Policy Document

Aboriginal and Torres Strait Islander Health in the Medical Curriculum (2022)

Position Statement

AMSA believes that:

1. Aboriginal and Torres Strait Islander Health is an integral part of the medical curriculum.
2. Aboriginal and Torres Strait Islander history, culture and philosophy must be taught within medical education to ensure the delivery of culturally appropriate and safe health care and health outcomes for Aboriginal and Torres Strait Islander peoples.
3. Australian medical schools have largely failed to sufficiently implement the 2004 Committee of Deans of Australian Medical Schools (CDAMS now MDANZ) Indigenous Health Curriculum Framework and Australian Medical Council (AMC) Aboriginal and Torres Strait Islander Health Curriculum Guidelines, and further action is required.
4. Aboriginal and Torres Strait Islander peoples and communities are instrumental in developing and implementing curriculum changes and must be further supported to represent within leadership roles in medical faculties with adequate remuneration.
5. Aboriginal and Torres Strait Islander medical students are not responsible for assisting faculties with the development of Aboriginal and Torres Strait Islander Health Curriculum.
6. Additional resource allocation is required for full implementation of published frameworks, including appropriate funding of mutually beneficial relationships with National Aboriginal Community Controlled Health Organisations (NACCHO).
7. The contributions and dedication of the Australian Indigenous Doctors Association (AIDA) and Leaders in Indigenous Medical Education (LIME) have been instrumental in improving medical education.
8. Local knowledges must be incorporated into the design of Aboriginal and Torres Strait Islander health in the medical curriculum, recognising the heterogeneity of Aboriginal and Torres Strait Islander People, Communities and Culture.

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Policy Points

AMSA calls upon:

1. Australian Medical Council (AMC) to:
    a. Develop more specific and actionable standards that address the core components of a culturally safe medical curriculum that educates students about Aboriginal and Torres Strait Islander health, culture, history and intergenerational trauma;
    b. Develop and enforce measurable outcomes for standards pertaining to Aboriginal and Torres Strait Islander health curriculum and content delivery;
        i. Implement the assessable accreditation standards called for in the Aboriginal and Torres Strait Islander Health Curriculum Framework;
        ii. Ensure that when medical schools fail to achieve current AMC standards, there are processes in place that hold them accountable;
        iii. Include Aboriginal and Torres Strait Islander academics and educators in AMC accreditation assessment teams.
2. Medical Deans of Australia and New Zealand (MDANZ) to:
    a. Commit to adhering to the MDANZ (formerly CDAMS) *Indigenous Health Curriculum Framework 2004,* prioritising strengths-based pedagogy across all primary medical school curricula;
    b. Undergo extensive reviews that are advised by an Aboriginal and Torres Strait Islander identified position (external or internal), for matters pertaining to Aboriginal and Torres Strait Islander medical education;
    c. Commit to ongoing professional development of staff in cultural safety and competency;
    d. Prioritise Aboriginal and Torres Strait Islander staff being involved in the deliverance of the curriculum pertaining to Aboriginal and Torres Strait Islander health and history education in primary medical schools.
3. Australian Primary Medical Schools to:
    a. Develop sustainable and ongoing clinical partnerships with local Aboriginal Medical Services for students to gain clinical experience in Aboriginal and Torres Strait Islander communities and services;
    b. Acknowledge that systemic racism and the colonial history of Australia has continued to exacerbate the current health

disparities of Aboriginal and Torres Strait Islander Peoples within teaching and learning;

c. Develop curriculum that is underpinned by strengths-based, self-reflexive and anti-racist pedagogy devoid of deficit-based discourse and tokenism;
d. Deliver Aboriginal and Torres Strait Islander health content/education in both a vertical and horizontal approach, with equal weight on each framework;
e. Create a curriculum written with consideration for Aboriginal and Torres Strait Islander medical students, including access to culturally informed social and emotional wellbeing support for content related to trauma and attendance exemptions and/or alternatives for Aboriginal and Torres Strait Islander students;
f. Deliver cultural safety training based on frameworks developed by Aboriginal and Torres Strait Islander Peoples to all staff and medical students prior to being allowed on placement, which includes but is not limited to:
    i. Aboriginal and Torres Strait Islander Models for health
    ii. Self-assessment tools by medical students in practice, including during placement;
    iii. Extensive ongoing review of contents being taught;
g. Employ Aboriginal and Torres Strait Islander academics and community leaders to ensure embedment of curriculum in ways that are culturally and historically correct;
h. Introduce and develop holistic curriculum that includes Aboriginal and Torres Strait Islander peoples cultural, historical and community teaching, including but not limited to:
    i. Examples of sustainable models of educational delivery such as 'Learning on Country' and cultural immersion programs;
    ii. Social and Emotional Wellbeing lenses and trauma-informed frameworks of education around Stolen Generations and Aboriginal and Torres Strait Islander Health.
i. Ensure Aboriginal and Torres Strait Islander people are present in the leadership of medical schools;
j. Incorporate Aboriginal and Torres Strait Islander Models for Health into Public Health units of medical school curriculum and acknowledge the strength that these models deliver to the Aboriginal and Torres Strait Islander community;

k. Incorporate mandatory assessments pertaining to Aboriginal and Torres Strait Islander health;
l. Monitor and re-evaluate the quality of teaching pertaining to Aboriginal and Torres Strait Islander health in the curriculum
    i. These processes of curriculum evaluation should include Aboriginal and Torres Strait Islander health professionals, community and students.

4. Commonwealth, State and Local Governments
    a. Develop funding models that facilitate partnerships between primary medical schools and Aboriginal Community Controlled Health Organisations (ACCHOs) to allow more community health-based clinical placements for medical students that recognises the heterogeneity of ACCHO structures and funding models to facilitate self-determination of ACCHO governance;
5. Medical School Societies
    a. Ensure there is an identified position within the leadership group or executive for direct advocacy on the medical curriculum;
    b. Focalise the perspectives and lived experiences of Aboriginal and Torres Strait Islander medical students within internal advocacy structures.

Background

Introduction

Disclaimer: Aboriginal and Torres Strait Islander people, please be advised that the following texts includes contextual information regarding colonisation, the Stolen Generations, intergenerational trauma, and other historical and cultural topics.

Australia's medical students are primarily represented through the Australian Medical Students Association (AMSA), a national body of students who advocate on their behalf, to ensure that their concerns are heard and respected. After a decade of government failure to 'Close the Gap' on health outcomes for Aboriginal and Torres Strait Islander Peoples [1], pedagogical reform in medical curricula of Aboriginal and Torres Strait Islander health education is required in order to start producing critically reflexive students, who can actively understand and address systemic biases [2]. Further information on the Close the Gap strategy and Aboriginal and Torres Strait Islander Health discrepancies and the determinants affecting these inequities can be found in AMSA's Aboriginal and Torres Strait Islander Health Policy.

AMSA believes all medical students must receive adequate education to develop a culturally safe medical workforce, as well as providing future clinicians with the skills and competency to best advocate for and support Aboriginal and Torres Strait Islander patients [3].

Traditionally, perspectives within Australian primary medical schools and within the wider health care community have approached Aboriginal and Torres Strait Islander health through a deficit-based and homogenous lens, which is reflected in the ongoing pejorative and patronising race-based discourse in the education of healthcare students [4]. This education often lacks a focus on the systems-based approaches to addressing Aboriginal and Torres Strait Islander health inequities or highlighting effective and culturally safe models of care that are being implemented successfully on a community-based level [4]. The Australian Doctor of Medicine accreditation stipulates that 'the medical program provides curriculum coverage of Aboriginal and Torres Strait Islander Health (studies of the history, culture, and health of the Aboriginal and Torres Strait Islander peoples of Australia or New Zealand), as well as having effective partnerships with relevant local communities, organisations, and individuals in the Aboriginal and Torres Strait Islander health sector to promote the education and training of medical graduates' [5].

A shift in the paradigm within the Australian medical curricula to promote strengths-based education and community-led intervention which acts to improve Aboriginal and Torres Strait Islander health care is necessary to begin developing self-reflexive and culturally responsive clinicians who are able to effectively care for Aboriginal and Torres Strait Islander patients [2]. A review of Aboriginal Health Consumers Experiences of an Aboriginal Health Curriculum Framework (2021) [6] conducted by Monash University research-academic staff, including Petah Atkinson, Professor Marilyn Baird, and Professor Karen Adams, concluded that:

'*Medical practitioners are promoting ill health through racist practices with Aboriginal health consumers. Aboriginal people's experiences of racism via continued settler colonial processes and anti-racism in the Australian health system, are critical to meaningful curricula. However, there is a risk for tokenism if the academy continues its coloniality by privileging the biomedical model of illness and health over other models of health.*' [6].

These findings elucidate the imperative nature of developing sustainable medical curricula that have meaningful cultural and heterogenous approaches to educating medical students in Aboriginal and Torres Strait Islander health. Currently, many medical faculties in Australia approach Aboriginal and Torres Strait Islander health education with a tokenistic or superficial lens and are ignorant of the multitude of factors that influence Aboriginal and Torres Strait Islander peoples' interactions with the health system and overall wellbeing and health outcomes [7]. Focalisation of Aboriginal and Torres Strait Islander perspectives on their experiences of racism via continued settler colonial processes and development of anti-racism pedagogy in the Australian health system is critical to forming meaningful curricula [6].

Guidelines and Frameworks for Supporting Aboriginal and Torres Strait Islander Health Curriculum

The current Australian Medical Council's (AMC) *Standards for Assessment and Accreditation of Specialist Medical Programs and Professional Development Programs 2015* were developed to hold medical schools accountable to a national standard of teaching [8]. Currently, the majority of these guidelines are not being met nationally [9]. See appendix 1 for AMC standards pertaining to Aboriginal and Torres Strait Islander Medical Education.

In 2004, Medical Deans of Australia and New Zealand (formerly CDAMS) published the Indigenous Health Curriculum Framework in partnership with the Office of Aboriginal and Torres Strait Islander Health. This framework presented guidelines for the implementation of Aboriginal and Torres Strait Islander health into core medical curricula [9]. This framework outlines the importance of incorporating a strengths-based model of Aboriginal and Torres Strait Islander health into medical education with both vertical and horizontal integration. This framework also highlights the necessity of Aboriginal and Torres Strait Islander staff and community in the deliverance of curricula. This remains the only curriculum framework fully endorsed by the AMC and incorporated into the above medical school accreditation standards and thus has enduring relevance [10].

AIDA Review of Aboriginal and Torres Strait Islander Health in Medical Education

A qualitative review of the implementation of Indigenous Health Curriculum Framework was completed by the Australian Indigenous Doctors' Association (AIDA) in 2012 [7], where data was collected using student focus groups, semi-structured interviews and audit proformas. This review found that while the last eight years saw more incorporation of Aboriginal and Torres Strait Islander health content and highly effective and culturally appropriate pedagogical approaches in some schools, most medical schools failed to implement the framework. This is despite the 2007 publishing of a critical reflection tool [11] aimed at supporting medical schools in their implementation of the 2004 framework. Key factors that supported successful implementation were the AMC's inclusion of some aspects of the framework in accreditation standards, and the commitment of AIDA and Leaders in indigenous Medical Education (LIME) to building capacity. Areas of growth were identified whereby recommendations were made to establish Indigenous Health Units (IHUs) to support the integration of Aboriginal and Torres Strait Islander health content into clinical teaching. Additionally, it was also recommended to increase placement in Rural Clinical Schools (RCS) and Aboriginal Medical Services (AMS) [7].

Common weaknesses of Aboriginal and Torres Strait Islander health programs within Australian medical schools included insufficient time dedicated to Aboriginal and Torres Strait Islander health, lack of vertical integration (inclusion of content consistently across the degree), lack of compulsory or assessable content which has been linked to a lack of valuing by medical students [7,12] and a lack of Indigenous staff in senior leadership roles, as only 5 out of 14 schools had an Indigenous staff member leading the IHU [7].

Within the 2012 report, AIDA identified the barriers that would need to be overcome to allow for more robust implementation of the 2004 recommendations. Resourcing issues were highlighted as a barrier to funding, recruiting and developing staff as well as establishing mutually beneficial partnerships with AMS [7]. Given this, AIDA called for the development of a funding partnership between medical schools and the Commonwealth, in a similar manner by which the Rural Health Training Scheme has facilitated an increased focus on rural health in medical schools [13]. AIDA have also identified the need for specific professional development pathways for Aboriginal and Torres Strait Islander staff to raise their professional profile and assume senior leadership roles, in recognition of their role as curriculum developers and deliverers. Finally, given that cultural insensitivity of staff and students hinders successful implementation, AIDA recommends implementation of locally relevant cultural awareness programs for all staff and students.

The 2014 Aboriginal and Torres Strait Islander Health Curriculum Framework, which encompasses all health education, calls for changes in the accreditation process to ensure that graduate cultural capabilities are improved [14]. Additionally, this document reaffirms the impetus for improving graduate cultural capabilities, robust review processes and the establishment of organisation Reconciliation Action Plans. This document also provides best practice accreditation guidelines that include assessable outcomes. These span five domains; curriculum design, staff recruitment, professional development, graduate capabilities and community engagement. These standards and outcome measures are attached as appendix 2. The framework also calls upon accreditation authorities to take leadership by designing robust accreditation standards and implementing accreditation assessments. It is also recommended that Aboriginal and Torres Strait Islander academics be included in the AMC assessor teams.

It is worth noting that the Medical Deans recently published the Indigenous Health Strategy 2021-2025, which highlights many of the same necessary changes that were identified in 2004 Indigenous Health Curriculum Framework [15]. This indicates that the Medical Deans are aware of their failure to implement the 2004 framework, yet they have not addressed the reasons behind this. The inaction of MDANZ is shown in their first priority being to 'leverage the voice of medical deans' to advocate for systemic reform', when there remains many medical schools that have not implemented reforms

called upon by AIDA over a decade ago. This explicitly raises the impetus for further interrogation of this failure to meet the necessary standards, and highlights the inconsistency of MDANZ's position. Accordingly, the following sections of this document discuss enduring barriers to change and evidence-based educational frameworks that require implementation.

Systemic Racism and Colonisation Incorporation into Medical Curricula

There is currently a lack of medical education around how racism is a determinant of Aboriginal and Torres Strait Islander health and wellbeing [16]. Despite attempts to incorporate these frameworks into medical curricula, it has been shown that on a practical level across medical, nursing, and allied health settings that colonisation and racism are not as frequently included in curricula as they should be [17]. Currently, medical graduates who enter general practice struggle to communicate a formally developed pedagogy for deliverance of anti-racist, self-reflexive education, and it has further been shown that medical graduates and general practitioners felt underprepared to both teach and use Indigenous health frameworks on a practical level in community on Aboriginal and Torres Strait Islander patients [8]. This is not in line with the AMC's accreditation standards for medical schools that outlines the need to include education that aknowledges the interplay of history, culture and health of Aboriginal and Torres Strait Islander people and health outcomes [18].

There are many examples of the healthcare system failing to act sufficiently to mitigate the health disparities of Aboriginal and Torres Strait Islander peoples. This includes funding inequities for Aboriginal and Torres Strait Islander health care, whereby the overall funding is not in proportion with extra need [19]. Additionally, there is inequitable Medicare Primary Health Care whereby a remote Aboriginal community may receive $80 per head per year, but in a suburban city that number jumps to $900 per head per year [20]. Lastly, racism has also played a role in Australia with one example being that Aboriginal people in Western Australia born in the 1940s received low-cost nursing care in contrast to a white cohort of the same age who received higher cost care [21]. Hence, a stronger, anti-racist pedagogy is required in medical education as most frameworks in current medical curricula fail to emphasise the importance of medical institutional racism and how it affects health disparities of Aboriginal and Torres Strait Islander people today [9].

Historically, medical education has been complicit in furthering the goals of colonisation and perpetuating inequitable structures, processes, and outcomes of Aboriginal and Torres Strait Islander health [22]. It is important to recognise and address all levels of racism and even more important to educate medical students on how the colonial history of Australia has impacted the current health disparities of Aboriginal and Torres Strait Islander peoples [23]. Racism is seen in health institutions whereby Aboriginal and Torres Strait

Islander knowledges, beliefs and values are subjugated by the dominant western biomedical model in both policy-making and practice [24]. Therefore, medical schools should be teaching a culturally-developed framework that outlines the interplay between how colonisation and racism within Australia has led to the current Aboriginal and Torres Strait Islander health disparities [22]. This is also outlined in the CDAMS Indigenous Health Curriculum Framework whereby it is deemed essential to teach medical students the connection between history and racism and current health disparities [10].

Educational Frameworks: Vertical and Horizontal Approaches to Teaching

Approaches to the integration of Aboriginal and Torres Strait Islander health can be broadly categorised as either principally vertical or horizontally oriented within medical curricula. Vertical programs, as understood within the global health space, tend to 'call for solutions of a given health problem by means of a single-purpose machinery' [25]. In practical translation, vertically integrated Indigenous health curriculum may manifest as standalone didactic learning and self-education modules as key examples. The underpinning feature to all vertical programs is siloed learning that encompasses minimal continuity throughout the entirety of medical education. [26].

Conversely, horizontal approaches to global health issues 'seek to tackle the overall health problems on a wide front and on a long-term basis through creation of a system of permanent institutions'. This is often achieved through widespread health system changes that seek to strengthen the entire system [25]. This conceptual framework offers a translational approach to continuous, integrated learning on Indigenous health issues throughout the entirety of the medical curriculum. This approach will seek to appraise and understand Indigenous health and encourage respectful discussion in a variety of different contexts and in relation to different diseases and public health considerations.

Educational Frameworks: Learning on Country

There is an inherent importance of delivering holistic education around Aboriginal and Torres Strait Islander People's histories, local cultures, language, and systemic injustices to medical students as future clinicians who will be responsible for providing healthcare to Aboriginal and Torres Strait Islander patients during their career [2]. A systematic review entitled, 'Evidence Review of Indigenous Culture for Health and Wellbeing' was published in 2018 and provided evidence for the growing understanding within the healthcare community of the significant impact that culture and connection to community and Country in Aboriginal and Torres Strait Islander populations have on overall health and health outcomes of Aoriginal and Torres Strait Islander Peoples [27]. This study supports the positive associations between

health, wellbeing, and the cultures of Aboriginal and Torres Strait Islander peoples, demonstrating a positive relationship with Aboriginal and Torres Strait Islander cultures and culturally based interventions on social and emotional wellbeing. Evidently, with such a longstanding understanding in the health community that cultural connection influences health outcomes, it is imperative that medical education institutions prioritise educating medical students around Aboriginal and Torres Strait Islander peoples, their culture and cultural safety as part of their medical education [27].

Furthermore, this study acknowledges that there has been substantial growth in the number of publications over time that have explored the link between culture and health, thus as research begins to shift and become more prominent in this area of health, medical institutions should accordingly adapt their curricula to stay up to date with current health research [27].

Educational frameworks that have been developed and designed specifically to effectively deliver and educate students in histories, cultures and health topics pertaining to Aboriginal and Torres Strait Islander peoples should be included within medical curricula at primary medical schools [2]. A recent publication in the Journal of Curriculum Studies, 'Towards an Australian model of culturally nourishing schooling' [28] by lead author Associate Professor Kevin Lowe, explored the pedagogical advantages of the 'Learning on Country' model of teaching, finding that:

"*a deeper, ontological and political 'learning' that locates students in Country, rather than on and controlling land, requires a critical pedagogy of place to provide insights for all students concerning an Aboriginal worldview and the place within which different ways of existing are meaningfully understood*" [28]

As Aboriginal and Torres Strait Islander peoples and educators have understood and passed down through generations and in living culture, "*country is always teaching if we pay attention and listen*" [28], and this practice can be extrapolated to medical education to give students and our future medical professionals a greater understanding of Aboriginal and Torres Strait Islander communities and cultures. Implementation of on-country local health and cultural education within medical curricula would ultimately empower medical students to be better able to advocate for patients and connect with Aboriginal and Torres Strait Islander communities and peoples [28].

Educational Frameworks: Using a Strengths-based Lens

The medical curricula should have more predominant focus on teaching around contemporary issues and living cultures with Aboriginal and Torres Strait Islander communities [2]. An example of this includes education around maternal and child health practices for Aboriginal and Torres Strait Islander

people and their children, including Birthing on Country practices. A deficit-based approach, as part of current medical workforce perspectives and curricula [4], would emphasise that there is a disproportionate burden of adverse perinatal outcomes for Aboriginal and Torres Strait Islander people and their babies compared to non-Aboriginal and Torres Strait Islander people and babies. In this view, in 2019 14% of babies of Aboriginal and Torres Strait Islander people were born preterm, compared to 8.5% of babies with non-Aboriginal and Torres Strait Islander people. Perinatal mortality rates are also higher among babies of Aboriginal and Torres Strait Islander people and Aboriginal and Torres Strait Islander babies are 1.7 times more likely to be stillborn and 2 times more likely to die within the first 28 days of life than non-Aboriginal and Torres Strait Islander newborns [29]. Further information regarding Aboriginal and Torres Strait Islander birthing people and their health is detailed in AMSA's Pregnancy, Perinatal and Infant Health Policy.

However, this deficit discourse to medical education provides no depth of understanding as to why these disparities exist or how they are being addressed with systemic or community intervention [4]. In this example of deficit-focussed education, it can be extrapolated that harmful stereotypes around Aboriginal and Torres Strait Islander peoples abilities to care for their children could be developed by medical professionals. If deficit-based education continues to be utilised in the medical curricula for Aboriginal and Torres Strait Islander healthcare, harmful stereotypes and negative perception of Aboriginal and Torres Strait Islander people will continue to be perpetuated across the medical community. As well, a deficit-model develops systemic stereotyping amongst medical professionals of Aboriginal and Torres Strait Islander peoples as incapable of caring for their children, which is damaging to Aboriginal and Torres Strait Islander people's trust in the health system [4]. Avoiding further distrust of the health system among Aboriginal and Torres Strait Islander peoples is of paramount importance in the context of the lingering distrust of the Australian Government which arose in response to the systematic stealing of Aboriginal and Torres Strait Islander newborns and children from their parents during the Stolen Generations, which, in many instances, is within living history for Elders in community [6]

Using a strengths-based lens, 'Birthing on Country' models combine Western and Aboriginal and Torres Strait Islander health care models to provide safe and culturally nourishing healthcare. Birthing on Country is described as *"…a metaphor for the best start in life for Aboriginal and Torres Strait Islander babies and their families which provides an appropriate transition to motherhood and parenting, and an integrated, holistic, and culturally appropriate model of care for all"* [30]. In 2017, a $1.1 million National Health and Medical Research Council (NHMRC) grant was awarded to the Birthing on Country project, as a joint initiative of the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM), the Council of Remote Area Nurses of Australia (CRANAplus) and the Australian College of Midwives, which has been running successfully for the last 5 years [31].

As an example of strengths-based education around successful community interventions, this pedagogy should be implemented for all Aboriginal and Torres Strait Islander health education in the medical curricula. This would provide a more meaningful perspective to why there are Aboriginal and Torres Strait Islander health disparities in Australia and how these disparities are being addressed within the community through positive and culturally-safe interventions, devoid of stereotyping or tokenism [4].

Educational Frameworks: Observerships and Community Partnerships

Clinical observerships for medical students and cultural immersion models of holistic healthcare support improved Aboriginal and Torres Strait Islander health education [32]. These programs aim to produce sustainable outcomes and measures for students to learn cultural safety and competency and immerse themselves in local Aboriginal and Torres Strait Islander culture to develop a greater understanding and relationship with Aboriginal and Torres Strait Islander cultures [33]. A study undertaken by the Faculty of Health Sciences and Medicine, Bond University in 2014, entitled 'Using cultural immersion as the platform for teaching Aboriginal and Torres Strait Islander health in an undergraduate medical curriculum' explored how a cultural immersion program can be used to effectively teach a holistic and strengths-based Aboriginal and Torres Strait Islander health curriculum that develops medical students' cultural safety and patient advocacy skills [33]. This review found that:

> "*The use of immersion in the early part of a cultural awareness program for medical students provides an extremely valuable platform from which to launch more detailed information about the history of Aboriginal and Torres Strait Islander Australia and its impact on the current health status of Aboriginal and Torres Strait Islander Australians. Doing this in a safe, supportive cross-cultural environment with highly skilled facilitators is essential."*[13].

This cultural immersion program also identified a key feature of storytelling as a means of teaching students about local Aboriginal and Torres Strait Islander culture. As explained in the analysis, 'Decolonising Indigenous Education', "*Storytelling as methodology, and story-as-theory, serves an important purpose in disrupting and rejecting positivism. The emerging diversity of Indigenous methodologies offers complex ways to justify and share Indigenous knowledge that reach beyond storytelling*" [34]. From these studies, it is made apparent that inclusion of cultural immersion and storytelling methodologies in medical curricula would add value to medical students' understanding of Aboriginal and Torres Strait Islander peoples' community, self-determination, and cultures [34]. It should also be noted that AMSA believes all students should receive adequate cultural safety training

before being allowed to enter and practise within an Aboriginal and Torres Strait Islander community space or health practice [3]. Additionally, any developed cultural immersion programs should have ongoing monitoring and evaluation from student perspectives to develop sustainable and self-reflexive models of Aboriginal and Torres Strait Islander education within the medical curricula [12].

Cultural Safety Training in Medical Education

Australia is a signatory to the UN Convention on the Rights of Indigenous Peoples, which states that Aboriginal and Torres Strait Islander Peoples have the right to self-determination and diversity of culture, which must be reflected in education [35]. For Aboriginal and Torres Strait Islander Peoples, self-determination and identity is strongly associated with culture and links to improved health outcomes [36]. Medical students have a major role in improving Indigenous health through engaging in culturally-safe practice as defined by Aboriginal and Torres Strait Islander Peoples. Thus, to align with international human rights law, Australian medical schools have a responsibility to deliver culturally safe education to facilitate this process.

Internationally, there is ambiguity surrounding terminology such as cultural competency and safety and the cultural perspective behind these definitions is often unclear [37]. Many health professionals and students experience difficulties distinguishing between terms such as cultural awareness, cultural competency and cultural safety. Thus clear differentiation between terms and education which improves understanding of the role of medical students in engaging in culturally safe practice is needed. The Victorian Aboriginal Community Controlled Health Organisation (ACCHO) describes cultural safety as “service provision that respects cultural practices differing from dominant culture to minimise effects of power imbalances, institutional discrimination, and colonisation” [38]. The Australian Institute of Health and Welfare (AIHW) Cultural Respect Framework further includes the impact of racism on First Peoples’ Health [39]. The Australian Health Practitioner Regulation Agency (AHPRA) released a consensus definition of cultural safety indicating that cultural safety must be determined by Aboriginal and Torres Strait Islander individuals, families and communities [40]. It acknowledges that culturally safe practice involves ongoing self-reflection of health practitioner knowledge, attitudes, behaviours and power differentials to minimise racism and delivering safe, accessible healthcare [40]. Cultural safety education must only be defined by Indigenous communities, thus input and collaboration with local leaders is critical [41].

Cultural awareness differs from cultural safety and is described as “basic understanding of Indigenous histories, peoples and cultures” [39]. However this has less impact on inequities than power imbalances, marginalisation, bias, unexamined privilege, and racism [42]. Healthcare professionals and medical students must acknowledge power imbalances and privilege due to

dominant systems of culture and minimise the effect of historical events and systemic bias on Aboriginal health [43]. Cultural safety involves self-reflection on culture and privilege,to facilitate understanding of the impact of colonisation on Indigenous health outcomes and relate it to power imbalances within the Western healthcare system [43]. Challenging dominant perspectives through decolonisation helps dispel media-constructed stereotypes [44]. Thus, medical curricula should include decolonisation strategies, self-reflection techniques and culturally-safe language in education and should incorporate the Indigenous perspective in content delivery.

Healthcare defined by the dominant Western perspective creates barriers to provision of care. Current definitions of health originating from the Western perspective do not accurately capture Indigenous perspectives of health influenced by generations of cultural traditions, and the interrelatedness of physical, spiritual, cultural and community wellbeing with connection to Country [43]. Indigenous Models for Health represent a holistic perspective of Indigenous wellbeing and should be incorporated into curricula. Additionally, the Calgary–Cambridge model considers connection to country, family and cultural commitments, as well as the impact of marginalisation, colonisation, racism on patient care [45] and should also be included in medical school curricula.

Currently, cultural competency is integrated into medical curricula worldwide, however it is limited as it focuses on dominant cultural perspectives and assumes cultural proficiency is an end result, rather than a lifelong process [37,46]. Cultural competency describes cultural awareness through developing skills and attitudes which improve quality of care to diverse populations [47]. As this is determined by the practitioner, without community or patient input from the minority culture, it does not address power imbalances [41]. As a result, racial discrimination still exists, often unintentionally. In contrast, cultural safety is determined by both practitioner and community and focuses on “social, structural and power inequities that underpin health inequalities/disparities” , thus it addresses upstream determinants of health [48].

Curriculum competency promotes the development of patient empowerment strategies to enhance health outcomes and this must be monitored for efficacy. Currently, evaluating cultural safety in healthcare systems and education, and its impact on access to safe healthcare is limited by a lack of national and state level data [49]. Australian Bureau of Statistics (ABS) Indigenous health surveys, such as the National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) 2018–19, designed to collect cultural safety information and Indigenous patient experience, are limited by infrequent data collection and lack of regular update of data or monitoring [49]. The Royal Australasian College of General Practitioners (RACGP) Aboriginal and Torres Strait Islander health curriculum undertakes cultural safety assessment in programs [37]. Currently, limited evidence demonstrates effectiveness of

methods that assess cultural safety in healthcare, with no reported Australian quality indicators for cultural safety in patient-centred care [50-54]. Causes of this paucity include lack of validity of cultural safety measures and ambiguity in cultural safety definitions [55]. Thus a robust, universal method to assess, monitor and evaluate medical school curricula competency in delivery of culturally-safe medical education is proposed. This approach requires alignment with an accepted definition of cultural safety, defined by the Aboriginal and Torres Strait Islander community. A systematic review of literature published on cultural safety in medical curricula across Australia, New Zealand, Canada and the US revealed cultural safety application into clinical practice linked to stronger relationships between practitioners and patients, improved health outcomes, and increased number of Aboriginal and Torres Strait Islander Peoples entering the health sector [56].

To address the lack of evaluation of the effects of incorporation of Indigenous content into curriculum, we propose curriculum and course evaluation measures including formative assessment containing formal and informal, summative, or reflective feedback. For example reports, interviews, course evaluations, reflective journals, qualitative surveys, critical reflective papers, and exam questions. For consistency across medical schools, curricula should adapt a universal framework such as the Aboriginal and Torres Strait Islander Cultural Safety Framework and include strategies such as the Continuum Reflective Tool for measurement of critical reflection and other practices [57]. Incorporation of the Indigenous perspectives and continual evaluation of delivery of culturally safe medical education is necessary to support culturally safe clinical practice and healthcare provision.

Educational Frameworks: Trauma-informed and culturally reflexive teaching using Social and Emotional Wellbeing Frameworks

Aboriginal and Torres Strait Islander health is impacted by intergenerational, personal and complex traumas that resonate through communities, as well as individuals, affecting their self-determination, social and emotional wellbeing, and physical and mental health [58]. There is extensive evidence to indicate that historical events continue to impact significantly on Aboriginal Australian peoples in the form of complex trauma [58].

To provide context to the importance of trauma-informed education of Aboriginal and Torres Strait Islander health in the medical curricula, it is important to contextualise how trauma affects health and health outcomes for Aboriginal and Torres Strait Islander peoples. Under the 'Close the Gap' strategy the role of individual and historical trauma in the health of Aboriginal Australians was explored in a 2013 review conducted by Australian Institute of Health and Welfare, entitled 'Trauma-informed services and trauma-specific care for Indigenous Australian children' [59]. This review explains that histories

of traumatic events that have occurred from colonisation, including dispossession of land, forcible removal practices and the oppressive legislative policies of the day can pass on to children and future generations of Aboriginal peoples. The review states that,

'*Even if protected from the traumatic life experiences of family, some Indigenous children, like non-Indigenous children, directly experience trauma through exposure to an accident, family violence and abuse. Although the effects of childhood trauma can be severe and long lasting, recovery can be mediated by appropriate interventions.*' [59]

Historical trauma (or intergenerational/transgenerational trauma) is defined as the subjective experiencing and remembering of events in the mind of an individual or the life of a community, passed from adults to children in cyclic processes as 'cumulative emotional and psychological wounding' [59]. Native American Post-Colonial Psychology researchers, Duran and Duran (1995) suggested that historical trauma can become normalised within a culture because it becomes embedded in the collective, cultural memory of a people and is passed on by the same mechanisms through which culture, generally, is transmitted [59]. From this it can be extrapolated that historical events such as the Stolen Generations and other cultural, language and land dispossession policies have reverberated traumas through many generations of Aboriginal and Torres Strait Islander Australians and still impact on the health of all generations today. As Dr Charles Nelson Perrurle Perkins AO explained:

'*We know we cannot live in the past but the past lives in us.'*[59]

Additionally, Aboriginal and Torres Strait Islander people may experience their own direct trauma, such as abuse, neglect, and exposure to violence, and are at increased risk of experiencing complex trauma [59]. Complex trauma is as a result of an individual's exposure to multiple or prolonged traumatic events that do not categorically fit psychiatric criteria for post-traumatic stress disorder [59]. These events are typically of an interpersonal nature, such as psychological maltreatment, neglect, physical and sexual abuse. The events often begin in childhood and can extend over an individual's life span [59].

Trauma-induced changes to the brain can result in varying degrees of cognitive impairment and emotional dysregulation that can lead to a host of problems, including difficulty with attention and focus, learning disabilities, low self-esteem, impaired social skills, and sleep disturbances [60]. Since trauma exposure has been linked to a significantly increased risk of developing several mental and behavioural health issues—including posttraumatic stress disorder, depression, anxiety, bipolar disorder, and substance use disorders—it is important for practitioners and medical students to be aware of steps they can take to help minimize the neurological effects of child abuse and neglect and promote healthy brain development [61].

Trauma can also produce other negative psychological and social consequences. Drawing on clinical experience and literature reviews, Van der Kolk (2007) argued trauma can [62]:

- Violate a child's sense of safety, trust, and self-worth, with a loss of a coherent sense of self
- Trigger emotional distress, shame, and grief
- Result in unmodulated aggression and difficulty negotiating relationships with caregivers, peers and (later in life) marital partners
- Disrupt attachment styles. Because attachment appears to play a central role in developing socio-emotional skills, the disruption can lead to interpersonal difficulties.

As well, victims of childhood trauma are also more likely to adopt behaviours destructive to themselves and others. These behaviours include alcoholism and other drug misuse, sexual promiscuity, physical inactivity, and smoking [62]. Further, researchers have noted a link between experiences of childhood trauma and suicide [62].

Moreover, adults with a childhood history of unresolved trauma are more likely to experience health concerns, including heart disease, cancer, stroke, diabetes, and liver disease [62, 63], all of which can contribute to lower life expectancy.

The evidence of the profound effects of varying types of trauma on the health outcomes for Aboriginal and Torres Strait Islander people gives evidence to why a trauma-centred approach to education of Aboriginal and Torres Strait Islander health is important so that future clinicians are able to appropriately provide trauma-informed and appropriate care for their patients. As well, it is important to consider that this education should be integrated into the specific education of the local community in which students are on clinical placement or living, as:

> '*Experience is not necessarily transferable; Indigenous culture is not homogenous, and a local educational cultural programme is imperative – insufficient consideration of local Indigenous context and practices leads to uncritical assumptions and untheorised interventions. Cultural support and supervision need to be ongoing, based on reflection and self-directed learning, and with attention to local nuances and values*' [59]

The Social and Emotional Wellbeing (SEWB) Program, funded by the Australian Government, addresses the importance of providing culturally responsive care in which a holistic approach to Aboriginal and Torres Strait Islander healthcare is taken [64]. The SEWB program provides enhanced health service delivery to Aboriginal and Torres Strait Islander people and communities, prioritising members of the Stolen Generations, through more flexible models of service delivery and increased capacity to meet demand for services [64]. This framework highlights that,

'*Health does not just mean the physical well-being of the individual, but refers to the social, emotional, and cultural well-being of the whole community. This is a whole of life view and includes cyclical concept of life-death-life. Health care services should strive to achieve the state where every individual can achieve their full potential as human beings and thus bring about the total well-being of the communities*' [64]

The SEWB framework, as well as acknowledging and addressing the complex interplay of intergenerational trauma on health, also acknowledges that traditional knowledges and perspectives significantly impact how a patient interacts with and engages with their health and healthcare team [64]. Thus, it should be encouraged that SEWB frameworks are taught to medical students who will be required to engage with this culturally reflexive care when engaging with Aboriginal and Torres Strait Islander patients throughout their careers. Currently, within the current medical curricula teaching around SEWB frameworks is not mandatory as part of the AMC guidelines [5], thus this policy encourages further engagement with trauma-informed teaching and the learning of SEWB frameworks as part of the medical curricula.

References

1. Allam L. Closing the Gap doomed to fail without Aboriginal people's input, leaders say. The Guardian [Internet]. 2020 [updated 2020 Feb 12; cited 2022 May 20] Available from: https://www.theguardian.com/australia-news/2020/feb/12/closing-the-gap-doomed-to-fail-without-aboriginal-peoples-input-leaders-say
2. Vass A, Adams K. Educator perceptions on teaching Indigenous health: racism, privilege and self-reflexivity. Med Educ. 2020 Aug 9;55(2)
3. Travis CR, Goff B. Aboriginal and Torres Strait Islander Health Position Statement [Internet]. Australian Medical Students Association; 2019 Sep [cited 2022 May 21]. Available from: https://amsa.imiscloud.com/common/Uploaded%20files/AMSA/Policy/F/Aboriginal%20and%20Torres%20Strait%20Islander%20Health%20(2019).pdf
4. Fogarty W, Bulloch H, Mcdonnell S, Davis M. Deficit Discourse, and Indigenous Health How narrative framings of Aboriginal and Torres Strait Islander people are reproduced in policy [Internet]. 2018 [cited 2022 May 20]. Available from: https://www.lowitja.org.au/content/Document/Lowitja-Publishing/deficit-discourse.pdf
5. Australian Medical Council. Medical School Accreditation Committee Standards for Assessment and Accreditation of Primary Medical Programs by the Australian Medical Council 2012 [Internet]. 2012. Available from: https://www.amc.org.au/wp-

content/uploads/2019/10/Standards-for-Assessment-and-Accreditation-of-Primary-Medical-Programs-by-the-Australian-Medical-Council-2012.pdf

6. Atkinson, P., Baird, M., & Adams, K. 2021. Aboriginal Health Consumers Experiences of an Aboriginal Health Curriculum Framework. Australian Indigenous Health Bulletin [Internet], 2(3). Available from https://ro.ecu.edu.au/aihhealthbulletin/vol2/iss3/3
7. A Review of the Implementation of the Indigenous Health Curriculum Framework and the Healthy Futures Report Within Australian Medical Schools [Internet]. AIDA. 2022 [cited 2022 May 23]. Available from: https://medicaldeans.org.au/md/2018/07/Medical-Deans-AIDA-Review-Final-Report.pdf
8. Assessment and accreditation of specialist medical programs [Internet]. AMC. 2022 [cited 2022 May 23]. Available from: https://www.amc.org.au/accreditation-and-recognition/assessment-accreditation-specialist-medical-programs-assessment-accreditation-specialist-medical-programs/
9. Vass A, Adams K. Educator perceptions on teaching Indigenous health: Racism, privilege and self-reflexivity. Med Educ. 2020;55(2):213-221
10. CDAMS Indigenous Health Curriculum Framework [Internet]. Medicaldeans.org.au. 2022 [cited 2022 May 23]. Available from: https://medicaldeans.org.au/md/2018/07/cdams-indig-health-frameworkreport.pdf
11. Medical Deans Australia and New Zealand. Indigenous Health Project Critical Reflection Tool. [Internet]. Melbourne (AU): MDANZ; 2007. Available from: https://limenetwork.net.au/wp-content/uploads/2021/11/Interactive_CRT_FINAL.pdf
12. Delaney C, Doughney L, Bandler L, et al. Exploring learning goals and assessment approaches for Indigenous health education: a qualitative study in Australia and New Zealand. High Educ. 2017 Mar 21;75:255-270
13. KBC Australia. Independent Evaluation of the Rural Health Multidisciplinary Training Program. [Internet]. Orange (AU): KBC Australia; 2020. Available from: https://www.health.gov.au/sites/default/files/documents/2021/10/evaluation-of-the-rural-health-multidisciplinary-training-rhmt-program-final-report_0.pdf
14. Department of Health. Aboriginal and Torres Strait Islander Health Curriculum Framework. [Internet]. Canberra (AU): Department of Health; 2014. Available from: https://www.health.gov.au/resources/publications/aboriginal-and-

torres-strait-islander-health-curriculum-framework#:~:text=The%20framework%20is%20a%20set,authorities%20to%20assess%20the%20curricula

15. Medical Deans Australia and New Zealand. Indigenous Health Strategy 2021-2025. [Internet]. Sydney: MDANZ; 2021. Available from: https://medicaldeans.org.au/md/2021/10/MDANZ-Indigenous-Health-Strategy-FINAL-2021-2025.pdf
16. McDermott D. Can we educate out of racism?.MJA. 2012;197(1):15-15
17. Pitama S, Palmer S, Huria T, Lacey C, Wilkinson T. Implementation and impact of indigenous health curricula: a systematic review. Med Educ. 2018;52(9):898-909
18. Drummond A, Cox L, Brough M. Indigenous academics teaching Indigenous health: 'it's part of who we are, our spirit, our soul, our knowledge… that goes into our teaching'. Aust J Clin Ed. 2021;8(1)
19. Australian Institute of Health and Welfare. Expenditures on health services for Aboriginal and Torres Strait Islander people 1998–1999. Canberra: AIHW, 2001
20. Wakerman J, Tragenza J, Warchivker I. *Review of health services in the Kutjungka Region of WA*. Perth: Office of Aboriginal Health, Health Department of Western Australia, 1999
21. McGuire T, Houston S, Rohwedder E, Montague G. Identifying Aboriginal person care in hospital and Medicare documentation. Perth: Health Department of Western Australia, 1998
22. Jones R, Crowshoe L, Reid P, Calam B, Curtis E, Green M et al. Educating for Indigenous Health Equity. Academic Medicine. 2019;94(4):512-519
23. Durey A, Thompson S. Reducing the health disparities of Indigenous Australians: time to change focus. BMC Health Services Research. 2012;12(1)
24. Henry B, Houston S, Mooney G. Institutional racism in Australian healthcare: a plea for decency. Medical Journal of Australia. 2004;180(10):517-520
25. Partners in health: Engage. Horizontal vs. Vertical: Challenges in Approaches to Global Health [Internet]. PIH, 2022 [cited 2022 May 23]. Available from: https://www.pih.org/sites/default/files/2019-03/8%20Challenges_in_Global_Health-_Horizontal_and_Vertical_Approaches.pdf
26. Arja S, Arja S, M. Venkata R, Nayakanti A, Kottathveetil P, Acharya Y. Integrated curriculum and the change process in undergraduate medical education. Medical Teacher. 2018;40(5):437-442
27. Bourke S, Wright A, Guthrie J, Russell L, Dunbar T, Lovett R. Evidence Review of Indigenous Culture for Health and Wellbeing. The

International Journal of Health, Wellness, and Society. 2018;8(4):11–27

28. Lowe K, Skrebneva I, Burgess C, Harrison N, Vass G. Towards an Australian model of culturally nourishing schooling. J Curr Studies. 2020;53(4):1–15
29. Australian Institute of Health and Welfare. Australia's mothers and babies 2018 - in brief [Internet]. Canberra: Australian Institute of Health and Welfare; 2020 [cited 2022 Mar 21]. 76 p. Cat. no. PER 108. Available from: https://www.aihw.gov.au/getmedia/aa54e74a-bda7-4497-93ce-e0010cb66231/aihw-per-108.pdf.aspx?inline=true
30. Kildea, S., Magick Dennis, F. and Stapleton, H. 2013. Birthing on Country Workshop Report. Alice Springs: Australian Catholic University and Mater Research Unit on behalf of the Maternity Services Inter-Jurisdictional Committee for the Australian Health Ministers' Advisory Council;2012
31. Dragon N. Birthing on Country: Improving Aboriginal & Torres Strait Islander infant and maternal health. ANMJ [Internet]. 2019 [cited 2022 May 20]. Available from: https://anmj.org.au/birthing-on-country-improving-indigenous-health/#:~:text=Birthing%20on%20Country%20generally%20refers
32. Cavanagh J. Medical Deans - AIDA National Medical Education Review [Internet]. 2012 Feb. Available from: https://medicaldeans.org.au/md/2018/07/Medical-Deans-AIDA-Review-Final-Report.pdf
33. Smith JD, Wolfe C, Springer S, Martin M, Togno J, Bramstedt KA, et al. Using cultural immersion as the platform for teaching Aboriginal and Torres Strait Islander health in an undergraduate medical curriculum. Rural and Remote Health [Internet]. 2015 Jul 1 [cited 2022 Feb 9];15(3):3144. Available from: https://pubmed.ncbi.nlm.nih.gov/26245939/
34. Burgess C, Bishop M, Lowe K. Decolonising Indigenous education: the case for cultural mentoring in supporting Indigenous knowledge reproduction. Discourse: Studies in the Cultural Politics of Education. 2020 Jun 5;43(1):1–14
35. United Nations Department of Economic and Social Affairs [Internet],Geneva: UN; 2007. United Nations Declaration on the Rights of Indigenous Peoples. 2007 [cited 2022 May 12]. Available from: https://www.un.org/development/desa/indigenouspeoples/declaration-on-the-rights-of-indigenous-peoples.html

36. Marmot, M. Social determinants and the health of Indigenous Australians, Med J Aust [Internet]. 2011[cited 2022 May 19]; 194 (10): 512-513. doi: 10.5694/j.1326-377.2011.tb03086.x
37. Brumpton K, Sen Gupta T, Evans R, Ward R. Assessment of cultural safety in a post–Objective Structured Clinical Examination (OSCE) era. Australian Journal of General Practice [Internet]. 2022 [cited 16 May 2022];51(1-2):90-93. Available from: https://www1.racgp.org.au/ajgp/2022/january-february/cultural-safety-in-a-post-osce-era
38. Victorian Aboriginal Community Controlled Health Organisation, An introduction to cultural safety in Aboriginal health [Internet]. 2014[cited 2022 May 17]. Collingwood: VACCHO. Available from: http://www.vaccho.org.au/assets/01-RESOURCES/TOPIC-AREA/CULTURAL-SAFETY/CS-4-HOURS.pdf
39. Australian Health Ministers' Advisory Council, Standing Committee on Aboriginal and Torres Strait Islander Health Working Party 2014, AHMAC Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2016-2026 [Internet], 2014 [cited 2022 May 16], Canberra: AHMAC, 22p. Available from: http://www.coaghealthcouncil.gov.au/Portals/0/National%20Cultural%20Respect%20Framework%20for%20Aboriginal%20and%20Torres%20Strait%20Islander%20Health%202016_2026_2.pdf
40. Australian Health Practitioner Regulation Agency Aboriginal and Torres Strait Islander Health Strategy Group. A consistent baseline definition of cultural safety for the National Scheme. Melbourne, Vic: AHPRA, 2019
41. Kurtz DLM, Turner D, Nyberg J, Moar D. Social justice and health equity: urban Aboriginal women's actions for health reform. Int J Health Wellness Soc. 2014;3:13-26.
42. Robson B, Harris R. Hauora, Māori standards of health. Wellington: Te Rōpū Rangahau Hauora A Eru Pōmare; 2007
43. Taylor K, Guerin P. Health care and Indigenous Australians. 3rd ed. UK: Macmillan Education UK; 2019
44. Dudgeon P, Walker R. Decolonising Australian Psychology: Discourses, Strategies, and Practice. JSPP [Internet]. 2015 [cited 2022 May 22];3(1):276-97. Available from: https://jspp.psychopen.eu/index.php/jspp/article/view/4857
45. McKivett, A., Paul, D. & Hudson, N. Healing Conversations: Developing a Practical Framework for Clinical Communication Between Aboriginal Communities and Healthcare Practitioners. J Immigrant Minority

Health. 21. 596–605. 2019. https://doi.org/10.1007/s10903-018-0793-7

46. Curtis E, Jones R, Tipene-Leach D, Walker C, Loring B, Paine SJ, Reid P. Why cultural safety rather than cultural competency is required to achieve health equity: a literature review and recommended definition. Int J Equity Health. 2019;18:174
47. Hart-Wasekeesikaw F. Cultural competence and cultural safety in First Nations, Inuit and Matis nursing education: an integrated review of the literature; 2009. [cited 2022 May 18]; Available from: http://www.cna-aiic.ca
48. Smye V, Josewski V, Kendall E. Cultural Safety: an overview; 2010 [cited 2022 May 18]; Available from: https://www.troubleshumeur.ca/documents/Publications/CULTURAL%20SAFETY%20AN%20OVERVIEW%20(draft%20mar%202010).pdf
49. Australian Institute of Health and Welfare. Cultural safety in health care for Indigenous Australians: monitoring framework, Summary. Canberra:AIHW; 2021
50. Bainbridge R, McCalman J, Clifford A, Tsey K. Cultural competency in the delivery of health services for Indigenous people. Cat. no. IHW 157. Canberra, ACT: AIHW; 2015
51. Lie DA, Lee-Rey E, Gomez A, Bereknyei S, Braddock CH 3rd. Does cultural competency training of health professionals improve patient outcomes? A systematic review and proposed algorithm for future research. J Gen Intern Med 2011;26(3):317–25. doi: 10.1007/s11606-010-1529-0
52. Alizadeh S, Chavan M. Cultural competence dimensions and outcomes: A systematic review of the literature. Health Soc Care Community 2016;24(6):e117–30. doi: 10.1111/hsc.12293
53. Truong M, Paradies Y, Priest N. Interventions to improve cultural competency in healthcare: A systematic review of reviews. BMC Health Serv Res 2014;14:99. doi: 10.1186/1472-6963-14-99
54. Francis-Cracknell A, Murray M, Palermo C, Atkinson P, Gilby R, Adams K. Indigenous health curriculum and health professional learners: A systematic review. Med Teach. 2019;41(5):525–31
55. Grant J, Parry Y, Guerin P. An investigation of culturally competent terminology in healthcare policy finds ambiguity and lack of definition. Aust N Z J Public Health. 2013;37(3):250–56
56. Kurtz DLM, Janke R, Vinek J, Wells T, Hutchinson P, Froste A. Health Sciences cultural safety education in Australia, Canada, New Zealand, and the United States: a literature review. Int J Med Educ. 2018 ;9:271-285

57. Victorian Government. Aboriginal and Torres Strait Islander cultural safety [Internet]. Victoria: Department of Health; 2022 [updated 2021 Nov 20; cited 2022 May 20]. Available from: https://www.health.vic.gov.au/health-strategies/aboriginal-and-torres-strait-islander-cultural-safety
58. Haythornthwaite S. The relevance of trauma informed care to Aboriginal primary health care services [Internet]. NRHA - National Rural Health Alliance. 2013. Available from: http://www.ruralhealth.org.au/13nrhc/images/paper_Haythornthwaite
59. Atkinson J. Closing the gap Trauma-informed services and trauma-specific care for Indigenous Australian children [Internet]. 2013. Available from: https://www.aihw.gov.au/getmedia/e322914f-ac63-44f1-8c2f-4d84938fcd41/ctg-rs21.pdf.aspx?inline=true
60. Nemeroff Charles B. Paradise Lost: The Neurobiological and Clinical Consequences of Child Abuse and Neglect. Neuron [Internet]. 2016 Mar [cited 2019 Feb 3];89(5):892–909. Available from: https://miami.pure.elsevier.com/en/publications/paradise-lost-the-neurobiological-and-clinical-consequences-of-ch
61. Shonkoff JP. Protecting Brains, Not Simply Stimulating Minds. Science. 2011 Aug 18;333(6045):982–3.
62. Van der Kolk BA. Developmental Trauma Disorder: Toward a rational diagnosis for children with complex trauma histories. Psychiatric Annals [Internet]. 2005 May 1 [cited 2019 Apr 12];35(5):401–8. Available from: https://traumaticstressinstitute.org/wp-content/files_mf/1276541701VanderKolkDvptTraumaDis.pdf
63. Australian Bureau of Statistics. Australian Bureau of Statistics [Internet]. www.abs.gov.au. 2006 [cited 2022 Jun 26]. Available from: http://www.abs.gov.au/ausstats/abs@.nsf/mf/4715.0/
64. Balaratnasingam S, Chapman M, Chong D, Hunter E, Lee J, Little C, et al. Advancing social and emotional well-being in Aboriginal and Torres Strait Islander Australians: Clinicians' reflections. Australasian Psychiatry. 2018 Sep 20;27(4):348–51

Appendix

Appendix 1: AMC Accreditation Standards pertaining to Aboriginal and Torres Strait Islander medical education enclosed in the 2012 Standards for Assessment and Accreditation of Primary Medical Programs by the Australian Medical Council.

1. The education provider has effective partnerships with relevant local communities, organisations and individuals in the Indigenous health sector to support specialist training and education (Standard 1.6.4).
2. The education prodiver's purpose addresses Aboriginal and Torres Strait Islander peoples of Australia (Standard 2.1.2).
3. The curriculum develops a substantive understanding of Aboriginal and Torres Strait Islander health, history and cultures in Australia as relevant to the specialty (Standard 3.2.9).
4. The curriculum develops an understanding of the relationship between culture and health. Specialists are expected to be aware of their own cultural values and beliefs, and to be able to interact with people in a manner appropriate to that person's culture (Standard 3.2.10).
5. The education provider supports increased recruitment and selection of Aboriginal and Torres Strait Islander people (Standard 7.1.3).
6. The education provider's criteria for accreditation of training sites link to the outcomes of the specialist medical program and support training and education opportunities in diverse settings aligned to the curriculum requirements including settings which provide experience of the provisions of health care to Aboriginal and Torres Strait Islander peoples in Australia and done so in a culturally safe manner (Standard 8.2.2)

Appendix 2: Aboriginal and Torres Strait Islander Health Curriculum Framework Accreditation Recommendations.

CRITERIA/ELEMENT	RECOMMENDED SOURCES OF EVIDENCE
There is a consultative and collaborative approach to curriculum design and implementation which includes Aboriginal and Torres Strait Islander health professionals and/or health service users	• Organisational Commitment and Health Professional Program Readiness Assessment Compass (OCHPPRAC) or similar completed with relevant action plans • Terms of Reference of Advisory Boards, Curriculum Committees etc. • Minutes of meetings of Advisory Boards, Curriculum Committees etc. • Minutes of meetings with Aboriginal and Torres Strait Islander health professionals or service users
The program actively recruits/ draws upon, trains and supports Aboriginal and Torres Strait Islander staff and community members	• Number of Aboriginal and Torres Strait Islander staff or community members associated with the HPP • CVs of Aboriginal and Torres Strait Islander staff
The program actively recruits/ draws upon staff with the specialist knowledge and cultural capabilities to facilitate learning in Aboriginal and Torres Strait Islander health	• Number of staff with relevant expertise • CVs of staff
There is professional development for all HPP staff to develop the required cultural capabilities which makes the program a culturally safe learning and teaching environment	• Professional development programs available to staff • Number of staff who have completed relevant professional development programs
There is specific professional development for educators in Aboriginal and Torres Strait Islander health to ensure they have the requisite knowledge, reflexivity, facilitation skills, self-care and strategies to work in partnerships through collaboration and engagement	• OCHPPRAC Tool or similar has been completed with relevant action plans • Specific professional development programs available to educators in Aboriginal and Torres Strait Islander health • Number of staff who have completed relevant professional development programs
There are specific admission, recruitment, support and retention strategies for Aboriginal and Torres Strait Islander students	• Policies related to admission, recruitment, support and retention for Aboriginal and Torres Strait Islander students • Retention rates for Aboriginal and Torres Strait Islander students (benchmarked against all students) • Support accessed by Aboriginal and Torres Strait Islander students • Dedicated staff member allocated to supporting Aboriginal and Torres Strait Islander students

CRITERIA/ELEMENT	RECOMMENDED SOURCES OF EVIDENCE
There is specific subject matter which develops the Framework graduate capabilities and learning outcomes and which gives students an appreciation of the health and diversity of Aboriginal and Torres Strait Islander peoples in both foundation units and integrated within the curriculum	• Recommended Sources of Evidence • Unit/Course outlines for those units which develop the Framework cultural capabilities • Curriculum map demonstrating syllabus, unit learning outcomes, learning experiences and assessments which are aligned to the learning outcomes
Aboriginal and Torres Strait Islander peoples' history, culture, health, and wellness in accordance with the principles and curriculum content of the Framework are incorporated within the curriculum	• Unit/Course outlines for those units which develop the Framework cultural capabilities • Curriculum map demonstrating syllabus, unit learning outcomes, learning experiences and assessments which are aligned to the learning outcomes
The Framework graduate cultural capabilities are assessed	• Examples of a range of assessments of the Framework cultural capabilities e.g. written, journals, oral presentations, clinical assessments, simulation • Evidence of student performance in relevant assessment items
Students can demonstrate their achievement of cultural capabilities prior to completion of their program	• Interviews with students (Aboriginal and Torres Strait Islander and non-Indigenous students) • Portfolios or e-portfolios of achievements • Clinical placement assessment forms
There is evidence of meaningful engagement with and responsiveness to the local Aboriginal and Torres Strait Islander community through involvement in curriculum design, delivery, monitoring and evaluation	• OCHPPRAC Tool has been completed with relevant action plans • Number of community members involved in curriculum design, implementation, monitoring and evaluation • Types of engagement with curriculum delivery e.g. lectures, tutorials, sharing stories, provision of case studies, involvement in practical assessments, simulation etc. • Evidence of contribution to Aboriginal and Torres Strait Islander community i.e. reciprocity by the HPP/ HEP
There is a commitment to the time and resources required to build and maintain relationships with Aboriginal and/or Torres Strait Islander stakeholders	• OCHPPRAC Tool or similar has been completed with relevant action plans • Staff who are involved in teaching and working with Aboriginal and Torres Strait Islander community have appropriate workloads • Interviews with staff about workloads
Formal linkages with Aboriginal and/or Torres Strait Islander health services	• Signed partnership agreements with Aboriginal and/or Torres Strait Islander health services

Policy Details:

Name: Aboriginal and Torres Strait Islander Health in the Medical Curriculum (2022)

Category: B – Medical Education

History:

Reviewed, Council 3, 2022

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Adopted, 2010