Policy Document

First Nations Health in the Medical Curriculum (2026)

Executive Summary

The Australian Medical Students' Association (AMSA) believes that First Nations, or Aboriginal and Torres Strait Islander, health education is a non-negotiable component of Australian medical curricula, and that the current implementation of it in Australian medical schools is inadequate, inconsistent, and in many instances, actively harmful. AMSA further believes that adequate medical education is essential for addressing the health gap between First Nations and non-Indigenous Australians. Medical schools not prioritising First Nations health curricula risk producing and graduating culturally unsafe, underprepared, and potentially discriminatory clinicians that are entering the workforce.

AMSA asserts that appropriate First Nations health education must be grounded in truth-telling about Australia's colonial history, continued systemic racism, and its ongoing consequences for health. It must centre the First Nations holistic approach to health and recognise the heterogeneity of the over 250 distinct First Nations Countries and cultures across Australia. It must move beyond deficit-based framings that position Indigeneity as a risk factor and toward strengths-based approaches that accurately represent the diversity, resilience, and self-determination of First Nations peoples and communities. AMSA believes First Nations ways, knowing and beings benefit and advance not only First Nations people but everyone.

Further, AMSA insists that cultural safety and curriculum co-design must be the foundational standard for First Nations health education. Medical schools must create permanent First Nations leadership positions and form collaborative partnerships with the National Aboriginal Community Controlled Health Organisation (NACCHO), Aboriginal Community Controlled Health Organisations (ACCHOs), local First Nations communities and the Leaders in Indigenous Medical Education (LIME) Network to engage in curriculum co-design. This co-design must be genuine, ongoing, and community-led, free from superficial, tokenistic consultation. First Nations voices must be centred and respected at every decision-making stage, and must not bear colonial/cultural load without recognition, support, and financial remuneration.

Furthermore, First Nations content and cultural safety training must be delivered and assessed longitudinally throughout the medical curriculum, facilitated by approved providers (as per government-registered training organisations) and First Nations educators, and embedded experientially through meaningful

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clinical placements in ACCHOs. All non-Indigenous medical educators must also undergo this training. Cultural safety requires clinical application, a focus on lived patient experience and ongoing self-reflection. Standalone online modules and isolated workshops are insufficient for building genuine cultural safety.

AMSA believes that meaningful reform is both urgent and overdue. Despite First Nations-designed national frameworks existing for over two decades, including the Committee of Deans of Australian Medical Schools' (now Medical Deans Australia and New Zealand - MDANZ) Indigenous Health Curriculum Framework in 2004, implementation of these standards across Australian medical schools remains inconsistent, superficial, and insufficiently accountable. A need for cultural safety is embedded throughout the Australian Medical Council's (AMC) current 2023 accreditation standards, representing progress, yet AMSA believes these standards lack enforceable outcomes and adequate resourcing, and thus, are insufficient to produce the change that First Nations communities deserve. AMSA further believes that some Australian medical schools do not meet these standards and are merely implementing tokenistic curricula to tick boxes. This is an active mechanism through which medical education contributes to the very health inequities it should be working to eliminate.

AMSA calls upon the AMC to enforce its accreditation standards with measurable, assessable outcomes and consequences. AMSA calls upon MDANZ to work with the LIME Network and Australian Indigenous Doctors' Association (AIDA) to update MDANZ's Indigenous Health Strategy to align with current standards and commit to genuine co-designed curriculum reform. AMSA calls upon Australian medical schools to implement culturally safe, truth-telling, longitudinal, experiential, and co-designed curricula, and to establish funded, reciprocal partnerships with ACCHOs. AMSA calls upon the Commonwealth, State and Territory Governments to fund sustained partnerships between medical schools, National Aboriginal and Torres Strait Islander Education Corporation (NATSIEC), and ACCHOs, as well as dedicated First Nations leadership positions within medical faculties, and national reviews on First Nations health in medical curricula.

Australia cannot close the gap in health outcomes without first closing the gap in medical education.

Policy Points

AMSA calls upon:

1. The Australian Medical Council to:

a. Develop and mandate detailed measurable outcomes tied to accreditation standards regarding First Nations health curricula and content delivery for all Australian medical schools:
    i. Measurable outcomes must be defined by a panel of experts, including First Nations accreditors, educators and health professionals, and specialised non-Indigenous First Nations health educators;
    ii. Outcomes must be detailed, preventing superficial and tokenistic implementation of First Nations curriculum standards into medical programs; such as:
        1. A mandatory, summative First Nations patient OSCE station every year, designed and moderated by a First Nations educator.
    iii. First Nations-related outcomes must be reported in full in every annual/biennial monitoring submission from Australian medical schools to the AMC, as well as the NATSIEC, and assessed comprehensively during every formal accreditation assessment by the AMC; and
    iv. Deliver consequences to medical schools when accreditation standards are not met without impacting medical students.

b. Establish permanent First Nations evaluator leadership positions in AMC accreditation assessment teams who are consulted at every stage of the accreditation process without tokenism;

c. Enforce rigorous, external institutional accountability when accreditation standards are not met, through an Administrative Remediation Framework that mandates quality improvement without impacting medical students. This framework must:
    i. Remove internal oversight and ensure remediation plans and progress audits are designed and monitored by an external panel of independent First Nations health experts and AMC representatives, stripping medical schools of the authority to self-monitor their own non-compliance;
    ii. Trigger external intervention by the AMC should an institute fail to meet accreditation benchmarks, including, but not limited to:
        1. Evidence of First Nations leadership appointment within the medical school's governance structure and their role in curriculum design;
        2. Site visits and assessment by independent First Nations expert panels; and
        3. Transition to "Conditional Accreditation" where necessary.

2. The Australian Indigenous Doctors' Association, Leaders in Medical Education Network, Medical Deans Australia and New Zealand and the National Aboriginal and Torres Strait Islander Education Corporation to:

a. Commission national reviews every 5 years of First Nations health curricula across all Australian medical schools, as per the 2012 Medical Deans – AIDA review, led and evaluated by Aboriginal and Torres Strait Islander health professionals:
    i. Reviewers must have an in-depth understanding of each medical school's curriculum content and structure.
b. Update the MDANZ Indigenous Health Strategy 2021 – 2025 and the 2007 Indigenous Health Project Critical Reflection Tool against current targets.

3. Australian Medical Schools to:

a. Develop First Nations health curricula that must cover, but not be limited to:
    i. The heterogeneity of First Nations cultures and how different Countries and cultures necessitate different regional models of care;
    ii. Australia's colonial history, intergenerational trauma, and ongoing systemic racism as determinants of Aboriginal and Torres Strait Islander health;
    iii. First Nations holistic models of health, including the Social and Emotional Wellbeing (SEWB) framework;
    iv. Supportive factors and common barriers First Nations people experience when accessing healthcare, such as:
        1. Importance of culturally safe services in delivery of First Nations healthcare and what this specifically entails; and
        2. How implicit biases and interpersonal and systemic racism lead to the health gap experienced by First Nations people, culturally unsafe care and lack of trust from First Nations patients.
    v. How intersectionalities compound the health gap and systemic inequities for Aboriginal and Torres Strait Islander people, without falling into stereotype and deficit-based discourse.
b. Develop First Nations health curricula with a strengths-based lens that demonstrates the resilience and self-determination of First Nations peoples, devoid of deficit-based discourse and tokenism, including:
    i. ACCHO case studies;
    ii. Positive representations of First Nations patients in cases, devoid of stereotypes;
    iii. Not listing Aboriginal and/or Torres Strait identity as the risk factor for health issues when structural conditions such as poverty and overcrowding are responsible;

iv. Teaching content on First Nations cultures and historical determinants prior to health inequities; and
v. Teaching that First Nations ways of doing, living and being have positive health impacts for everyone, not just First Nations patients.

c. Establish permanent First Nations leadership positions and increase staffing places for First Nations educators and guest lecturers to deliver First Nations health curricula;
    i. First Nations educators should be prioritised for curriculum delivery; however, trained non-Indigenous educators with experience in First Nations healthcare can also be employed for this purpose, but cannot educate on lived experience and cultural information content.
d. Ensure all non-Indigenous medical educators teaching First Nations health content have been educated and assessed on relevant topics by First Nations educators and approved cultural education/training providers;
e. Teach and assess all medical students' and medical educators' cultural safety aligned with the AMC and Australian Health Practitioner Regulation Agency (AHPRA) definitions, and why cultural awareness and competency are insufficient for practice. Needed learning opportunities include, but not limited to:
    i. Cultural safety training programs;
    ii. Clinical yarning; and
    iii. 715 health checks.
f. Run mandatory cultural safety training events every academic year, for all medical educators and students to attend, run by First Nations facilitators, or by First Nations and trained non-Indigenous co-facilitators. This must occur prior to any mock assessment of, or actual, First Nations clinical exposure:
    i. Cultural safety training must also involve ongoing self-reflection, where participants examine racial power imbalances, privilege and biases.
g. Develop genuine lasting partnerships with local First Nations communities and organisations for support with curriculum co-design and cultural safety evaluation, ensuring:
    i. Consultation is genuine and incorporated at every decision-making stage, with no tokenism or coercion involved;
    ii. Informed consent for cultural knowledge use is sought at every stage from all knowledge holders, including if the medical school wants to use the knowledge for a different purpose;
    iii. Co-designed programs are continuously reviewed for improvement, led by First Nations representatives;
    iv. Evaluations are disseminated with and approved by relevant communities and representatives before being shared with larger audiences; and

v. Medical schools establish cultural consideration protocols specific to communities they have education and placement partnerships with, in co-design and collaboration with, but not limited to: local ACCHOs, First Nations liaison officers, First Nations Elders and First Nations educators.

h. Ensure cultural immersion opportunities for all medical students, such as through local partnered First Nations-owned and operated organisations;

i. Establish sustainable partnerships with local First Nations health services, such as ACCHOs, Aboriginal Liaison Officers or Aboriginal and/or Torres Strait Islander Health Practitioners, to provide longitudinal and experiential multidisciplinary clinical placements for all medical students;

j. Implement horizontal and longitudinal teaching and assessment of First Nations health curricula and cultural safety across the entire curriculum, designed and evaluated by First Nations educators and communities:

    i. Assessments must match learning goals. Practical and clinical skills such as cultural safety must be assessed practically, for example, through First Nations patient OSCEs:

        1. First Nations patient OSCE scenarios and evaluation criteria must be developed by local ACCHOs and First Nations educators;
        2. Offer paid positions to First Nations educators and community members to facilitate the assessment of students' cultural safety practice as OSCE patients and workshop facilitators:

            a. Ensure that First Nations patients, cases, and perspectives are never portrayed by non-Indigenous simulated patients, to maintain cultural safety; and
            b. Establish a culturally informed risk and wellbeing protocol for First Nations simulated patients and educators, including the right to pause or cease an assessment where a student's conduct is culturally unsafe or causes distress.

    ii. Students that fail assessments or assessment components relating to First Nations content must receive feedback and repeat them until passed (no change to original grade required), demonstrating competency.

k. Establish university policies that allow First Nations staff to receive financial remuneration for tasks outside their role conferring colonial/cultural load;

l. Provide all medical students opportunities to contribute to curriculum development through reporting lines and annual focus groups led by

First Nations educators, with separate sessions for First Nations students to ensure cultural safety;

i. Students must not be individually contacted or targeted to participate in focus groups. A First Nations educator must advertise this opportunity to the cohort with students participating voluntarily, and input anonymised; and
ii. Students submitting feedback through reporting lines. should receive a response indicating acknowledgement

m. Provide 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;
n. Establish culturally safe reporting lines for racism and cultural safety concerns, necessitating anonymity and minimising the recipient's involvement and recounting of the event;

i. Escalation pathways should be managed by First Nations leadership positions to maintain cultural safety, with reporter input anonymised, where possible; and
ii. Reporters should receive updates on the progress of their case whilst minimising their need to recount the event.

4. Medical School Societies to:

a. Ensure identified student First Nations representative and First Nations ally positions within the executive medical society for direct advocacy on First Nations student issues and consultation on the cultural safety of society events:

i. Representative and ally positions must be consulted genuinely without tokenism or coercion, with the representative's and ally's input incorporated; and
ii. Students in allied leadership positions must be passionate about First Nations advocacy, ideally with experience, and submit an application that is approved by a First Nations staff leadership position in the respective medical school.

5. Commonwealth, State, and Territory Governments to:

a. Provide sustained funding to facilitate partnerships between Australian medical schools and ACCHOs and NATSIEC, or other opportunities in First Nations health services, to expand community health-based clinical placements;
b. Provide dedicated funding for First Nations leadership positions within Australian medical faculties to support curriculum co-design, delivery and evaluation; and
c. Fund AIDA, LIME Network and MDANZ to conduct national curricula reviews every 5 years, update curriculum frameworks and provide curriculum support to Australian medical schools.

Background

INTRODUCTION AND CASE FOR UPDATED NATIONAL STANDARDS

Aboriginal and Torres Strait Islander peoples continue to experience profound and preventable health disparities compared to non-Indigenous Australians. Under the National Agreement on Closing the Gap, the target to close the life expectancy gap by 2031 remains off track: in 2020–2022, First Nations males and females had life expectancies 8.8 and 8.1 years shorter than those of their non-Indigenous counterparts, respectively.[1,2] These inequities are not explained by pathology alone. Approximately 35% of the health gap is attributable to social determinants, and the remaining unexplained portion is at least partly attributable to racism and the absence of culturally safe care.[3] Between 2014 and 2022, the proportion of Aboriginal and Torres Strait Islander peoples reporting racial discrimination by medical staff nearly doubled, from 11% to 20%.[3] In the same period, 32% of Aboriginal and Torres Strait Islander peoples who did not access needed health services cited cultural reasons for doing so.[3] Qualitative research has documented how racist and settler colonial practices perpetuated by medical practitioners actively promote ill health, and that culturally responsive care is what Aboriginal and Torres Strait Islander patients desire.[4]

Several national frameworks articulate what a prepared medical workforce should involve. The AMC's Standards for Assessment and Accreditation of Primary Medical Programs mandate graduate competency in culturally appropriate care.[5] The MDANZ Indigenous Health Curriculum Framework provides guidelines for developing and delivering Indigenous health content.[6,7] The Aboriginal and Torres Strait Islander Health Curriculum Framework recommends a holistic, strengths-based approach.[8] Despite this policy architecture, implementation remains inconsistent, with significant variation between universities,[9] ongoing deficit-based educational framing, and a lack of longitudinal community-based learning.[10] Furthermore, more up-to-date curricula reviews are required, with most national comprehensive publications now outdated by over a decade.[9,10] Effective First Nations health teaching must be strengths-based, anti-racist,[11] grounded in holistic models of health, embedded longitudinally, and co-designed with Aboriginal and Torres Strait Islander communities.[4,7] This policy advocates for such an approach across all Australian medical schools.

TRUTH-TELLING, INTERGENERATIONAL TRAUMA, AND SYSTEMIC RACISM AS HEALTH DETERMINANTS

Truth-Telling.

The ongoing health inequities experienced by First Nations peoples cannot be understood in isolation from Australia's colonial history, and medical education that fails to teach this history produces clinicians inadequately prepared to provide culturally safe care for Aboriginal and Torres Strait Islander patients.[12,13] Before the 1967 Referendum, the Australian Constitution explicitly stated that *"aboriginal natives shall not be counted"* in population tallies.[14,15] This exclusion meant First Nations peoples had no national

political representation and no Commonwealth provision for health, education or welfare services, with policy control resting with individual states who used this power to enact deeply discriminatory laws, including those that enabled the systematic removal of Aboriginal and Torres Strait Islander children from their families, known as the Stolen Generations.[14-16] Importantly, these harms are not confined to the past; there are living Stolen Generations survivors today, living as parents, grandparents and Elders whose lived experiences of government-sanctioned removal directly shape how Aboriginal and Torres Strait Islander families engage with institutions, including health services, to this day.[16,17]

This history of colonisation, dispossession and government-sanctioned harm has produced intergenerational trauma with measurable, ongoing health consequences.[18,19]

Racism in Medicine.

Racism is now recognised as a major social determinant of health, manifesting both explicitly, through discriminatory comments and dismissal of patient concerns, and unintentionally, through negative biases and the privileging of Western biomedical frameworks over First Nations models of health and wellbeing.[3,20] These experiences create culturally unsafe environments that directly cause delays in care-seeking, higher rates of discharge against medical advice, and are strongly associated with psychological distress and reduced access to services.[21] Social determinants of health, driven by the ongoing structural effects of colonisation, account for 35% of the total health gap between Aboriginal and Torres Strait Islander and non-Indigenous Australians.[20]

Medical education has not adequately responded to this evidence and, in many cases, is actively compounding these health inequities. Research has found that medical practitioners are actively promoting ill health through racist practices, and that settler colonial processes, including the devaluing of Indigenous worldviews against the Western biomedical model, remain embedded in clinical practice.[4] Research using the Racial Segregation Audit Tool further found that existing curricula can actively embed and reinforce systemic racism through deficit-based framing, associating First Nations patients with disease burden, and the absence of strengths-based content.[13] Curricula that fail to critically address these issues risk perpetuating them. Teaching the truth of Australia's colonial history and its consequences for Aboriginal and Torres Strait Islander health today is not an optional addition to medical education; it is a clinical necessity and a moral imperative.

STRENGTHS-BASED EDUCATION, DISMANTLING DEFICIT DISCOURSE AND THE HETEROGENEITY OF FIRST NATIONS CULTURES

Strengths- Versus Deficits-Based Education.

Deficit-based framing continues to dominate much of First Nations health education. Whilst it is important to teach the causes of health inequities experienced by Aboriginal and Torres Strait Islander peoples, an overemphasis

on pathology and disadvantage risks reinforcing harmful stereotypes and unconscious bias.[22] In medical teaching, Aboriginal or Torres Strait identity is often framed in disease association, dysfunction, or social disadvantage, unintentionally positioning Indigeneity as a risk factor rather than the structural conditions of colonisation, poverty, overcrowding, and unequal access to healthcare as the true determinants.[11,23] From a neuroeducational perspective, repeated exposure to negative associations strengthens neural pathways through negativity bias.[24] If students repeatedly encounter First Nations patients only within discussions of illness or poor outcomes, these associations may become unconsciously ingrained, influencing clinical judgement and patient interactions.[25]

A strengths-based approach provides a more balanced and accurate understanding of First Nations health and involves recognising the positive impacts of connection to Country, community and culture. ACCHOs, represented through NACCHO, are powerful examples of successful, culturally safe healthcare delivery yet are rarely given significant attention in medical curricula.[26] Positive representations of First Nations patients as healthy, successful and diverse individuals are equally important in disrupting deficit-based stereotypes.[27]

First Nations health education should also adopt an intersectional lens, recognising higher rates of disability, geographic barriers, and socioeconomic disadvantage, and acknowledging that First Nations people may also be part of other groups experiencing health inequities,[28] whilst still maintaining a strengths-based approach that centres community resilience, adaptability and self-determination.[3,26]

Understanding the Heterogeneity of First Nations Peoples, Cultures and Health.

Understanding First Nations health requires first understanding First Nations cultures, histories, and worldviews. It is also essential to recognise the heterogeneity of Aboriginal and Torres Strait Islander peoples. Australia contains more than 250 distinct First Nations Countries, each with their own histories, cultures, customs, languages and lore systems. Aboriginal and Torres Strait Islander understandings of health are holistic, extending beyond physical wellbeing to encompass connections to family, community, culture, Country, spirituality, and identity. Medical education must therefore incorporate First Nations models of health, including the Social and Emotional Wellbeing (SEWB) framework, which acknowledges the complex interplay of intergenerational trauma on health and recognises that traditional knowledges and perspectives significantly shape how patients engage with healthcare.[23]

Reducing First Nations people to a single narrative contributes to simplistic and inaccurate understandings in healthcare education and ineffective First Nations-targeted healthcare interventions.[29]

CULTURAL SAFETY, CURRICULUM CO-DESIGN AND COMMUNITY PARTNERSHIPS IN MEDICAL EDUCATION

Cultural Safety.

Cultural safety is now recognised as the foundational standard for addressing health equity for Aboriginal and Torres Strait Islander peoples, both in closing the gap,[30] and in retaining First Nations talent in medical training.[31] Cultural safety is defined by AHPRA as "determined by Aboriginal and Torres Strait Islander individuals, families and communities… Culturally safe [practice] is the ongoing critical reflection of health practitioner knowledge, skills, attitudes, practising behaviours and power differentials in delivering safe, accessible and responsive healthcare free of racism."[5,32] Cultural awareness and competency are insufficient substitutes; both focus on knowledge acquisition without the self-reflection or power analysis necessary for genuinely safe clinical practice.[8,33] Despite the AMC's 2023 accreditation standards mandating cultural safety as a graduate outcome, implementation of cultural safety training remains highly variable across institutions, ranging from superficial, tokenistic programs to deeply embedded, comprehensive approaches.[9]

Curriculum Co-Design.

Achieving genuine cultural safety in medical education requires curriculum co-design with Aboriginal and Torres Strait Islander peoples and communities at every stage. Best-practice co-design places First Nations educators, communities and health providers in positions of genuine decision-making authority across curriculum development, delivery and evaluation, with dedicated First Nations leadership positions embedded within university structures.[8,34,35] This requires institutions to prioritise building trusting, reciprocal relationships with local First Nations organisations as a foundational prerequisite, not an outcome, of co-design, with ongoing informed consent regarding how cultural knowledge is used and the right of communities to withdraw that knowledge at any point.[36]

Sustained increased funding to Aboriginal Community-Controlled Organisations is necessary for effective First Nations-led co-design of programs.[37] Schools nationally should collaborate to ensure they are meeting standards relating to First Nations health, and to share strategies and expertise.[38] Further, the Australian Indigenous Doctors' Association (AIDA) and the LIME (Leaders in Indigenous Medical Education) Network are key national organisations that can be consulted for the provision of cultural safety training and to help develop and evaluate First Nations health curriculum in medical education.[39,40]

Teaching Cultural Safety.

Cultural safety must be taught and evaluated as an ongoing clinical skill, through multiple methods and clinical experience in First Nations health services, not simply a one-off training event.[32,41] Cultural safety training events are still essential, alongside other methods, and are most effective when co-facilitated by First Nations and trained non-Indigenous educators. This model reduces the colonial/cultural load on First Nations co-facilitators, provides practical frameworks for examining privilege and power imbalances, and fosters the meaningful cross-cultural relationships that cultural safety training seeks to

develop.[33] Clinical yarning, combining First Nations communication preferences with biomedical understandings of health to improve healthcare delivery and rapport, is a further applied method, with evidence demonstrating significant improvements in medical students' self-rated communication skills, confidence and knowledge following training.[42,43] Central to all approaches is students' ongoing critical self-reflection to challenge internalised biases and understand privilege and racial power imbalances.[44]

Evaluating Cultural Safety.

Evaluation of cultural safety cannot be reduced to a single measure and must ultimately be defined by the experiences of Aboriginal and Torres Strait Islander peoples and communities.[41,45] First Nations-designed instruments such as the Wathaara scale provide a valuable starting point for assessing cultural safety outcomes, but do not capture the relational and experiential dimensions of genuinely safe practice.[45] Partnerships with local communities are therefore essential for defining what cultural safety looks like in each local context.[41,46] The evaluation of cultural safety must therefore be embedded throughout assessment across the entire medical degree.[8]

LONGITUDINAL AND EXPERIENTIAL LEARNING: BEYOND MODULES AND LECTURES

Contemporary approaches to First Nations health education within Australian medical curricula remain predominantly episodic and cognitively oriented, commonly delivered through isolated lectures, short-term workshops, or online compliance-based modules.[47] Whilst these approaches facilitate the acquisition of declarative knowledge, they are insufficient for developing the relational, reflexive and communication capabilities required for culturally safe clinical practice.[48] The AMC's 2023 accreditation standards require numerous clinical opportunities for students to engage in culturally safe First Nations healthcare and to engage in ongoing learning in cultural safety.[5] Both longitudinal and experiential learning are therefore necessary; longitudinal integration embeds First Nations content vertically across every year of the degree, whilst horizontal integration ensures it appears across all clinical disciplines rather than being siloed in a single unit.[8]

Experiential Learning.

Experiential learning creates multidisciplinary clinical placement opportunities in First Nations-based organisations, fostering cultural responsiveness alongside clinical skill development.[6] Experiential learning in remote Aboriginal communities enhances initiative, cross-cultural communication, and a deeper connection and responsibility to Country and its people.[49] Medical students who undertook longitudinal integrated clinical placements in ACCHOs developed greater capacity for culturally safe practices, including clinical yarning skills, overcoming apprehension, and opportunities to discuss difficult topics with First Nations staff and practitioners.[50] Cultural immersion programs similarly provide a valuable platform for beginning detailed experiential learning about First Nations cultures, history, and their impact on current health outcomes, and have been shown to be most effective when delivered in safe, cross-cultural environments with skilled First Nations facilitators.[51]

Community Partnerships.
Reciprocal community partnerships are foundational to effective experiential learning. Institutions must establish reciprocal, ongoing relationships with local First Nations communities and ACCHOs, not one-off placement arrangements, to ensure students are learning in environments where they are genuinely welcomed and where First Nations communities have agency over what is shared and how.[8,34] As ACCHOs are significantly under-resourced, sustained Commonwealth funding is essential to expand placement capacity and ensure these partnerships are mutually beneficial rather than extractive.[26,50]

ASSESSMENT REFORM: EMBEDDING ASSESSMENTS ON FIRST NATIONS HEALTH ACROSS THE DEGREE

The Australian Medical Council's 2023 accreditation standards necessitate ongoing teaching and assessment of Aboriginal and Torres Strait Islander health and cultural safety throughout the curriculum, ensuring that knowledge and skills are continually developed.[5] Further, assessments and evaluation criteria must be developed by First Nations people and organisations in partnership with medical schools, as cultural safety can only be defined by their experiences.[5,8,32] Assessments are critical to assessing if students are meeting learning outcomes, and they must be compulsory and 'high-yield', as otherwise, students devalue First Nations health content.[10,44]

The Aboriginal and Torres Strait Islander Health Curriculum Framework details assessment guidelines and examples of assessments best suited to certain learning outcomes and goals that medical curricula can use.[8] Despite this and other national resources, gaps between learning goals and assessments exist for First Nations health content, necessitating assessment redesign to more innovative types that accurately assess learning goals.[52] Practical skills, such as communication and cultural safety are either not being assessed or have been reduced to, and inadequately assessed, via written responses.[52]

Improving Assessment Styles.
Higher levels of assessment and teaching could involve giving students Objective Structured Clinical Examinations (OSCEs) of unfamiliar First Nations health contexts, where students must practically integrate a range of knowledge, skills and understanding of First Nations life experiences to engage in a culturally safe manner.[52] Teaching and assessing 715 health checks,[53] dermatological exams on all Fitzpatrick skin types[54,55] and reflective practice,[5] as well as the First Nations holistic approach to health, historical determinants and impacts of systemic racism,[8] is also necessary to creating culturally safe practice.

EDUCATOR TRAINING AND GOVERNANCE STRUCTURES IN MEDICAL SCHOOLS

Educator Training.
Due to workforce capacity and student numbers, non-Indigenous educators currently deliver much of the First Nations health content within medical

programs, yet many feel underprepared and unskilled.[8,56] It cannot be assumed that educators are culturally safe simply because they are practising clinicians; First Nations patients continue to experience racism from health practitioners.[4] Education on the social determinants of health for First Nations people is highly variable across medical schools, indicating significant differences in curriculum and educators.[9] Educators must understand First Nations health, histories, cultures and pedagogical principles, engage in cultural safety training, and actively self-reflect on bias, attitudes and power imbalances.[8,57]

Many approved cultural awareness and cultural safety training providers exist; however, there are no clear national or state databases for them, and registration is generally sector or state-specific.[58] One example is the NSW Government's 'Everyone's Business' cultural capability online training package.[59] The LIME Network should be consulted to find training providers best suited to medical educators and students.[39] AIDA is the cultural safety training provider approved by the Medical Board of Australia, relevant for clinicians, medical educators and students.[60,61]

Responsibility of Governance Structures in Medical Schools.
At an institutional level, medical schools must actively pursue organisational change to become culturally safe environments, including through policy reform, educator training and accountability measures.[56] Permanent First Nations leadership positions in governance and curriculum are essential; their expertise and decision-making authority must be meaningfully embedded to avoid tokenistic approaches to co-design.[62] Universities should engage in ongoing critical self-reflection using tools such as the MDANZ Indigenous Health Project Critical Reflection Tool.[63,64] Cross-institutional collaboration between medical schools on First Nations health curricula is also essential, as sharing knowledge, strategies and resources reflects the collectivist approaches characteristic of Aboriginal and Torres Strait Islander ideologies.[38] It ensures no institute works in isolation and that medical schools nationally are meeting AMC's accreditation standards.[38] Ultimately, institutional accountability for cultural safety is not an administrative exercise; it is a direct determinant of whether Aboriginal and Torres Strait Islander patients receive safe, equitable care from the graduates these institutions produce.

Colonial/Cultural Load.
Whilst increasing First Nations representation in medical education is essential, colonial/cultural load, the invisible, uncompensated burden placed on First Nations staff to educate, represent and perform cultural work outside their professional role, must be recognised and addressed.[65,66] This load can manifest as vicarious trauma, burnout and isolation,[66,67] and is being placed on First Nations medical educators and students.[7] The University of Wollongong's Indigenous Cultural and Colonial Load Allowance Guideline provides a model for recognising and financially remunerating this work.[68]

For More Information

This framework from the Australian Government comprehensively details how Aboriginal and Torres Strait Islander health curricula should be taught and implemented within universities, including learning outcomes and recommended assessment tasks, resources, important graduate cultural capabilities and pathways to achieve them. The LIME Network can also be consulted in adjunct to this, for more up-to-date support in developing First Nations health content in medical curricula.

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Policy Details:

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