonance. Comments displaying a sense of betrayal jostled with others indicating denial or resistance. A reluctance to stay engaged with curricular material was evident. The final group, dubbed 'Hostile/Rejecting', often evidenced anger and class disruptiveness (McDermott 2016).

The San'Yas Indigenous Cultural Safety team of the Provincial Health Services Authority of British Columbia had gathered data (by 2018) on 30,000 interactions with the on-line training by practicing health professionals - and found a parallel pattern of responding, a spectrum, or continuum, of emotional response they termed the Participant Profile Continuum. Their schematic representation of the groupings is depicted in Figure Two.

Figure Two - Participant Profile Continuum
(Daniels and Ward, 2015)



[This slide depicts findings from the work of the San'yas Indigenous Cultural Safety Training, Provincial Health Services Authority of British Columbia, Canada. It is used with permission and acknowledgement]

Substantive work on generation of a good practice framework - upon which to base such recommended strategies as are captured in this Guide to Good Practice - began with a rapid evidence assessment of the pertinent literature, as part of a wider realist review. Our evidence gathering continued through

individual and group interviews with selected Indigenous health academics involved with related curriculum development and teaching delivery in both Australia and New Zealand, to which were added interviews with key scholars in the field who were presenting at a first event, in April 2015. A summary of our approach, and findings, are captured in the Fellowship Report, available on the Australian Government's Department of Education and Training website. For those seeking a more-comprehensive account, the same report lists, amongst its appendices, a full account of this aspect of the fellowship's programme of work.

Over two days then, in April, 2015, a **Symposium and Roundtable: *Having the Hard Conversations: Good practice in working with resistance to Indigenous health and cultural safety*** was held at Flinders University in Adelaide, South Australia. It attracted 42 national and international participants with expertise in the field, who contributed to the further development, or refining, of issues, approaches and good practice strategies. A number of **Dissemination Workshops** (Melbourne, Perth, Sydney and Canberra) followed, in 2015 and 2016, which provided opportunity for educators and other stakeholders - including the National Aboriginal & Torres Strait Islander Higher Education Consortium (NATSIHEC) and the Australian Government Office of Learning and Teaching (OLT) - to engage with the issues, and strategies-in-response, arising from the Fellowship's **Literature Review, Interviews**, and other elements of its programme of work. Numbers of participants at each site ranged from 45 to 70). The developing findings of the Fellowship also informed a further sixteen national and international **Seminars, Webinars and other Fora**.

A number of direct **Consultations with Government and Industry**, including the Australian Government's Department of Health and Ageing, and the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM), provided opportunities to embed Fellowship findings in the implementation of nationally-relevant policies and training.

Academic outputs included five keynote **Conference Presentations**, invited **Plenary Presentations** and **Invited Public Seminars**, as well as seven **Concurrent Sessions**. Two Fellowship-related, refereed **Journal Articles** have been published - Sjoberg, DB and **McDermott, DR** (*International Journal of Critical Indigenous Studies*, 2016) and Lavery M, **McDermott, DR** and Calma T (*Medical Journal of Australia*, 2017) - with a third article submitted and a fourth in draft form.

Print and Electronic Media Coverage: Fellowship-related content informed coverage in The Australian newspaper's Higher Education Supplement, along with interviews with Indigenous radio and ABC Television News. Both activities and content continue to inform educational discourse and practice in the form of freely-available, web-based video-recordings of seminars/webinars (Australia and Canada), as well as post-conference video interviews.

1.4 Some notes on terminology

To have meaningful conversations around education for effective practice in Indigenous health settings means that individuals and organisations need to sift through the array of cross-cultural models to navigate a path between competing frameworks. These include, but aren't limited to cultural awareness / respect / appropriateness / competence / capability / sensitivity / safety / security / humility / ease. The models overlap on many agreed elements, but can also take differing positions on some fundamental principles. One such is the central question: Is it more important to know reams about the 'other', or better know and understand the self? Definitive answers on which language and models offer the most effective outcomes are hard to come by, the evidence available is limited and made less-reliable by widespread inconsistency in how frameworks are defined and applied.

In attempting to find common ground, a 2015 forum of national and international scholars, expert in this area, explored different ways of conceptualising, then responding to, approaches to developing effectiveness in health care delivery within Indigenous health contexts - then sought ways out of the '**terminology trap**'. This Poche Key Thinkers Forum, FINDING COMMON GROUND - AVOIDING THE TERMINOLOGY TRAP: *Identifying and applying the critical elements of Cultural Competence/Humility/Safety for effective cross-cultural work*, attempted to clarify our understanding of

which elements, across the array of models, are critical to success, along with identifying any less-obvious barriers to effectiveness. They contributed to a video resource and an opinion paper, which sought sharper understanding of good practice in identifying, integrating, and applying the key dimensions of successful approaches.

FINDING COMMON GROUND ... WHICH ELEMENTS, OR ISSUES, APPEAR ESSENTIAL TO A GOOD-PRACTICE MODEL?

The forum critically examined the experiences of teaching and applying such common approaches as cultural safety, cultural competence and cultural humility. A number of key issues emerged which are capable of informing good practice.

A. We need more-sophisticated frameworks

If improved health outcomes are our goal, then we need to respond to all the areas that need addressing to allow relevant aspects of health practice to be properly addressed. Firstly, our theoretical underpinnings must be clear. Secondly, the wider contexts in which training and delivery take place require a fully consideration - and response. Finally, the spectrum of student and institutional response - which runs from 'accepting' and 'fully embracing' at one end, to 'hostile' and 'rejecting' at the other - needs factoring in. "We have to avoid the 'black box' of the learner". Our models need to be both comprehensive enough to address such issues as health equity and nuanced enough to allow a real flexibility in how a practitioner engages with the person in front of them.

B. "Every clinical encounter is a 'cross cultural' encounter"

If diversity is the only norm, embracing complexity becomes the only option. Localised, population-specific cultural awareness may provide useful signposts, but we certainly can't reduce the person in front of us to a collection of givens, or easily-knowable 'facts'.

C. Effective clinical or population health practice occurs at the intersection of population-level social determinants and personal uniqueness of identity and experience

This intersection comes with flashing amber lights - proceed with care. The health professional may need to, simultaneously, hold in mind social determinants of health of potential relevance to the person or community, whilst remaining alive to the unique identity and experience of the person or, indeed, community, with whom they're working. There are aspects of both cultural safety and cultural humility that can contribute, here, to a common ground of good practice. These could be summarised as:

- (a) keeping your professional skill set at the ready, but accepting you can't presume to know the complex circumstances behind this patient's, or client's, presentation;
- (b) working with consequent humility; and
- (c) creating a sufficiently safe space for both engagement and a helpful narrative to emerge.

D. "What is shared is oppression."

A good practice model would foster comprehension of the role of structured power and privilege. This is a difficult task. The issues involved are central, but sensitive as they include analysis of what has been termed 'white' privilege or 'settler' privilege: an un-earned advantage bestowed simply by membership of the culturally-dominant group. Analysis can usefully include examination of how control exercised by a dominant culture not only shapes the way things are done, but imbues them with the aura of the 'normal' - they become the automatic 'default' position for the way things are done - which then drives the ways services are designed and delivered: "Settler health institutions are designed for settlers". Addressing, and freeing up the automatic nature of this dominance, would require institutions - a health service or a university faculty - to take stock of which of their processes side-line Indigenous knowledge or experience, or constrains an active role for Indigenous perspectives.

Students need strategies to minimise power differentials in their own health encounters - such as self-reflective practice - along with the means to deal successfully with oppressive clinical or organisational hierarchies. Taking such charged material on board requires ways with which to examine things that may have never been questioned before. This suggests a powerfully-useful role for building both student and institutional criticality (explored further in Point H, below). Criticality can engender discomfort, at least initially, and discomfort can produce resistance. It is important, then, for institutions to be fully live up to their oft-stated goals of being socially-accountable. Thus, a truly-comprehensive model would incorporate modes to successfully address institutional resistance, recognising that institutional change requires “deep change”.

E. Cultural competence, like all models, needs to evolve so we can attain the health outcomes we desire

Forum discussion on cultural humility, which was developed in contra-distinction to cultural competence, noted that “We [all] made a contribution - at a particular time in history - that was useful.” We now need to come to some place that works for all of us. It was additionally noted that it’s “all about the dialogue ... we shouldn’t get bogged down by definitions, but rather expand. It’s important not to be trapped by the terminology, but instead keep the conversation going.” There was a recognition that many of the ways that we’ve been developing cultural knowledge are not working. For example, a simplistic, piece-meal, cultural ‘voyeurism’ is not cultural competence. Neither is cultural awareness about how much content you know. Succinctly put, we have “only whispers of understanding about others”.

If the question is ‘does a health professional need to know about *self* or *other*’, the answer is ‘*both*’! There is no place, however, for the anthropologist’s gaze: it’s not about ‘knowing the native’. Simplistic models of cultural competence have been criticised as lacking flexibility, sometimes leading to a ‘check-list’ approach to interacting with a person from another culture. More sophisticated versions avoid this patient-stereotyping pitfall by acknowledging that we are *all* ‘culture bearers’. There are strong calls to build cultural competency into the processes of all university faculties. Whichever model is utilised would need to embed practitioner listening and critical reflection into its schema, in the service of de-colonising the academic environment and avoiding culturally-unsafe interactions.

F. “Could you just listen?” Listening, hearing - then responding to what is heard - as a crucial, ‘common ground’ dimension: resonance with Indigenous notions of ‘deep listening’

As with models that fore-ground cultural safety, a major contribution of cultural humility is recognition of the pre-eminence of the individual patient’s desires, or that of their community. Both practitioner and organisation need to hear, then heed, how people wish others to understand their identity. Similarly, there needs to be an ability to pick up on how they would prefer services to be structured and delivered, that: ‘We get to say: who we are and what we want’. For these models, the community member also guides the individual health professional in not only how their narrative unfolds but, also, their treatment preferences. This can be simply expressed as: “Listen as if the speaker is wise”.

If, then, there is something that needs to be done about a wrong, it is not enough to simply acknowledge the wrong. There are strong resonances here with Indigenous notions of ‘deep listening’. In Australia, though going by particular names in different language groups - such as Dadirri, Ngara, or Kungun - this is a widespread mode of respectful, attentive listening, combined with real-time reflection, that importantly also includes an *obligation to act* on what has been gleaned.

G. “When your belly hurts, that’s the process of self-reflection.”

Life-long, self-reflective practice is a key to ‘knowing self’, rather than (presuming) to know the ‘other’. Critical self-reflection is a core strategy for minimising barriers to practitioner understanding and maximising communication and engagement. It is, however, not necessarily a comfortable process - particularly at the outset. In educational settings the deliberate creation of a ‘safe’ classroom, for *all* - or its on-line equivalent - is vital. When allied with comprehensive moves to create a culturally-safe environment within a faculty or organisation, this supports a necessary ‘un-learning’. It assists students

or professional development participants to disassemble some of the planks of their existing learning that may actually hamper their practice. Self-reflection also ‘interrupts’ racism.

H. “We fail our medical students if we don’t help them become critical in their approach.” The persistence of colonial narratives, student and health practitioner stereotyping, and racism in the delivery of health care, all call for a workforce that thinks critically.

Teaching experience suggests that students of the health professions can fail to see Indigenous people as fully human. The elements of their training that would assist them to attain a de-colonised world-view - one where Indigenous people and culture were valued - are, however, often viewed as peripheral to ‘real’ clinical work. Yet a medical degree, for example, that doesn’t include core elements of criticality and medical humanities, risks the tag of a medical ‘technician’s’ degree. Students, also, may be so anxious about attaining clinical competence, that it dominates their view of what is important to learn. Along with the ‘right/wrong’ styles of assessment required in some parts of their courses, this can lead to a ‘concrete’ thinking that is uncomfortable with ‘not knowing’. Finding the ‘common ground’ of good practice for such a dimension, then, would involve the explicit teaching of critical thinking, with particular focus on the areas of:

- de-colonising our taken-for-granted thinking;
- de-constructing our unchallenged stereotypes; and
- working through racism’s impact on health, on health service engagement, on treatment adherence, and on systemic failure to follow proper procedure.

Attaining workforce criticality would greatly assist the creation of culturally-safe environments that allow effective treatment, or a healing practice, to occur

I. Reciprocal relationships are a key

“Relationships are built over time ... they have to be conscious”. There are potent, international examples of health services, including hospitals, needing to rebuild community trust. Trust may have dissolved as a consequence of a range of historical and contemporary practices. One of the most internationally-potent of these has been through either inappropriate compliance with, or misapplication of, child-removal policies. Mechanisms that develop, then maintain, on-going trusting relationships in the service of better health outcomes are our final, central ‘common ground’ dimension. In some Indigenous Australian contexts, genuine relationships have been succinctly described as centring on the ‘Three Rs’: Respect, Responsibility, and Reciprocity. In the next section, under, we introduce a number of Indigenous notions that can serve a genuine, organic development of such relationships. They include *Kanyini*, *Ngapartji Ngapartji* and *Ganma*.

Section Two

Contexts relevant to effecting change in both educational and health care settings

Effecting change requires a comprehensive re-think of what could be characterised as an uncritical approach to organisational ‘business as usual’. Influential writers on the principles underlying success in developing culturally-safe practitioners, Kerry Taylor and Pauline Guerin, exhort us to be “regard-ful” (not regardless) of the unique health care context involved (Taylor and Guerin, 2016). Other authors expand these concerns to include developing a nuanced understanding of subtle constraints in educational settings, including: *curricula* (the existence of informal and ‘hidden’ curriculum, as well as the better-recognised formal curricula), *pedagogy* (the need to develop approaches that account for student, and staff, resistance); and *organisational processes* (the existence and effect of ‘gate-keeping’) (Gabb and McDermott, 2008; Paul, Ewen and Jones, 2014; Sjoberg and McDermott, 2016).

2.1 Recognise the breadth and depth of Indigenous health inequities - and act on them

The 2015 Finding Common Ground Forum noted that given there was “very little evidence that one model provides better outcomes, more so than another, what is important might be to focus, rather, on what contributes to health inequalities.” A major question for teaching practice then becomes: ‘What processes are driving disparities between health outcomes that are both unfair and avoidable - outcomes termed health inequities?’ There is a real need for health professional training courses to both acknowledge, and incorporate into teaching, any determinants of health of specific relevance to Aboriginal and Torres Strait Islander health, or African-American health, or other population-level groupings. This is a separate, though practice-related, task to developing the self-knowledge and modes of working that may lead to a higher level of (say) culturally-safe practice. A comprehensive understanding of the social determinants in relation to health equity may well provide an essential, prior frame within which other elements of good practice can develop.

2.2 Racism and health

Medicine and health always sees itself as benevolent and caring for people. It's not true for many Indigenous people, it's a violent encounter. (Lavallee 2017)

A genuine engagement with Indigenous health issues challenges students of the health professions and practitioners alike. When participants in Indigenous health education analyse racism as a social determinant of health, the challenge deepens. The experience can range from disquieting to profoundly disturbing. For educators, the experience can be stressful, even daunting.

Analysing racism, though, is not an optional extra, given that there is a nationally mandated objective of training health professionals to work effectively with Aboriginal and Torres Strait Islander Australians. A solid grounding is needed in the health consequences of racism and an appreciation of the widespread, systemic discrimination that exists. This includes understanding how the resultant inequitable access to services, patient non-compliance, “taking own leave” from hospital and ineffective health promotion compromise Indigenous health outcomes (McDermott, 2012).

The literature provides solid evidence that racism is a noteworthy determinant and driver of inequities in health. Several meta-analyses have shown many effects on mental health and over 100 studies from the past 15 years address the increasingly recognised physiological consequences for the person targeted with racism, including cortisol dysregulation. Racism is not only an everyday occurrence for many Indigenous Australians, but also one that gets under the skin, and “makes us sick”. (McDermott, 2012)

In brief, Aboriginal and Torres Strait Islander Australians face a number of racialised modes and experiences:

- ‘Everyday Racism’ - Some 97 per cent of recently surveyed Aboriginal Victorians had experienced racism in the previous 12 months. (Szoke, 2012)
- Structural/Institutional Racism- *Aboriginal people admitted to hospital are much less likely to get a procedure for that condition than non-Aboriginal people in Australia.* (Australian Institute of Health and Welfare, 2014)
- Unconscious/Implicit Bias - Evidence of the damaging physiological, as well as psychological, health impacts of overtly racist and discriminatory practices are slowly forcing change in Indigenous health policy and health professional training. Less-discernible and, unsurprisingly, less-addressed are the range of ways in which ‘business as usual’ in healthcare translates into Aboriginal and Torres Strait Islander Australians receiving fewer interventions in hospital than their presenting diagnoses call for: just one aspect of ‘institutional’ or ‘structural racism’.

Of all such issues that require a rethink of health care practice and health practitioner education, a particular ‘sleeper’ issue is the harm arising from ‘unconscious’, or ‘implicit’, bias. Stereotypical beliefs can override good clinical decision-making, with resultant poor treatment outcomes, avoidable injury, even death. Yet, how do you change practices that clinicians may not even be fully aware of? And how do you assist students to work through material that can profoundly challenge them?

This fellowship’s seminar/webinar of August 2028, on ‘Outing’ Unconscious Bias, suggests that unconscious bias may not be fixed, but can be “malleable”. The task is not easy, though: in Canada, the Indigenous patient is described as entering the health system only in stereotype. Suggested strategies relevant to all three countries from which the presenters were drawn included:

- Working towards a race-critical agenda, one that recognised realness of race and racism, and found ways to make the brutality of unconscious bias explicit.
- This would involve developing the racial literacies of health students and a moving beyond one’s own emotion, intentions, or virtue.
- It would also involve developing intellectual and other environments for change.

2.3 Our duty of care: professionals and stewardship

In Port Hedland, in the north of Western Australia, an Aboriginal woman (since known as) Ms Dhu died on 4 August 2014 (after three days in police lock-up) from staphylococcal septicaemia - a severe bacterial infection - and pneumonia, which were complicated by a previously obtained rib fracture. Ms Dhu’s medical care in one instance was deemed “deficient” and both police and hospital staff were influenced by preconceived notions about Aboriginal people.

CCTV footage showed Ms Dhu moaning from pain, saying it was ten out of ten.

An emergency doctor considered her pain real, but exaggerated for “behavioural gain”. Another doctor also noted Ms Dhu suffered from “behavioural issues” while a constable thought she was “faking” her suffering

Ms Dhu’s aunty, Vanessa Brockman, said:

Everybody seems to forget that the hospital and the Dept of Justice are responsible for what happened. She was taken to the hospital three times, three times, and they sent her home. They breached their duty of care ... they’ve done it now and they’ll do it again.

Embracing Indigenous notions of an ‘interconnectedness-of-all-things’ can lead, in turn, towards not just an expectation of interpersonal responsibility - a professional seriousness to ‘duty of care’ - but also an intra-society responsibility (Kanyini), along with a disposition for stewardship.

2.4 Building on Indigenous foundations: Embedding Indigenous knowledge, values and processes

Apart from pan-Indigenous and African-American scholarship on cultural safety/humility/competence, this fellowship drew, specifically, on core Indigenous Australian epistemologies - ways of knowing, being and doing - that offered concepts and approaches applied and honed over millennia for contextual problem-resolution. Such concepts included: *dadirri* (deep listening); *seeing ‘two-ways’* (considering both sides simultaneously); *kanyini* (the principle of interconnectedness, activated through stewardship and responsibility); *ngapartji ngapartji* (reciprocity); and *ganma* (the potential for new knowledge arising from the intersection of western [‘saltwater’] knowledge and Indigenous [‘freshwater’] knowledge).



Aboriginal Elders Uncle Lewis Yerloburka O'Brien (Kurna) and Auntie Miriam-Rose Ungunmerr-Bauman (Malak Malak), who have, respectively, introduced non-Indigenous Australia to notions of Dadirri and Seeing-two-ways ('Doublies')

A further teasing-out of pragmatic strategies that not only simply enabled, but also facilitated, a 'wrap around' commitment - a student engagement that could yet persist through the dissonance of encountering the (profoundly-disturbing) 'new' - encouraged the introduction of a Western-Desert (north of Western Australia) notion of Kanyirninpa, or 'holding'. This is one manifestation of a widespread Aboriginal mechanism to assist difficult or threatening transitions, such as the passage into adulthood. 'Holding' students through a necessary, but challenging, transition is an educational duty-of-care that models the duty-of-care of the later, culturally-safe, health professional. Through the development of relationship and trust, of 'safe' educational spaces, resistance is lessened, disengagement is minimised and disquiet rendered manageable.

Consider, then, whether elements of such approaches, honed over millennia, might assist a student, or practicing health professional's, better grasp of curricula they may find challenging, as well as aiding their progress towards practicing with criticality and cultural safety.

Dadirri (Deep Listening)

An inner, deep listening and quiet, still awareness ... something like what you call contemplation (Ungunmerr-Baumann 1988)

Deep Listening is more than western notions of 'active' listening. It is the more-comprehensively articulated manifestation (to western audiences) of a widespread Aboriginal mode of positively-structuring interpersonal communication so that authenticity, comprehension and validation are all privileged - a 'deep listening'. It evokes poly-attentiveness - to what's being said, and not-said - with simultaneous reflection on what's being proffered, or gleaned, leading to a listener responsibility to take up, and potentially act upon (if needed), the information so-gained. Under different names, in varied Aboriginal nations, it yet shows a remarkable consistency of purpose and application. In Pitjantjatjara/Yankunytjatjara, in Central Australia, the verb to listen to, *kulini*, also implies 'to heed'. At the bottom of the continent, the Ngarrindjeri word, *kungun*, means 'to respectfully listen'. On the east coast, in the Eora language of the Sydney region, the verb, *ngara*, carries the sense of listening that involves simultaneous reflection - and obligation to act. In the Kurna language of the Adelaide plains, listening emerges as a self-immersion in what is being proffered -- a search for the import of the communication -- with the verb, *yurringarnendi*, translating as 'inquiring with the ears'. Deep listening, a process with a strong resonance with mindfulness, is a 'performative epistemology' across the breadth of Aboriginal Australia that is capable of adding a dimension of purposeful, person- and perspective-inclusive, cooperative activity towards mutually-important goals - a crucial activity for arriving at the kinds of research outcomes that both extend academic knowledge of the social determinants of health equity and offer realisable application in policy and programmes.

Dadirri - Listening with your ears and heart (Atkinson 2002)

‘Doubles’ (Seeing ‘two-ways’ - considering both sides simultaneously)

The most profound philosophy I learnt from our people is this idea of seeing the world differently - in two ways. What about the hidden story? You need to ask: Have you looked around the mountain? What’s on the other side? What’s beneath the story? What’s between the lines? What else can you gather? (Yerloburka O’Brien, 2011)

It has obvious parallels to western modes of critical inquiry, but adds the element of seeing utility in holding disparate, even contradictory, views at the same time. Yunkaporta makes use of the similar principle under the name of Dwongtjen, a Yaidtmidtung word from the Snowy Mountains, one he describes as:

[R]eferring to the pluralistic ability to hold multiple world-views. (Yunkaporta, 2009, p vii)

The interface is a complex and often contradictory domain, a space in which oppositional thinking must be acknowledged alongside calls for a non-oppositional paradigm (Yunkaporta 2009, p. 55)

Kanyini (the principle of interconnectedness), activated through stewardship and responsibility

Stewardship implies a conscious, and conscientious, embrace of responsibility for pro-actively fostering national health and well-being.

Ngapartji ngapartji (reciprocity)

Ngapartji Ngapartji ... turn in turn. Not one / listen to one ... that’s why we got to do it together - Ngapartji Ngapartji. (Togni, Heffernan, Nangala, Bonney 2017)

Ngapartji Ngapartji is the Pitjantjatjara term for a core value of Aboriginal and Torres Strait Islander nations that involves an expectation of a, many-faceted, interpersonal reciprocity - one linked to the spiritual reciprocity seen in the obligation for stewardship of the land.

Ganma

The Yolgnu concept of Ganma also notes the potential for new, mutually-beneficial, knowledge from the confluence of western (‘saltwater’) knowledge and Indigenous (‘freshwater’) knowledge:

In coming together, the streams of water mix across the interface of the two currents and foam is created. This foam represents a new kind of knowledge. The forces of the stream combine and lead to deeper understanding and truth (Laycock et al, 2011 p50)



As with ‘deep listening’ and ‘yarning’ as research methodologies, Ganma’s ‘foam’ can allow ‘what we don’t know we don’t know’ (to paraphrase Donald Rumsfeld) to emerge:

In order to hear the quiet sounds of foam, one needs to listen with one’s heart, “to be aware of the experiencing not just the experiences” (Kelly, 2008. p90 - after Yunggirringa & Garngulkpuy 2007)

Section Three - *In the classroom / building the curriculum / refining pedagogy*

3.1 Creating a safe space

“Why don’t we just give them all guns, so they can shoot themselves?” (Third year nursing student 2009)

Many non-Indigenous people find studying Indigenous health a confronting experience. The incorporation of history and racism as significant social determinants requires exposure to unsettling ways of looking at Australian society. Given the long-existent paucity of education about Indigenous Australia and the thin apprehension of the concept of a shared national history in our primary and secondary schools, many come to a tertiary institution with not only little knowledge, but also a mindset mired in myth and misinformation.

Once at university, some students are silenced in class by the fear of sounding ignorant or causing offence, perhaps inhabiting a space of hypervigilance (Rasmussen, Willingham & Trinh 1996), or paralysis, that is not conducive to learning. At Flinders University, many non-Indigenous students have reported in their evaluations of their topics (subjects within their health professions courses) that they appreciated a space within which they could participate in discussions about sensitive issues and, yet, experience a measured response from fellow students and tutors or lecturers; one that ensured a safe learning environment free from judgement. In Section 1.2, ‘Why do we need a guide?’, four groups were identified, who each exhibited a different emotional response to Indigenous health and cultural safety curricula. The third of these groupings, described as ‘Disturbed/Flummoxed’, often evidenced dissonance - arising from the new information - and, commonly, a subsequent airing of a sense of betrayal - from being let down by the old sources of information. The unsettling emotions reported could manifest as negative class comments. A ‘safe’ classroom was noted to be even more under threat from the final group, dubbed ‘Hostile/Rejecting’. Along with the anger and class disruptiveness, noted in Section 1.2 as, often, being evidenced by members of this cohort, at times this spilled over into overt racist commentary or behaviour (McDermott 2016). Perhaps the most graphic of this group’s comments was, “Why don’t we just give them all guns, so they can shoot themselves?”.

When teaching a group of health profession students, one may not expect to hear such a comment-one, perhaps, more likely to be aired in a front bar, rather than a tutorial setting. Yet, this comment was proffered in response to a discussion concerning the social determinants of Indigenous health. Such a comment is commensurate with colonial, discursive practice evidencing a genocidal flavour (Said 1978; Spurr 1993). The tutor, in this instance, was shocked and unsure of how to progress with a student’s contribution that was not only non-academic and unprofessional, but quite disturbing. Whilst debriefing and supporting the tutor, supervisors and/or mentors were compelled to consider ongoing discussions about alternate pedagogies and the development of curricula focussed on Indigenous health education.

We argue that tutors must be supported to cope with overt racism, as well as ‘common sense’ racism (Hollinsworth 1998), utilising teaching strategies that facilitate an unpacking of these types of comments, so as to comprehend how a racialised framework might present itself in the tutorial setting. Extreme comments, such as the one under discussion, are an indicator of a level of negative socialisation that persists regarding Indigenous peoples and one which educators need to facilitate the critical analysis of, in order to genuinely assist health profession students to make the transition into culturally safe health practitioners.

In a topic or subject that first exposes students to the principles of cultural safety, a ‘culturally violent’ response is not uncommon. To name offending, ignorant comments as ‘culturally violent’, however, is going to make tutorial discussion strained and unproductive. To avoid combative or ineffective interaction, we train tutors to deal with racist and problematic student responses in a manner that maintains student engagement, and cares for the student struggling in a confronting space, whilst still

promoting learning. Developing teaching strategies that specifically target racialised, belligerent or ignorant attitudes is a challenging and exciting field, and one that requires reflective practice from educators and students alike.

One method employed is to start the semester with an 'anonymous question' session, so that students are able to ask questions about Indigenous Australia in a non-threatening environment. It is essential that facilitators or tutors foster a 'safe room' for a discussion that may be highly charged with emotion, misinformation, fear and confusion, and which can easily become counterproductive, if the tutor is not well versed in guiding students on a non-combative journey of learning. An approach that confronts students with difficult material, yet lacks a manageable pathway for learning, is more likely to cement entrenched misinformation than to develop or enhance criticality.

Providing a 'safe room' models the principles of cultural safety. Students often ask questions in the initial, anonymous forum that they may not feel comfortable asking publicly. Instead of answering all of the questions, the tutor can proffer some of them for group discussion, not immediately, but throughout the semester, so as to provide an opportunity for the discussion to coalesce with the weekly module or issue. It is during these discussions that the tutor can introduce the students to how a 'culturally safe' (Papps & Ramsden 1996) approach might materialise.

A carefully facilitated approach - one that closely monitors the emotional tenor of the teaching environment, whether online or face-to-face - is crucial, so as not to overwhelm students with input that is difficult to digest. Much of the evidence about historical and contemporary injustices, and the consequences for Indigenous health outcomes, is incommensurate with what might be considered 'common knowledge', which, in turn, is heavily influenced by structured 'white' or 'settler' privilege, and reinforced by a robust culture of denial that pervades Australian institutions, the media and, in turn, our student cohorts (Hage 1998; McDermott 2004; Ziersch et al 2011).

Teaching strategies that are informed by Indigenous knowledge systems, together with authors such as Fanon (1968), Foucault (1985), Freire (1972), Said (1988) and Moreton-Robinson (2004), give students an opportunity to consider power and its construction of knowledge and 'truths', whilst introducing concepts such as 'structured white privilege' and 'the other'. Comparative studies of patterns of power abuse and its effects on the powerless also canvass the experience of many countries, informing the students of global issues, rather than supporting any perception of a simple focus on Australia as a 'rogue nation'. It is not enough to identify 'whiteness' and its impact on continuing Indigenous disadvantage if we do not handle the fallout of receiving such unsettling perspectives of Australian society.

'Introducing the invisible' is always a shock and the presenter must expect and manage the resultant surprise (Sjoberg, Guerin & McDermott 2011).

3.2 Invoking empathy

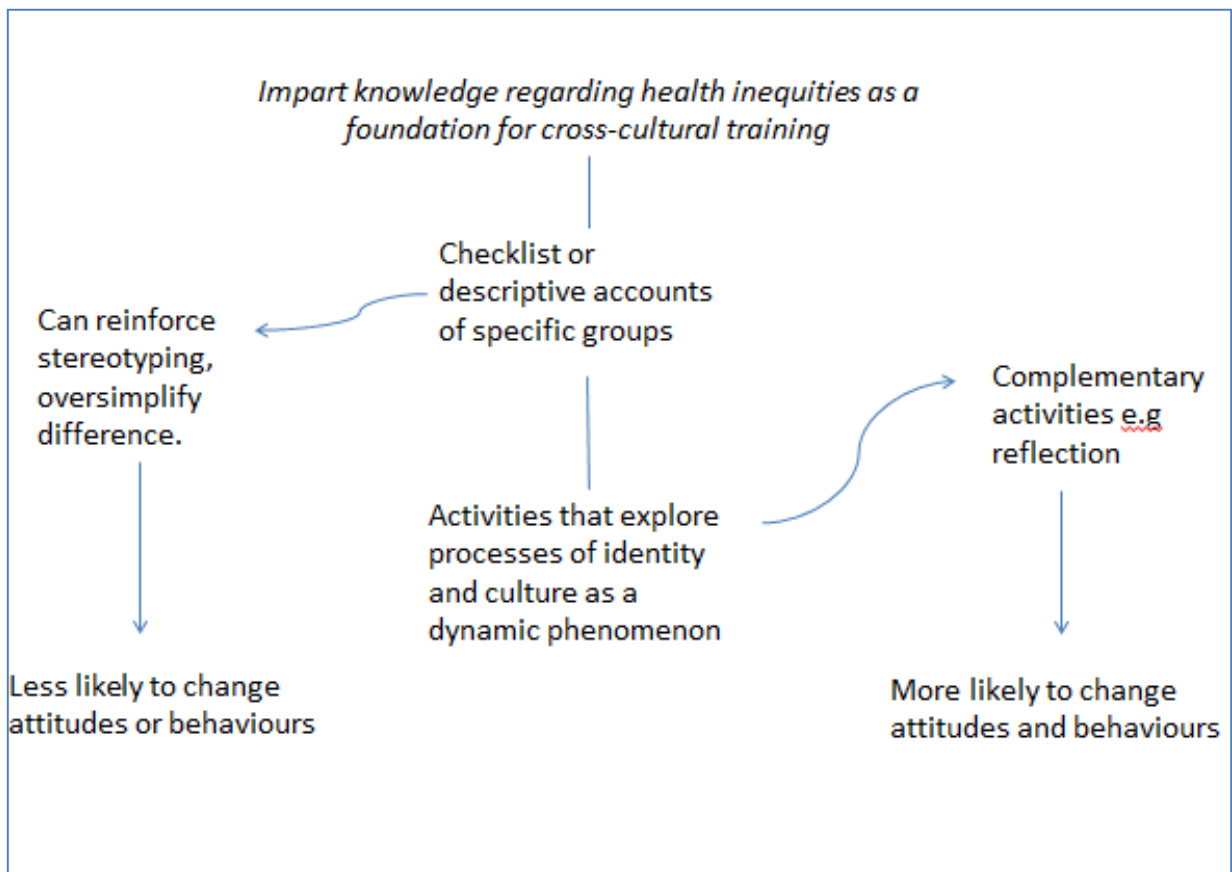
While the literature finds a role for invoking empathy, some authors, such as Wear and Aultman (2005) raise questions about the efficacy of reflective exercises, usually on narratives, in generalising to other experiences - does the empathetic response "follow them out of the classroom door?" Whilst a student may empathise with an individual character or person it may not lead to reflection on the broader structural issues or their role in these. These authors also found many students were unable or unwilling to engage critically with a selected text that drew on oppression. They drew on Boler's 'pedagogy of discomfort' (1999) to suggest there is a need to move beyond passive empathy, sympathetically connecting with another, to understanding one's social position and power which implicates oneself in the issues raised in the text. This would suggest a role for critical reflection and challenging of beliefs in the curriculum.

3.3 Dealing with culture

Australia has a decades-long history of deploying cultural awareness training as a major Indigenous health training modality. Sometimes this has been locally-specific, but often it has taken the form of

either an amalgam of ‘helpful’ hints - such as “Always avoid eye-contact” - or a generic, catch-all form. However, neither the provision of cultural knowledge, nor exposure to other cultural groups does not necessarily directly facilitate culturally competent care. It is in combination with strategies that encourage reflexivity that positive outcomes are more likely (Durey 2010). The number, type and duration of cultural encounters may mediate the effectiveness of this mechanism with a risk that generalisations may be made from a small number of encounters (Campinha-Bacote 2002). Pedersen, Walker et al (2005) warn that while positive results of inter-group contact to decrease racism have been documented, intergroup contact alone may do more harm than good.

Figure Three



One large scale program reported the importance of providing a diversity of speakers to challenge commonly held stereotypes of Aboriginal people and the success of engaging large numbers of Aboriginal tutors providing students with “the opportunity to meet professional Aboriginal people (Kickett et al 2014).” The lack of diversity in the medical workplace overall means the majority demographic comprise the majority of role models and exert significant influence on the broader school context and culture (Paul, Ewen et al 2014).

3.4 Learning to listen

Our expert informants interviewed for the set of video resources constantly returned to the skill of listening, Aboriginal way - deep listening as a foundational attribute of good practice. They reinforced, though, the lessons of deep listening as more than western approaches - expecting, and respecting, silence was an important element. Listening was verbal and non-verbal. Listening, then hearing what was trying to be conveyed, carried an obligation, that:

Listening requires something of you ... you need to complete the circle. Hearing should lead to action.

One presenter noted that an ability to listen was the key factor arising from research into what kept doctors, in their jurisdiction, still practising in a rural location a decade later.

3.5 Building critical reflection: deconstruction as a decolonising strategy

What Happens when We Employ ‘Deconstruction’ as a Strategy-and Why?

The deconstruction exercise shifts the direction of the ‘white gaze’ so that the focus is no longer the ‘colonised other’ (Fanon 1968; Said 1978). The analytical focus is redirected to the process of colonisation; the reflective focus is now the health practitioner themselves:

The transcultural paradigm is the ‘equation’ formed when individuals of different cultures interact... Transcultural teaching for health professionals requires that the study of ‘clients in the fishbowl’ should be abandoned, as in that model there is no account taken of the culture and values of the clinician, who forms part of the clinical equation. (Gabb & McDermott 2008, pp. 69 & 78)

Employing deconstruction as a pedagogical approach innovatively harnesses an Indigenous-generated strategy, designed to maintain engagement of non- Indigenous discussants within a race relations discussion, in the service of enhancing the critical thinking of students of Indigenous health. It offers particular utility with regard to decolonising students’ cognitive processes and, in turn, their practice; a key prerequisite of culturally safe health care (NACCHO 2011). This assessment exercise at the heart of the strategy utilises questions about Indigenous Australia from students of varied health professions. The questions are then deconstructed in a manner that foregrounds the role of language in simultaneously perpetuating stereotypes and masking the racialised assumptions that underpin particular questions (Taylor 2011). Discussions about prejudice and privilege often expose ‘white fragility’ (Bond 2015; DiAngelo 2011). This approach gives an opportunity for productive, sustained educator-student engagement within what, otherwise, might be a highly charged, unproductive discussion. Through a closely facilitated disruption of common default positions, it allows an apprehension of challenging material to proceed in the face of both a potential cognitive dissonance and emotional disquiet. It sets the conditions for a move into critical reflection and addresses some of the ‘hard conversations’ (McDermott 2016) that Australia must have.

In particular, this exercise responds to “the critical and pressing need to develop race scholarship within health” (Bond 2015). Our method highlights the pedagogical process by which the *very question* becomes the focus, rather than any attempt at an answer. Students are actively requested to *not* answer the question and are supported in learning appropriate mechanisms to interrogate the question itself. Students critique the worldviews, philosophical positions and assumptions inherent in the question. Analysis of the question itself must build a cogent argument that examines the position from which the question was asked. In order to start the journey toward cultural safety, it is essential to equip students with an analytical tool that enables the unpacking of deeply ingrained, racialised understandings of Australian society. The pragmatic nature of this exercise is designed with the knowledge that many non-Indigenous peoples are unaware of the privilege they hold-as ‘settlers’ in a colonised land-and often resist attempts to reveal it.

3.6 Decolonising educational institutions and health care organisations

Taking a process of organisational or institutional decolonisation as a serious, and worthy, endeavour adds a deeper dimensionality to the work of cultural safety described thus far. The changes are even less-obvious and require a deep, nuanced understanding of, not only, the devaluing of Indigenous culture, knowledge and ways resulting from colonisation, but an appreciation of the consequences for the content of academic courses, the relevance of university processes and the retention of Indigenous students and staff. In 2015, Universities Canada recognised the need to exhaustively decolonise the academy in a comprehensive way. Amongst other benefits of creating a more culturally-safe and supportive institution, it noted that embracing a fuller Indigenisation agenda is a crucial facilitator of Indigenous student retention and completion (Universities Canada, 2015).

Indigenous perspectives talk, also, of the benefit of addressing an underlying context enabling racism and bias: it notes the potential to shift the academy's assumptions and givens by decolonising the university and its processes.

3.7 Evaluating our practice

A sustaining of good practice, over time, within any teaching institution requires a well-articulated and enacted commitment to on-going research and evaluation. Both are needed to inform and refresh programme development, as well as to contribute to the collaborative knowledge base regarding Indigenous health and cultural safety training.

Section Four - *Building the scaffold / setting the stage / organisational change*

4.1 Organisational readiness/support

Educators wishing to bring about change would benefit from a systematic plan to evidence the need for change, then co-create - with institutional-wide representation - an agreement with specific, but whole-of organization, measures. Many educational or health organisations are particularly reluctant to take on issues of overt and systemic racism. Non-Indigenous health professional disbelief/dismissal of racism and its impact. Even health professionals who see themselves as non-racist can resist the role of 'white privilege' / 'settler privilege'.

A scaffold for real change would have collegial, potentially-challenging, but non-blaming/non-shaming modes to ensure real group engagement with the substantive issues built-in. Sophisticated strategies and experienced facilitators are essential.

Developing organisation-specific ways to bring Indigenous perspectives on racism and cultural safety from the periphery to the centre are key. The noted scholar of cultural humility, Dr Melanie Tervalon, suggests that a necessary step is to embed measures of cultural humility / cultural safety into organisational core business:

Part of the success ... at Children's Hospital (Oakland) had to do with the fact that it was simultaneously an education program and ... an organising effort ... and so [we] were clear that in order for the program to be successful it had to be embedded in the institution and that wasn't simply going to happen by us asking ... but that we had to think of the ways in which transformation would occur within the relationships in the institution so that it would become part of what was important for the institution to hold on to. (Tervalon 2017)

4.2 Leadership

Early, possible initial, Indigenous cultural safety training for institutional leaders and line managers is required before other change measures can take hold. To ensure that, potentially-difficult, change is seen as real, happening and authorised, it is critical that senior management undergo effective training. There is a need for both top-down understanding and bottom-up good practice.

The imprimatur of senior management is essential to successfully facilitating the necessary 'hard conversations' for educational or health organisational change in the service of developing culturally-safe health professionals, services and programmes. It also maximises the likelihood of building or retaining critical funding mass and capacity - particularly if overall funding is contested, or shrinks.

4.3 Well-Being and resilience of educators

Hard-won experience in both Australia and Canada point to a central need - to ensure both the sustainable delivery of Indigenous health and cultural safety training over time, as well as the retention and continued well-being of the educators involved - is to recognise the 'emotional labour' involved in this work. Student resistance, staff isolation, collegial denial of the effects of colonisation - or contemporary manifestations of racism and structural discrimination - the effects of the 'hidden' curriculum, constraints on curriculum time or comprehensiveness, under-resourcing, all combine to create the potential for staff-overload. Comprehensive, centrally-mandated measures to support Indigenous health and cultural safety teaching staff are essential for not only the continuity of their careers, but also that of the teaching programme.

4.4 Partnerships and networks

The barriers thrown up by institutional resistance, manifesting as gatekeeping, marginalisation or underfunding, may require organisational change mandated by standards. (Laverty, McDermott and Calma 2017)

Individual course or departmental change is vulnerable to marginalisation or 'gate-keeping'. An organic movement from scholarly or disciplinary collaboration into wider-based partnerships of enhanced potency is one measure to maximise the likelihood of embedding real change over the long-course. In the Indigenous health policy literature it has been posited that one way in which aspects of Indigenous-preferred approaches deemed controversial by key policy actors within the bureaucracy - including culture, the social determinants of health and racism - were successfully included in a landmark national Indigenous policy remake, was that the cohort pushing for change was adjudged sufficiently creditable and authoritative to establish a 'claim to a hearing', in the sense used by policy scholar John Kingdon (Battams et al, 2018).

Establishing such committed partnerships and networks, then harnessing their power - not just for disciplinary and institutional change, but also in the service of sectoral transformation - may be a necessary, final step in ensuring the 'hard conversations' are had beyond the academy, wherever structural, policy and discourse barriers threaten effective, culturally-safe Indigenous health care delivery, or health promotion. One mechanism of change would be to ensure partnerships or networks develop the capacity and potency to shape the standards to which disciplinary, educational and health care bodies must be accountable - to embed cultural safety within quality assurance requirements.

As Laverty, McDermott and Calma note:

Cultural safety requires embedding in not only course accreditation for each health profession - including measures to reduce resistance-but also in the standards governing clinical professionalism and quality, such as the Royal Australian College of General Practitioners Standards for general practices, 19 and the Australian Commission on Safety and Quality in Health Care National safety and quality health service standards.

Such commitment will need investment in clinician education and professional development, together with measures for accountability. [We need partnerships and networks] to formally collaborate on a systematic revision of standards to embed culturally safe practice and develop health settings free of racism.

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Appendix C

Symposium/Roundtable Programme

A NATIONAL SENIOR TEACHING FELLOWSHIP ACTIVITY
OFFICE FOR LEARNING AND TEACHING (OLT)



HAVING THE HARD CONVERSATIONS

Good practice in working with resistance to Indigenous health and cultural safety

PROGRAMME

8:30am	Registration - Tea and coffee on arrival
9:00	Prof Dennis McDermott: Introduces Kurna Elder Uncle Lewis O'Brien Uncle Lewis: Welcome to Country Prof Andrew Parkin: University and OLT Welcome Prof Dennis McDermott: Background to Symposium and Roundtable Assoc Prof Wendy Edmondson: Overview of the Day
9:30	SESSION ONE – HOW DO STUDENTS AND HEALTH PRACTITIONERS RESPOND TO INDIGENOUS HEALTH AND CULTURAL SAFETY CURRICULUM? Chair – Assoc Prof Kerry Taylor (Flinders University)
9:35	David Sjoberg and Courtney Ryder (Poche Centre, Adelaide): The response of University students, and participants in professional development, to challenging material, self-reflection and requests for critical thinking in Indigenous health and cultural safety curriculum
9:50	Facilitated Discussion
10:00	Rain Daniels (Facilitator, San'yas Indigenous Cultural Safety Program, Provincial Health Services Authority, British Columbia): "Just Get Over It and Other Narratives": Responses of health professionals in British Columbia to Indigenous Cultural Safety training
10:15	Facilitated Discussion
10:25	Dr Angela Lawless (Flinders University): What does the literature say?
10:40	Facilitated Discussion
10:50	MORNING TEA
11:20	SESSION TWO – INSTITUTIONAL RESISTANCE AND THE CHALLENGE OF FOSTERING INSTITUTIONAL CHANGE Chair – Dr Tamara Mackean (Flinders University)
11:25	Dr Barry Lavalley (University of Manitoba): The face and challenge of institutional resistance

11:45	Dr Melanie Tervalon (Former Director of Multicultural Curriculum Project, Children's Hospital and Research Center, Oakland, California): Inside the process of Institutional Change: The emergence and embedding of 'cultural humility'
12:05pm	Facilitated Discussion
12:35	LUNCH
1:35	SESSION THREE - WORKING <u>WITH</u> RESISTANCE AT BOTH THE INDIVIDUAL AND THE INSTITUTIONAL LEVEL Chair – Ms Di Gabb (formerly, Victorian Transcultural Psychiatric Unit [VTPU])
1:40	Panel (Short presentations followed by facilitated discussion): Ms Rosalie Thackrah (Curtin University), Dr Chelsea Bond (Queensland University of Technology), Dr Elizabeth Rix (UCRH, University of Sydney), Mr Alwin Chong (University of Adelaide) Rapporteur: Prof Lambert Schuwirth (Flinders University) Facilitated Discussion
2:40	AFTERNOON TEA
3:00	SESSION FOUR - EMBEDDING CHANGE IN CURRICULUM AND SECURING INSTITUTIONAL CHANGE: THE POTENCY, AND POLITICS, OF ACCREDITATION Chair – Assoc Prof Wendy Edmondson
3:05	Panel (Short presentations followed by facilitated discussion) Australian Indigenous Doctors Association – <i>Dr Kali Hayward, Vice President / Congress of Aboriginal and Torres Strait Islander Nurses and Midwives – Ms Janine Mohamed, Chief Executive Officer / Indigenous Allied Health Australia – Ms Donna Murray Chief Executive Officer / Australian Nurses and Midwives Accreditation Council – Clinical Professor Fiona Stoker / Australian Medical Council – Professor Ian Puddey, Chair Medical School Assessment</i>
3:35	Facilitated Discussion
4:00	SESSION FIVE – DISCUSSION PAPER INTRODUCED – TOWARDS A GOOD PRACTICE FRAMEWORK TO ADDRESS INDIVIDUAL AND INSTITUTIONAL RESISTANCE Dr Angela Lawless / Other OLT Fellowship Collaborators
4:30	Facilitated Discussion
4:55	CONCLUDING REMARKS – Prof Dennis McDermott
5:00	CLOSE

Appendix D

Dissemination Activities

This National Senior Teaching Fellowship has developed a variety of **Web Resources** designed to be of practical assistance to educators. *Having the Hard Conversations: A guide to good practice in Indigenous health education* is freely downloadable from:

<http://www.flinders.edu.au/medicine/sites/poche.adelaide/cultural-safety.cfm>.

The Guide offers a comprehensive suite of responses to the dilemma of how best to maximise the continuing engagement of a student or health professional with Indigenous health and cultural safety education, despite the personal, professional and political challenges thrown up by the nature of curriculum material and pedagogical approaches. Six three-minute **Video Resources**, drawn from interviews with key national and international scholars in this field, aim to assist educators further in this process (Challenges / Cultural Safety / Power Imbalances / Self-Reflection / Listening / Mechanisms of Change). Along with a thirteen-minute video, for use in organisational change contexts, they are also freely available for download at the site above. Learning objectives and questions/prompts for facilitators are also available for each video.

Over two days in April, 2015, a **Symposium and Roundtable: *Having the Hard Conversations: Good practice in working with resistance to Indigenous health and cultural safety*** attracted 42 national and international participants with expertise in the field, who contributed to the further development, or refining, of issues, approaches and good practice strategies. A number of **Dissemination Workshops** (Melbourne, Perth, Sydney and Canberra) followed, in 2015 and 2016, which provided opportunity for educators and other stake-holders - including the National Aboriginal & Torres Strait Islander Higher Education Consortium (NATSIHEC) and the Australian Government Office of Learning and Teaching (OLT) - to engage with the issues, and strategies-in-response, arising from the Fellowship's **Literature Review, Interviews**, and other elements of its programme of work. Numbers of participants at each site ranged from 45 to 70). The developing findings of the Fellowship also informed a further sixteen national and international **Seminars, Webinars and other Fora**.

A number of direct **Consultations with Government and Industry**, including the Australian Government's Department of Health and Ageing, and the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM), provided opportunities to embed Fellowship findings in the implementation of nationally-relevant policies and training.

Academic outputs included five keynote **Conference Presentations**, invited **Plenary Presentations** and **Invited Public Seminars**, as well as seven **Concurrent Sessions**. Two Fellowship-related, refereed **Journal Articles** have been published - Sjoberg, DB and **McDermott, DR** (*International Journal of Critical Indigenous Studies*, 2016) and Laverty M, **McDermott, DR** and Calma T (*Medical Journal of Australia*, 2017) - with a third article submitted and a fourth in draft form.

Print and Electronic Media Coverage: Fellowship-related content informed coverage in The Australian newspaper's Higher Education Supplement, along with interviews with Indigenous radio and ABC Television News. Both activities and content continue to inform educational discourse and practice in the form of freely-available, web-based video-recordings of seminars/webinars (Australia and Canada), as well as post-conference video interviews.

Social Media Coverage: Fellowship content also informed academic and community discourse alike through extensive tweeted coverage of such events as Teaching While Black (two seminars in April 2018), an international conference presentation (International Federation of National Teaching Fellows World Summit, May 2018), a national conference keynote (@SpeechPathAus, July 2018), a Poche Key Thinkers Forum 'Outing' Unconscious Bias (August 2018) and a research retreat for @crehealthequity (November 2018). All spawned further Twitter activity, including discussions and video-posts. Further Fellowship dissemination resulted from an invited week of guest tweeting activity (#Seven Days) for @WePublicHealth, part of @croakeyblog (11-17 June 2018).

Appendix E

External evaluator report

Evaluation – Hard Conversations

Evaluation has been an ongoing component of the Fellowship. In keeping with the purpose and values of the fellowship, developmental evaluation was chosen as an appropriate approach to facilitate evidence based reflection and inform practice. Developmental evaluation, as described by Patton [1], supports innovation development and guides adaptation and implementation in real-life, complex environments. It is particularly applicable where multiple ways forward are possible. The role of the evaluator is as part of a team, posing questions, applying evaluation logic, and gathering information and data to shape ongoing development of the initiative and respond to varying contexts.

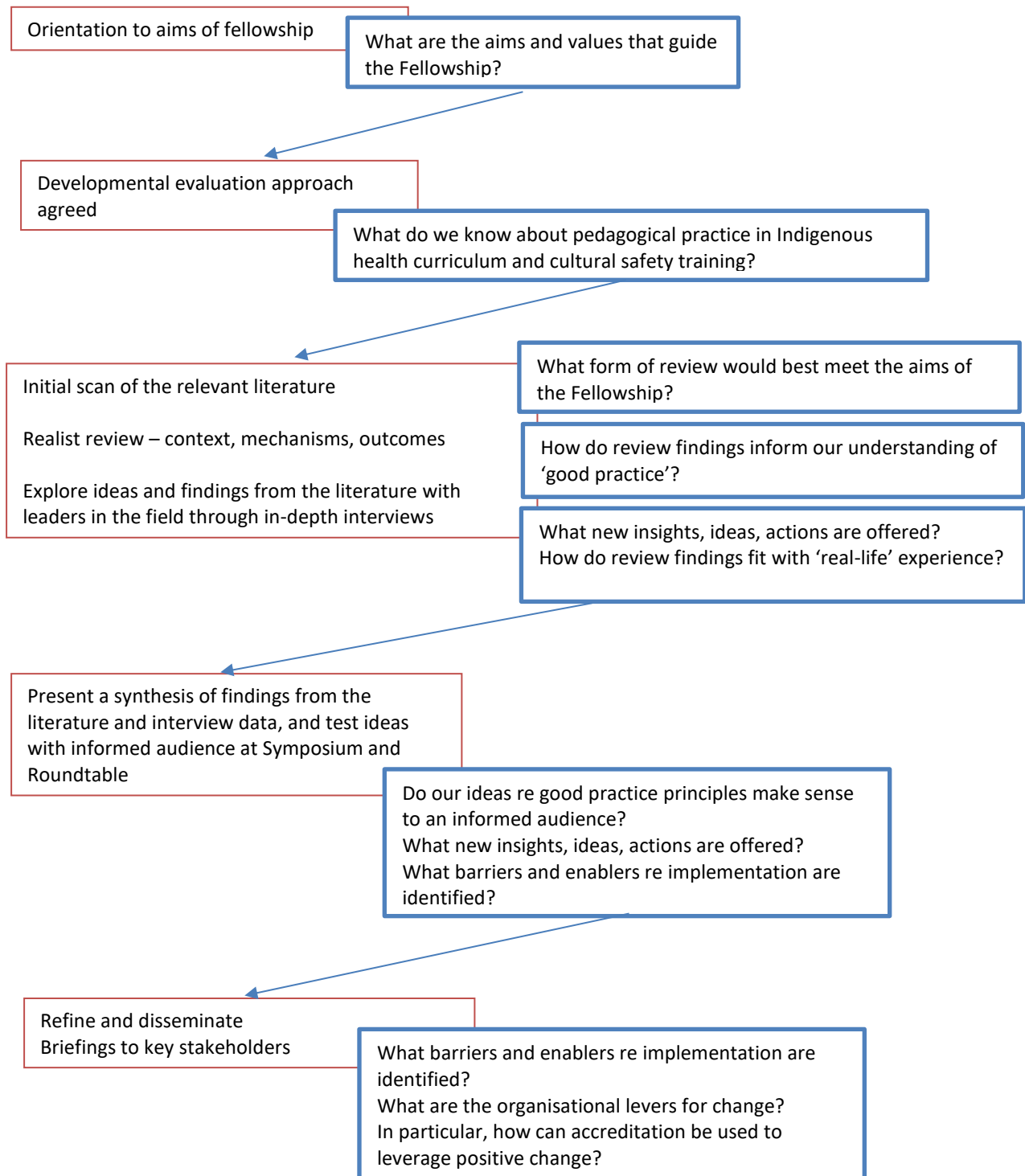
Dr Angela Lawless was engaged to provide developmental evaluation support to the fellowship. The evaluation process was co-created with Professor McDermott ensuring evaluation activities could provide timely feedback, generate discussion and ideas, capture lessons and aid dissemination.

In line with this utilisation focussed approach the evaluator was engaged in various ways across the course of the fellowship. Specific activities included:

- Fellowship team meetings - with a brief to bring 'evaluative thinking' to the development of fellowship activities.
- Regular conversations with Professor McDermott regarding progress of the Fellowship.
- Examination of current understandings and debates in the literature regarding Indigenous cultural training.
- Application of realist review principles in examination of the literature in order to uncover effective principles that can inform Indigenous cultural training in a range of contexts.
- Interviews with key national and international scholars in the field exploring key debates, issues and principles identified in the literature review.
- Participation in the "Having the Hard Conversations' Symposium and Roundtable including presentation of the realist review Captured feedback, discussion and ideas generated at the Symposium and Roundtable.
- Observation of a cultural training workshop, facilitated by Prof McDermott and Mr Dave Sjoberg, with senior members of faculty in the School of Medicine at Flinders University
- Observation of a Dissemination workshop in Canberra.
- Presentations related to the Fellowship work.

Figure 1 provides examples of the 'evaluative thinking' that was brought to individual activities and informed the ongoing development of Fellowship.

Figure 1: Activities and priority questions



Key Findings

This section provides a brief account of some of the key findings that informed the development of Fellowship activities and outputs.

From the literature

The realist review of the literature identified a number of possible mechanisms to engage students and address resistance when teaching Indigenous health and cultural safety:

- Impart knowledge regarding health inequities as a foundation for cross-cultural training
- Impart knowledge about cultural groups
- Provide cultural encounters
- Encourage reflection on individual and societal attitudes, practices and culture
- Teach cross-cultural skills
- Challenge beliefs
- Invoke empathy
- Address organisational/institutional factors

These are discussed in detail in the discussion paper prepared for the Symposium and Roundtable (available through Flinders Academic Commons). A peer-reviewed paper detailing the realist review is in preparation.

The review also identified factors that support successful implementation of programs. These include:

- Positive student disposition
- “High yield” for students
- Demonstrated relevance to clinical performance
- Appropriate resources, time etc
- Integral part of curriculum
- Alignment of formal, informal and hidden curriculum
- Whole of school approach
- High-level commitment & leadership

From the interviews

8 in-depth semi-structured interviews were undertaken. These were audio-recorded and transcribed and analysed thematically. Interviewees reinforced many of the themes uncovered in the review of the literature as well as providing new insights, ideas and examples.

Key messages included:

The need to **address racism** directly was raised by a number of interviewees. This includes challenging individual prejudiced attitudes, social power relations, and institutional racism.

“We teach them about racism. So in the context of health care we actually get them to practice. So we create scenarios for the students ...we bring racist encounters in and we get them to practice interrupting that.”

The ongoing impact of colonisation on Aboriginal people’s health was noted as was the need for ways to **decolonise health care**.

“Do you have enough de-colonising tools within your team? Have you talked about what they are so

that you're not caught off guard, you're less defensive, you're more likely to have a really clear answer?"

The need for action at the **organizational level** was stressed.

"And it shouldn't be dependent on one individual, being supportive, it should be the institution, the school."

"One of the things I would say is that you really have to have strategies at a whole lot of different levels. From the classroom, you know from the very micro level, but right up to the echelons of power within the institution."

The process of **Accreditation** was identified as a powerful means of gaining organizational attention and creating a lever for change.

"We need to have strong accreditation documents that make it compulsory to have significant Aboriginal health content, because if that accreditation document states that all graduates should have the ability to provide culturally appropriate care to Aboriginal or Torres Strait Islander patients, then the content of the curriculum needs to reflect that."

"We went from almost 12 hours to almost 80 hours and through the whole medical school year, and that was done by accreditation, the power to change it was from accreditation. You won't be accredited if you don't meet these obligations."

From the Symposium and Roundtable

Robust discussion and debate again reinforced identified themes but also added new ideas and insights.

In particular, discussion promoted the importance of including an Aboriginal world view. Aboriginal cultural values include **reciprocity, respect and relationships** which are intrinsically linked to spiritual and belief systems. They underpin an Aboriginal worldview of "peoples of the Land, from the Land". Understanding these core values and how they are expressed in Aboriginal culture can provide a positive underpinning to relationships between Aboriginal and non-Aboriginal people. This does not mean non-Aboriginal people need to adopt an Aboriginal world view – it does mean accepting the right of others to have a different perspective and may include validating explanations for that do not come out of the biomedical paradigm.

The idea of incorporating **deep listening** into curriculum was also discussed. Deep listening, or '**Dadirri**', is characterized by inner quiet, still awareness, and waiting. This concept has been incorporated into practices of some health professionals and was promoted as a practical strategy.

Another important theme emerging from discussions was appreciation of the **emotional labour** entailed in this teaching particularly for Aboriginal staff and the need to provide personal and organisational supports.

Other observations

- Fellowship and programme development was enhanced by development and maintenance of strong networks bringing together recognised leaders in the field and key stakeholders.
- Work was strongly informed by evidence and drew on the experience of people currently working in this field. This involvement of potential 'end users' sparked keen interest and ensured understanding of the issues involved and notions of 'good practice' were grounded in, and applicable to real-life experiences.
- Synergies between the aims of the Fellowship and other like-minded organisations such as LIME were identified and built on.
- The Symposium and Roundtable provided both a forum for discussion and debate, increased the reach of the project and cemented existing networks and created new ones.
- The visibility of issues addressed in the Fellowship has been promoted through a range of fora including conference presentations, webinars and workshops.

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1. Patton, M.Q., *Developmental evaluation: Applying Complexity Concepts to Enhance Innovation and Use* 2011, New York: The Guildford Press.