

# Towards Reconciliation in Aboriginal Health:

Initiatives for Teaching Medical Students about Aboriginal Issues

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THE UNIVERSITY OF  
MELBOURNE

Lisa Rasmussen

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# Dedication

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This report is dedicated to Peter Clarke who died in January 1999, aged thirty. Peter was a Koori educator and a member of the advisory committee for this project. In addition to his long-standing commitment towards a more appropriate and accessible education system for young Kooris, Peter was involved for many years in increasing the awareness amongst other Australians about Indigenous issues. He treated people with great respect and believed that it was particular experiences, as well as lack of contact and a lack of information, which were key to the beliefs and perceptions non-Indigenous Australians often carried about his people. He was strongly committed to the power of educational processes in bringing about positive and lasting change in this area. Peter's ideas about cross-cultural teaching were central in the development of the pilot project and he made a lasting impression on all thirty-two students who participated. All of us involved in this project will never forget him.



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# Abbreviations

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ABS	Australian Bureau of Statistics
ACES	Aboriginal Community Elders Service
ACT	Australian Capital Territory
AFI	Australian Film Institute
AGPS	Australian Government Publishing Service
AIJA	Australian Institute of Jewish Affairs
AMA	Australian Medical Association
ATSIC	Aboriginal and Torres Strait Islander Commission
ASU	Advanced Study Unit
CEO	Chief Executive Officer
CSV	Community Services Victoria
df	Degree of Freedom
GP	General Practitioner
HbA1C	Glycylated haemoglobin A1C
HBV	Hepatitis-B Virus
HREOC	Human Rights and Equal Opportunity Commission
JAMA	Journal of the American Medical Association
LFT	Liver Function Test
MRAI	Multifactor Racial Attitude Inventory
MRS	Modern Racism Scale
NACCHO	National Aboriginal Community-controlled Health Organisations
NAD	No Abnormality Detected
NAHSWP	National Aboriginal Health Strategy Working Party
NIDDM	Non-Insulin-Dependent Diabetes Mellitus
NSW	New South Wales
OATSIHS	Office for Aboriginal and Torres Strait Islander Health Services
PRC	People's Republic of China
RACGP	Royal Australian College of General Practitioners
RBG	Random Blood Glucose
RCADC	Royal Commission into Aboriginal Deaths in Custody
ROC	Republic of China
SAS	Situational Attitude Scale
SPSS	Statistical Package for the Social Sciences
TWIG	Third World Interest Group
VACCA	Victorian Aboriginal Child Care Agency
VACCHO	Victorian Aboriginal Community - Controlled Health Organisations
VAHS	Victorian Aboriginal Health Service
WA	Western Australia



# Preface

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*Towards Reconciliation in Aboriginal Health: Initiatives for Teaching Medical Students about Aboriginal Issues* brings together a body of research that was conducted at the University of Melbourne between 1994–1996. Whilst the work was conceived as a whole from the outset, it evolved over this three-year period through a series of developmental stages. Problems in Aboriginal health teaching at the University had been identified. This led to a series of focus group discussions exploring students' attitudes to Aboriginal issues and to Aboriginal health teaching. The findings from these discussions, in turn, led to a larger student survey. It was this initial work which informed the development of a pilot teaching intervention. This intervention was delivered and evaluated during 1996. Finding solutions to problems is always a process. All of us involved learnt as we went, with each step enabling the next.

This report has been organised into four sections. Section One, entitled 'Why this project?', discusses the importance of teaching Aboriginal issues to medical students and sets out the problems experienced in teaching at the University. Section Two comprises the needs assessment. It presents findings from the literature, focus group discussions and surveys, and draws this work together to present a model for understanding the factors which may act as barriers to learning and those which may facilitate student learning in this area. Section Three describes the development, delivery and evaluation of the pilot teaching project and finally, Section Four offers a set of recommendations for future undergraduate medical teaching on Aboriginal issues.

The work described here has since allowed us to move further in developing and integrating core and elective teaching on Aboriginal health in the new undergraduate medical course at the University of Melbourne. We hope that the ideas shared in this report will be of help to others in various institutions who are thinking about teaching Aboriginal issues to students in a range of disciplines in the health sciences.



# Section 1:

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## Why This Project?



# Chapter One: The Problem

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## 1.1 Why does teaching Aboriginal health matter?

The continuing poor health status of Aboriginal people, both in terms of mortality and morbidity, is well documented <sup>1</sup>. Aboriginal people die more frequently and at an earlier age than people in any other sector of the Australian population. Despite advances in medical knowledge, the gaps between Aboriginal and non-Aboriginal health remain large, at a time when the health of Indigenous communities elsewhere has undergone significant improvement (Kunitz, 1994).

Whilst acknowledging that the medical profession has worked to fulfil its obligations in addressing Aboriginal ill-health, the history of the relations between Aboriginal people and medicine has been deeply problematic. Medical institutions have mirrored, and in some cases helped construct, prevailing attitudes towards Aboriginal people.

In the early 1900s, the profession gave legitimacy to Darwinian notions of racial hierarchy (Ward and Bingham, 1994). Doctors were involved in implementing segregation policies for Aboriginal people 'suspected of having' communicable diseases and were also quite likely to hold the position of chief medical officer at the same time as that of Protector of Aborigines (Hunter, 1991). In the 1950s and 1960s, medical opinion, whilst often of 'benevolent intent', continued to be informed by paternalistic racial stereotypes and romantic anthropological notions of 'the primitive' (Anderson, 1994), often actively endorsing and justifying existing legislation, assimilationist policies and even past atrocities (Barrack, 1958; Cleland, 1960). Up until the mid-1960s, in remote areas of Australia Aboriginal people were denied access to superior mainstream services, and were treated instead in separate 'native hospitals' (Hunter and Fagan, 1994). During the same period and into the 1970s, health professionals and hospitals were often involved in facilitating the removal of Aboriginal children from their families (Human Rights and Equal Opportunity Commission, 1997). Finally, the 1970s and 1980s saw a burgeoning of research into Aboriginal health which often served to further medicalise health problems with complex causes. Such research was often seen as insensitive, intrusive and exploitative, by Aboriginal people and others, and of little benefit to the communities involved (Maddocks, 1992).

The last twenty-five years has seen more constructive debate on Aboriginal issues within the health professions (Kerr, 1974; Nurcombe, 1974; Gracey, 1974). In the 1970s a number of doctors and others began to argue for more community-based and interdisciplinary approaches to Aboriginal health (Tatz, 1970; Spargo, 1975). It has effectively only been since the 1980s, however, that researchers and practitioners within Medicine have begun to advocate with the Aboriginal community for Aboriginal involvement and Aboriginal control, and medical literature has begun to include and refer to the writing of Aboriginal authors (Ward and Bingham, 1994; Reid, 1978; Gracey, 1985; Houston, 1985).

<sup>1</sup> Information on core Aboriginal health teaching was gathered in the preliminary stages of the research through communication with staff at the Department of Public Health and Community Medicine (now the Department of General Practice within the School of Population Health.)

More recently, medical schools have acknowledged the need to improve student learning about Aboriginal health. In 1992, the University of Newcastle instituted an innovative program in their Aboriginal health curriculum (Gibson, 1997). Since then, a number of other universities have begun to employ Indigenous staff and to review their Indigenous health teaching (Teubner and Prideaux, 1997; University of Newcastle, 1997a).

All medical students in Australia need to be exposed to teaching on Aboriginal health. The majority of medical graduates are likely to work with Aboriginal families and individuals at some stage during their working life, either within mainstream services or in Aboriginal-controlled organisations. However, most medical students have had little contact with Aboriginal people and, like many other non-Aboriginal Australians, do not know how to relate to Aboriginal people (Langton, 1993). Kaufman, who has had a long history of involvement with Aboriginal people and medical students, states:

*The current, sparse contact medical students have with Aborigines in hospitals and clinics appears to have done little to reduce prejudice, little to bridge the gap between cultural values and living circumstances of white Australians and those of Australia's neediest minority... Few Australian medical students will have known an Aboriginal person as a friend or colleague before entering medical school (Kaufman, 1984: 24).*

It is unreasonable to expect doctors to deal meaningfully with the complex problems confronting Aboriginal patients if they have had no meaningful contact with Aboriginal people outside the hospital (Anderson, 1994). Mobbs (1986) in her work with new graduates and their difficulties communicating effectively with Aboriginal patients, has argued that it is 'the medical community as a whole, including its educators', who need to take responsibility for these difficulties (1986: 55).

Poor Aboriginal health cannot be improved by focusing solely on those practitioners who will ultimately work in Aboriginal-specific organisations, or by relying on the small pool of Aboriginal medical graduates (Brown, 1998)<sup>2</sup>. The challenge in improving Aboriginal health lies at least partly with the capacity of undergraduate medical education to engender increasing understanding about the issues that effect Aboriginal health (Kamien, 1998; Garvey and Atkinson, 1999). An understanding of the historical and contemporary relations between the medical profession and Aboriginal people is particularly important for both the development and delivery of any educational programs. As Kaufman has suggested, teaching also needs to consider how it can foster meaningful contact between Aboriginal people and students.

<sup>2</sup> In 1998, there were approximately thirty Indigenous doctors and sixty Indigenous medical students in Australia (Brown, 1998)



## 1.2 Aboriginal health teaching at the University of Melbourne

Prior to 1994, when the initial focus groups were conducted, the Department of Public Health and Community Medicine (now the Department of General Practice within the School of Population Health) at the University of Melbourne had a small teaching program in Aboriginal health (Table 1-1).<sup>3</sup>

**Table 1-1. Teaching Aboriginal health at the University of Melbourne 1994–1996<sup>1</sup>**

YEAR-LEVEL	TEACHING IN ABORIGINAL HEALTH
First-year	<ul style="list-style-type: none"> <li>• 1 lecture (1 hour) on epidemiology, focusing in part on Aboriginal health statistics</li> </ul>
Third-year	<ul style="list-style-type: none"> <li>• 1 lecture (1 hour) on historical and cultural influences on Aboriginal health</li> <li>• Optional Advanced Study Unit, [see p 100] undertaken by approximately 15 students per year</li> </ul>
Fifth-year	<ul style="list-style-type: none"> <li>• 1 tutorial (1 hour) exploring student attitudes to Aboriginal issues</li> <li>• 1 lecture (4 hours) from a clinical perspective, interweaving epidemiological, social and cultural factors in Aboriginal health</li> </ul>

<sup>1</sup> Information on core Aboriginal health teaching was gathered in the preliminary stages of the research through communication with staff at the Department of Public Health and Community Medicine (now the Department of General Practice within the School of Population Health).

Anecdotally, students were communicating their dissatisfaction with teaching in Aboriginal health. Individual feedback from students was varied, divergent and somewhat contradictory, indicating students' own uncertainties with the subject area. Some saw any discussion of Aboriginal issues as paying the area too much attention, taking time away from more important areas, whilst others felt outraged that Aboriginal issues were receiving so little attention. Many students wanted more direct contact with 'real' Aboriginal 'patients' similar to their undergraduate teaching in hospitals. Others were frustrated with the 'lack of organisation' and with the nature and style of information presented to them on field visits to Aboriginal organisations, often seeing this information as irrelevant to their medical training (Personal communication with students).

The call to address the problems in teaching Aboriginal health came from a number of sources at all levels both within and outside the university. Staff, Aboriginal people and Faculty all had identified a number of problems that needed addressing, each from their own particular viewpoint. Firstly, teaching staff were frustrated at the small amount of time devoted to teaching in this area. Block teaching produced further difficulties, making it harder to engage the students in the subject in any depth and hence to effect a change in their attitudes.

<sup>3</sup> At this time, at the University of Melbourne, Medicine was a six-year course with three pre-clinical years and three clinical years. This teaching on Aboriginal health occurred as part of 'Health and Illness in Society' in first-year; as part of 'Public Health in Community Medicine' in third-year; and as part of a ten-week rotation in Community Medicine in fifth-year.

Aboriginal people were also dissatisfied with existing teaching, and were arguing for change. I held informal discussions with Aboriginal people, from both the general Melbourne community and the Victorian Aboriginal Health Service (VAHS) who had had some involvement with the teaching program. People commonly described lecture-based teaching to large groups, where only a small amount of time was being devoted to the subject, as inappropriate. They did not want to be involved with such teaching, where they had little input or control over the material taught or the approach adopted. Also, Aboriginal organisations such as the VAHS were becoming increasingly frustrated with one-off visits to their services by large numbers of students. Those involved with talking to students often described the process as very distressing and draining, feeling 'on show' as a kind of token or all-encompassing Aboriginal representative. Student requests to simply sit/in on consultations failed to take into account the complexities of the situation they were entering. Given that so many Aboriginal people have had such traumatic experiences with health professionals in the past, having students unknown to them sitting in on consultations often powerfully rekindled very painful memories. In 1995, VAHS resolved to stop participating in the educational program in its current form.

Finally, senior staff within the Department of Public Health and Community Medicine were also starting to realise that the Faculty had a problem. The Department was finding it increasingly hard to attract Aboriginal people to do any teaching and there were problems with the overall coordination of the teaching that was taking place. Some students had described informal teaching that they were receiving in the area, but from the Department's perspective it was very difficult to determine what informal teaching was occurring and to deal with any potential overlaps in teaching or contradictory teaching approaches<sup>4</sup>. In addition, the Department needed to address student concern and frustration with the teaching of Aboriginal health.

These difficulties were not peculiar to the University of Melbourne. The Aboriginal Students Liaison Officer at the University of Newcastle's Faculty of Medicine submitted the following to the 1988 Inquiry into Medical Education and Medical Workforce:

*Poor curricula in Aboriginal health are widespread. There are often individuals who have a commitment and ensure that their area of influence covers Aboriginal health well. What is needed, however, is an integrated course where students can build knowledge and appropriate skills from a core of information. (Committee of Inquiry into Medical Education and Medical Workforce, 1988: 137).*

In his article outlining a more positive intervention with medical students in Aboriginal health teaching, Kaufman describes the trepidation with which the Faculty approached the new pilot session on Aboriginal health precisely because past sessions organised by the Faculty had gone badly, 'generating anger and confrontation without resolution or productive gain' (Kaufman, 1984: 25).

<sup>4</sup> Informal teaching refers to any teaching on Aboriginal health outside of the formal curriculum. This includes beside tutorials where the patient happens to be Aboriginal, clerking Aboriginal patients in hospitals, sitting in on consultations where the patient is Aboriginal. Lectures where Aboriginal health is referred to.

Informal discussions (conducted during this project) with a number of lecturers involved in teaching Aboriginal health in undergraduate medical curricula in various Australian universities suggested that there was minimal compulsory teaching at most institutions. This teaching was often described as being marginalised within the undergraduate curriculum, and a number of lecturers felt that it was frequently not well received or was dismissed by students. Aboriginal people reported finding it very difficult to teach and were often not involved in development of the material being taught. Most of the compulsory teaching was still being conducted in large lecture theatres. There was a clear tension between the overall orientation of medical education in general and the ways in which lecturers in Aboriginal health wanted the subject to be taught. Participants articulated similar problems both informally and in formal presentations at the Second Indigenous Medical Conference (University of Newcastle, 1997a).

Thus, in 1994, it seemed that any teaching was consistently provoking significant frustration and difficulty for Aboriginal people, students and the Department alike, reflecting the complex and historically based social relations in the wider community between Aboriginal and non-Aboriginal people. It was clear that there was a need to rethink the nature of Aboriginal health teaching at the University of Melbourne, and to develop a more strategic approach that could respectfully take into account these divergent positions.

### **1.3 Towards an improved curriculum in Aboriginal health**

This project was conceived to identify the limitations of existing Aboriginal health teaching, and to contribute to addressing those limitations. The broad aim of the proposal was to begin to work towards developing new initiatives in Aboriginal health teaching to undergraduate medical students. We commenced with a formal needs assessment, and from this developed a pilot teaching project for a group of students. Funding was provided through the Faculty of Medicine's Teaching Initiatives Program. A steering committee with representation from the Koori community, the University and the student group involved in the project, was formed in 1995 to oversee the project during 1995–96 (see Appendix 1).

The specific aims of the needs assessment were:

- to identify all current teaching in Aboriginal health within the Faculty of Medicine at the University of Melbourne;
- to determine current successes in teaching and potential areas for improvement both at the University of Melbourne and elsewhere in Australia;
- to develop a greater understanding of student attitudes to Aboriginal issues and Aboriginal health; and
- to identify factors which may act as barriers to learning and those which may facilitate learning in this area.

The needs assessment employed three methodologies:

- a literature review;
- focus group discussions with fifth-year students; and
- a survey of medical students in first, fourth and fifth-years.

The specific aims of the pilot teaching project were:

- to design, implement and evaluate a new educational model in cross-cultural teaching in Aboriginal health; and
- to identify mechanisms and strategies to develop a well-coordinated comprehensive subject for the undergraduate medical course.

## Section 2:

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## Needs Assessment



# Chapter Two: Literature Review<sup>5</sup>

## **2.1 Recommendations on Aboriginal health teaching**

Over the past ten years, many Federal and State Government inquiries, Aboriginal organisations and medical bodies have developed recommendations regarding the undergraduate teaching of medical students. These recommendations reflect an overall concern regarding the lack of teaching on Aboriginal issues in general and how poorly informed medical students and doctors are about Aboriginal people.

In 1989, the National Aboriginal Health Strategy was devised as the result of partnerships between Aboriginal people, peak Aboriginal organisations such as the National Aboriginal Community-controlled Health Organisations (NACCHO) and government. A Joint Forum of the Australian Ministers for Health and Aboriginal Affairs endorsed the Strategy's recommendations in 1990 (Beaton, 1994: 186).

<sup>5</sup> This literature review was undertaken as the initial phase of the needs assessment and was updated throughout the course of the project. Key articles published between 1997 and 2000 have also been included where appropriate. While these more recent articles obviously had no bearing on our project, they have been included, either in the text or as a footnote, for completeness.

### **Figure 2-1. Recommendations of the National Aboriginal Health Strategy for undergraduate medical education**

**That:**

- tertiary institutions responsible for undergraduate and post-graduate medical, nursing and paramedical courses be approached to include the compulsory study of Aboriginal culture and history and health issues as part of formal course work;
- where possible, Aboriginal people should be involved in the development and teaching of these units;
- course work foster a primary health care approach to professional practice, adopting the principles of community control and participation, health awareness, health promotion and health education;
- where clinical experience is a component of formal studies, or necessary for professional registration, opportunities be provided and placements actively sought for supervised clinical experience to be undertaken in Aboriginal health services, remote communities, and other appropriate health care facilities;
- health services be provided with resources to allow communities and their health services to accept placement of students;
- every effort be made to attract and retain Aboriginal people in courses of study which will qualify them for careers as health professionals;
- Aboriginal students be exempt from payment of the tertiary graduate tax to encourage them to undertake tertiary studies;
- educational strategies recommended by the Committee of Inquiry into Medical Education and Medical Workforce (developing skills in medical counselling and communication; using community settings in undergraduate training; broadening the selection process for medical students) be implemented [Recommendations 5(iii), 5(vii), 6(iv), 6(v), 7(vii), 8(iii), 8(iv), 11(xiv), 12(iii), 12(iv), 12(v)].

Source: National Aboriginal Health Strategy Working Party, 1989

Two of the defining investigations into the causes and consequences of social injustice for Aboriginal people - the Royal Commission into Aboriginal Deaths in Custody and the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from their Families - have highlighted the importance of the education of health professionals.



### **Figure 2-2. Recommendations of the Royal Commission into Aboriginal Deaths in Custody**

- That more and/or better training be provided in a range of areas taking note of the following:
  - a) Many non-Aboriginal health professionals at all levels are poorly informed about Aboriginal people, their cultural differences, their specific socio-economic circumstances and their history within Australian society.
  - c) The primary health care approach to health development is highly appropriate in the Aboriginal health field, but health professionals are not well trained in this area. [Recommendation 247]
- To institute specific training programs for non-Aboriginal health professionals regarding Aboriginal people's cultural differences; their specific socio-economic circumstances; and their history within Australian society; communication barriers most likely to interfere with the optimal health professional/patient relationship; and their knowledge base regarding unusual conditions and unusual presentations of common conditions. [Recommendation 946]

Source: Royal Commission into Aboriginal Deaths in Custody, 1992

### **Figure 2-3. Recommendations of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from their families**

- Professional training
  - 9b That all under-graduates and trainees in relevant professions receive, as part of their core curriculum, education about the history and effects of forcible removal.
- Health professional training
  - 34b That all health and related training institutions, in consultation with Indigenous health services and family tracing and reunion services, develop under-graduate training for all students in the history and effects of forcible removal.

Source: Human Rights and Equal Opportunity Commission, 1997: Appendix 9 — Recommendations

In addition to these recommendations made by bodies concerned with Aboriginal health and social justice, medical conferences focusing on education have also made specific recommendations in this area.

#### **Figure 2-4. Recommendations of the Second Rural Undergraduate Curriculum Conference**

- That each university have a requirement for an individual cultural awareness course for all medical students.
- That a national project be established, headed by a national task force reflecting a partnership between NACCHO, universities and government, utilising state/territory based mechanisms, the terms of reference to include Aboriginal and Torres Strait Islander health as part of the formal medical school curriculum.

Source: Commonwealth Department of Health and Family Services, 1996a: 49

#### **Figure 2-5. Recommendations of the Fourth National Rural Health Conference**

- Aboriginal and Torres Strait Islander people must be involved in training and education for all health professionals. [Recommendation 6]
- To build an appropriate health workforce, rural and remote Aboriginal and Torres Strait Islander communities should be funded to develop culturally appropriate education and training programs for non-Indigenous health workers. [Recommendation 12]

Source: National Rural Health Alliance, 1997

#### **Figure 2-6. Recommendations of the Second Medical Indigenous Conference**

- That the deans of the medical schools make a commitment to increasing the content and awareness of Indigenous issues within the medical curricula.
- That emphasis be given to developing communication skills to enhance cross-cultural awareness so that the needs of Indigenous people within Australian society can be better met.
- That teaching of Indigenous health issues be embedded as a theme throughout the whole medical curricula, recognising that Indigenous health is a specialist area requiring specialist knowledge. There is a need to incorporate within this teaching direct experience of Indigenous issues.
- Ongoing consultation with and participation of Indigenous communities and key national representative Indigenous bodies, and recognition of the important role of Indigenous academics and teachers in both content and process, are essential elements in ensuring that the content and context of teaching on Indigenous health is culturally appropriate.

Source: University of Newcastle, 1997b

In summary, these recommendations emphasise the need to increase and improve teaching on Aboriginal issues in general. They highlight the importance of developing teaching in such a way that it focuses on the attitudes of students towards Aboriginal people, as well as students' skills and knowledge base. The involvement of Aboriginal people and Aboriginal organisations through the formation of partnerships and relationships is fundamental in any teaching program. Aboriginal health teaching should be framed within the context of: Aboriginal people's history within Australia; cultural differences; relationship to the land; their particular socio-economic circumstances; and barriers to health care. This material should become part of a compulsory core curriculum on Aboriginal issues.

Several strategies to implement these broad approaches can also be excerpted from these recommendations. These include: the development of Aboriginal and Islander faculties within universities; the education of faculty members in Aboriginal issues; the use of interdisciplinary and locally based teaching; and the integration of Aboriginal issues throughout the medical curricula. Finally, the development of courses specifically aimed to develop cultural awareness was also advocated.

Whilst a large number of recommendations currently exist, it is important to remember that an evaluation of the National Aboriginal Health Strategy in 1994 pointed to a failure in its own recommendations being adequately implemented and a failure in aligning this broad body of recommendations with those of the National Aboriginal Health Strategy (National Aboriginal Health Strategy Evaluation Committee, 1994).

## 2.2 Imagining Aboriginality: what students bring to learning about Aboriginal health

There is a small body of literature on tertiary students' attitudes to Aboriginal issues (Stanley, 1969; Chaples et al, 1978; Augoustinos et al, 1994; Australian Institute of Jewish Affairs, 1993; Ryan, 1997)<sup>6</sup>. A number of these more general studies have been located in the field of psychology and, as will be discussed, are somewhat problematic, particularly with respect to the way 'prejudicial views' have been defined and framed and in the conclusions drawn from the research. Very few studies have specifically focussed on medical students and their attitudes to Aboriginal issues (Mobbs, 1986; Hunter and Fagan, 1994).

Psychologists Stanley (1969) and Chaples and his colleagues (1978) used different attitudinal scales (MRAI, or Multifactor Racial Attitude Inventory, and SAS, or Situational Attitude Scale respectively) to argue that there was a 'positive bias' overall towards Aboriginal people amongst Australian tertiary students. Both, however, found that the more visible a minority group was within the dominant culture, the more likely it was that the minority group would be perceived unfavourably. They argued that this positive bias towards Aboriginal people could be due to the fact there was very little interaction between Aboriginal people and the majority of non-Aboriginal Australians, but both studies made a rather simplistic and falsely positive conclusion that 'prejudiced views' were declining amongst this group. Such a conclusion implies that the 'solution' to reducing prejudicial views is to maintain lack of exposure in some way; to keep the lid on any potential problems.

6 A more recent review of the literature found just one additional article on tertiary students' attitudes to Indigenous Australians. Augoustinos and her co-researchers (1999) examined data from discussions of eight non-Aboriginal psychology students. Their summary findings are referred to in the text.

A number of these studies have been flawed by certain beliefs around notions of prejudice. Augoustinos and her co-researchers, for example, in basing their work around 'high' and 'low' prejudiced beliefs, have clearly assumed a hierarchy of prejudice. These terms originate from the same terms as defined by the Modern Racism Scale (MRS), and are defined as follows: 'high' prejudiced people are simply those whose personal beliefs are consistent with negative cultural stereotypes, and 'low' prejudiced people are those whose personal beliefs are not consistent with these stereotypes (1994:126) <sup>7</sup>.

What is of concern in these approaches is that the relationship between people's class and education background and the way prejudice is expressed is largely unexamined, and this is to ignore more theoretically informed work on concepts of culture and prejudice (Langton, 1981 and 1989; Rowse, 1988; Lattas, 1992; Dodson, 1994; Cowlshaw, 1997). Augoustinos's work, in privileging one form of prejudice over another, assumes that there is a privileged space, at least for some of us, from which we can critique levels of prejudice. In doing so, the idea that prejudice is something we all have to look at remains unacknowledged. The idealisation of Aboriginal culture over other cultures by one student, the smiling student who doesn't say what he or she thinks to an Aboriginal person for fear of offending them, the person who says outright that Aboriginal people are 'bludgers', are all problematic for Aboriginal people and are all examples of prejudice. There is not necessarily a hierarchy here. Our class and education background does not prevent or protect us from being prejudiced. It simply means that we show our prejudice differently by virtue of these different backgrounds. Research which teases these issues out has been lacking and is important because ideas which continue to privilege one form of prejudice over another have significant currency in mainstream commentaries about race and racism. These ideas, in fact, prevent us from really exploring these issues more productively <sup>8</sup>.

Augoustinos's studies reported quite conflicting findings. The two 1994 studies surveyed predominantly tertiary students and found that, while all those surveyed were very familiar with a wide range of negative stereotypes regarding Aboriginal people, there was a tendency for students to display relatively 'low levels of prejudice' (Augoustinos et al, 1994). In a later study, however, Augoustinos and her colleagues, whilst anticipating 'low levels of prejudice' amongst tertiary students, found that students' views on Aboriginal people were dominated by: an 'imperialist narrative of Australian history exculpatory of colonialism; an economic rationalist discourse on the plight of Aboriginal people; a discourse of balance and even-handedness, discounting serious discrimination and racism in Australia; and a nationalist discourse stressing the importance of all people to identify as Australian (Augoustinos et al, 1999: 351).

<sup>7</sup> The MRS was a seven-item scale developed by McConahy, Hardee and Batts in 1981 to assess a subtle variant of racism thought to more accurately reflect contemporary racial beliefs in the United States (Augoustinos et al, 1994:127).

<sup>8</sup> Other Studies examining the attitudes of non-Aboriginal Australians in general to Aboriginal issue have reflected on such positive stereotyping, but this large body of work is beyond the brief of the literature review. Many of these studies are summarised in House of Representatives Standing Committee on Aboriginal and Torres Strait Islander Affairs, 1992.

A study commissioned by the Australian Institute of Jewish Affairs and the Australian Union of Jewish Students in 1992 surveyed over 400 students from ten campuses around Australia about their 'attitudes on a wide range of political questions, foreign policy, immigration and minorities, including Jews, Aborigines, Italians and Asians' (Australian Institute of Jewish Affairs, 1993:1). While the greatest amount of hostility seemed to be directed towards 'Asian' people, 33% of students believed that Aborigines would 'rather go on welfare than work' and 40% maintained that Australia's Indigenous people should not be given further land rights (1993: 1–2) <sup>9</sup>.

In a study of education students at a rural university, Ryan (1997) analysed students' responses to an exam question following a unit on Australian Indigenous perspectives, and found widespread prejudicial beliefs <sup>10</sup>. Students displayed a tendency to see Aboriginal cultures as foreign and as deficient; to regard Aboriginal people as significantly 'other' to the rest of Australians; to see the only option for the Aboriginal child as one of assimilation; and to view any significant accommodation of the needs of Indigenous people as being a danger to non-Indigenous Australians (Ryan 1997:19).

There has also been little research (at times by the researchers' own admission) on the factors leading to particular types of prejudice; issues behind the lack of contact between Aboriginal and non-Aboriginal Australia; the effect of different qualities of exposure to Aboriginal issues and of relationships with Aboriginal people on people's perceptions and attitudes. One of the studies reviewed was clearly interested in attempting to determine if there was any relationship between increasing economic hardship and increasing prejudicial views, but its design did not make it possible to draw such conclusions (Australian Institute of Jewish Affairs, 1993). Finally, these studies, with the exception of Ryan's, have often simply identified prejudiced attitudes of students towards Indigenous people and have left it at that, without any consideration as to how teaching and learning may be conducted in order to bring about attitudinal change.

With respect to medical students specifically, most of the studies describing the positive teaching interventions (Kamien, 1975; Kaufman, 1984; Copeman, 1989; Jamrozik, 1995; Garvey and Hazell, 1997) have referred in passing to observed high levels of negative stereotypes or prejudicial views and the impact of such views, though they generally have not explored this in any systematic way.

In his report of an orientation session for a rural rotation <sup>11</sup>, Kaufman (1984), commented on the prejudicial views amongst medical students towards Aboriginal people. He described the 'degree of ethnocentrism and prejudice' among many students as significant.

*Prejudice on the part of the doctor affects the willingness of his [or her] patients to seek care and comply with medical recommendations. It can diminish the willingness of the doctor to invest the extra time needed to establish a trusting relationship with a patient, a relationship so necessary for the full benefits of personal care. (Kaufman, 1984: 24)*

<sup>9</sup> 'Yes' or 'No' answers were required to the following: 'Aborigines would rather go on welfare than work'; and, 'Should Australian Aborigines be given more land rights?'

<sup>10</sup> Ryan makes no mention in the article of the number of student responses analysed.

<sup>11</sup> Medical students commonly have rotations to rural areas as part of their undergraduate studies. This orientation session was conducted prior to a three-week rural rotation for fourteen senior students at the University of Western Australia.

Only one study in the literature reviewed specifically explored perceptions of medical students to any great extent. Hunter and Fagan (1994) surveyed 133 medical and public health students, general practitioners and psychiatric trainees regarding the commonly encountered stereotypes within the general community. All of those surveyed were attending lectures on Aboriginal health at various academic institutions in New South Wales. Similar to the findings of Augoustinos et al (1994), Hunter and Fagan found that the six most common stereotypes identified by students were Aborigines as 'having problems with alcohol'; as 'lazy', as 'uneducated', as 'poor', as 'unemployed' and as 'violent' (1994: 18).

While they acknowledged that respondents' views on stereotypes might not represent the personal views of respondents themselves, Hunter and Fagan surmised that some respondents were certainly expressing their personal opinions from the tone and nature of accompanying comments (1994: 18–19). In particular, they found a 'pervasiveness' of comments around laziness and alcohol use.

Hunter and Fagan argued that health professionals have privileged access to Aboriginal communities and are powerfully located to confront prevailing negative perceptions of Aboriginal people, but warned that this would require 'acknowledging and examining the prejudices and preconceptions that constitute our own private repositories of racial stereotypes' (1994: 23). They called for a questioning of generalisations and an examination of how the process of stereotyping affects the attitudes and effectiveness of the health-care provider.

Although the research findings on tertiary students' attitudes towards Aboriginal people have been contradictory and, on occasion, problematic, the overall finding has been the prevalence of negative stereotypes and prejudicial views towards Aboriginal people. There are, however, significant gaps in understanding what shapes the beliefs of medical students' in general, as there are difficulties in gauging the impact of these attitudes on students' approaches toward Aboriginal people and their practice. As Gibson (1997) has discussed, it is clear that attitudes held by medical students in particular are only partly understood.

## **2.3 Theoretical frameworks for cross-cultural learning in health**

Much of the theory for teaching cross-cultural issues to students in the various health professions has come from the fields of nursing and, to a lesser extent, medicine. In nursing, learning theory in this area is often regarded as beginning with Leininger, with her development of the term 'transcultural nursing' (Leininger, 1978, 1985). Transcultural nursing described 'the study of specific cultures and the meanings they give to caring' in order to improve health-care provision by nurses (Palmer, 1997: 67). Leininger's approach has been widely criticised as essentialising culture (Bruni, 1988; Gerrish, 1997; Palmer, 1997; Wear, 1997) and there have been significant developments away from this approach over the past fifteen years.

More recent theoretical approaches to cross-cultural learning in both medicine and nursing have argued for teaching which acknowledges: how all cultures are formed within specific social, economic and political systems in specific historical contexts (Bruni, 1988; Hollinsworth, 1994; Gerrish, 1997; Carrillo et al, 1999); the importance of appreciating diversity within cultural groups (Gerrish, 1997); the changing nature of all cultures (Palmer, 1997); and the importance of developing an understanding of institutional racism (Gerrish, 1997)<sup>12</sup>.

Hollinsworth, who has written extensively on educational issues relating to Indigenous health states:

*Courses must incorporate sufficient sociological and political understanding to enable the health professionals to engage with Aboriginal health in the broadest possible sense. Without such a background it is unlikely that the next generation will be any more successful than previous ones in implementing high-quality primary health care in culturally appropriate and professionally responsive ways. (Hollinsworth, 1994:148)*

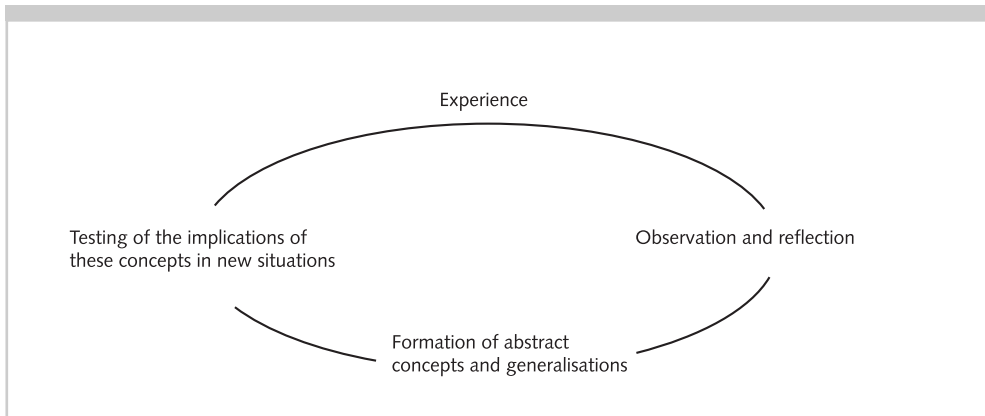
Hollinsworth's approach to learning in this area includes a 'multi-pronged and coordinated program of education' which includes 'Aboriginal Studies and training in anti-racist strategies as well as a comprehensive sociology of health and illness and a critical stance towards orthodox health service and delivery' (1994: 141).

Similarly, Wear (1997) argues that any cross-cultural learning needs to take place within the context of students learning the skills of critical inquiry into 'the nature of medical knowledge, the social and economic organisation of medical institutions, power relations within medical institutions and the relationships between medical institutions and all groups in society' (1997: 1061). Without this broader focus on medicine itself, Wear argues, cross-cultural learning will do little to address the foundations of racial inequality (1997: 1060).

In terms of methodological approaches in the field of cross-cultural learning in medicine, Kolb's learning cycle has been influential. Kolb suggested that every learning process goes through a particular cycle of 'experience, followed by observation and reflection and the formation of abstract concepts, ending with the testing of the implications of these concepts in new situations' (Lewis and Bolden, 1989: 187).

<sup>12</sup> Over recent years, several new terms have been used to incorporate these theoretical approaches: cultural humility (Tervalon and Murray-Garcia, 1998), cultural sensitivity (Palmer, 1997), cultural competence (Wear, 1997) and cultural safety (Polaschek, 1998). These have all been published since this study was completed.

**Figure 2-7. Kolb's Learning Cycle**



Source: Lewis and Bolden, 1989: 187

Prior to the advent of problem-based learning in medicine, education for undergraduate medical students almost universally encouraged students to enter the learning cycle at the level of abstract theory, thus limiting the learning experience and leading to fairly high levels of course dissatisfaction (Ramsden, 1992). Many learning theorists have supported strategies that entail entering the learning cycle at different points, such as at the level of experience or reflection.

A number of cross-cultural programs have attempted to develop processes that engage students and initiate learning from these different points. Immersion-style programs in medicine (Kamien, 1975; Jamrozik, 1995; Garvey and Hazell, 1997) and nursing (Bartz et al, 1993; Bond and Jones, 1994; Kavanagh, 1998) for example, have attempted to engage students at Kolb's initial point of 'experience'. As Kavanagh points out:

*Immersion-style teaching by its very nature provides nearly limitless teaching moments and learning opportunities. (Kavanagh, 1998: 73)*

Some teachers in the field have argued that, if such approaches are adopted, students will need particular levels of support to prepare themselves for an experience which may require learning in an unfamiliar style (Thiederman, 1988; Doherty, 1997; Palmer, 1997). Thiederman has suggested that, in order for such approaches to be successful in cross-cultural learning, students need to know that 'the changes required of them will not threaten their psychological safety or way of life' (1988: 26). She argues that to foster an environment that is psychologically safe for students, they need to be given permission to take issue with material being discussed and to voice their views or discomfort (1988:26). If students' views are validated or respected and given some psychological room, Thiederman believes they will be more comfortable to reflect on the source of their responses and to adopt different perspectives around ethnic diversity. Other authors have also emphasised the importance of fostering a safe and cooperative social context allowing for close interactions and exchange of ideas (Hayes et al, 1994) and the capacity to express one's own views and feelings (Harris, in Thiederman, 1988; Doherty, 1997). Small-group teaching is, understandably, often advocated as an important way of achieving this (Robins et al, 1998).



Providing the opportunity to focus on students' own cultural values and practice as the key starting point to any understanding of other cultures or cross-cultural teaching has also been advocated (Harris, in Thiederman, 1988; Eisenbruch, 1989; Gibson, 1997; Gerrish, 1997; Palmer, 1997; Polaschek, 1998; Robins et al, 1998). The importance of developing a life-long commitment to self-evaluation and self-critique has also been regarded as key to learning in this area (Tervalon et al, 1998). Student ownership of the process is a key strategy (Mao et al, 1988; Robins et al, 1998). Mao and co-workers argue that involving students in the delivery and development of the teaching increases motivation (Mao et al, 1988).

Some educationalists have reflected on the importance of personal relationships across groups as a specific learning approach in areas where students may bring negative attitudes or prejudicial views to the topic (Barnard and Benn, 1987; Hayes et al, 1994; Kaufman, 1984). Lorna Lippman, who has written on intergroup interactions, advocates that:

*Prejudice declines between groups when personal relationships are established, when the two groups interact on an equal social or economic basis, when age and occupation are similar and when a project is shared — the success of which depends on a cooperative effort. (Kaufman, 1984:25)*

Building on this argument, Kaufman suggests that:

*When different cultures come into contact, relationships between the two are facilitated when they recognise in each other similarities rather than differences. (Kaufman, 1984: 25)*

Given that students often have well-developed attitudes on Aboriginal issues, determining how to positively engage students in learning is an important factor to consider when dealing with an area such as Aboriginal health. The challenge for educators is to engage all students, whether their motivation is high or low, in the learning process.

## **2.4 Teaching Aboriginal health to undergraduate medical students: what models exist for more successful teaching?**

### **2.4.1 Structural issues**

There have been a number of attempts to develop more successful alternative approaches to teaching Aboriginal health to undergraduate medical students. All these attempts, whether the result of overarching change or proceeding from small isolated pilot projects, have involved a large number of Aboriginal people and Aboriginal-controlled services in local areas, as well as academic staff at the various universities. As others have acknowledged, there has clearly been a broad-based desire to foster the development of an aware and sensitive medical profession with a greater understanding of the issues which shape Aboriginal health (Anderson, 1994). Considerable efforts have been made by many individuals to promote discussion and to develop ways of instituting within individual institutions the range of national recommendations discussed earlier.

Hollinsworth, however, raises a number of important issues about the more structural issues relating to the delivery of teaching on Indigenous issues in Medicine. He asks a number of crucial questions: Who is selected into medicine, and are selection processes ensuring that the make-up of the student body reflects the broader composition of the community? How can issues of racism and political conflict be dealt with if studying Indigenous issues is seen as optional rather than as essential for the entire profession? How can Aboriginal people be involved in curriculum design, development and delivery given their scarcity as staff in tertiary institutions generally and in the health services in particular? How can a range of Aboriginal people be involved? How can we ensure that students understand the nature of the competing perspectives in Aboriginal health? (1994: 146–61)

Hollinsworth also describes a number of pitfalls if teaching in Aboriginal issues is derived from only one discipline or one perspective (Hollinsworth, 1992a, 1994). The importance of developing interdisciplinary teaching programmes in any cross-cultural training has been articulated by others both in Australia and overseas (Eisenbruch, 1989; Wang, 1994; Australian Medical Council, 1998).

A few universities have attempted such structural shifts and, through instituting broad changes in the compulsory curriculum and employing Indigenous staff, are beginning to alter the way Aboriginal health is received by students (Gibson, 1997; Teubner and Prideaux, 1997). To date, the University of Newcastle has probably been the most successful in this regard. Newcastle has taken the approach that a properly developed curriculum in Aboriginal health, which draws on a number of disciplines including Aboriginal studies and race relations, anthropology and epidemiology, is a valid and important area of study for all medical students (Gibson, 1997:126–27).

This process has taken a number of years to unfold and is still developing. The Faculty increased its compulsory teaching in Aboriginal health significantly during 1992–1994, but found that the issues were still perceived as marginal by many students and not regarded as relevant to 'core curriculum', that is, to individually oriented clinical medicine. In 1996 a complete revision of the curriculum was begun and a number of structural changes were instituted in first-year. It is anticipated that similar broad changes will be progressively instituted in the following year-levels. Within the first year curriculum, the Faculty has: increased course content on Aboriginal health from eight hours in 1992 to thirty hours in 1995 and 1996; reshaped the year to ensure greater integration between the two learning domains — individual and population medicine; and developed content in such a way that students begin the year with opportunities to examine their own cultural backgrounds first before looking at those of any particular group in society. In addition, a broader sociological and culturally oriented approach is taken throughout the year. Aboriginal health is viewed from a number of perspectives and students regularly revisit questions such as who are the more marginalised groups in Australian society (Gibson et al, 1997: 27–31).

Such structural change appears to be shifting the way that students view health problems and, in turn, how they frame Aboriginal health. It has been Newcastle's experience that, whilst interventions such as increasing the hours devoted to the subject, instituting small-group work and adopting a problem-based approach have been extremely important in improving the way that Aboriginal health is taught in the compulsory curriculum, these measures have not been enough to ensure the necessary shifts.

The majority of universities have recently undertaken or are soon to adopt completely revised undergraduate and postgraduate medical curricula. Many are also demonstrating a serious commitment to further developing Aboriginal health curricula, to employing Indigenous staff, and to increasing the number of Indigenous students. One needs to take care that the pressure and demands associated with developing a new curriculum do not result in the failure to properly integrate the new teaching, resulting in turn in the issue being re-marginalised.

## 2.4.2 Examples of discrete teaching initiatives in Aboriginal health

### Undergraduate medical education

Reports of several isolated pilot projects in Aboriginal health teaching to undergraduate medical students have been published in the literature over the past twenty-five years (Kamien, 1975; Kaufman, 1984; Copeman, 1989; Jamrozik, 1995; Garvey and Hazell, 1997). With the exception of Garvey and Hazell, working at the University of Newcastle, these initiatives in Aboriginal health teaching have not been related to any major structural change in the compulsory curriculum. Most have taken the form of more discrete or 'one-off' interventions which have trialed different learning approaches with small groups of volunteer students. While these studies do have limitations in the context of the broader considerations outlined above, they give a good overview of what has been tried in this area and the processes by which they were evaluated.

Four of these five projects (Kamien, 1975; Kaufman, 1984; Jamrozik, 1995; Garvey and Hazell, 1997) involved small-group teaching, significant contact with Indigenous people, a degree of flexibility in program structure, less-structured teaching time, and the central incorporation of historical, cultural and social perspectives. Three (Kamien, 1975; Jamrozik, 1995; Garvey and Hazell, 1997), involved teaching away from students' usual environments in the form of field trips or camps. Three (Kamien, 1975; Kaufman, 1984; Jamrozik, 1995), however, involved relatively small numbers of students, and conclusions drawn by the authors need to be viewed in this light.

With the exception of Copeman's study of 201 students (which had an unclear evaluation response), the projects were all described as being successful, particularly with respect to attitudinal change amongst students. For example, Kamien found a clear attitudinal shift in students' comments. At the beginning of the project, most expressed the view that the condition of Aboriginal people was 'simply a manifestation of their 'laziness and drunkenness'. By the end of the project, all students, according to Kamien, had 'at least the beginning of an understanding of how a group's culture and norms can affect its way of life' (1975: 510). Three students had chosen the elective because they had an existing special interest in Aboriginal people, but at the end of the project all fourteen students stated that the project had stimulated such an interest.

*The greatest gain in this particular medical clerkship was the way in which a narrow authoritarian, judgemental view of Aborigines gave way to a more understanding approach as the students became able to step outside of their own cultural capsule and into that of the Aborigine [sic]. (Kamien, 1975:512)*

**Table 2-1. Examples of discrete teaching initiatives in Aboriginal health in undergraduate medical education**

<b>RESEARCHER(S)</b>	<b>YEAR</b>	<b>STUDENTS INVOLVED</b>
M. Kamien (1975)	1971–72 2–5 weeks	Fourteen students in fifth- and sixth-year during their elective period
A. Kaufman (1984)	1984	Fourteen students in their senior years at University of WA
R. Copeman (1989)	1985	201 students in fourth-year at University of Queensland
K. Jamrozik (1995)	1995	Nine undergraduate medical students at University of WA
G. Garvey and R. Hazell (1997)	1997	Students in first-year with members of staff at University of Newcastle (number of students not specified)

<h2>PROJECT DESCRIPTION</h2>	<h2>PROJECT EVALUATION</h2>
<p>Students spent between 2–5 weeks in Bourke, NSW, working alongside GPs, specialists, allied health workers and others. They visited Aboriginal organisations and attended clinics on field trips to various Aboriginal communities. Much of their time was left unstructured and they were required to write a life history on an Aboriginal person in the community.</p>	<p>Students letters pre and post project. Recorded interviews with students 2–3 months after the project.</p>
<p>Orientation session prior to a three-week rural rotation. Session conducted informally by two Aboriginal health workers. Two questions used to facilitate discussion were:-</p> <ul style="list-style-type: none"> <li>•‘What barriers exist for Aborigines seeking care in predominantly white health-care facilities?</li> <li>•‘What strategies could students employ to meet Aboriginal people and become accepted in the Aboriginal community during their rural attachments?’ Session covered historical, social, cultural and linguistic factors and the importance of building relationships with Aboriginal people.</li> </ul>	<p>Informal feedback from both facilitators and students. Personal observation (on the part of the researcher) with respect to impact evaluation</p>
<p>Students attended a symposium, visited a community-based organisation and attended a tutorial where each student presented a case history on either a first-generation migrant or an Aboriginal person. Each tutorial consisted of six presentations: four Aboriginal presentations and two migrant presentations.</p>	<p>Pre and post questionnaires. (69% were successfully matched). Both surveys consisted of the same series of nine statements of opinion about Aborigines and migrants (six statements related to Aborigines) and two statements of fact about Aboriginal and migrant health (one statement related to Aborigines). There were also two questions relating to students’ own appraisal of their competency in the post-questionnaires.</p>
<p>A week-long field trip to Aboriginal communities and local health services near Kalgoorlie, preceded by a preparatory lecture. Students undertook one of three projects in community health. They did their own background research and during their trip had discussions with Aboriginal people, health service providers (Aboriginal and non-Aboriginal) and others. Students wrote a 5,000-word report on the accessibility, appropriateness and effectiveness of services in their chosen area and explored ideas around improvements. The field trip was kept deliberately ‘fluid’ so that students would be able to ‘make the most of opportunities as they arose’.</p>	<p>Pre and post surveys, including fifteen questions assessing knowledge of Aboriginal history, culture and health and twelve statements about Aboriginal people using five-point Likert scales assessing attitudes.</p> <p>Visit to the host community six months after the field trip to discuss the project with community members.</p>
<p>As part of its new first-year curriculum in Aboriginal health, staff and students at Newcastle spent a weekend with Aboriginal people in one of the traditional areas at Wollombi. The camp followed a similar model to others run for Occupational Therapy students. In this model the key aims were: to explore Aboriginal culture in a different learning environment; to ask questions about issues experienced by Aboriginal people in a more informal environment; and, to investigate cultural influences on Aboriginal people and their concepts of health and health-service delivery.</p>	<p>No formal evaluation in the available literature other than two descriptive ‘testimonials’ by participants. (O’Reilly, 1997; Grey, 1997)</p>

Jamrozik, comparing mean Likert scale scores from before and after the field trip, found 'relatively large changes' in some of the attitudes held by students (1995: 593). Changes particularly noted were with respect to questions concerning the homogeneity of Aboriginal people and the hostility students anticipated from Aboriginal people. Jamrozik also found more of the factual questions were answered correctly and there was a large increase in the number of students who could identify one or two ways in which doctors might offend Aboriginal patients (1995).

One of the problems with all these programs is their sketchy evaluation. Most have used pre- and post-test attitudinal scales in very small groups of students. Copeman, who had a much larger sample of students, used this system exclusively to evaluate his project in an attempt to provide some 'objective' measurement of the changes that could possibly be attributed to the program' (1989). However, his use of fairly blunt and inflammatory stereotypical statements as his tool for assessing attitudinal change makes his evaluation problematic.<sup>13</sup> Learning which increases student's understanding of the complexity of the issues in Aboriginal health cannot be properly evaluated simply by 'Yes' and 'No' answers to negative stereotypical statements. Responses to these statements become more difficult the more one understands the complexity involved. Students soon learn, if they don't already know, which statements are supposedly 'incorrect'.

The author himself acknowledged the disappointment amongst the tutors (no reference is made as to whether these tutors were Aboriginal or not) about some of the results from the evaluation, and made a number of valuable suggestions for further teaching programs in this area. He noted that more contact with Aboriginal people would be required in any teaching program to significantly counteract the negative stereotypes which students held (Copeman, 1989: 86). Copeman also argued that any development in students' understanding of Aboriginal issues would need to begin in more broadly based teaching, such as medical sociology, in the early undergraduate years. He also advocated more use of videotaped consultations, tutorial presentations with Aboriginal health workers as resource people, and greater utilisation of electives and general practice attachments to places with significant Aboriginal populations.

A significant failing of most of the studies is the absence of Aboriginal voices in the development and evaluation of the programs. Teaching projects need to have a clear understanding of the views of those Aboriginal people involved and those of the local community. Only two of these studies included any consideration of how Aboriginal tutors felt about the process and what systems of learning they viewed positively for themselves as tutors (Kamien, 1975; Kaufman, 1984). The only reported instance of consultation during program development was by Newcastle University, which consulted widely with its own Indigenous graduates and staff from the Faculty's Aboriginal Liaison Office when determining the primary orientation of their cultural program (Garvey and Hazell, 1997). Despite the limitations outlined above, these studies suggest that small isolated projects can be successful provided that certain conditions are met.

13 Copeman included the following statements with Likert scales as part of his evaluation. 'Aborigines expect to get more out of life for nothing than white people.' 'The incorporation of Aborigines into our communities could well lower our standard of hygiene.' 'Migrants and Aborigines should be free to live their lives as they wish, without having to integrate into mainstream Australian society.' 'Restrictions should be placed on the Aboriginal to protect him from his own lack of responsibility.'

## Other models

Aside from these examples outlined in Medicine, most other documented cultural awareness training with a focus on Indigenous Australians has occurred in nursing (Hayes et al, 1994; Doherty, 1997; Ramsay and Kermode, 1997).<sup>14</sup> There have also been a number of cultural awareness or Indigenous health undergraduate programs overseas (Mao et al, 1988; Thiederman, 1988; Tuck and Harris, 1988; Bartz et al, 1993; Bond and Jones, 1994; Nora et al, 1994; Wang, 1994; Shah et al, 1996).<sup>15</sup> With a few exceptions (Tuck and Harris, 1988; Ramsay and Kermode, 1997) the majority of these programs have been brief and discrete and have not been structurally integrated into broader teaching programs.

These programs have employed a variety of teaching methods including small-group discussion, the use of simulated patients, community visits, seminars, panel discussions and language acquisition programs. Most programs have taken place within the students' usual teaching environments in small groups (Hayes et al, 1994; Mao et al, 1988) with a smaller number of cultural immersion processes (Bartz et al, 1993; Bond and Jones, 1994). Overall, there have also been significant gaps in evaluation with few projects attempting to identify valid methods likely to have helped achieve attitudinal change amongst students and with little long-term evaluation.

14 A recent review of the Australian literature has highlighted four key Indigenous cultural awareness projects that were developed parallel to our pilot project and which have since been published. Three of these are in nursing (Doherty, 1997; Cunningham et al, 1998; Hardy et al, 1998; Main et al, 1998) and one is in education (Reynolds, 1998). Two of the more recent programs for nursing students — 'Introduction to Aboriginal Studies' offered to Queensland nursing students at the Australian Catholic University, and 'Studies in Aboriginal Health' offered to nursing students at La Trobe University's Bendigo Campus — clearly demonstrate greater integration than earlier programs as well as the development of more detailed evaluation processes. The Queensland program, for example, is conducted in three phases: a provocative phase which provokes students' perception and knowledge; an appreciative phase where students participate in field experiences; and a visionary phase where students explore practical ways of achieving reconciliation. The course also allows opportunities to apply this knowledge at a later stage. This unit is properly assessed and evaluated through a number of processes including a reflective journal. Teaching is also properly integrated into the course overall (Doherty, 1997). The Australian Catholic University is now developing and evaluating new units on Indigenous health issues across the states and, in addition to the teaching methodologies described above, the university is developing new electronic teaching strategies as well as attempting more detailed pre- and post- evaluation with students undertaking field trips (Hardy et al, 1998). The Bendigo course demonstrates the importance of forming relationships between the local Indigenous community and the University and developing processes that enable community members to be actively involved in the development and delivery of the teaching. Whilst the program has only been run for two years, it clearly demonstrates the strength of experiential learning (Main et al, 1998).

15 A recent review of the International literature has also found a number of Indigenous cultural awareness programs in nursing and medicine which have been published since our pilot project (Kavanagh, 1998; Zweifler and Gonzales, 1998; Loudon et al, 1999; Redwood-Campbell et al, 1999). Loudon et al reviewed the international literature from 1963–1998 and identified seventeen cultural awareness programs in undergraduate medical courses. The majority of these programs were elective, and were conducted over relatively short time-frames. Most had not been running for more than a couple of years and there were significant gaps in evaluation processes. Redwood-Campbell et al published a review of all Family Medicine Programs in Canada that had any teaching on Aboriginal health issues between 1997–1998. The review's findings were similar to those of this literature review: namely, that while the majority of programs offered elective access to Aboriginal health-care experiences and to Aboriginal people, there was a widespread lack of goals and objectives in the teaching of Aboriginal health and few had any teaching in the core curriculum.

Three particularly successful programs warrant further attention as they have incorporated a range of more innovative approaches and highlight what is possible in cultural awareness teaching.

A ten-year lectureship program in Ontario, Canada (Shah et al, 1996) which began in 1990 and remains ongoing, explores a different theme in Indigenous health over a three-week period each year. The program provides lectures, seminars and workshops by a range of Indigenous experts to undergraduate, graduate and postgraduate health professionals and members of the community. It is aimed at helping people deliver culturally appropriate services and develop culturally relevant policies, and to become advocates for Indigenous causes (Shah et al, 1996: 273). Each week has a specific focus, which sets up a framework for contextualising the material covered in the following week. The first week focuses on historical background; the second on current problems; and the third on future solutions. The program is quite unique in its degree of institutional commitment over an extended period of time, and in acknowledging the level of complexity required to deal with the necessary range of areas.

A second notable project has been a compulsory 150-hour semester unit on the Health of Indigenous people in the Southern Cross University's Bachelor of Health Sciences course (Ramsay and Kermode, 1997). This is the first course for nurses, and possibly for any group of health professionals, to devote 150 hours to Aboriginal studies. This course demonstrates aspects of what is necessary for compulsory teaching in the area to be successful and to go well for the Indigenous people involved.

A third program was run by the Rush Medical College in Chicago, and aimed to improve the cross-cultural skills of medical students. The students participated in twenty two-hour sessions on cultural competency and an eight-day visit to rural and urban areas of Mexico. A crucial feature of the success of the project was the fact that it was devised and run in close partnership with the Hispanic community. The project coordinators concluded that universities need to have established relationships with the community involved and that such community partnerships are a key factor and improve any program (Nora et al, 1994).



## 2.5 Summary

This literature review has brought together various national recommendations that relate to undergraduate medical education, highlighting key concepts. It has sought to give a broad overview of what is known about what students themselves may bring to the area of Aboriginal health, and the difficulties as well as the successes experienced in teaching in this area.

The literature has demonstrated the need for students to have access to constructive experiences in engaging and interacting with Aboriginal people and for all universities to attempt this at a local level with the involvement of local Indigenous people. The importance of addressing structural issues in the curriculum in order to achieve positive outcomes was also emphasised. Most studies had determined significant positive shifts in students' attitudes towards Aboriginal people even with short interventions, provided certain teaching methodologies were adopted. Field trips were identified as one successful way to go about this. There was a need to develop more rigorous process and outcome evaluation of such projects.

My own research sought to draw from this body of work and, as much as possible, to address identified gaps in the literature. I wanted to provide an alternative model for teaching within my own University and to shed more light on some of the unanswered questions. To this end, a series of focus group discussions was planned around gaps identified in the literature, and these discussions were led by Ian Anderson and Ellen Herlihy. These discussions were held with one year-level. Subsequently I conducted surveys with students from three different year-levels. The aim was to explore in more depth: medical students' beliefs and perceptions relating to Aboriginal people and Aboriginal health; possible influences shaping these beliefs; and how these perceptions function as barriers both to learning and to students' attitudes about their future involvement with Aboriginal people in their practice as doctors. Finally, I wanted to draw this information together with the findings of previous research and, from our own pilot project, to develop recommendations for strategies to make teaching in this area more successful.



# Chapter Three: Focus Group Discussions

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## 3.1 Introduction

During the course of 1994, seven focus group discussions were conducted with fifth-year students during their Community Medicine semester in the Department of Public Health and Community Medicine, at the University of Melbourne.

The objectives of these discussions were:

- to determine how students conceptualise Aboriginal people and Aboriginal health issues; and
- to better define the key issues which would underlie an effective teaching strategy in Aboriginal health.

## 3.2 Methodology

### 3.2.1 Focus group discussions: development and delivery

Seven focus groups lasting one hour each, and comprising twenty-five to thirty students per session, were held in 1994. These discussions were conducted by a Koori facilitator (Ian Anderson)<sup>16</sup> and a non-Koori facilitator (Ellen Herlihy).<sup>17</sup> Five of the focus groups were jointly facilitated and two were facilitated solely by Ellen Herlihy.<sup>18</sup> These discussion groups were offered to all students and they were conducted during class time. Participation was voluntary. Written consent was obtained from the students and they were given a clear explanation of the method and purpose of the study. Seven hours of discussions were audio-taped and later transcribed by the Qualitative Solutions and Research Unit at La Trobe University. Individual students remained anonymous with respect to the analysis of the data.<sup>19</sup>

The discussions were focussed around three thematic streams. Each stream contained a series of probing questions that were used by the facilitators where discussion was slow or where students were unsure what direction to take (see Appendix 2).

- Stream One examined general perceptions of Aboriginal people.
- Stream Two discussed the teaching of Aboriginal issues in Medicine.
- Stream Three explored students' perceptions of their future professional role in relation to Aboriginal people. (This included two handouts given to students for discussion.)

<sup>16</sup> At the time of the focus groups, Ian Anderson was the Medical Director and Chief Executive Officer at the Victorian Aboriginal Health Service (VAHS). Ian is the first Koori to graduate from Medicine at the University of Melbourne. He had worked at VAHS as both a health worker and a doctor prior to becoming CEO and had also been lecturing in Aboriginal health in the fifth-year program at the University of Melbourne for a number of years.

<sup>17</sup> At the time of the focus groups, Ellen Herlihy was head of the Epidemiology Unit within the Department of Public Health and Community Medicine at the University of Melbourne and was coordinator of the fifth-year teaching program in Community Medicine.

### 3.2.2 Analysis

A content and thematic analysis of the data was undertaken. Material was organised thematically into four sections: the emotions that students bring to the learning experience and key issues that provoked strong feelings; student perceptions of Aboriginal people and Aboriginal culture; student understandings of the key influences in shaping these perceptions; and finally, student perceptions of their future relationships as doctors with Aboriginal people. I conducted the content and thematic analysis in collaboration with one of the researchers from the original focus groups, with both of us coding sample sections of transcripts. We met to discuss areas of disagreement and to ensure that the interpretation accurately reflected discussions.

## 3.3 Results

In this section, I discuss ways in which students subjectively engage with Aboriginal issues and Aboriginal people in a learning context. Throughout the research, it was apparent that students brought with them a range of emotions that shaped this engagement.

It is important to note that we are describing the emotions that were present and experienced in a group context. This does not predict the experience of individual students but does help predict the response of a group of students and how this can flavour the quality of learning about Aboriginal issues for the whole group.

### 3.3.1 Emotions that students bring to the learning experience

Some students articulated positive emotions in discussions: they felt hopeful about Aboriginal health in that they saw an increasing autonomy for Aboriginal people and an increasing acceptance of Aboriginal people by non-Aboriginal Australia. Most students, however, came to the area of Aboriginal health with a complex range of negative emotions. Key emotions articulated were: a sense of feeling overwhelmed or powerless whenever Aboriginal issues were raised; guilt towards Aboriginal people; anger towards Aboriginal and non-Aboriginal people; and fear or anxiety about having closer associations with Aboriginal people.

Often these emotions were conflicting. Some students, for example, articulated both a fear of retribution by Aboriginal people on the one hand and anger towards Aboriginal people on the other. At times this was expressed by the one student whilst at other times these positions were articulated and argued by different students. Many students described feeling as if they were on a tightrope with very few avenues to explore the issues, either at an emotional or theoretical level. A few students described feeling frustrated at being unable to 'get at these different emotions' for fear of 'saying the wrong thing'. As one student said:

<sup>18</sup> I was not involved with facilitating the focus groups as they were done prior to the larger pilot teaching grant.

<sup>19</sup> Ethical approval was received from the University of Melbourne's Human Research Ethics Committee.

*Perhaps the pendulum in terms of 'political correctness' and not saying the wrong thing and not offending has gone so far that people don't actually get a chance to air their views, and their deep-down prejudices. Perhaps there should be a place to do that so that they see the light of day and can be dealt with. I suppose that's what a focus group like this can potentially do.*

While many students stated that they wanted a place to discuss all these emotions, many still felt very inhibited by this sense of having to say the 'right thing'.

### **Powerlessness**

Many students felt inadequate, discouraged or overwhelmed when thinking about Aboriginal health. This view was commonly expressed by those who said they would like to see the situation for Aboriginal people improve. For example:

*For the Aboriginal people...even though some attempts are being made to improve the situation, already the damage has been done. There's a lot of people who have lost their culture...and it is difficult to sort of get them back.*

Students often described feeling overwhelmed by this sense of loss, by the complexity of the issues and by hearing different views on the topic. There was a belief amongst some students that they often hear only the views of non-Aboriginal people or those of specific 'vocal' people in the Aboriginal community. These students were unsure how representative such views were or how to interpret different views. Others described feeling overwhelmed by racism that they witnessed within the medical profession, with very few places to take their concerns. These incidents were not necessarily always to do with Aboriginal people and in fact were often about other minority groups. As one student described:

*I get the feeling that, I mean it's not their fault, it's not the medical profession's fault, but I find...that nurses and the doctors do tend to just say, 'Oh no, here we go again'. That sort of attitude... I guess the feeling is that these people are just seen as more difficult. They tend to want to dismiss the patient more quickly. I mean not everyone, but [the] majority of the doctors and nurses I've just observed. And it's not just Aborigines. It's Vietnamese, Chinese, Italians, Greeks.*

### **Guilt**

A number of students described feeling guilty about the historical treatment of Aboriginal people. At times, students spoke of a national guilt while at others they spoke of their own personal sense of guilt. Students often conveyed ambivalence or a sense of confusion over whether or not they should feel guilty. While not explicitly stated by students, there was a general impression throughout the discussions that these complex reactions to feelings of guilt in some sense drove other emotions. Often feelings of guilt were not overtly articulated but were nevertheless an undercurrent in other responses. This appeared to be particularly so for students who felt very angry towards Aboriginal people. Interestingly, expressions of both national and personal guilt were universally located in events of the past and did not relate to the present treatment of Aboriginal people or to events in people's lived history.

A few students stated that the origins of any guilt they felt when Aboriginal issues were discussed were more complex, being based also in one's own personal and cultural history. Simply being told by a tutor or teacher in the area 'not to feel guilty' did not address the issue in any useful way and often left feelings of guilt acting as a barrier to productive learning:

*I mean it was quite good [learning about] Aboriginal health in psychiatry. A couple of people did say, 'You know...we're not trying to make you feel guilty about the history. It's not part of us to want to make other people feel guilty'... [But] that's not understanding us from a cultural point of view. Being an Irish-Italian Catholic myself, guilt's one of the big things...in the culture. And to say to someone, 'Look we don't want you to feel guilty'...doesn't really address me as a person. You know this is the way things have gone in my sort of culture... I can't get out of that and say, 'Look, you know this has nothing to do with me'.*

### **Anger**

A number of students expressed anger towards Aboriginal people during discussions. This anger was often driven by a perception that Aboriginal health is well-funded and that Aboriginal people have misused these funds and resources. One student was particularly angry about what he had observed whilst travelling in the Northern Territory with respect to housing:

*There are a lot of Aboriginal communities set up that have concrete walls and roofs built, and there's been a hell of a lot of money put into the community. For whatever reason the white people can't explain, the Aborigines are living next to the house, they're not living in the house. They don't use the plumbing system. Whether it's that they don't understand it...[or] they're vandals... You know, why wouldn't you want a roof over your head?*

Some were angry at Aboriginal people for 'not blending in' or for 'always being angry'. One student expressed anger at the singling out of Aboriginal people as a separate group:

*I sometimes wonder why we single out Aborigines as one group, and make them special. I can't understand it.*

### **Anxiety**

Many students experienced anxiety with respect to how to interact with Aboriginal people or with an Aboriginal patient. Students' anxiety over both potential interactions and past interactions was often governed by a lack of knowledge and by a lack of personal contact with Aboriginal people:

*I've never ever met personally an Aboriginal person... I wouldn't have the faintest idea what an Aboriginal person is... I have never sat down and spoken to an Aboriginal person. I have never [asked], 'What is the story from your side...because you are obviously the subject matter?'*

Many students wanted to quickly find out 'cultural answers' about how to interact with Aboriginal people, so as to relieve this anxiety or sense of not knowing. Also, some students described being fearful of becoming the target of Aboriginal people's 'anger':

*Because of the history and everything...you really get a picture of Aboriginal people being very angry. And because of that I think that engenders a bit of fear. Definitely in me. And so, over the teaching we've had you can come to see Aboriginal people as maybe a threat, rather than actually seeing them as people.*

Several students described brief interactions of this nature with Aboriginal people which had then shaped their perceptions of the whole area:

*Because, they're angry, blaming...[and] distrust[ful]. It's like "Bonfire of the Vanities", where everyone was just sort of worried that black people would suddenly get a bit too angry and really do something. I think, I personally have only seen one Aboriginal patient and he had pneumonia. So I was listening to his chest and he had markings. And me being curious, I asked, 'How do you actually make the scar. What do you put there?' And he put me down. He said I was a woman, it was none of woman's business, what are you doing there anyway, and that he did not [want me near him]. So I just went, 'Oh'. I got really angry about that. So I can't really say that all Aboriginal patients are that way. But all Aboriginal lecturers I've had are that way. They make me feel angry because...it's like a defence. When someone tells you how awful you are, you still get angry.*

Another said:

*Their anger seems to be certain. I don't know that the people who speak on behalf of Aboriginal people are always representative of the Aboriginal people themselves. You know what I mean. I mean they're obviously a stronger, more fighting people who go round universities and talk about these things, and I don't know that that represents all Aboriginal people. And that sort of makes us feel, I don't know if defensive is the right word, or guilty or whatever else. And yet if we came into contact with, you know, a normal Aboriginal citizen who wasn't an activist and who wasn't in that sort of role, then I think we can probably interact differently with them.*

### **3.3.2 Key issues that provoked strong emotion**

Throughout the discussions, five broad issues relating to Aboriginal people engendered the strongest emotions in the students. These were: the process of defining who is Aboriginal; the level of attention students thought Aboriginal people should receive as a minority group; the assimilation or integration of Aboriginal people versus the maintenance of a separate culture; land rights; and the role of government in dealing with Aboriginal people.

#### **Aboriginal identification and Aboriginal identity**

There was a wide range of views amongst students regarding Aboriginal identity. Identification of Aboriginality for a significant group of students was located around Aboriginal people demonstrating certain external features, such as those of Aboriginal people from the Western Desert. For these students there was a sense that those fitting this picture were the 'real Aborigines' and that those who did not fit this picture were in some way fake, not 'real Aborigines'. Some students expressed anger at these 'other' Aborigines as being impersonators or of 'hopping on a bandwagon for their own gain'.

A number of students did not hold such views but felt frustrated as to how to identify or recognise someone as an Aboriginal person. There was acknowledgment by some students that they did not really have enough personal contact with Aboriginal people to know how to. There was also a sense amongst a number of students that there is no representative person and that you would in some sense need to keep the possibility of someone being Aboriginal in mind when seeing all people:

*Yeah, I suppose I'd only identify someone as Aboriginal if they told me.*

Many of these students felt that living in Victoria made recognition of Aboriginal people hard — they felt that Aboriginal people in urban and non-remote settings were somehow rendered invisible to them.

### **Aboriginal people as a minority**

One issue which came up for students was around how much attention one minority group should receive compared with other minority groups. It seemed that for many students, any attention given to Aboriginal groups triggered a pre-existing, but often unexpressed, sense of frustration over the lack of attention given to other cultural groups. For some, even the smallest focus on Aboriginal issues generated anger that such a minority group should be receiving 'so much' attention. This was often connected to students feeling that Aboriginal people were invisible and that they never had any contact with them compared with other groups:

*I don't know, I'm sort of going on our hospital experience. I think I've known two Aboriginal patients in the whole time that I've spent in hospitals. And you compare that to any other nationality, it would be heaps more than two. Especially since you know we're talking about the public hospital system where we see the lower income groups. And Aborigines just aren't well represented in those situations.*

### **Assimilation or integration versus separation**

Another common area in which students expressed significant emotion was around the issue of integration and separation of Aboriginal people. Students spoke of integration and separation as polar opposites, pitted against each other as mutually exclusive options. The following quotes are representative of ideas expressed:

*I never sort of know whether they want to be integrated into western society or whether they want to be integrated back into their own sort of culture. And I think, even the people who come and talk to you about this have different views...about what you should do. I mean would you build them a house or [would you] give them some land to do their traditional sort of things on? And that's very hard. You don't know which way to go.*

*Another thing I'm wondering about is do all Aborigines want to be treated as someone separate? I mean, you know, as defined as Aboriginal, or would they rather just be assimilated into the community?... Are there other Aborigines in the community who would rather just accept...[and] just be more assimilated into the community?*

A number of students were angry with Aboriginal people or saw them as less willing than other minority groups to assimilate into mainstream Australian society:



*The Aborigines are more reluctant to blend in with us, to break down the barrier.*

The discussions were held around the time of the Commonwealth Games and a number of angry or disgruntled comments were made which related to Cathy Freeman running with both the Aboriginal and the Australian flag:

*For her to have the need to show her flag...what's going on in Australia? Why doesn't she regard herself as Australian like all other cultures? If it was me that was up there I wouldn't show a red flag sort of thing. [It's] actually saying there's a problem... [P]eople are against [her] because [of that].*

Other students articulated a very different perspective, putting the focus on non-Aboriginal Australia. They spoke of how much Aboriginal people are misrepresented by non-Aboriginal Australia; how unwilling non-Aboriginal people are to accept Aboriginal people as equals or to truly see them as part of the community in any capacity:

*I don't think that Australians really feel that Aboriginal people are equals [and] I don't think that [we should] totally put the blame on [Aboriginal people]... The Aboriginal person has been misrepresented in a way...[as a person] that we need to help... But really they are people who need to become part of our community. I don't think we readily accept Aboriginal people in our society. They're sort of a subset almost.*

## **Land rights**

Land rights also evoked considerable emotional reaction but there was a wide range of views amongst students. Some students felt positive about Mabo <sup>20</sup> and the increased attention that land rights was receiving in the media. These students felt it was the first time that issues were being dealt with in a less tokenistic way:

*Over the last 200 years I don't think things have developed...favourably for Aboriginal people in terms of them having a lot of rights. [But] in recent times there seems to be a lot of discussion about Aboriginal rights or Aboriginal land rights. [In the past] there has been a kind of tokenism about everything that's been [done] and yet more recently with the Mabo legislation, [things are becoming] more concrete.*

Some students, particularly those from overseas, were shocked at the level of fear and prejudice that they saw the Mabo debate had raised in the community. Fears were expressed amongst students that land rights incite racism. Others spoke of some of the underlying issues:

*As a non-Australian person that recently came to Australia... I don't know whether I had preconceived ideas about Australia, but I was surprised about the prejudice being raised by some quite high-level politicians [around the Mabo debate].*

*It's not necessarily surprising. I mean land is important to people for different reasons and it's a source of wealth to people... [It's not surprising] that they'd be threatened or [that Mabo would] bring out strong feelings. And whether it's rational or not, people sort of say things that sound prejudiced because it's their livelihood.*

20 The Mabo case refers to the decision made by the High Court of Australia in 1992, which found that the Mer people had owned their land prior to annexation by Queensland. This case is regarded as a landmark case as it was the first time that terra nullius was refuted in the courts.

### **Approaches taken by governments with respect to Aboriginal people**

A number of students expressed disillusionment over the role they felt the Australian government had played in relation to Aboriginal people. Some students were upset by the way in which they believed Aboriginal culture was exploited by government to attract tourism and to shape or construct an Australian identity for all Australians. They felt that this 'orchestrated' Aboriginality or cultural identity often ignored the 'reality' for Aboriginal people:

*I think Australia uses Aborigines...the boomerang...the art work...the music and the Dreamtime as a kind of attraction for people overseas. I mean they're not really doing much. Well they're doing some things to help the Aboriginal people, but they sort of foster the culture more as a tourist attraction in a lot of ways. Certainly seems that way. I mean people come here and they are attracted to the boomerang and the nice artwork and they want to know about the Dreamtime and they want to go to Alice Springs. And they might get sort of quite a different picture when they get there, to how Aborigines [live].*

*I...get the feeling that we're still exploiting the whole [area]. Yeah sure, we take all the good things that they offer us and increase our profitability. At the same time we're not addressing the real problems. We're good enough to take advantage of all the good things, but why don't we sort of make more of an effort...to improve their quality of life. You know it's not good enough. We're still taking it but we're not giving.*

Others felt upset that the 'government put on an act' for the public in terms of appearing to deal with the issues but that this was often tokenistic and on 'white man's' terms:

*Yeah...offering resolution of dilemmas with sort of European or white man's terms or ways. Even the government projects that look to the public as though we are doing something, or addressing the issues...are really [only based] on a power sort of basis.*

### **3.3.3 Students' perceptions of Aboriginal culture and Aboriginal people**

Many students come to the area of Aboriginal health with clearly defined and often rigid perceptions about Aboriginal people and Aboriginal culture despite limited exposure. It emerged in the focus groups that individual levels of understanding, however, varied considerably and opinions covered a similar wide-ranging spectrum as may be seen in the general community.

#### **Perceptions of Aboriginal culture**

While some students demonstrated a more complex understanding of Aboriginality, it was more common for students to hold a binary oppositional view of 'Aboriginal Culture' defined through and against 'Western Culture'. Students often perceived these separate cultures as pitched against each other, almost in battle.

In such a framework, Aboriginal culture often occupies the position of 'primitive' culture, one steeped in traditional practice and completely separate to the contemporary world that students place themselves in. This sense of oppositional cultural difference meant that for many students, any thinking about Aboriginal people was based on a rather extreme perception of 'us' and 'them':

*It's not as developed a society, as we sort of know it in the first and second worlds. A tribal sort of existence...small communities within huts.*

*How much do you respect their need to remain aside...[or do you] go in and say, 'Look we actually want you to raise your standard of living because you can be so much better than you are now.'*

Within this framework many students perceived that for Aboriginal culture to remain 'true' or valid as an Indigenous culture, it needed to remain virtually unchanged. These students had a sense that you would need to go into the heart of the Australian 'wilderness', where time had supposedly stayed still, and where contact with western culture had been minimal, to find 'real' Aboriginal culture. Urban and Victorian Aborigines were thus considered, in terms of their Aboriginal heritage, almost cultureless by some students who, within these strict binary notions, found it difficult to see these groups of Aboriginal people as any different from non-Aboriginal people. It was clear throughout the discussions that where such beliefs about both remote and urban Aboriginal were held, this shaped students' perceptions of Aboriginal issues in general. Remote Aborigines remained largely in the realm of the 'noble savage' steeped in a culture as remote to students as their location, while urban and non-remote Aboriginal people became stripped of any Aboriginal cultural context from which to understand the issues facing Aboriginal people and Aboriginal health:

*Well, in Victoria I'd suggest that their lifestyle isn't much different [from ours], apart from every now and then.*

*I always thought that there were kind of two groups of Aborigines. There was one group that was more westernised in the way that they were brought up, you know, in a family sense and things like that. The Aboriginal people that I knew in my home where I grew up were like that... They played football and they went to school and whatever. And then there's sort of another group that want to have their more traditional lifestyle, a tribal group more than a family group, and teaching their own way, and cooking and eating in their own way. I mean, the Aborigines that I knew as kids went to the supermarket, the same as the rest of us and had Cornflakes for breakfast... [This] tainted my view a bit about what the rest of us should do to help Aboriginal people.*

For many students, a cultural hierarchy was implicit in this notion of two discrete cultures. This took opposing forms amongst students. Some held idealised views of a 'traditional Aboriginal culture' whilst others, as the following quote demonstrates, saw 'western culture' as the desirable state:

*I think [Aborigines] perceive people coming from outside as a threat to whatever has been passed down from generations... That something [is] so sacred and is mutually [felt]. People from the outside don't know anything about that and they're coming in going, 'Listen, we've got such fantastic lives, and I think you guys are missing out big time and this is how you should be'. And yeah, so I think it takes people from the inside who have had experience of a western education and western background, to actually convey that to [Aboriginal people], so they don't feel it as a threat.*

Clearly not all students held these particular views of 'Aboriginal culture' and 'western culture'. A number articulated more complex ideas, incorporating very different understandings of urban and rural Aboriginal communities and of cultural difference within these communities:

*Even when a number of tribes have settled in the one area they can be quite different. In New South Wales it's the Murri people and their traditions and their language and how they organise themselves into groups and how they deal with issues. [This] is very different from say the Kooris in Victoria. So there is a great deal of variety.*

*It's important to know where [Aboriginal people] are coming from. I don't think we actually get enough exposure as to where they are now. We make a lot of assumptions about those in the rural areas, how they live and all. But the Aboriginal people we are going to come into contact with are the ones living in the city and we need to know their culture in a sense [and how they have] adapted to life now.*

Many of these students, however, still maintained a number of particular cultural frameworks within their thinking. A common theme throughout the groups, for example, was the perception that Aboriginal culture embodied a foreignness of greater proportions than other known cultures in Australia, that Aboriginal culture was 'less understandable' to students than other cultures. Some students thought that, when compared to Aboriginal culture, other cultures were more understandable to many Australians:

*I think Italian culture, Chinese culture and so forth are not really that fundamentally different from Western culture. I'm sure there are a lot of differences. But we have the same idea about time, about relationships. Whereas Aboriginal people they have a very different culture... So they're not really mainstream as such. If you get my drift. They're very different.*

*I really think that the Aboriginal sense of spirituality is very hard for, say, me to understand and for other people to understand [compared to] a lot of other cultures that have come to Australia. For instance, my background's a Greek background. Each group of people have brought their own religion, if you like... And, for instance, people with my background will go to a particular church. That's a very recognisable sort of symbol and spirituality. And for the Aboriginal people it seems very important that a lot of their basis is, you know...on this sense of spirituality. So different for individual groups of Aboriginal people too. So it's very, very hard for us to kind of know where they're coming from. When you're trying to understand Aboriginal people you've got to really understand where their sense of spirituality is. It's very difficult. I don't know.*

Because of this sense of great cultural foreignness, a number of students felt that it was much harder to cross this perceived cultural chasm with Aboriginal people than with other cultural or ethnic groups and thus harder to feel that they could get to know Aboriginal people or understand their culture:

*Just the question I'm trying to work out. Why do Aborigines seem a more difficult or distant group to get to know [compared with] other ethnic groups? There's some greater barrier for some reason. There are a lot of ethnic groups in Australia and, you know, just from my experience, I have contact with a lot of other groups rather than the Aboriginal groups.*

*And we might know the Italian culture or the Asian culture. It's easy to know...because as you mix with people you get a feel of their culture. Just mixing with the Greeks you can tell roughly what it is.*

As these comments demonstrate, cultural stereotypes were not solely located with Aboriginal people. Whilst many students described having more contact with other cultural groups, a number made obviously inaccurate or grand statements about other cultural groups. However, where other cultural groups were used as a comparison, there was less social distance than from Aboriginal culture. One example of this was the number of students who claimed how easily or rapidly they could get an understanding of say 'Greek culture' or 'Chinese culture' or how similar these cultures were to their own.<sup>21</sup> Students' perceptions of Aboriginal culture as particularly hard to understand or know meant that they felt separate from Aboriginal people and thus were less likely to feel comfortable in making any contact with an Aboriginal person. On the other hand, similarly inaccurate perceptions of other cultures served, at least in these students' minds, to evoke a sense of familiarity and to increase a sense of possibility of connection with that group.

For some, this sense of a separation from Aboriginal culture was explained differently. Some students stated that they felt they should already know about Aboriginal people and that to make contact with Aboriginal people without 'knowing' would be more impossible than it would be with other cultural groups. In this case, students regarded their sense of social distance as being far greater from Aboriginal people than from other cultural groups. Here, they felt so distant that they did not know how to ask. In part, this was related to a fear of Aboriginal people's anger if they put a foot wrong, a potential anger that students generally did not ascribe to other groups:

There are a lot of cultures that I get very confused with. Especially Muslim cultures. But I always feel that I can ask people about their culture, [about] what they believe, or their religion and whatever else. Except maybe for Aboriginal groups, because I feel that I should already know that. I think it's harder to ask them those questions without offending them than it is to ask other groups.

A lack of personal experience therefore did not mean that students came to the area with a blank slate in cultural terms. These taken-for-granted assumptions about 'us' and 'those not like us' organise students' perceptions of Aboriginal people and can be reinforced in the learning experience.

21 Students also commonly assumed that there was one 'Chinese culture' or one 'Greek culture'.

### **Perceptions of where Aboriginal people live**

When considering where Aboriginal people live in Australia, some students had quite accurate perceptions and were able to consider other issues, such as how Aboriginality is defined, in giving their answers. These students described the majority of Aboriginal people as living in Queensland and NSW and many more living in rural towns and urban areas compared with more remote localities.

Most students, however, perceived that the majority of Aboriginal people lived in the Northern Territory and in Western Australia and in remote communities:

*Well, you'd probably say that most of them live in the northern parts of Australia. What would you say, outback of Australia? Northern and western, I guess.*

*I guess it depends on who you define as an Aboriginal person. And there's varying degrees of assimilation as well. If you're talking about traditional Aboriginal communities...well, you probably would find them in north and Western Australia. But there's, you know, Aboriginal people all around us, all the time I guess, in different aspects to varying degrees.*

Students commonly stated that they never saw Aboriginal people in Victoria. For these students, the cultural separateness described above was also mapped onto a similarly extreme sense of geographic separateness. Throughout the discussions this could be seen to impact on a number of issues, such as where students believed the 'Aboriginal health dollar' should be spent, and on their sense of readiness to consider significant groups of Aboriginal people living in localities outside this perceived remote locality.

### **3.3.4 Key influences on student understanding of Aboriginal issues**

Students were asked to consider what sort of influences had shaped their understanding of Aboriginal people or their appreciation of Aboriginal issues prior to coming to university. They were also asked if they regarded their own individual experience as common to other medical students and to non-Aboriginal Australians in general, and whether or not they thought that the University had changed their understanding of Aboriginal people or appreciation of Aboriginal issues (see Appendix 2).

#### **Lack of contact with Aboriginal people: Impact of casual and observer experience**

Many students had experienced casual or fleeting contact. These often 'one-off' experiences with Aboriginal people were commonly described in negative terms and seemed to strongly influence their perceptions of Aboriginal people and Aboriginal issues.

A number of students described fairly brief periods of time in more remote parts of Australia where they had experienced considerable culture shock, often having to grapple with many difficult issues on their own:

*Once I had a fight with them... Yeah it was a real fight, I mean the people in the Northern Territory are definitely pretty rough. It's a totally different culture. I mean who wants to go and live in the Northern Territory, unless you're making money. I mean...you want to live on the eastern seaboard. Most people want to live on the eastern seaboard. Alice Springs: it's rough, it's hard, it's a pretty harsh environment.*

More could vividly recall what could be described as 'observer' or even, as was commonly the case, 'second-hand observer experiences'. These observations from afar did not involve any direct contact between the student and Aboriginal people:

*I went up to the Northern Territory myself when I was about twelve years old, and I don't think I had any preconceived ideas... The problem is even if say only 10% of the population are getting drunk, [it makes an impact] because that's what you see. You see the smashed bottles on the ground. It definitely sticks out in your mind, seeing that. And I don't know [if] that was representative of the whole town, but that was definitely the image I got.*

*I have a friend who, he comes from Tennant Creek, a township of 3000 people. There's just a massive divide between the Kooris and the whites. You know, they get drunk, that's what he told me. They smash all the windows. And he's just fed up with them. He's got exactly that sort of attitude as the doctor there [who] describes [Aboriginal people] as pests. And apparently everyone in that town feels exactly the same way towards them.*

Some comments reflected students' distress at acts of racial violence directed towards Aboriginal people, whether observed by the student or heard about second-hand:

*One of the friends who went up north, he was out somewhere at some party or something in the Northern Territory, and one of his friend's cars got stolen by a few Aborigines and they smashed it up or something. And the cops said, 'Oh, we know who took the car. Come with us'. So these two guys got in the car and went off to the families of the Aboriginal guys. The cops got one of them, put him in the back of the wagon and then the cops said to the guy whose car it was... 'Do you want to go in and, you know, smash him up?' Then the guy went in there and just beat this guy with the cop's baton. And then they kicked him out and went out. So that sort of stuck in my mind, that one.*

Students described different experiences depending on whether they had lived in the country or in the city. Students raised in country areas often had experienced more contact with Aboriginal people but also had often witnessed greater levels of racism.

These casual encounters described by students were overwhelmingly negative. Given the lack of real contact or relationships overall, the effects of these generally negative, fleeting or second-hand experiences often went unchecked, with little other personal experience to offer a different or deeper perspective. That is, students' ideas and emotional reactions towards Aboriginal people appeared often to be strongly influenced and informed in quite an ad hoc manner by these chance encounters or stories heard second-hand.

Only a handful of students described having had any longer-term personal contact with Aboriginal people. However, where students did describe specific relationships, most were of a positive nature. These students were often aware that the Aboriginal people they knew did not fit prevailing negative stereotypes. Some students described having to create two kinds of Aboriginal people in their own minds as a way of making sense of this marked mismatch. One student who lived in an inner-city suburb, commented:

*I've come across a lot of Aboriginal people in the area I live in. They're not different from anybody else out of the people I socialise with. So they're not really like the Aboriginal people we're talking about in the rural sectors. They don't abuse alcohol, they don't do any of the things people stereotype them with. So you really have to classify which type of Koori people you're talking about.*

## **Media**

Many students in the focus group discussions regarded the media as a crucial source of information about Aboriginal people. Some went so far as to say it was their only source of information. How this influenced students' perceptions, however, varied.

Many students criticised the role of the media and its representations of Aboriginal people. Many regarded most media representation as both issue-based and controversy-oriented and commented on how these two media perspectives had shaped their perceptions and their knowledge. Other students were less clear about any relationship between their perceptions and particular media representations:

*If you listen to the news and nothing else about Aboriginal people, you think that all they can say for themselves is really land rights.*

*My perception of all this is that the media is always being very negative about Aboriginal people. They're oppressed...they're always diseased, no one seems to care...and everything seems to be negative.*

*Stereotyping. [I remember one program]. [They were] talking about the problems in...Kalgoorlie or somewhere like that...and the only...people they interviewed were white. They didn't interview one single Aboriginal person and the problem was caused by Aboriginal people. Alcoholism, violence, drugs. And they didn't talk to them about it. So there's a certain element of bias in the media too.*

Some students did not see the role of the media in these terms and thought that it was increasingly dealing with the issues with greater awareness and sympathy:

*Reading the paper I find that you get a view from both sides. Like reading an article about land rights, you find just as many written by Aborigines as you do written by white Australians. So the picture isn't, well maybe slightly tainted, but you do get an image of both sides.*

For many students there was certainly significant awareness of the complex and changing role played by the media, but comments often demonstrated that students' perceptions of the media were still caught in binary structures. Several students, as demonstrated in the above quote, believed that any representation of Aboriginal issues required two sides in order for the 'argument' to be balanced. These two sides were commonly represented as Aboriginal and non-Aboriginal Australia. Anything else would somehow be 'tainted'. The difficulty here is that such a framing, and an acceptance of such a framing as natural or necessary, can pit one group against the other and can deny difference amongst Aboriginal people themselves as well as amongst non-Aboriginal people.



## School Teaching

Many students commented on a general lack of teaching about Aboriginal issues in their primary and secondary school years. Students described isolated instances of positive teaching on Aboriginal issues but this good teaching was often dependent on the philosophy of specific individual teachers, particularly in the primary years. Teaching was also described as differing according to location and students who had gone to schools in both urban and country settings generally described having had more teaching on Aboriginal issues in the former:

*I went to primary school in the western suburbs and I remember my classes were particularly...multi-cultural... I remember we did do a number of projects on Australian history and Aborigines. But then in about Grade 6, I moved down to Warrnambool. It's a very Anglo-Saxon community...but there's [an Aboriginal] reserve nearby... Throughout that whole six years of secondary school down there we never talked about any Aboriginal issues... And the closest you got to dealing with Aboriginal issues in Warrnambool was the sudden influx [of Aboriginal people in town] on pension day. You know it was real, everyone took note.*

One theme to arise from discussions was that of an 'arrested' teaching about Aboriginal issues within schools. It was common for students to have learnt about the 'pre-contact tribal Aborigine' in school or at best to have learnt about 'early Aboriginal post-contact history'. After that, however, the subject was invariably dropped. Students described this happening both in primary and in secondary school:

*I remember in primary school learning about Aborigines. But the history that [we] got sort of coloured [us]. So you had this concept of us settling in Australia and all the horrific things that happened to Aborigines, but that's where it ended. We didn't quite know what happened after that. And that happened right through school.*

*It was the kind of education we had. Certainly what I had in high school was all about a people 200 years ago. What they did as hunters and gatherers. Which, I mean, doesn't equip me to deal with Aboriginal people in this day and age. I mean, they're not hunters and gatherers any more, especially not in the Melbourne setting anyhow.*

Students' primary schooling, in particular, seemed to endorse both an exoticisation of culture and stereotypical notions of 'the noble savage', with significant silences and omissions:

*Like we had an Aboriginal touring party. They brought all these spears...kangaroo furs and stuff to our primary school for a day. And everyone was really rapt and going, 'Oh, how do you make a spear? How do you light a fire?' and so forth. There was no discussion on issues about land rights or anything like that.*

Whilst this teaching style is sometimes used for teaching young people in order to captivate their attention, problems arise if teaching ceases at this point. As one student commented:

*That's probably very damaging. Because you know the memories you hold onto are the ones [you get] as a kid, and [your] opinions and bias[es] are formed in childhood. So, I mean, if your experience of Aboriginal culture is a person with a spear who makes fires, that's what you think all Aborigines do.*

There was general agreement from several students, on reflection, that such teaching can foster the development of a number of notions that were common to these medical students' perceptions of Aboriginal people and Aboriginal culture, namely: a sense that real Aboriginal people are a feature of the past; that 'real' Aboriginal people are a feature of some other place; and that 'real' Aboriginal culture has been lost.

### **3.3.5 Medical relationships with Aboriginal people: students' perceptions of themselves as future doctors**

Students expressed a number of interesting beliefs around the particular relationship between doctors and patients. One view articulated by students was that somehow doctors are rendered impartial, with no bias or prejudice, simply by virtue of being doctors. That is, that learning the various 'tools' of Medicine, history taking, examination and ordering investigations, ensures almost a universal impartiality on the part of the doctor. These students found it difficult to appreciate any value in exploring their own assumptions and beliefs and, in fact, thought at times that this process caused problems. Instead, they felt that being a doctor was just a matter of 'treating everyone the same'. Some students did not believe in the possibility of simply treating everyone in the same way or in the notion of a learned impartiality. One student, for example, argued for the need to acknowledge one's assumptions and biases with all patients; that they are features of any consultation.

Another view expressed was that assumptions made by doctors should be endorsed rather than explored:

*I reckon that's fair enough. If they come in and they're, I was going to say Aboriginal, then certain things will spring to mind that may not have if they weren't. And I think that's fair enough.*

Some students felt that the doctor could correctly make a set of assumptions about a patient and about their health simply by looking at them:

*But if they walk in and they're well-dressed and they're clean and they've got a high standard of personal care, and they've got a briefcase. It doesn't matter if they're Turkish or whatever, you're going to say this person's got a high level of health.*

A number of students spoke about problems and poor communication between doctors and Aboriginal people:

*It's usually quite antagonistic. At Larundel there's a special unit for Aboriginal people. And these Aboriginal people didn't really like the psychiatrists or doctors. They didn't have much to do with them. They're just coexisting on their own there. The impression I got was that whenever I wanted to see one of them [the psychiatrists would] say, 'I don't think you should see one of them because they're not going to talk to any of us'.*

Some articulated various barriers for Aboriginal people such as the impact of past actions, and the general manner in which most mainstream services run, often with limited time and to fairly tight schedules:

*I'm saying the way [Aborigines] mark time is not compatible with...private practice where you have problems with money and paying nurses, you have a lot of overheads. You've got to make a [living] as well. Many doctors find it very difficult to cope with Aboriginal patients. So there's other factors as well. It's not just that they're different. It's also we don't have the right system. So the Aboriginal Medical Service sort of had to come about so that they can perhaps spend a lot more time and also organise things in a different manner. The actual organisation, how the medical care is delivered, has to be changed.*

In this way, several students saw the needs of Aboriginal people as being incompatible with much of medical practice. Interestingly, they only spoke of the need for there to be a separate service for Aboriginal people. The inference was often that such a service would not involve themselves and that mainstream services did not have any particular responsibility to respond to the problem or to change in any way.

Overall, there was an impression that most students found it hard to engage in even imagining a professional relationship with Aboriginal people and that personally they did not envisage themselves as being involved with Aboriginal people in their future work.

### 3.5 Summary and discussion

The focus group discussions demonstrated that there was a wide range of attitudes and levels of understanding amongst students towards Aboriginal issues. There is a large body of work by Indigenous writers and others which supports the key themes that emerged in the focus group discussions with respect to students' perceptions of Aboriginal people and Aboriginal culture.

Some students came to the area with considerable knowledge and experience, but the majority had had very little contact with Aboriginal people. This lack of contact was a key issue behind the many themes that emerged. bell hooks argues that stereotypes are created across boundaries of racial difference when real contact is not possible or not allowed:

*Stereotypes, however inaccurate, are one form of representation. Like fictions, they are created to serve as substitutions, standing in for what is real. They are there not to tell it like it is but to invite and encourage pretence. They are a fantasy, a projection onto an 'other' that makes them less threatening. Stereotypes abound when there is distance. They are an invention, a pretence that one knows when the steps that would make real knowing possible cannot be taken — are not allowed. (bell hooks in Langton, 1997: 84)*

Students who are engaged with Aboriginal issues in a learning context deal with a complex range of emotions. Common emotions expressed were: powerlessness; a sense of being overwhelmed by the level of loss and the scope of the problem; guilt; anger, towards Aboriginal and non-Aboriginal people and towards government; fear of Aboriginal people's anger; and a general sense of anxiety about having closer associations with Aboriginal

people. Several issues seemed to particularly evoke strong emotions: Aboriginal identity; the treatment of minority groups in general; assimilation versus the maintenance of a separate culture; land rights; and approaches taken by governments with respect to Aboriginal people.

Many students held strong and often seemingly rigid views with respect to Aboriginal culture. Students commonly perceived 'real' Aboriginal culture as a culture frozen in time, as remote, as steeped in traditional practice and, in some way, as being in direct opposition to their notion of contemporary/western culture. In the face of this perception, Aboriginal people in urban settings were often rendered as not 'real' Aboriginal people and as somehow invisible. Mick Dodson has spoken of the invisibility of 'real' Aboriginal lives for the non-Aboriginal population. He writes powerfully of how Indigenous people have been excluded from non-Aboriginal people's perceptions of themselves:

*Because Aboriginality has been defined as a relation, Indigenous peoples have rarely come into a genuine relationship with non-Indigenous people, because a relationship requires two, not just one and its mirror. Our subjectivities, our aspirations, our ways of seeing and our languages have largely been excluded from the equation, as the colonising culture 'plays with itself'. It is as if we have been ushered onto a stage to play in a drama where the parts have already been written. Choose from the part of the ancient noble spirit, the lost soul estranged from her true nature, or the aggressive drunkard, alternately bucking and living off the system. No other parts are available for 'real Aborigines'. (Dodson, 1994: 9)*

Marcia Langton (1981) has also explored various Aboriginal stereotypes common in non-Aboriginal Australia, such as 'the noble savage', and has assessed their impact on perceptions of urban versus remote Indigenous people. Hunter and Fagan have spoken of how the perception of 'Aboriginal culture as stagnant, locked in some distant and mythical "authentic" past', can deny both the 'reality of an increasingly urban-based and sophisticated Aboriginal population' and the impact of Aboriginal history (1994:22).

Others have explored how these perceptions affect Aboriginal people; how areas like Aboriginal health are viewed; and the nature of interactions between Aboriginal and non-Aboriginal Australians. Again, Mick Dodson has commented:

*Take, for example, the image of Aboriginality as a timeless and unchanging culture: pristine, exotic, a relic of an ancient past. This true, pure-blooded, traditional Aborigine is at once posited as the arbiter of authentic Aboriginality, and as a member of a doomed race. Hence all of us whose mothers were raped by white men, or who were forced or chose to incorporate other elements into our Aboriginality are 'not real Aborigines'. By defining our Aboriginality in terms of purity of blood or purity of culture, the assimilation of those who didn't fall within the narrow ambit of the definition could not even be considered cultural genocide, because the individuals concerned were seen as not actually being Aboriginal. (Dodson, 1994: 7)*

Aboriginal culture was viewed by many students as embodying an extreme foreignness in comparison to other cultures. For many students, these emotions and perceptions served to separate them from Aboriginal people in their imagination and to make contact seem unlikely or impossible compared with other groups. Perceptions of Aboriginal culture as

beholding an extreme foreignness have also been discussed by others (Hollinsworth, 1992b and Rowse, 1988).

With respect to students' perceptions of key influences on their understanding of Aboriginal people and Aboriginal issues, the often negative impact of casual or observer experiences emerged as a strong theme. However, students who had had the opportunity to have more ongoing relationships with Aboriginal people tended to describe the very positive impact of such experiences. The media was also identified as a key influence, though students' experiences of the impact of this on their perceptions varied and no consistent themes could be identified. On the whole, students described minimal past teaching experiences of varying quality in primary and secondary school. What was significant, however, was that students commonly experienced this teaching as having been 'arrested' in some way and of unwittingly endorsing a notion of Aboriginal people as primarily a feature of the past.

Many students appeared to have difficulty envisaging having contact with Aboriginal people in their future work as doctors and found it difficult to know where to situate themselves in any practical sense in terms of responsibility for Aboriginal health. Most located this responsibility outside of themselves.

Many of the perceptions and emotions which students bring to the area of Aboriginal health, as identified by the focus group discussions, clearly have educational implications and give support to a number of the recommendations from cross-cultural theorists outlined in the literature review. For example, the focus group discussions strongly supported the need for any teaching to ensure that students are taught in an environment where they can express their pre-existing emotions, define their own cultural background and deal with their own cultural 'baggage'. The discussions also demonstrated the need to provide students with safe opportunities to debrief about cross-cultural interactions that arise in clinical situations. In addition, they gave support to Hollinsworth's arguments around the need to address structural issues, demonstrating the difficulties that students have in dealing with the needs of minority groups and their general understandings of race and culture.

Teaching also needs to focus on a range of concepts which many students clearly have a poor understanding of, such as: Aboriginal identity; the diversity and changing nature of Indigenous cultures; and contemporary Indigenous cultures and their validity in contemporary society. Students need to be provided with a range of learning opportunities to help address the extreme level of foreignness they attribute to 'Aboriginality' and the degree to which they see Aboriginal people as separate from their own lived experience. Teaching methodologies which enable students to hear multiple Indigenous voices and which allow for the potential for more positive interactions with a range of Indigenous people would be key to such processes.

Whilst the focus group discussions shed light on students' emotions and perceptions of Aboriginal people, they had not been particularly helpful in evaluating existing teaching. We therefore decided to survey a larger group of students. This survey was used to validate some of the findings from the focus groups and to attempt to quantify influences on student understanding. The survey was also undertaken to further explore students' perceptions of causes of poor health amongst Aboriginal people, their perceptions of their own future involvement and notions of responsibility towards the area.



# Chapter Four: Survey of Students' Understanding of Aboriginal Health and Aboriginal Issues

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## 4.1 Introduction

The Aboriginal health survey was developed in conjunction with the steering committee, with assistance from members of the Melbourne Aboriginal community and staff at the Department of Public Health and Community Medicine. Ethical approval was received from the University of Melbourne's Human Research Ethics Committee. The survey was developed from the preliminary analysis of the focus group data, using the themes identified from the preliminary results of the focus group discussions.

The specific objectives of the survey were:

- to further explore students' understanding of Aboriginal health and Aboriginal issues;
- to identify key influences involved in shaping this understanding; and
- to explore students' perceptions of their future involvement as doctors with Aboriginal people.

## 4.2 Methodology

### 4.2.1 Survey content and administration

The survey included both closed and open-ended questions, addressing students' knowledge of Aboriginal issues, their understanding of the causes of poor health amongst Aboriginal people, their expectations of future work in Aboriginal health, key influences upon their understanding of Aboriginal issues, and their opinions on formal and informal teaching. The survey was piloted amongst a small group of students and administration staff in the Department. Questions which proved difficult to understand, or were ambiguous in some way, were amended at this stage (see Appendix 3).

Students surveyed were asked to complete a five-point scale regarding their self-assessed knowledge across three broad areas: 'contemporary Aboriginal Australia'; 'Aboriginal history, culture and politics'; and 'Aboriginal health'. These categories had been previously identified from an analysis of comments made by students during the focus group discussions. Four questions were asked which related to some aspect of student knowledge of Aboriginal health. These questions were not intended to be comprehensive. Two questions asked students about Aboriginal health funding. Results of the focus group discussions suggested that misinformation in this area was common and that students' ideas about funding often acted as a barrier to learning about Aboriginal issues. The other two questions asked students about specific Aboriginal health statistics with respect to life expectancy and the prevalence of diabetes. These questions were intended to represent one

aspect of general knowledge in Aboriginal health and one aspect of Aboriginal health with clinical significance. They were asked to select from five options the figure that best represented the average life expectancy of an Aboriginal male living in Victoria. They were also asked to select from four options the statement that accurately reflected the overall prevalence of non-insulin dependent diabetes (NIDDM) in the Aboriginal population when compared to the non-Aboriginal population.

To explore students' knowledge and perceptions of Aboriginal people's poor health status, students were also invited to respond in their own words to an open-ended question as to why the health status of Aboriginal people is lower than that of non-Aboriginal people. Students were asked to consider a series of eight possible influences that may have shaped their understanding of Aboriginal issues and to rank their three most notable influences. They were also asked to complete a five-point scale regarding how much involvement they expected to have with Aboriginal patients after graduation and to expand further in their own words on why they thought this. The scale was described to students as follows: 1 — never, 3 — periodically, 5 — frequently. A final component of the survey involved a process evaluation of teaching. Results of this are presented in Chapter 5.

The study population for this survey comprised all medical students in first- (a pre-clinical year), fourth- and fifth-years (both clinical years). These years were selected in order to choose a representative sample of medical students, and to include those who had already undergone teaching on Aboriginal health through the existing teaching program. The survey was delivered to these students over a five-month period. All student groups in these three years were visited at the relevant teaching sites and invited to complete the survey. Fifth-year students were surveyed at the end of third semester in 1995. First- and fourth-year students were surveyed in first semester in 1996. The survey was delivered to each student group when maximal numbers of students were gathered for lectures. Each student group had approximately 15–20 minutes to complete the survey. Hence all medical students in three year-levels present at lectures and teaching sites at the time of survey administration were invited to complete the survey. Participation was voluntary and written consent was obtained from the students with a clear explanation of the method and purpose of the survey. Individual students remained anonymous with respect to the analysis of the data. The year-level distribution in the group surveyed was almost entirely a reflection of student attendance rates in the particular years on the day the survey was distributed.

### **4.2.2 Data Analysis**

Answers to open-ended questions were thematically organised. Samples of these data were analysed by a second researcher to ensure validity of coding categories, and a coding manual was developed for data entry. Codes were agreed upon after reviewing a large sample of questionnaires and students were allocated single or multiple codes, depending on their answers. These data were then aggregated into descriptive form. (p-value <0.05 was used as the cut-off to assess for statistical significance.)

Non-qualitative data were initially analysed using Epi-info, version 6. SPSS was used for descriptive statistics and, where appropriate, Chi Square test was used in the analysis to compare differences in categorical data. Linear regressive models controlling for dependent variables running under SPSS were used for predictive statistics.



## 4.3 Results

### 4.3.1 Demographic data

Four-hundred-and-three students returned fully completed questionnaires for this study, an overall participation rate of 62% (Table 4-1).

**Table 4-1. Year-level of medical students who completed an Aboriginal health survey (n = 403)**

YEAR IN MEDICINE	NO. OF STUDENTS	NUMBER IN YEAR <sup>22</sup>	PARTICIPATION RATE IN EACH YEAR
Year 1	162	213	81.4%
Year 4	136	212	65.8%
Year 5	105	229	45.9%
Total	403	654	61.6% response overall

Responses were weighted towards first-year, with 40% of respondents in first-year, 34% in second-year and 26% in third-year. Two-hundred-and-thirty-four (58%) were male and 169 (42%) were female (cf. 59.9% male and 40.1% female in the total study population).<sup>23</sup> Three-hundred-and-eighty-four (95%) were under twenty-five years of age.

Two-hundred-and-eleven (52%) students were born in countries other than Australia. One-hundred-and-seventy-two (43%) students were born in Asian countries. Of the students born outside of Australia, 142 (66%) had been in Australia for less than ten years. Thus, a sizeable proportion had only been in Australia for a relatively short time. Details of the age breakdown and countries of origin of the total study population are not readily available.<sup>24</sup> In Faculty surveys, 99.4% of students were under the age of twenty-six, 52.1% were born outside Australia and 40% were born in Asian countries. No question was asked in these surveys regarding years in Australia. From these figures, it would appear that the students who responded to the survey were representative of the total study sample in terms of age, gender and years in Australia.<sup>25</sup>

<sup>22</sup> Figures used here for the total number of students enrolled in these year-levels were drawn from the recent publication Statistics 1998 (University of Melbourne Planning Office 1999: 1–48, 49).

<sup>23</sup> Figures compiled from reports by the University of Melbourne to the Australian Faculties of Medicine Students Statistics 1995 & 1996.

<sup>24</sup> All students are invited to complete a survey about their social background in first-year but the response rates vary (94% amongst the total student group in first-year; 61% amongst the total student group in fourth-year and 59% amongst the total student group in fifth-year. In addition, the surveys amongst students in fourth-year of our survey did not include the twenty-three international students.)

<sup>25</sup> See Summary of social background of first-year medical students – 1991; Summary of social background of first-year medical students – 1993; Summary of social background of first-year medical students – 1996. Internal Reports. Faculty of Medicine. University of Melbourne.

**Table 4-2. Country of birth of medical students who completed an Aboriginal health survey ( n = 403)**

COUNTRY OF BIRTH	NO. OF STUDENTS (%)
Australia	192 (48)
Malaysia	64 (16)
Hong Kong	24 (6)
Vietnam	23 (6)
Asia other <sup>26</sup>	61 (15)
Europe	13 (3)
The Americas	3 (1)
Other	23 (6)
Total	403

Among students in their clinical training years, slightly more students answered the survey, which reflected the time and manner in which these students were surveyed. <sup>27</sup>

**Table 4-3. Hospital base of medical students in years 4 & 5 who completed an Aboriginal health survey (n = 242)**

HOSPITAL	NO. OF STUDENTS%
Austin and Repatriation Medical Centre	95 (39)
Royal Melbourne Hospital	64 (26)
St Vincent's Hospital	83 (34)
Total	242

<sup>26</sup> The countries making up the majority of responses coded as 'Asia other' were: China (PRC), Taiwan (ROC), Singapore and Sri Lanka.

<sup>27</sup> During an afternoon of lectures, when there was usually a very high attendance rate, a time was specifically scheduled for the Austin students to complete the survey.

### 4.3.2 Students' self-assessed knowledge of Aboriginal issues

Students overwhelmingly assessed their knowledge as limited. Only one student assessed their knowledge as 'comprehensive'.

**Table 4-4. Self-assessed knowledge of Aboriginal issues by medical students who completed an Aboriginal health survey (n=403)**

AREA OF KNOWLEDGE	POOR %	FAIR %	ADEQUATE %	QUITE GOOD %	COMPREHENSIVE %
Contemporary Aboriginal Australia	18	55	22	5	0.2
Aboriginal history, culture and politics	27	44	23	5	0.2
Aboriginal health	2	47	26	5	0.2

Across these three broad categories of knowledge relating to Aboriginal issues, students ranked their levels of knowledge remarkably similarly.

More overseas students ranked their knowledge in all three broad areas of knowledge as poor when compared with Australian-born students (Table 4-5). Asian-born students made up the largest group when compared with those born in other countries.

**Table 4-5. Country of origin of students who ranked their knowledge as poor**

KNOWLEDGE	% OF OVERSEAS BORN STUDENTS	% OF AUSTRALIAN-BORN STUDENTS	$\chi^2$	P
Contemporary knowledge	24.6%	10.4 %	20.6	<0.001
Health knowledge	14.6 %	28%	16.9	0.001
Historical knowledge	36.5%	10.4 %	23.3	<0.001

There was a trend towards higher levels of self-reported knowledge from first- to fifth-year. While the majority of students in all year-levels ranked their knowledge across the board as poor or fair, more first-years were represented in the group that ranked their knowledge as poor and there were more fifth-years in the group that ranked their knowledge as adequate or above (contemporary knowledge:  $\chi^2=42.1$ ,  $df=6$ ,  $p<0.001$ ; historical knowledge:  $\chi^2=19.5$ ,  $df=6$ ,  $p=0.003$ ; health knowledge:  $\chi^2=73.7$ ,  $df=6$ ,  $p<0.001$ ). There were no differences with respect to students' hospital base in all three areas of knowledge.

### 4.3.3 General knowledge about Aboriginal health

#### Government spending on Aboriginal health

Students surveyed were asked to select from six options the figure they thought best reflected the percentage of the federal health budget specifically allocated to Aboriginal health over 1994–1995. They were also asked whether, in general, they thought that Aboriginal health funding had increased, decreased or remained the same over the past ten years when adjusted for inflation.

During the 1994–1995 financial year, specific Aboriginal health funding was still under the auspices of the Aboriginal and Torres Strait Islander Commission (ATSIC). Over this twelve-month period, approximately 0.6% of the federal health budget was specifically allocated to Aboriginal health (Commonwealth Department of Health and Family Services, 1996b).<sup>28</sup> The majority of students over-estimated the amount of funding for Aboriginal health (Table 4-6).

**Table 4-6. Medical students' views of the percentage of the federal health budget specifically allocated to Aboriginal health over 1994–1995 (n=395)<sup>1</sup>**

PERCENTAGE OF FEDERAL HEALTH BUDGET - PERCEIVED TO BE ALLOCATED TO ABORIGINAL HEALTH	NUMBER OF STUDENTS (%)
20%	10 (2.5)
10%	56 (14)
5%	98 (25)
1%	148 (37.5)
<1% <sup>29</sup>	83 (21)
Total	395

1 Eight students did not answer this question.

28 During the 1994–1995 financial year, the Commonwealth Department of Health and Family Services spent \$13,409,374,000 on Program 1: Health Advancement and Program 2: Health Care Access. ATSIC was specifically allocated \$84,700,000 for its health and substance-abuse budgets. Using these figures, 0.6% of the total federal health budget was specifically allocated to Aboriginal health.

29 Categories for students to consider on the survey were 20%, 10%, 5%, 1%, 0.1% and <0.1%. These categories were based on figures we initially had at our disposal which suggested that the percentage of the overall federal health budget spent on Aboriginal health was approximately 0.1%. This later proved to be an underestimate, the more accurate estimate being 0.6%. For this reason these last two categories have been combined for the purposes of this discussion. (13.4% of students had selected 0.1% and 7.6% had selected <0.1%.)

There was an overestimation of specific federal funding to Aboriginal health by 79% of the students, with a marked overestimation (that is, an estimation that 5–20% of the federal budget was allocated to Aboriginal health) by 41.5% of students. Responses were grouped into three categories (<1%; 1% and 5%; 10% and 20%) and tabulated with year-level, years in Australia, and country of birth. First-year students were more likely to overestimate the amount of federal funding allocated to Aboriginal health ( $\chi^2=31.2$ ,  $df=4$ ,  $p<0.001$ ) as were overseas-born students overall ( $\chi^2=10.9$ ,  $df=2$ ,  $p=0.004$ ). Using a linear regression model controlling for year-level and overseas origin, the two factors were independently significant but year-level was the strongest predictor ( $p=0.005$ )

**Table 4-7. Knowledge of federal funding of Aboriginal health**

VARIABLE	STANDARD ERROR		* P
Year-level	0.056	-.205	0.005
Years in Australia	0.058	-.141	0.053

### Aboriginal life expectancy and prevalence of diabetes

The average life expectancy of an Aboriginal male in Victoria is 49 years (Anderson, 1988: 40) and the prevalence of NIDDM in the Aboriginal population is approximately 5–10 times higher than the non-Aboriginal population (Harrison, 1991: 154; OATSIHS, 1998: 20–21). In contrast to perceptions on Aboriginal health funding, the majority of students gave correct answers to these basic statistics in Aboriginal health (Tables 4-8 & 4-10).

**Table 4-8. Life expectancy of Aboriginal men in Victoria as estimated by the medical students surveyed (n=402)<sup>1</sup>**

ESTIMATED ABORIGINAL LIFE EXPECTANCY	NUMBER OF STUDENTS (%)
30 years	7 (1.7)
40 years	57 (14)
50 years	224 (56)
60 years	108 (27)
70 years	6 (1.5)
Total	402

1 One student did not answer this question

Progressively more students correctly answered this question in the latter years. 'Years in Australia' appeared to be significant but was confounded by 'year-level'. Using a general linear regression model controlling for 'year-level' and 'years in Australia', 'year-level' (sig. 0.017) remained a significant predictor of a correct response rather than 'years in Australia' (sig. 0.427) (Table 4-9).

**Table 4-9. Predictors of correct response to question on life expectancy of Aboriginal people amongst medical students surveyed**

VARIABLE	STANDARD ERROR		* P
Years in Australia	0.066	0.059	0.427
Year-level	0.06	-0.18	0.02

**Table 4-10. Prevalence of diabetes in the Aboriginal population compared to that of the non-Aboriginal population as estimated by the medical students surveyed (n=402)<sup>1</sup>**

COMPARATIVE PREVALENCE OF DIABETES	NUMBER OF STUDENTS (%)
the same	16 (4)
twice as high	80 (20)
5–10 times as high	297 (74)
50 times as high	9 (2.2)
Total	402

1 One student did not answer this question

The majority of students (74%) selected the correct answer on the prevalence of diabetes. When correct answers were compared with all incorrect answers (coded as a single entity)<sup>30</sup>, Australian-born students were more likely to correctly estimate the prevalence of diabetes (52.9% of Australian-born students versus 47.1% of overseas born students ( $\chi^2 = 21.8$ ,  $df=3$ ,  $p<0.001$ ). Students in fifth-year were also more likely to give the correct answer ( $\chi^2 = 17.4$ ,  $df=2$ ,  $p<0.001$ ).

#### 4.3.4 Students' perceptions of the causes of poor health

Students expressed a wide range of views as to the causes of poor health among Aboriginal people. Most students (91.8%) responded to this open-ended question and the results are shown in Table 4-11.

**Table 4-11. Causes of poor health amongst Aboriginal people as defined by the medical students surveyed <sup>1</sup>**

STUDENT DEFINED CAUSES FOR POOR ABORIGINAL HEALTH <sup>2</sup>	NUMBER OF STUDENTS (%)
Poor geographic access to health services	141 (38)
Low socio-economic status	141 (38)
Poor resources in Aboriginal health	114 (31)
Cultural difference	101 (27)
Lack of education for Aboriginal people	92 (25)
Historical legacies	68 (18)
Culturally inappropriate health care by non-Aboriginal people	54 (15)
Racism	51 (14)
Issues of self-determination and land rights	19 (5)
Single lifestyle factor (eg alcohol consumption or poor nutrition)	53 (14)
Negative role of Aboriginal people themselves	37 (10)
Genetics	23 (6)
Single disease (eg diabetes)	17 (5)
Other	18 (5)

<sup>1</sup> Thirty-four students did not answer this question.

<sup>2</sup> Categories are not mutually exclusive.

When defining causes for Aboriginal ill-health, most respondents listed a series of discrete causes for poor health with little synthesis or sense of the interrelationships between causes. A few, however, gave such well-synthesised answers as these:

*Aboriginal people's health is poor because of] historical dispossession and relegation of Aborigines to an inferior racial status. Break up of Aboriginal communities, families, culture, homeland. Loss, alienation, decreased support networks, foreign and unsympathetic political and legal system. Poverty, poor education, alcoholism, distrust of Anglo medical systems, poor nutrition, hygiene and resources, domestic violence, crimes etc.*

*[Poor health] is strongly tied in with cultural and social reasons. Social inequality [leads to] poor health because of lack of money, poor housing, poor diet. Cultural problems and lack of self-determination [lead to] disenchantment and depression.*

Students more readily identified four of the fairly concrete or discrete social and economic factors at higher rates over other identified causes. These were 'low socioeconomic status' (38% of students), 'poor access to health services' (38% of students), 'poor resources in Aboriginal health' (31% of students) and 'lack of education' (27% of students).

Four key areas regarded by Aboriginal people as central to their community's poor health status (Briscoe, 1978; Sykes, 1978a and 1978b; Houston, 1985; Dodson, 1994; Anderson, 1988), were mentioned by students to a far lesser degree. These areas are: self-determination and land rights; historical legacies; racism; and culturally inappropriate health care. Only 5% of students listed self-determination or land rights as key factors in Aboriginal people's poor health. The other three categories, historical legacies, culturally inappropriate health care and racism, were mentioned by about only 20% of students.

There was a trend for students in the latter clinical years to mention historical legacies, culturally inappropriate health care and self-determination or land rights as causes for ill-health. Interestingly, fifth-year students were also more likely to mention genetics as a cause for ill-health.

**Table 4-12. Percentage of students mentioning particular causes of poor Aboriginal health during an Aboriginal health survey**

CAUSE OF ILL-HEALTH MENTIONED BY STUDENTS	FIRST -YEAR	FOURTH -YEAR	FIFTH -YEAR
Historical legacies	9%	20%	31%
Culturally inappropriate health care	7%	16%	25%
Self-determination/land rights	1.4%	1.6%	16%
Genetics	3%	5%	12.5%

It can be noted that 10% of students commented that they saw Aboriginal people themselves as significantly responsible for their poor health. They saw Aboriginal people as 'dirty', 'primitive', 'passive', 'unwilling' and 'non-compliant' and felt that Aboriginal culture per se, was somehow working in direct opposition to Aboriginal people's good health. Many students within this group saw health as simply unimportant to Aboriginal people and that this was key to the community's poor health.

*Health is less of a priority for Aboriginal people than for non-Aboriginal people.*

*Cultural differences meaning that Aboriginal people take perhaps slightly more health risks — smoking, drinking, diet etc, and do not seek help as early as non-Aboriginals.*

*They are the more traditional type. [They] tend to think of things like 'someone has put a witchcraft on me' instead of thinking of the fact that they are sick. [They] have no faith in medicine [and] believe in traditional healing methods — herbs etc.*



### 4.3.5 Key influences on student understanding of Aboriginal issues

Although asked to rank their three greatest influences on their understanding of Aboriginal issues, seventy-five students (19%) ticked a series of boxes and did not rank them. In the table below, they have been excluded from 'students' greatest influence', but where students had ticked three options they have been included in 'students' top three influences' (Table 4-13).

**Table 4-13. Key influences shaping medical students' understanding of Aboriginal issues**

INFLUENCE	RANKED AS STUDENTS' GREATEST INFLUENCE (N=312)	RANKED AS ONE OF TOP THREE INFLUENCES (N=387) <sup>1</sup>
General media reportage	36%	74%
Teaching in the Faculty of Medicine	23%	55%
School education (primary and secondary)	16%	42%
Aboriginal people in the media	5.8%	34%
Friends	2.2%	16.5%
Family	5.8%	16%
Aboriginal people known personally	5.5%	12%
Experiences at university outside of Faculty teaching	2.6%	12%
Other <sup>31</sup>	3.5%	5.5%

<sup>1</sup> Sixteen students did not answer this question

The media was ranked as the top influence by more than one-third of students, with 74% ranking it in their top three. Whilst being the greatest influencing factor in all year-levels, this was particularly the case for first-year students and it was of progressively less influence with the fourth-year and fifth-year students. 80.5% of first-year students, 73% of fourth-year students and 66% of fifth-year students ranked the media in their top three influences. Aboriginal people in the media were ranked as one of the top three influences by 34% of students.

The second most commonly listed influence was teaching in the Faculty of Medicine. Fifty-five percent listed teaching in the medical faculty as one of the top three key influences. This

<sup>31</sup> Travel and reading were the two most commonly stated influences coded as 'other'.

was quite surprising given the fact the students had such minimal teaching (see Section 1). Sixty-two percent of fourth-year students, whose formal teaching in Aboriginal health had consisted of one lecture covering the historical and cultural issues, cited their medical teaching as one of their top three influences (compared with 43% of first-year students and 64% of fifth-year students).

The third most commonly listed influence by students was their schooling. Forty-two percent of students ranked their schooling as one of their top three influences. These students were more likely to be in the earlier years of Medicine with a progressive reduction in the number of students listing it as one of their top three influences as the years progressed (first-year students 59%; fourth-year students 34%; fifth-year students 26.5%).

#### 4.3.6 Critical events in influencing student understanding

When asked to describe any incidents that had been critical influences on students' understanding of Aboriginal people, 55.1% of the survey group overall, responded. The three areas students most commonly described at greater length as critical influences in shaping their understanding were: formal teaching in the undergraduate medical course, personal experience and the media.

What was quite striking here was the significant detail students gave when describing any past personal relationship or direct contact with Aboriginal people, even if this contact was casual or fleeting. These responses conveyed the powerful influence of personal contact with Aboriginal people in shaping attitudes to Aboriginal issues in general. This was the case whether experiences had been positive or negative.<sup>32</sup>

*Visited an Aboriginal centre in Bairnsdale and chatted with an elder. Every incident, really, I have seen has shaped my understanding (or lack thereof).*

Students spoke of the major impact of second-hand or observer experiences. Several students described one single negative incident or an accumulation of incidents from earlier years, commonly involving physical violence, which had stayed with them.

*Being punched in the face for looking at one when I was fourteen years old.*

*Being hassled at Lakes Entrance by young Aborigines when I was ten years old.*

*Local Aborigines from home - their attitudes to housing and government funding.*

*Previously lived in Darwin with many Aboriginal neighbours. All day: eat, sleep, smoke, steal my bike.*

<sup>32</sup> We did not ask students how many had relationships with Aboriginal people because we thought the question would not give us any meaningful answers — the question itself could be interpreted in a number of ways. Also, given that the vast majority of students do not have contact with Aboriginal people, we thought that a number of students might find such a question threatening or might think they had to give a particular 'correct' response.

Students also described more neutral or positive experiences. These experiences had taken place in a variety of situations including family, school, university and travel. Most of these students had experienced a greater depth of contact with Aboriginal people.

*Being infatuated by a young girl whilst I was holidaying in Perth when I was fifteen years old.*

*A friend of mine is Aboriginal and lives in an Aboriginal community outside of his uni semesters. He tells me a lot about this.*

*My primary school had one-third of its population from an Aboriginal background so I grew up with Aboriginal people and culture.*

*I met this Aboriginal ranger 'up north' who was a top bloke.*

A number of students spoke of the influence of Aboriginal medical students and Aboriginal doctors with whom they had had close relationships or more fleeting personal contact through their studies.

*Knowing a medical student of Aboriginal heritage who is passionate about issues affecting them as people.*

### 4.3.7 Student assessment of their future work in Aboriginal health

Students were most likely to estimate their future life as involving general practice or specialist practice, with 10% of students anticipating work in Aboriginal health.

**Table 4-14. Future areas of work being considered by medical students during an Aboriginal health survey (n=403)**

CONSIDERATIONS FOR FUTURE WORK <sup>1</sup>	FREQUENCY (%)
No preference	80 (20)
General practice	166 (41)
Hospital-based specialist medicine	186 (46)
Private-practice-based specialist medicine	150 (37)
Community health	61 (15)
Aboriginal health	41 (10)
Research	41 (10)
Other <sup>33</sup>	29 (7)

<sup>1</sup> Students could nominate more than one category.

<sup>33</sup> Responses which were coded as 'other' included: third world health, women's health, sexual health, health administration and teaching.

When estimating their future level of involvement with Aboriginal patients, 95% of students predicted that they would have minimal involvement (48.4% 'periodically', 38.5% 'very occasionally', and 8.1% 'never') with Aboriginal patients after graduation, and only 5% of students thought that they would see Aboriginal patients 'fairly often' or 'frequently'. Six students did not respond to this question. Eighty-three percent of students in the survey group expanded on this response by answering the open-ended question.

### **Locality of work**

Students' perceived locality of their future work affected their perceptions about whether or not they would be involved with Aboriginal people after graduation. Forty-five percent of students described their anticipated future involvement as doctors with Aboriginal people in terms of the locality of their future work. A separate 11% of students stated that they would be working overseas after graduation and virtually all of these students stated that they would never see Australian Aboriginal people as a result.

While a number of the comments of the 45% of students intending to work in Australia accurately reflected current Aboriginal demographic data, the majority of comments contained particular misconceptions about where Aboriginal people live. These inaccurate perceptions clearly informed students' ideas on how much contact they may have in the future with Aboriginal patients.

Only a small number of students who anticipated some future involvement in Aboriginal health demonstrated an accurate understanding of the demographics. They understood that there are relatively less Aboriginal people in Victoria than the other states, but that 50% live in Melbourne and that many regional centres in Victoria have significant Aboriginal populations.<sup>34</sup>

*In Melbourne [I] will definitely come into contact with Aboriginal people.*

*If I practice in a rural area I may have contact. If near Framlingham or near Swan Hill, for example, I would probably encounter Aboriginal patients.*

I wish to work in a regional centre on graduation and completion of specialist training and most regional centres have some Aboriginal component to the community.

The majority of comments however, demonstrated a flawed understanding of Aboriginal demographics. Many students stated that working in Melbourne, and for some students any city, would mean minimal or no contact with Aboriginal people. A number of students thought that working in rural Victoria would also mean virtually no contact with Aboriginal people.

<sup>34</sup> According to the 1996 Census, 21,503 Indigenous people live in Victoria, which is less than 2% of the population and 6% of the total Aboriginal population (ABS, 1996). This is widely acknowledged to be an under-reporting and the Victorian Aboriginal Community-controlled Health Organisations (VACCHO) estimates the Victorian Indigenous population to be closer to 33,000 (personal communication with Alan Brown, CEO at VACCHO). The 1991 census estimated that 50% of the Aboriginal community lived in Melbourne. According to the 1996 Census, 29% of the national Indigenous population lives in NSW, and 27% in Queensland. Only 13% of the Indigenous population lives in the Northern Territory but Indigenous people make up 27% of the population. Since the last Census the greatest increases in the counts of Indigenous people have been in metropolitan and large urban centres and it is estimated that more than 76% of the Indigenous population live in urban centres (towns with populations of more than 1,000 people) (ABS, 1996).

*Aboriginal people seem to be more scarce and rare around city areas, especially Melbourne.*

*Probably not in rural areas in which I may practice (ie, Gippsland) or in Victorian city areas population is rather low.*

The majority of students said that they had experienced virtually no contact with Aboriginal people in the past and consequently saw their lived environment in these terms; that is, one devoid of Aboriginal people. If they lived in Melbourne or in country Victoria most of their lives and had had no contact with Aboriginal people, then they thought that if they continued to live and work in this area that this lack of contact would continue.

### **Future area of work**

Thirty-two percent of students explained their future medical involvement with Aboriginal people specifically in terms of their anticipated area of work. Underlying this appeared to be a perception of Aboriginal health as a separate area in which Aboriginal people are dealt with separately from the mainstream system.

Students commonly thought that learning was only really relevant to those wanting to work specifically in the field or in rural health. Many students did not see the area as relevant otherwise.

*It is only necessary for people who intend to work in this area, but not fair on those who don't.*

*Waste of time for majority of doctors who have little to do with Aboriginal patients in Melbourne.*

These perceptions frequently tempered students' sense that the area was important at a more theoretical level.

*As Australians we should have an understanding of Aboriginal history etc and as doctors we should have an understanding of Aboriginal health. However, many doctors in Australia will have very little, if any, contact with Aboriginal people, therefore I don't think this is 'extremely' important.*

## **4.4 Discussion**

This study had a number of limitations. The overall participation rate was only 62%. First-year students were over-represented in our sample and the response rate amongst fifth-year students was below 50%. The results need to be interpreted in the light of these limitations, though in terms of other demographic characteristics our surveyed group was similar to the total student group.

## **Knowledge about Aboriginal health and issues**

Anecdotally, those involved with tutoring or lecturing often felt that students came to lectures or tutorials believing that they knew quite a lot about Aboriginal issues. Contrary to the subjective experience of these lecturers or tutors and consistent with comments made by students in the focus group discussions, more than two-thirds of students surveyed saw their knowledge levels across these three areas as being less than adequate.

The majority of students overestimated the specific funding allocated to Aboriginal health. This is not surprising in view of general media representations. It is interesting, therefore, that students' knowledge of Aboriginal health statistics is more accurate. This may be as a result of existing Aboriginal health teaching, or it may be as a result of increased general knowledge and maturity.

Teachers and tutors in Aboriginal health had been concerned that the teaching was having little impact on students' perceptions. What was interesting from the survey findings was that despite teaching being fairly minimal and despite its various shortcomings, over 50% of students still ranked it as one of their top three influences. This can be interpreted in a number of ways. It may have been a result of some positive bias, given that this survey was about Aboriginal health and Aboriginal health teaching, though this is unlikely to account for everything given the frankness with which students spoke of their perceptions of Aboriginal people and their criticisms of existing teaching. This result does suggest that even small amounts of teaching can be quite influential in the face of other key influences such as the media. It is also possible that because of students' lack of contact with Aboriginal people and lack of detailed information in general, that any place which attempts to deal with these issues is regarded as influential.

Students' comments suggest that contact with Aboriginal people can be critical in informing their understanding of Aboriginal issues. Although only a small percentage of students had had contact with Aboriginal people, this contact, whether substantial or fleeting, greatly influenced students and in many cases overrode other influences. Our results suggest that even a few Aboriginal people in a student group can have a positive impact in shifting people's perceptions and broadening their knowledge base through personal contact.

In this study, I identified some assumptions and cultural perceptions that informed medical students' views of the causes of poor health among Aboriginal people. It is important, however, to be cautious about over-interpreting students' apparent perceptions from such a question. Asking the students to comment on the causes of ill-health among Aboriginal people as a whole may have supported a notion that Aboriginal people formed a distinct and unitary entity. The question thus may have precluded any acknowledgment on the part of the student of difference or diversity amongst Aboriginal people.

While bearing this in mind, our results do suggest that students often appeared to hold particular notions of Aboriginality. A notion of Aboriginal people as completely geographically 'remote' was common, particularly amongst the 27% of students who listed poor access to health services as a key reason for poor health.

When considering causes of ill-health, 'low socioeconomic status', 'poor access to health services', 'poor resources in Aboriginal health', 'lack of education' and 'cultural difference' were all identified by at least 25% of students (25–38%). On the other hand, 'issues of self-determination and land rights', 'historical legacies', 'racism' and 'culturally inappropriate health care' were not as readily identified by students as causes for poor health (being identified by between 5–18% of students).

That the majority of students readily articulated these more concrete social and economic and, to some extent, cultural factors as causes of poor health amongst Aboriginal people, reflects the paradigm shift that has taken place in Medicine over recent years to a more bio-psycho-social model of health (Morgan et al, 1997; Grbich, 1996). In this model, through the 'social', there has been an acknowledgment and an incorporation of perspectives relating to age, gender, class, religion and ethnicity (Morgan et al, 1997). Many teachers in Medicine, both academic and clinical, have incorporated this model into their teaching and generally it is expected that students will approach their future practice and negotiation of problems in Medicine from such a perspective.

However, the application of this model to Aboriginal health amongst the medical students who responded to our survey had some limitations. Aboriginal cultural stereotypes appeared to frame students' perceptions of the more readily identifiable socio-economic and cultural causes. Broader social and historical factors, including issues such as racism and land rights, were identified only by a minority of students.

The particular cultural perceptions and omissions that students bring to their understanding of Aboriginal health appear to be at odds with the frameworks for viewing poor health as defined by Aboriginal Australia. It is not that Aboriginal people and Aboriginal-controlled health services don't agree that specific social and economic issues are of great importance. The issue at stake is how these issues are often taken up separately and not in a broader context and how the underlying cultural perceptions of non-Indigenous people are often not examined (Sykes, 1978b; Langton, 1981):

*There can be no doubt in anybody's mind that the social and economic conditions under which most Blacks live are an important contributory factor to the pattern of ill-health which exists. However, because it is easy to see the link between living conditions and ill-health, and because so little has been done about the eradication of unhealthy living conditions, there is a danger that these conditions alone will be blamed or tackled. And the more serious effects of trauma from loss overlooked. (Sykes, 1978b: 16)*

### **Future involvement with Aboriginal patients**

Most students did not envisage that they would have much to do with Aboriginal people in their future work. Aboriginal health was commonly perceived as a separate area of Medicine. This expectation appeared to have two ramifications for many students. One was that the area did not seem relevant to learn about in the light of their future work and lack of interest in the area. Secondly, the majority of students did not see themselves as having any particular responsibilities towards improving the health of Aboriginal people or towards Aboriginal people. That is, it was someone else's responsibility. This may in part be a consequence of the curricular 'bracketing' of Aboriginal health under the auspices of Community Medicine. Since all medical graduates will have contact with Aboriginal people, it may be necessary to integrate Aboriginal health more widely into the medical curriculum, so that a degree of competency in Aboriginal health becomes recognised as essential for Australian graduates.

## **4.5 Summary**

This study has demonstrated that medical students in general assess their own knowledge of Aboriginal issues as less than adequate. Students born overseas tended to rate both their knowledge and their contact with Aboriginal people as particularly low. The high proportion in the student population of students born overseas, which has increased since this survey was undertaken, must be taken into account when planning curricular activities, since many will bring little knowledge of this area to the learning experience.

The medical school has an important role to play. Many students cited their medical training as a critical influence on their understanding of Aboriginal health and cultural issues, despite the fact that the Faculty offered minimal teaching in this area. Over 50% of students ranked the teaching they received at university as one of their top three influences.

One potential influence identified in the survey, with ramifications for future undergraduate teaching, is the powerful role Aboriginal medical students within the student group and Aboriginal doctors as teachers and mentors could play in developing students' knowledge in this area. Similarly, the fact that any past personal relationships with Aboriginal people was regarded as significant (whether ongoing, casual or fleeting) has ramifications for future teaching.

Most students believed they were unlikely to work in the future with Aboriginal people, and therefore that teaching in Aboriginal health had tangential relevance to their professional lives. These beliefs were often informed by inaccurate perceptions of Aboriginal people as geographically remote and of Aboriginal health as an area dealt with completely outside of mainstream services. Our results suggest that the practical relevance of teaching about Aboriginal health needs to be clarified for students. The next chapter further explores student responses to teaching in Aboriginal health.



# Chapter Five: Survey of Student Attitudes towards Teaching in Aboriginal Health

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## 5.1 Introduction

At the time that the focus groups and surveys were conducted, students were receiving very little formal teaching and, as has been discussed previously, there was anecdotal evidence that a number of students were responding fairly negatively to this teaching. There was also anecdotal evidence that informal teaching was influencing students, but the nature of this teaching was unclear: who was conducting it, how many students was it reaching, and how was it being received by students?

Amongst the fifth-year students who participated in the focus group discussions, there was general disappointment about how little teaching on Aboriginal health and related issues they were receiving at a tertiary institution, especially from students who reported positive school teaching experiences. Some students described constructive learning experiences within the Faculty, but these had been very 'hit and miss'. Others reported quite negative clinical experiences. Some expressed frustration that their formal learning on Aboriginal health and related issues had hardly amounted to any more than 'a snapshot'. Individual students expressed various positive and negative reactions to this small amount of formal teaching on Aboriginal health, but it was difficult to extract any common themes from the range of comments made.

This chapter reports evaluation data obtained from students on their attitudes towards teaching in Aboriginal health (see Appendix Four).

Our specific objectives were to:

- elicit students' attitudes to Aboriginal health teaching in general;
- identify the extent of informal teaching on Aboriginal health;
- elicit student opinions on current formal and informal teaching in Aboriginal health; and
- elicit student opinions on future teaching in Aboriginal health.

## **5.2 Methodology**

### **5.2.1 Survey Content**

The study instrument was a questionnaire delivered to students in first-, fourth- and fifth-years (see Chapter Four for description of development and delivery of this questionnaire). First-year students were invited only to answer the more general questions on Aboriginal health teaching, as they had had minimal contact with the existing Aboriginal health teaching program.

The students surveyed were asked to complete a 5-point scale regarding how important it was for them to learn about Aboriginal health and related issues such as Aboriginal history, culture and politics. They were then invited to explain this further in their own words. The scale was described to students as follows: 'unimportant' — 1, 'important' — 3, and 'extremely important' — 5. Students were then asked to list possible benefits and possible disadvantages of learning about Aboriginal health and related areas such as Aboriginal history, culture and politics as part of the medical curriculum. Students were invited to complete a similar 5-point scale as to the perceived level of adequacy for their year-level regarding the amount of teaching on Aboriginal issues that they had received. With respect to future teaching, students were also asked: whether they thought Aboriginal health should be taught as a set subject or as a subject incorporated into a wide range of existing subjects; when they would prefer a set subject in Aboriginal health to be taught; and what issues or topics they would like to have included in any teaching. They were invited to give any other suggestions as to how Aboriginal health teaching could be improved.

In addition, students were asked to report instances of informal teaching in their training. Informal teaching was defined for this survey as any teaching outside of formal or elective teaching time specifically dedicated to Aboriginal health (lectures, tutorials, seminars and Advanced Study Units in Aboriginal health). This informal teaching included bedside teaching, clerking of patients, case presentations, tutorials, and lectures in other areas of Medicine where some aspect of Aboriginal health was discussed.

### **5.2.2 Data analysis**

Data obtained from Likert scales were aggregated into frequency tables using SPSS. Data from open-ended questions were coded using codes generated by a thematic analysis of the data (see Chapter Four for description of coding).

## **5.3 Results**

Participation rates and demographic details of the sample population are presented in Chapter Four. Not all questions were answered by all students. Response rates and respondent numbers to specific questions are listed below where appropriate.

### 5.3.1 Student evaluation of the role of Aboriginal health teaching

#### Perceived importance of learning about Aboriginal health

All 403 students responded to the Likert scale on perceived importance of learning about Aboriginal health. Three-hundred-and-thirty-one students (82%) rated learning as 'important', 'very important' or 'extremely important'. Of the fifty-three students who gave reasons why Aboriginal health teaching was unimportant or of only minimal importance: 28% stated that it was because Aboriginal people were a minority; 28% stated that it was because the area was not relevant to their future work; and 5.7% stated that it was because of course workload.

Of the 282 students who gave reasons as to why they ranked Aboriginal health teaching as 'important', 'very important' or 'extremely important': 44% spoke of general knowledge as Australians/Australian doctors; 22% commented on Aborigines as an important part of Australia historically and culturally; 18.4% spoke of the poor health status of Aboriginal people; and 24% spoke of the importance of improving Aboriginal people's health status and quality of care.

#### Perceived advantages and disadvantages of learning about Aboriginal issues

Three-hundred-and-sixty-two (90%) students responded to the question on possible benefits of learning. Only 197 (49%) identified possible disadvantages. A large number of students spoke of the benefits of learning about Aboriginal health in a cultural, historical and political context, particularly in terms of improving quality of care or addressing health needs in general. The majority of these students also spoke of the benefits of learning in terms of broader factors such as general knowledge as Australian doctors or in terms of understanding a group who they regarded as holding a special and important place in Australian society.

**Table 5-1. Medical students' perceived benefits of learning about Aboriginal health and related issues (n=362) <sup>1,2</sup>**

BENEFITS OF LEARNING	NUMBER OF STUDENTS (%)
To improve health status or quality of care	182 (50%)
To increase general knowledge as Australian doctors	110 (30%)
To reduce racism	99 (27%)
To better understand the social origins of health	52 (14%)
To increase the number of doctors interested in Aboriginal health	37 (10%)
Cross-cultural applicability	24 (7%)
Other	14 (4%)
No advantage	3 (0.8%)
Number of responses from 362 students	521

<sup>1</sup> 41 students did not answer this question

<sup>2</sup> Categories are not mutually exclusive

Year-level affected the particular perceived benefit listed by students. Students in first-year were more likely to select 'to increase general knowledge as Australian doctors', fourth-year students were more likely to select 'to improve health status or quality of care'; and fifth-year students were more likely to select 'to better understand the social origins of health' when compared to the other years (see Table 5-2). Fifth-year students generally have a broader understanding of health and illness and are more likely to understand these concepts.

**Table 5-2. Percentage of students in the three year-levels who identified particular benefits to learning about Aboriginal health and related issues**

PERCEIVED BENEFIT GIVEN	YEAR 1	YEAR 4	YEAR 5	$\chi^2$	P
To increase general knowledge as Australian doctors	46.4%	35.4%	17.3%	7.07	0.03
To improve health status or quality of care	31.9%	41.2%	26.1%	12.8	0.002
To better understand the social origins of health	19.2%	30.8%	50%	19.3	<0.001

**Table 5-3. Medical students' perceived disadvantages of learning about Aboriginal health and related issues (n=197) <sup>1,2</sup>**

DISADVANTAGES OF LEARNING	NUMBER OF STUDENTS (%)
Adds to an overcrowded course	78 (40%)
Area not seen as relevant to future work in Australia	35(18%)
May increase racism	28 (14%)
Focuses on a minority of the population	25 (13%)
Poor teaching in this area	22 (11%)
Will be working overseas (so not seen as relevant)	5 (2.5%)
Other <sup>35</sup>	41 (21%)
Number of responses from 286 students	323

1 206 did not identify any disadvantage

2 Categories are not mutually exclusive

<sup>35</sup> 'Other' is quite a large category as a number of students spoke of issues that did not relate to the question. These comments, by and large, were repeated elsewhere. This category also included students who spoke of difficulties dealing with their emotions in relation to the topic, students who were angry about having to be examined on the area, and students who felt that other minorities were far more important.

## Cross-cultural applicability

I was interested to see how many students could identify the translation of cross-cultural principles as one benefit of learning about Aboriginal issues. Only a minority of students (6.6% of those that responded) identified this as a potential benefit.

One Australian-born student saw this as a key benefit, believing that it was better to gain a greater understanding of one cultural group than to be covering a large number of minority groups at a superficial level:

*The concepts of working with and caring for people of minority groups or different cultures are more important than specifics, but often the best way to appreciate this is to gain a better understanding of one particular group.*

One Malaysian student saw that he could apply such teaching back home after graduation:

*Can be applied to other minority groups - generalisable in most clinical settings.*

## Learning and racism

There was a degree of mixed feeling with respect to how students viewed the possible impact of learning on racism. Twenty-seven percent of students who responded to the question on potential benefits of learning about Aboriginal issues (25% of students surveyed overall) saw learning associated with a reduction in racism. On the other hand, 9% of students who responded to the question on potential disadvantages (7% of students surveyed overall) stated that they feared learning could lead to an increase in racism.

Students who saw potential benefits in this area spoke mainly of the valuable impact of knowledge on increasing understanding, changing attitudes and shifting 'negative myths' or 'stereotypes' and 'the fostering of a greater respect'. Others spoke of the role of doctors in promoting greater tolerance towards Aboriginal people by others in the community as a result of learning themselves.

*While it was a much smaller group of students who articulated concerns that learning could lead to an increase in racism, the themes they raised were reiterated on a number of occasions throughout the survey. One theme relates to students' concerns over the treatment of difference in the community. The following comment exemplifies those made by a number of students:*

*Often puts them into a different category as a special group. Best to avoid treating them as a special group and to treat them as you'd treat any people in society.*

Some students believed that a little bit of knowledge might lead to arrogance:

*Medical students will then feel that they 'know it all'. They need to have experience dealing with Aboriginal people in a non-patronising manner.*

Others were concerned that learning might create or force generalisations:

*Students may be led to make generalisations about Aboriginal people and, if these are assumed of Aboriginal patients in the future, problems will arise. Stereotypes are invariably unintelligent ways to look at people.*

*Bias towards Aborigin[es] as being different. Prejudice against all Aborigines as having health problems.*

Some students felt that learning could simply encourage the expression of racist views, somehow endorsing these views or making them real in their expression rather than helping to shift them. Others stated that learning might lead to stereotyping early; that students should be left to develop their own ideas once they are practising.

### **5.3.2 Student evaluation of past teaching experiences**

A number of students surveyed, especially those born in Australia, were frustrated by the small amount of teaching which some felt did not go any further than material they perceived as common knowledge. These students commented that such piecemeal teaching could only be very general or superficial. Students also identified problems with short, isolated lectures or a morning of lecture material, as was the case with the fifth-year students, where the teaching is not placed in a broader context. Approximately 8% of students who responded also commented on a lack of overall coordination in the teaching, which meant that even though there was only minimal teaching, the same material was often touched on by different lecturers.

#### **Informal teaching**

Informal teaching was referred to by only thirty-nine fourth- and fifth-year students (16.2% of students in fourth- or fifth-year). Several of the students who did mention instances of informal teaching mentioned more than one (Table 5-3).

**Table 5-4. Informal undergraduate teaching in Aboriginal health as identified by the fourth- and fifth-year medical students surveyed (n=39)**

PARTICULAR INSTANCES OF INFORMAL TEACHING DESCRIBED BY STUDENTS	NO. OF STUDENTS
Bedside tutorials	13
Clerking patients	7
Community Medicine country rotations	9
Case presentations and non-bedside tutorials	7
Advanced Study Unit (ASU) other than the ASU in Aboriginal health	3
Lectures - other	3
Student group meetings (TWIG, OUTLOOK) <sup>36</sup>	5
Total amongst 39 students	47

From students' comments, it appeared that most of this informal teaching focussed primarily on general medicine. Only a couple of students made any mention of Aboriginality being discussed in any broader sense or of social, cultural and family issues being discussed. Only one student made any specific comments about the actual process of this teaching. This student had had a fairly negative experience.

*Judgmental account of HBV-positive [Hepatitis-B virus] Aboriginal mother and her problems with CSV [Community Services Victoria]. Poorly handled case of young pregnant girl (15 and second child) with Condylomata accuminata.*

### **Evaluation of formal lecture content**

Of the 175 students who responded to these questions, 106 (61%) found the content of the lectures useful. These students generally appreciated: factual information on health problems in the community; information about cultural issues; learning about management issues; and gaining some insight into Aboriginal perspectives on health.

Forty percent of those who responded found some aspect of the lecture content problematic. One common theme in this group was that general discussions of Aboriginal health statistics were dull and of little use in promoting much meaningful discussion. Other themes related to difficulties students had with the relationship between history and health and a criticism of teaching as being 'politically tainted'. There was a large group who found it difficult to see much relevance in talking about issues that were seen as 'political' or 'historical' and, therefore, somehow not dealing with health 'directly'. Others criticised the teaching as being 'too emotive' or 'biased'. This criticism was levelled at both non-Aboriginal and Aboriginal teachers.

<sup>36</sup> TWIG (Third World Interest Group) was a student group that was later replaced by OUTLOOK, another student group with an interest in Indigenous, rural and 'third world' health.

## **Evaluation of teaching methodologies**

Teaching methodology was the area where relatively more students, of the 175 who responded, voiced criticism. With respect to the lectures, 44% of the students who responded expressed some criticism of teaching methods used, whereas only 12% specifically appreciated an aspect of teaching methods.

### **Compulsory teaching**

Of the 175 students who responded, some students reflected on how lectures were a boring and dry way of teaching. Teaching Aboriginal health through large lectures was regarded as difficult in that students could not adequately deal with emotions which came up as a result of the material being discussed and, in fact, this style of teaching often compounded them. Others spoke particularly unfavourably of the attempt in fifth-year to provide students with an opportunity to voice their opinions more openly about Aboriginal issues in a slightly smaller group (groups of sixty students).

### **Advanced Study Units**

Of the students surveyed, twenty-seven had done an ASU on Aboriginal Health (sixteen fourth-year students and eleven fifth-year students). These ASUs had involved approximately eight hours of small-group teaching, direct contact with Aboriginal people and self-directed learning. Generally those who had done an ASU found this style of learning more beneficial than lectures. Whilst four of these twenty-seven students criticised the overall organisation of the ASU, all twenty-seven spoke positively of the experience and stated that this was where their most valuable learning had taken place. What students most appreciated were the methodologies used. Students found it valuable working in small groups, doing their own independent research and having direct contact with Aboriginal people. Although a few students found it very confronting and difficult talking in small groups with Aboriginal people, most appreciated being encouraged to talk about the issues. It is important to remember, however, that these students were a self-selected group who had specifically chosen to do an ASU in Aboriginal health.

### **Evaluation of contact with Aboriginal people**

Many students commented on the lack of contact with Aboriginal people generally in the teaching, particularly the fifth-years who had received their fifth-year teaching in Aboriginal health by a non-Aboriginal doctor working in the field. Generally, where there had been contact with Aboriginal people, students responded to this favourably, with the exception of visits to VAHS. These visits, also viewed extremely unfavourably by staff at VAHS (personal communications with VAHS staff), had involved large groups of students virtually 'descending' on the health service for one-off visits. Students generally felt awkward and 'unwelcome' and often found it difficult to understand why they could not simply sit in with patients as they did on virtually all other field trips. This frustration over a lack of clinical contact was a major theme.

### **Impact and adequacy of these teaching experiences**

Two-hundred-and-thirty-five (97.5%) fourth- and fifth-year students responded to the question on the degree of influence they attributed to their medical teaching on Aboriginal issues. One-hundred-and-fifty-five students (66%) felt they were 'moderately, significantly or highly influenced' by this teaching.



At the same time, however, the majority of students (65%) thought their teaching was not adequate, while only 3.6% of students thought it was more than adequate (n=276).

### 5.3.3 Student attitudes to future teaching

Ninety-one percent of students (n=385) wanted to see Aboriginal health teaching incorporated into a range of existing subjects, whereas only 21% wanted it to be taught as both a set subject and an incorporated theme for other subjects.

Slightly over half the students, 55%, responded to an open question in the survey about what they wanted to learn (Table 5-5).

**Table 5-5. Most commonly requested topics to be included in any Aboriginal health teaching amongst medical students surveyed (n=223)<sup>1</sup>**

TOPICS MOST COMMONLY REQUESTED BY STUDENTS	PERCENTAGE OF STUDENTS
Health statistics or health information	51%
Aboriginal social and cultural systems	40%
Contemporary issues	13%
Aboriginal history	9%
Traditional medicine	5.4%
Aboriginal politics	4%

<sup>1</sup> Categories are not mutually exclusive

Almost 20 % of this group found it very difficult to be specific and described feeling at a loss as to what to recommend, or made general comments such as 'everything'. This was particularly the case with the first-years. When considering any further improvements, half the respondents requested further clinical teaching with Aboriginal patients.

### 5.3.4 Structural issues relating to Aboriginal health teaching

#### Effects of teaching Aboriginal health as an isolated subject

A number of students expressed considerable frustration that they had not received very much teaching about other cultural groups, particularly those cultural groups with whom they had experienced considerable contact in hospitals, or those with which they perceived they would have far more contact with once they graduated.

*Learning about Aboriginal health and related issues is important but only as part of learning about other cultures and health. For example, Vietnamese, Indians, Chinese, Italians, Greeks etc. [Student's emphasis]*

*Aboriginal culture is one of many cultures we need to learn about. [Student's emphasis]*

*Aboriginal culture is one relevant culture we will be exposed to in practice but is only one of many different cultures which I feel should be given appropriate teaching.*

For a number of students, any learning about Aboriginal people appeared to quickly trigger anger or frustration about the lack of teaching they had received about other cultural groups, or that other 'more important' cultural groups were being neglected or would be neglected by virtue of any attention to Aboriginal issues.

*Aboriginal health teaching will remove focus or sacrifice other relevant areas, for example, the health status of, say, migrant groups - also a neglected area of teaching [with regard to people with] special needs (cultural, etc).*

### **Treatment of social issues in Medicine**

A minority of students were extremely vocal about their resistance to any learning which adopted perspectives outside those of the majority of their teaching, seeing it as unimportant and irrelevant to medical education.

*Don't need to learn about any specific group, especially not the history, culture, politics, which is irrelevant. [Student's emphasis]*

Several students commented that existing ways of trying to teach social and cultural understanding of health fitted poorly within the medical structure. Many students saw this area as peripheral, and that it should not be part of their formal assessment.

*Whenever culture is taught in a medical course, the teaching is so broad that the area seems boring and irrelevant. Practical experience of shelters, clinics and people [seems] far better.*

*Having to be examined on it. It's ridiculous! Especially politics, culture, etc. If it relates directly to special health problems, then that's reasonable.*

Some students expressed reservations about different teaching approaches intended to raise self-reflectiveness being used in Aboriginal health, but not, they felt, elsewhere in the course.

*The seminar that preceded the Aboriginal Health Lecture in Comm. Med. 5th year. It seemed like a session for people to air their racist comments and have them listened to. We all have prejudices but why was time put aside to consider them for Aboriginal health but not, for example, for sexual health — because they are more acceptable?*

### **Effect of overcrowded courses**

A recurrent theme in the survey data was that many students experience Medicine as an extremely overcrowded course and often feel overwhelmed by the amount of material they have to learn. Many students' comments reflected an ongoing juggling of priorities, with students feeling they had to become their own arbiters of what was important because there was simply 'too much to learn'. Social health areas were often selected as one of the first things to 'go' in this prioritising. Some students described a sense that time was being 'wasted' when it was given to these areas. Others described a sense that when something like Aboriginal health was taught, an almost inevitable feature in a course seen as bursting at the seams would be that another thing, probably more important to medical practice, would be lost.

*Every subject has a limited number of hours and all of them seem to want more! Thus lack of time is a major issue — need to focus or emphasise more on issues regarding everyday practice.*

*It's rather important, but needs to be put into perspective with the incredible amount of work that needs to be covered in six years.*

A few students thought differently and argued that the course could be rationalised considerably, enabling social health areas to be taught more fully. They called for:

*Notions of responsibility towards particular minority groups in the community within the course.*

For a minority of students the fact that Aboriginal people represent only 2% of the population was a real barrier to learning and to perceiving the area as important.

*Teaching about Aboriginal health is a waste of time. It is a distortion of the ethnic mix of Australia.*

*A disproportionate amount of time is allocated to [Aboriginal] health issues when compared to population.*

The majority of students, while regarding Aboriginal health as important, also had real trouble grappling with the issue of the special needs of a minority group as opposed simply to the number of people involved. Students holding the view that the Medical course was already overcrowded often commented to this effect:

*The state of Aboriginal health is very poor but the proportion of Aborigines in Australia is not that high.*

*Other issues are of greater impact to a greater number of people.*

Finally, there was a sense that, in the face of these various factors, areas like Aboriginal health can only be tolerated if they are taught exceptionally well.

*If very good - only if very good - can be taught. [Student's emphasis]*

### **Notions of responsibility as doctors and as Australian citizens**

Although many student responses suggested they had difficulty understanding institutional barriers faced by Aboriginal people in the health system, many also (and often at the same time) presented a strong sense of responsibility as both future doctors and Australian citizens in a more general sense:

*To be leaders, healers and citizens in the wider community - otherwise we can just add to the problem by being ignorant and in positions of power.*

*The state of Aboriginal health, standard of living etc, is a problem we face as a nation [and one] that medical students and doctors have a significant role in changing.*

*Though I'm not likely to meet a lot of Aboriginal patients, I will still have to endeavour to give best care possible.*

Implicit or explicit in a number of the students' comments was an acknowledgment of past wrongs, and a desire to work towards reconciliation:

*For Australians to stand a chance at long-term reconciliation, we must first of all address the inequalities in opportunity provided to Aboriginal people.*

While such perspectives on the role of doctors were articulated by the majority of students, they were by no means universal:

*I'm a doctor not a politician, social worker, freedom fighter.*

### **The role of an undergraduate curriculum in Aboriginal health**

A number of students perceived the university as the only place or their last chance to learn something about Aboriginal issues, given their lack of exposure elsewhere and their sense of responsibility towards the area.

*We will be exposed to Aborigines in clinical practice and they need to be approached in a slightly different manner to non-Aborigines - medical course is the only chance many of us get to learn about the necessary skills and information.*

*Medical students [mostly] do not come from backgrounds where they have been exposed to Aboriginal people and their culture.*

*Learning at university is important in order to counter the media reportage. If no one teaches the facts - our views will mainly be biased on the way media portrays the issues. This is not ideal when wanting to help all our patients, Aboriginal or non-Aboriginal, in regards to health.*

## 5.4 Discussion

Our study showed that the majority of students (82%) surveyed believed that teaching about Aboriginal health and related issues was important. It is worth noting that Aboriginal and non-Aboriginal people who had taught Aboriginal health to medical students frequently believed that one of the factors that made teaching seem so difficult was that students simply were not interested in the area. Among the students we surveyed, this was clearly not the case.

The university was seen as having a special and vital place in teaching students about this area. Our findings confirm that even a small amount of teaching can have a significant impact on students. Of the fourth- and fifth-year students who ranked the impact of Aboriginal health teaching they had received, 45% said they were moderately influenced and 21% stated they had been significantly or highly influenced by the teaching. Although there may be a positive bias in these findings, in that students who found teaching influential may have been more likely to respond to the question, the fact that fairly minimal teaching could be so rated is still of interest.

### 5.4.1 Teaching strategies

Lectures were successful in giving factual information on health problems and cultural issues, in learning about management issues and in gaining some insight into Aboriginal perspectives on health. However, they were also described as boring and dry, and students described difficulties understanding the relevance of history and culture in isolated lectures. Students were often critical of the lack of contact with Aboriginal people, and attempts to teach Aboriginal health differently with still fairly large groups of students had not been particularly successful for students.

Informal teaching was certainly occurring but was referred to by only a minority of students (16% of fourth- and fifth-year students). It did not appear that it was occurring to the extent that I envisaged prior to conducting the surveys. It was difficult to gauge much about the nature of this teaching from students' comments. The fact that so few students specifically evaluated informal teaching experiences may have been because the teaching was fairly minimal or that the processes of teaching (such as bedside tutorials and case presentations) are viewed as the standard 'bread and butter' methods of teaching and did not warrant any specific evaluation.

Whatever teaching strategies had been employed, students described difficulties dealing with their emotional reactions to the material being presented. Again, this supports earlier findings that an important future teaching strategy would be to create a safe environment in which students can explore these emotions, particularly with complex issues such as racism, without being overwhelmed by them.

Students tended to request more clinical contact with Aboriginal people - either as patients or in clinical settings such as the VAHS. These requests need to be interpreted in the light of students' own limited contact with Aboriginal people. Although clinical contact is one of the main teaching tools in Medicine, some students may want clinical contact because of a

degree of uncertainty that they feel about themselves in relation to Aboriginal people. Clinical contact sets students up in a particular relationship which is governed by a familiar set of rules for themselves as student and future doctor, where they may feel less exposed or less vulnerable. It is important, therefore, to set up a variety of opportunities in which students can explore relationships with Aboriginal people.

These teaching requests highlight the potential differences between what students want taught and what Aboriginal people may want taught, and how essential it is to involve Aboriginal people in curriculum development.

### **5.4.2 Integrating Aboriginal health into the medical curriculum**

Our findings suggest a need to develop Aboriginal health as a vertically and horizontally integrated stream throughout the medical course. What this means is that students would learn about aspects of Aboriginal health and be exposed to Aboriginal issues throughout the year-levels (vertical integration) and that this teaching would also be woven into a range of subjects and disciplines in each year (horizontal integration).

With culture, class and race being taught as broad issues, horizontal integration would be made even stronger. Specific teaching on Aboriginal issues could then be integrated into this teaching by way of example. Our research found that teaching Aboriginal health without a broader cross-cultural course made students very hostile to any teaching on Aboriginal issues. Isolated lectures in this area, which are not properly coordinated or thematically related to other teaching, also run the risk of seeming very piecemeal to students and become 'bracketed off' in their minds. Students can respond very negatively to even a small amount of teaching as it can quickly seem like 'cultural overload' or simply just some 'insight into yet another culture'.

Such integration provides an opportunity to incorporate social, historical and political approaches to health as valid perspectives. Understandably, students can think that the treatment of social, historical and political perspectives takes less time or is at best, very vague or simplistic, if their experience has been that it has received such little time compared to other issues. They may subsequently feel that such perspectives are of only minimal usefulness. Students can think that the only legitimate way to learn about an area in clinical medicine is to have contact with patients if again this is their dominant experience. Thus teaching can run the risk of having very little impact or of alienating students if the context in which it occurs and the framing of health problems appear to be an aberration from students' main learning experiences.

Vertical integration would mean that learning could be built on with each year and that a curriculum could be properly developed with the involvement of the Aboriginal community. This would mean that the different learning requests of students in different year-levels could in fact be met to a significant extent. Our findings suggested that students certainly do have different educational needs at different stages in training. First-year students, for example, emphasised the importance of gaining broad general knowledge, while students in their latter years were more likely to emphasise clinical aspects. Even with minimal teaching, these students demonstrated, at least in part, a greater depth of understanding of the causes of poor health.

An integrated approach would also help resolve some of the tension students expressed between their own sense of responsibility and citizenship and their difficulty applying this to Aboriginal health within the medical course. While the majority of students had a clear notion, at least at a theoretical level, of responsibility and citizenship as Australian doctors in relation to the overall issues of Aboriginal health, most were not aware of structural issues such as institutional racism nor were they able to incorporate them into practice. Students almost universally thought only in terms of who would come through their door or who would be 'presented' to them in their capacity as doctors. Isolated lectures cannot adequately assist students to make such shifts in their thinking if such work is not developed to some extent throughout the course.

## 5.5 Summary

Students come to the area of Aboriginal health teaching with a number of strengths or factors that may support or enhance learning. Many students come to the area of Aboriginal health with a strong sense of responsibility, both as doctors and as Australians.

The vast majority of students surveyed regarded the university as having a special and important place in teaching students in this area and most perceived their current level of knowledge about Aboriginal health and related issues to be less than adequate. Many students found it difficult to see how the area would be relevant to their future work as doctors; some thought that learning may increase racism, whilst others found it difficult to deal with the issue of focussing on minority groups in general. Few could identify any cross-cultural applicability through the teaching.

Informal teaching was occurring but was referred to by only 16% of fourth- and fifth-year students and it was difficult to gauge from comments made by these students the real impact of this teaching. Most students requested that teaching be properly integrated into a range of subjects being taught and only some saw the relevance of also teaching Aboriginal health as a core subject. Requests for learning were fairly general, reflecting students' existing frameworks for understanding Aboriginal health. Requests for clinical contact were also prominent.

Finally, the survey demonstrated that future teaching should address key structural issues if it is to be successful. These structural issues are addressed in the next chapter, in which key factors which can act as barriers to learning about Aboriginal issues and those that can facilitate learning in this area are identified. Many of these issues are quite unique to the area and are not necessarily brought to bear on most of the general teaching in Medicine. There is clearly a significant potential for teaching to be successful for those involved if a number of potential barriers to learning are addressed.





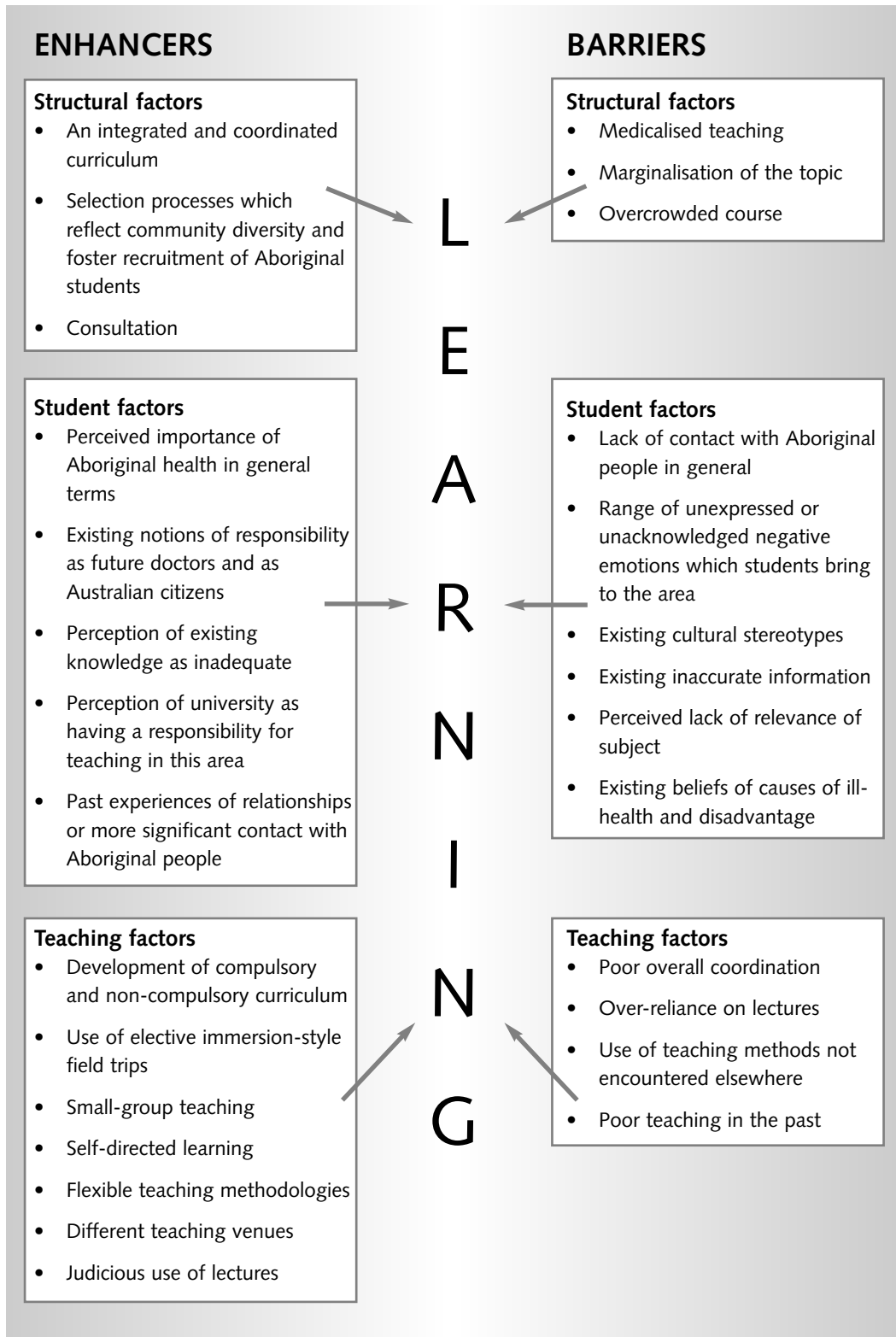
# Chapter Six: Future Directions

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## **6.1 Barriers and enhancers to learning about Aboriginal health: a model**

In this chapter key factors identified in the needs assessment as barriers and enhancers to learning about Aboriginal issues have been drawn together to develop a model. The three broad areas that emerged from the needs assessment as being necessary components to consider in effective learning about Aboriginal issues are structural, teaching and student factors. Outlined below is a model for teaching using these categories. Each factor in turn is discussed in more detail.

**Figure 6.1 Barriers and enhancers to learning about Aboriginal health: a model**



## **6.2. Barriers to learning about Aboriginal health and related issues**

### **6.2.1 Structural factors**

#### **Medicalised teaching**

One key structural barrier for learning about Aboriginal health is the situation where social, historical and political understandings of health and illness are not properly studied and are not centrally incorporated into the undergraduate course. If these perspectives remain marginal in some way or are seen as less important to 'real Medicine', teaching Aboriginal issues will remain extremely difficult. In this context, teaching can also remain less successful if it is derived from only one discipline. Allied to this, a further barrier identified in the surveys and the literature review was how negatively students viewed teaching if there was not a strong fostering of a notion of responsibility towards particular minority groups in the community throughout the course.

#### **Marginalisation of the topic**

Teaching Aboriginal health as a discrete topic is another key barrier to learning. Where teaching was not organised within the context of a well-organised cross-cultural course, it often triggered feelings of frustration at the lack of teaching about other cultural groups who were more frequently encountered by the students. This separation also meant that key cultural concepts needed to be taught first within the allocated time for Aboriginal health.

Teaching within a broadly based cross-cultural course would also help address the learning needs of the increasingly culturally diverse student group (both overseas-born Australian students and international students intending to return to their country of origin after graduation). In this context, teaching could draw on the experiences of these students with respect to broader cultural issues and the situation for Indigenous people in other countries. Students could be engaged through processes of reflecting on what unites and what distinguishes both themselves and other Indigenous groups from Indigenous Australians.

#### **Overcrowded course**

Students commonly described feeling overloaded by the medical course. If the course is perceived as overcrowded, students have little tolerance for any teaching that seems to take their focus away from the 'hard sciences'.

### **6.2.2 Teaching Factors**

#### **Poor overall coordination**

When teaching is poorly coordinated overall, students feel resistant to learning. If university teaching is repetitive or does not develop from what many students have learnt previously from the media or their schooling, students can believe that that is all there is to learn and feel increasingly distanced and frustrated by the topic.

### **Unhelpful teaching methodologies**

Teaching which relied primarily on lecture-based delivery was a significant barrier to learning. Paradoxically, however, where teaching attempted to use more reflective teaching methods, these were also viewed unfavourably by a number of students as they were outside those methods commonly encountered by medical students. If more innovative teaching methods are to be used, students need to be properly prepared and supported. Alternatively, new methods need to be used elsewhere in the course as well, so that they do not become barriers to learning simply by virtue of their 'foreignness'.

Not surprisingly, a lack of involvement of Aboriginal people in teaching was another identified barrier to learning. On the whole, however, the survey suggested that even when teaching staff are not culturally the most appropriate, where teaching methodologies are not ideal, and when hours devoted to the topic are quite minimal, teaching can still significantly influence students' attitudes.

### **Poor past teaching experiences**

Poor past teaching experiences, whether at school or at university, clearly negatively influenced students' approach to the material. Students' experience of an 'arrested' teaching at school, for example, affected their capacity to conceive of legitimate and diverse Indigenous communities in contemporary society. Teachers need to be aware of the diversity of student experiences and give students the opportunity to air perceptions they may have gained from prior learning.

## **6.2.3 Student factors**

### **Lack of contact**

Students' overwhelming lack of contact with Aboriginal people in general was a common theme throughout the needs assessment. Students had relied on fleeting experiences, events they had observed or experiences they had heard about second-hand to structure their approach to Aboriginal people. These experiences generally had a negative impact on students' perceptions of Aboriginal people and presented a significant barrier to learning. Therefore, one of the most important aspects to any teaching in this area is that methodologies adopted should foster relationships between a range of Aboriginal people and students.

### **Emotions**

For students, learning about Aboriginal health involves the interplay of deeply felt, often half-acknowledged emotions. The focus groups in particular identified a wide range of emotions which students bring to learning about Aboriginal health. Students may feel overwhelmed by the level of loss and the scope of the problem; they may feel guilt or anger, towards Aboriginal, non-Aboriginal people and government; they may fear Aboriginal people's anger; or feel a general sense of anxiety about having closer associations with Aboriginal people. Such powerful emotions may act as 'brakes' to attempts by students to engage with the subject matter.

Successful teaching therefore needs to ensure that students are taught in such a way that they can understand their pre-existing emotions. However, Aboriginal people need to be involved in a way that ensures that both students and Aboriginal tutors are supported enough for emotional issues to be dealt with and for interactions to go well. Solution-focussed examples would also help students appreciate where positive changes are happening and the conditions required to achieve such change (the importance of self-determination, examples of more culturally appropriate health care, positive examples of primary health care approaches to problems, etc).

### **Existing beliefs about Aboriginal people**

Students bring to teaching a range of positive and negative cultural stereotypes. Many students hold a belief that Aboriginal culture and Aboriginal people embody an extreme foreignness compared to other cultures and that the community is less approachable or less accessible for students to understand as a result. Another commonly expressed perception was the binary opposition of Aboriginal 'contemporary' culture with 'real' Aboriginal culture firmly located in the past or in a far-off location.

Students expressed difficulties dealing with the process of defining who is Aboriginal and demonstrated a significant lack of understanding of the vitality, complexity and dynamism of contemporary Aboriginal culture, particularly with respect to urban and rural culture. Students also tended to polarise the issue of maintenance of a separate culture into assimilation versus integration.

Again, teaching that facilitates constructive experiences in engaging and interacting with Aboriginal people would help to gradually break down these perceptions. Non-Aboriginal facilitators and Aboriginal facilitators working together to model the possibilities of relationships may also help address this sense of extreme foreignness articulated by students. In addition, having a wide range of Indigenous voices through writing and film and Indigenous facilitators of varying ages, expertise, views and experiences, may help students better understand the complexity and diversity of contemporary Indigenous communities.

### **Inaccurate information**

Students also demonstrated particularly inaccurate information in two key areas: namely, a lack of understanding of where Aboriginal people live, and an inaccurate perception about the amount of funding going into Aboriginal health. This first perception served to make learning seem of little relevance to the students' current situation and to their future work. The second, in a number of cases, fueled feelings of anger, or contributed to a sense of frustration that the problems in Aboriginal health had not been 'solved'.

Along with obvious inclusions to curriculum content, having teaching which is primarily locally based (in our case, focussing on both urban and rural communities), and placing small numbers of students in community-controlled organisations and with Aboriginal Hospital Liaison Officers would go some way to addressing this. Another possibility would be developing a pool of Indigenous actors who could 'play' the roles whenever simulated patients are used as part of the usual teaching.

### **Perceived relevance of the subject**

Many students believed that the subject had relevance only to those students who may work specifically in Aboriginal health or, to a lesser extent, in rural or remote localities. In addition to a poor understanding of where Aboriginal people live, this was often informed by a belief that Aboriginal people are not part of the mainstream health system. This meant that they often did not see themselves as having any personal responsibility towards Aboriginal health with respect to their future work.

Clearly students will have different learning needs. Some students will be more interested in the area and some will have more contact with Aboriginal people through deciding to work specifically with Aboriginal communities. Ensuring that both core and elective curricula are developed will be important. Nevertheless, all students need an understanding of the key issues to help ensure that Aboriginal people have better access to mainstream health services and are more appropriately managed when they are seen. Through problem-based learning, material could be woven into other areas of the teaching. Aboriginal examples could be developed in different areas of expertise in such a way that is consistent with the overall approach endorsed by local Aboriginal people and by the core teaching.

### **Existing beliefs about causes of ill-health and disadvantage**

The surveys in particular identified that, while students could more readily identify concrete social issues - such as low socio-economic status, poor access to health services, poor resources in Aboriginal health and lack of education - as causes of ill-health, there was a significant lack of understanding amongst students of the central importance of issues such as self-determination, land rights, racism, culturally inappropriate health care and historical legacies, in the poor health status of Aboriginal people.

Students also demonstrated a poor understanding of the institutional barriers which exist for Aboriginal people in accessing mainstream services, and grappled with why Aboriginal people need to be regarded as a particular group in their own right within the context of other minority groups. Framing Aboriginal health teaching within the context of Aboriginal people's history within Australia, cultural differences, relationship to the land, their particular socio-economic circumstances and barriers to health care is clearly central to an improved understanding.

## **6.3 Identified factors that can facilitate learning about Aboriginal health and related issues**

In general terms, it is important to note that as with any area of learning, students bring many other aspects of their own background and philosophy to Aboriginal health teaching which can override potential barriers. Comments made by the students surveyed, particularly those in the earlier years, demonstrated how students often attempted to bring a positive and enthusiastic approach to the area if there had been any experience or learning from elsewhere that they could translate in some way to Aboriginal health.

More specifically, the research identified a number of positive factors that could facilitate constructive learning in the future. These are summarised below.

### **6.3.1 Structural factors**

#### **Integrated and coordinated curriculum**

The experience of universities such as Newcastle has highlighted how the development of a more interdisciplinary approach combined with more progressive attempts to better integrate and coordinate teaching have helped make learning more successful. Findings from the focus group discussions and the surveys clearly support this.

#### **Broader selection processes**

The literature review identified the importance of the development of selection processes for Medicine that both reflect community diversity and actively foster the recruitment of Aboriginal students. The survey also identified the powerful role Aboriginal medical students within the student group, and Aboriginal doctors as teachers and mentors, could have in facilitating learning.

#### **Consultation**

A key recommendation from Federal and State Government inquiries, Aboriginal organisations and medical bodies has been that a range of Aboriginal people and Aboriginal organisations be involved in the design, development and delivery of curriculum. Successful past projects identified in the literature review have also highlighted the importance of developing partnerships between teaching institutions and Aboriginal communities. Unsuccessful past projects also demonstrate the complex issues involved in forming these alliances, as the situation that developed between Melbourne University and VAHS attests.

Other projects outlined in the literature review highlighted the importance of also involving students in the development of programs. Survey results suggest, however, that while student input is essential, it should always be considered in its context and in the light of other consultations. Student requests should not simply be taken at face value, as they often reflect the precise perceptions and beliefs of Aboriginal people that learning is seeking to address. Rather, these requests must be adequately dealt with within the course in order for teaching to be successful.

### **6.3.2 Teaching Factors**

#### **Constructive teaching methodologies**

Several constructive teaching methodologies have been identified by the needs assessment. These include: a combination of compulsory and non-compulsory curricula; immersion-style field trips as a non-compulsory teaching method; different teaching venues informal and flexible teaching methodologies; small-group teaching; and self-directed learning.

The research also suggested that lectures could have a positive role but only if used judiciously and if they are not relied on as the sole teaching method. As mentioned previously, the potential was clearly demonstrated for undergraduate teaching to make a significant difference to students and to be a key influence even if contact hours were minimal.

### **6.3.3 Student factors**

The needs assessment identified a number of factors which students themselves bring to the area of Aboriginal health. These are important to acknowledge in teaching, particularly when teaching and learning can feel overwhelming for both lecturers and students. Lecturers and tutors involved in Aboriginal health need to bear these strengths in mind and draw on them to help facilitate learning.

#### **Perceived importance of the topic**

In the survey, the majority of students believed that teaching about Aboriginal health and related issues was important. There was clearly a tension for them, however, between their support for the topic in a general sense and understanding how this importance might take shape for them in their professional lives.

#### **Existing notions of responsibility**

Throughout the surveys in particular, many students' comments conveyed a strong sense of responsibility both as doctors and as Australians, which they translated to this area of learning in an abstract sense. Once again, however, students had trouble translating this sense of responsibility when thinking about their future work in relation to Aboriginal health.

#### **Perception of existing knowledge as inadequate**

The survey findings demonstrated that the majority of students did not believe that they had a comprehensive knowledge of Aboriginal issues and regarded their current level of knowledge about Aboriginal health, Aboriginal history, culture and politics, and contemporary Aboriginal Australia as less than adequate. An important learning implication here is that despite all the barriers outlined above the students in our study group did not feel that their knowledge was adequate and at that level they did want to learn.

#### **Perception of the university's responsibility around teaching**

Many students regarded the university as having a special and important place for Aboriginal health teaching to occur. In addition, the majority of students stated that the amount of undergraduate teaching they had received on Aboriginal health was less than adequate, suggesting that they supported further teaching.

#### **Past positive contact**

Contrary to the often negative, fleeting and observer experiences of many students, those that had had the opportunity to form relationships with Aboriginal people - whether brief or ongoing - in general had a very different experience. Such relationships almost universally had a positive impact on students' perceptions. It is important therefore that teaching methodologies allow for the opportunities for these students to convey the positive impact of these experiences to other students.



## Section 3:

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### Intervention



# Chapter Seven: Pilot Teaching Project

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## 7.1 Introduction

From the findings of the needs assessment came the pilot project. On the basis of our understanding of the key factors that can act as barriers and facilitators to learning, we trialed an immersion-style process for a small group of volunteer medical students. This chapter will describe the project's aims; its development and delivery; approaches to evaluation and evaluation findings; and general recommendations.

The primary goal of the pilot teaching project was to design, implement and evaluate a new educational model in cross-cultural teaching in Aboriginal health. This model engaged students in a two-phased, sequential learning program. Phase one involved a weekend away at Brambuk, the Aboriginal cultural centre in the Grampians, while phase two involved an urban tour of Aboriginal community-controlled organisations in Melbourne the following week. The project was delivered over June–July 1996 during the semester break and thirty-two students participated.

## 7.2 Project aims

The project was developed with specific aims for both students and those who would be facilitating the learning process. These aims related to the pedagogical approaches taken and to the desired learning outcomes for the students. These aims were to:

- provide students with a series of opportunities to meet and build relationships with a wide range of Aboriginal people;
- develop a range of learning processes which would facilitate this contact between students and facilitators and be a positive and empowering experience for the Aboriginal and non-Aboriginal people involved;
- encourage students to reflect on their own cultural heritage and cultural practice;
- develop a broader and more personal understanding of Aboriginal issues in general;
- gain a greater understanding of both the diversity and the strength of the Victorian Aboriginal community;
- gain an understanding of the role of history, racism (particularly institutional racism), culture, self-determination and land rights in Aboriginal health both in terms of the causes of health problems faced by Aboriginal people and possible strategies for change;
- develop an increased understanding of the importance of the reconciliation process; and
- develop a sense that relationships with Aboriginal people are both possible and potentially positive and rewarding.

## 7.3 Project description: development and delivery

The pilot project was designed during February–May 1996. Initial input was obtained from members of the advisory group (see Appendix 1) and other key individuals with an interest or expertise in cross-cultural teaching (see Section 6.5). Information and advice was also sought from members of the Melbourne Aboriginal community, staff at VAHS, members of staff within the Department of Public Health and Community Medicine and Indigenous staff on campus in other departments. Key steps in the process included student and facilitator selection, pre-pilot meetings with both students and facilitators, delivery of the project, and post-project meetings. These are discussed in detail below. Evaluation processes were also developed and built into the project from the outset, enabling us to adapt the project as it progressed. We utilised a range of qualitative methods to evaluate both the process and the impact of the project. Our evaluation methods and a justification for the approach taken are also discussed below in Section 7.4.

## 7.3.1 Selection

### Student selection

Of the 403 students surveyed in first-, fourth- and fifth-year, approximately 110 expressed an interest in being involved in the pilot teaching project. From this group, thirty-two students were selected to participate in the pilot. Selection was undertaken with consideration given to achieving an even spread across the three year-levels, as well as gender and cultural background where possible. Fourteen students were male and eighteen students were female. One student was Koori. Unfortunately, the vast majority of sixth-year students who had expressed an interest in the project were unable to attend due to study commitments. The final breakdown of students selected is shown in Table 7-1.

**Table 7-1. Year-level of students who participated in the pilot teaching project**

YEAR-LEVEL	NUMBER OF STUDENTS
Year 1	13
Year 4	16
Year 6	3

Students were brought together from different year-levels to help us gauge from the evaluation whether students would benefit most, either personally or in terms of their learning, from a mixed-year arrangement, or whether the program would be best placed in a specific part of the course.

### Facilitator selection

A wide range of Aboriginal facilitators was approached and invited to be involved with the two phases of the project. These facilitators came from a range of different backgrounds, representing both urban and rural communities. Where possible, people were selected who could be involved with both aspects of the project. Approximately double the numbers of facilitators than were needed were invited. Given the demands on most people's lives within the Aboriginal community, this ensured that enough people would still be available on the actual days involved. Thirteen facilitators were formally involved with the Brambuk weekend and eleven were formally involved with the urban tour.

The project supported facilitators who wished to bring family members and friends away with them, and a number of these people also participated at a more informal level throughout the weekend. Four non-Aboriginal facilitators also participated, two of whom had experience in cross-cultural awareness work, the other two having experience working in remote Aboriginal communities.

## 7.3.2 Orientation

### Student orientation

Two planning meetings were conducted with the thirty-two students who were to attend the pilot project. The primary aims of these meetings were: to orient students to the project; to gain an understanding of their current level of knowledge about Aboriginal issues; to listen to students' ideas about what such a pilot project should incorporate; and to encourage a sense of ownership of the project by the students. In addition, possible methods of evaluation were discussed and a series of evaluation options, that students accepted, were developed.

Students were also given a collection of readings designed to provide some orientation to Aboriginal issues. These included specific information on areas that the project would not be covering in any great depth (see Appendix 5). Students worked in small groups to discuss what they would like to achieve from the project and to examine the draft program. Members of the steering committee facilitated each group. Students' learning requests arising from these meetings are summarised in Appendix 5.

By far the greatest area of interest for students was remote health and working in remote communities. Students were also very keen to hear from non-Aboriginal people working in Aboriginal health and to learn about difficulties and satisfactions experienced by non-Aboriginal people in providing health care to Aborigines.

Many of the students' learning requests reflected particular perceptions about Aboriginal people and Aboriginal issues which mirrored perceptions articulated in the needs assessment. Clear themes were: Aboriginal people as a homogenous group with one set of views and needs; a binary notion of culture, an unchanging Aboriginal culture steeped in tradition versus contemporary western culture; and 'real' Aboriginal people and 'real' Aboriginal health being almost solely located in remote Australia. These perceptions were what the project was seeking to address. They were deliberately not addressed in the planning meetings so as to allow evaluation of students' attitudes after the pilot project. Where possible, students' requests were adopted and the program adapted accordingly.

By the end of the two meetings, students had a sense of involvement in the project and their expectations of the learning process were, by and large, aligned with the aims of the project.

### Facilitator orientation

Facilitators were oriented to the project by a number of means according to people's preference and circumstance. Most contact was at an individual level and one general pre-pilot meeting was arranged at VAHS. Five facilitators attended this meeting. Special attention was given to facilitators' past experiences of talking about Aboriginal issues to largely non-Aboriginal groups. Past difficulties were articulated and strategies that could make this process a more positive one were discussed. Some facilitators had done very little work with student groups before, and both the process and content of the project were discussed at some length. Facilitators also decided on the areas they felt most comfortable talking about.

### 7.3.3 Weekend at Brambuk

The Brambuk Living Cultural Centre at Halls Gap in the Grampians/Gariwerd National Park was chosen as the site for the weekend away. The Centre, developed by four of the Aboriginal communities in the south-west region of Victoria in 1990, has an established cultural program of its own and the facilities to deal with a large group of facilitators and students. This allowed us some flexibility in designing our own program. A distant setting, which was under community control and of special significance to local communities, was chosen to 'immerse' students in an Aboriginal place, away from their own familiar environments. As much as was practicable, students and facilitators travelled together to Brambuk so that they could begin to get to know each other more informally before the weekend started. Separate accommodation was arranged for facilitators and students.

The weekend away was designed to be very flexible and to develop its own direction. The program entailed small-group work with facilitators, interspersed with cultural activities coordinated by educational staff at Brambuk. It also allowed for plenty of informal time over meals and breaks which gave students a number of opportunities to sit down together with Kooris and their families. These times were regarded as equally important as the formal program. The Brambuk program, including details of each session is outlined below (Figure 7)

### 7.3.4 Urban Tour

The urban tour was conducted over an afternoon and evening in the following week. It was held a number of days after the weekend so that people had time to digest the learning that had gone on over the weekend at Brambuk. The tour consisted of two distinct sections: visiting Aboriginal-controlled organisations, and a social gathering.

Six Aboriginal-controlled community agencies involved in addressing the health, welfare, housing and various social needs of the Victorian Aboriginal community in the Fitzroy, Brunswick and Northcote areas were visited.<sup>37</sup> Students visited each service in turn and coordinators spoke to the students about the history of their organisation and some of the issues facing Aboriginal people today specific to their area of work. Many also spoke about a number of positive projects going on and their visions for the future. At VAHS, students heard from a liaison officer from the Royal Children's Hospital who spoke about his experience of being taken away from his family at the hospital as a young child. With all the visits, opportunity for questions and comments by students were provided. Where possible, students made further contact with facilitators from the weekend.

37 Agencies visited were the Victorian Aboriginal Health Service (VAHS), the Aboriginal Community Elders Service (ACES), the Victorian Aboriginal Child Care Agency (VACCA), Yappera (an Aboriginal child care centre), the Aboriginies Advancement League and the Aboriginal Housing Board of Victoria Narandjeri House.

The project concluded with a barbecue at the house of one of the Kooris on the steering committee. Aboriginal hospital liaison officers, health workers from Aboriginal health co-operatives outside the Melbourne metropolitan area, and coordinators of Aboriginal-controlled drug and alcohol services talked informally about their work and how it might relate to the students in their future hospital rotations. Approximately half of the facilitators involved with the weekend away and the afternoon visits also came to this gathering, as well as others in the Koori community. Informal time in the evening provided students with a supportive social environment in which to continue to develop connections and new relationships with Aboriginal people.

### **7.3.5 Post-pilot project meetings with students**

Two post-pilot project meetings were held in August 1996. These meetings were designed for the students who had been involved in the pilot project and for students who completed the survey and were interested in discussing curriculum development further. Twenty-two students attended these meetings, and nineteen of the twenty-two had participated in the pilot project.

## **7.4 Project evaluation**

### **7.4.1 Introduction**

Using a range of qualitative and quantitative evaluation methods, previous Aboriginal health teaching initiatives in undergraduate medical education have all argued that they achieved attitudinal change amongst students (Kamien, 1975; Kaufman, 1984; Copeman, 1989; Jamrozik, 1995; Garvey and Hazell, 1997). Yet, as previously reviewed in Chapter 2, and often by the authors' own admission, most had significant limitations.

In this project, I was specifically interested in addressing some of these gaps and omissions. I collected qualitative data from students and facilitators before, during and after the pilot project. This consisted of: feedback from student and facilitator orientation meetings; anonymous written feedback during the weekend program; student and facilitator written feedback; post-project meetings with students and follow-up individual conversations with facilitators. Some of this information was used to modify the program as it was developed and delivered, whilst the main data collected immediately after the project was used to provide both process and impact evaluation. To evaluate the process and the impact of the project for both students and facilitators, I have used the material from student and facilitator written evaluation and from follow-up interviews with facilitators.

I elected to take a qualitative approach to evaluation. As implied by a number of previous studies, I believed that there would be greater value in using qualitative evaluation in this more complex area of attitudinal change.<sup>38</sup> I was also particularly keen to evaluate the project from the facilitators' perspectives and to identify processes which were key to

<sup>38</sup> As discussed in the literature review, participant testimonials (Garvey and Hazell, 1997), pre-and post-project letters and post-project recorded interviews (Kamien, 1975) and student essays or reports (Jamrozik, 1995) had been used in other studies.



ensuring that teaching was a constructive experience for them. Like Kaufman (1984) and Kamien (1975), I felt that placing equal importance on facilitator evaluation was an important measure of the success of the project and one that had sometimes been overlooked.

In addition, I wanted to employ a range of methods that would help determine the specific aspects of the project that had achieved the attitudinal change that students reported, again, something that previous projects had not specifically evaluated. Finally, employing various qualitative evaluation methods from the outset enabled adaptation of the program's development and delivery as it proceeded, thus adopting a process which was responsive to its own evaluation. Using more open evaluation questions, however, meant that we had a large volume of material to deal with, which was time-consuming but ultimately more useful.

All students completed written evaluation for the weekend at Brambuk. Because of time constraints, only seven of the students completed written feedback about the urban tour, but the majority spoke to me personally about their thoughts on this second aspect of the project. Overall, students' written feedback was remarkably frank, detailed and comprehensive. Amongst facilitators, the preferred method of giving feedback was by personal communication and most gave their feedback through individual follow-up conversations either on the phone or in person. Only four of the facilitators gave written feedback. Comments have been thematically organised and presented with illustrative quotes. Evaluation questions used during the project are included in Appendix 7.

## 7.4.2 Findings

### Process evaluation – Brambuk (students)

A detailed process evaluation for the Brambuk weekend has been included in Appendix 8. Some key points, however, are worth highlighting here, namely aspects of the pedagogical approach taken and the content covered.

### Pedagogical approach

Having the weekend away from student's usual teaching environment, in a rural setting and at a centre controlled by local Aboriginal people, was key to creating a good learning environment for the majority of students. Many of the students commented that they were impressed by a sense of being in an Aboriginal place and that this greatly enhanced their learning. Most also liked having the weekend in semester break, though a number said they would have preferred it in the summer months.

*I believe the venue was a crucial factor in the success of the communication process - this could not be achieved in a city conference centre. Being removed from my familiar urban territory and placed in a Koori context made me more respectful and receptive, and no doubt gave the Koori people more safety to present their story.*

*The weekend at Brambuk was an ideal place to hold such an event. It felt as though we were on Aboriginal land (which we were!) and more able to talk freely and communicate our ideas without too much trouble. If the weekend were held at a suburban venue, I feel that I would have felt as though this were another academic task I would have to fulfil. The Brambuk location made me reflect upon and experience the Aboriginal plight in a very deep and emotional way.*

**Figure 7-1. Brambuk Pilot Teaching Project - Program**

<b>28/6/96</b>	<b>DAY 1</b>	<b>INTRODUCTION AND SOCIAL GATHERING</b>
<b>29/6/96</b>	<b>DAY 2</b>	<b>SESSION 1</b> Hopes, fears and expectations
<b>9.00 - 10.00</b>	<b>am</b>	
<b>10.00- 11.30</b>	<b>am</b>	<b>SESSION 2</b> History/culture/identity
<b>11.45- 1.45</b>	<b>pm</b>	<b>SESSION 3</b> Talking circles
<b>1.45- 2.30</b>	<b>pm</b>	<b>LUNCH</b>
<b>2.30- 4.15</b>	<b>pm</b>	<b>NATURE WALK &amp; CULTURAL TALK (BRAMBUK)</b>
<b>4.30- 5.30</b>	<b>pm</b>	<b>SESSION 4</b> Small-group discussions on a range of contemporary issues <b>DINNER</b>
<b>30/6/96</b>	<b>DAY 3</b>	<b>SESSION 5</b> Visions for the 21st century for non-Indigenous and Indigenous Australia
<b>9.00 - 10.15</b>	<b>am</b>	
<b>10.30- 12.30</b>	<b>am</b>	<b>SESSION 6</b> Racism game
<b>12.30- 1.00</b>	<b>pm</b>	<b>LUNCH</b>
<b>1.00- 3.00</b>	<b>pm</b>	<b>ART SITE WALK (BRAMBUK)</b>
<b>3.00- 4.00</b>	<b>pm</b>	<b>SESSION 7</b> The enculturated self (reflections on the weekend) <b>CLOSE</b>

Students and facilitators gathered that evening and met informally over a barbeque. It had been intended to conduct Session 1 on the Friday evening, but it was postponed until the following day as many facilitators had been delayed leaving Melbourne.

Session 1 was aimed at providing a reference point for the weekend by clarifying learning and personal aims. Students and facilitators alike shared thoughts in small groups. Common themes were then identified in the wider group. People's hopes, fears and expectations were anonymously written down and kept on the wall over the weekend. Participants were also encouraged to add to these lists as the weekend progressed.

Session 2 began to explore the broader issues of Aboriginal history, culture and identity. Selected historical and contemporary films<sup>39</sup> were shown to introduce students further to the broader history of Aboriginal people (including pre-contact, early colonisation and later policies of segregation and assimilation) and to the impact of this history on contemporary culture and contemporary Aboriginal identity. Students then broke up into smaller groups to discuss their reactions to the films and to generate ideas and key questions prior to moving into the talking circles.

During this session, based around the idea of 'talking circles', facilitators took six groups of 5–6 students each (ratio approx. 1:3). Students rotated through three different groups, spending thirty minutes in each group. The session began with a clarification of group rules for the talking circles, particularly in relation to turn-taking and confidentiality. In the groups, students were free to ask any questions and to express their ideas and reactions after having seen the films. Everyone regrouped to sum up the session.

Brambuk staff led this session, which included a nature walk, giving students some understanding of indigenous plants and their medicinal value, and a talk on the history of the local area both pre- and post-colonisation. This gave students an understanding of cultural practices, both those lost and those retained over the last 200 years, as well as some idea of the contemporary structure of communities in the area.

In the final session for the day, students attended one of four topic groups which dealt with various contemporary issues previously identified in the planning meetings. Topics covered were land rights and native title; working in remote Aboriginal communities; Aboriginal families; and mental health issues. These informal discussion groups focussed on what Koori people and those working in the field are doing in these areas.

Session 5 focussed on participants' thinking about their visions for the next century for Aboriginal and non-Aboriginal Australia, particularly in areas such as health, education and the law. In small groups, students worked through a utopian scenario for Aboriginal Australia, focussing on one of these areas, thinking through the existing barriers to such a scenario and reflecting on what they believed was needed to overcome these barriers. Complex issues and possible systemic and specific solutions were discussed in small groups with facilitators and then brought back to the larger group.

In this session students were invited to participate in a game aimed at exploring racism, highlighting the structural and institutionalised nature of racial inequality and oppression.<sup>40</sup> This session was led primarily by the two non-Aboriginal facilitators with experience in cross-cultural work and in running the game. Other facilitators played roles in the game or acted in a more supportive capacity. The game aimed to give students an understanding of the 'wall of prejudice' experienced by Aboriginal people. It was designed to avoid reinforcing guilt by empowering students to change their understanding of and response to racism in some way. After playing the game students evaluated their responses to the process, particularly their emotional responses to the role they had had and how participation in the game had altered their understanding of structural or institutionalised racism (see Appendix 6). This session concluded with a simple visual exercise using matchsticks, where each matchstick represented a period of time in Australia's history. This exercise powerfully contextualised Australia's post-contact history over the last 200 years.

This session, run by Brambuk staff, involved a walk to an art site within the national park. During the course of the weekend it became clear that traditionally the site had special significance to men and would not have been visited by women. An alternative walk was organised for those female students and facilitators, and others, who did not wish to visit the art site.

The planned 'structured conversation', exploring the notion of an 'enculturated self', with a panel including Aboriginal facilitators, students and non-Aboriginal facilitators was abandoned as it was clear that there was a need for all participants to talk freely about the impact of the weekend in a confidential manner. This session gave all students and facilitators a chance to reflect on their original hopes, fears and expectations and about their own cultural identity.

The majority of students also appreciated having a mix of year-levels participating and the opportunity this provided to share and learn from each other. Most students found that whilst year-levels or hospital groups initially may have 'stuck' together, this changed as the weekend progressed. Three older students, however, found the mix of year-levels somewhat frustrating, feeling at a different level in terms of their life experience to the first-years.

Half the student group specifically discussed their own role in the learning process when invited to. These students, by and large, felt that they had been respectful of others; had been enthusiastic and honest, and very willing to learn and to participate fully in the process. A number spoke of how students helped each other 'risk' something in some way, particularly in relation to dealing with emotional responses to difficult issues as they came up. Most thought this was particularly possible because the students were all there on a voluntary basis. Four students mentioned that they had difficulty in expressing their opinions or in disagreeing with the opinions of others, or perceived that other students had some difficulty with this.

The majority of students specifically praised the interactive and less formal approach taken throughout the weekend and stated that this had facilitated a much deeper and more meaningful understanding of the issues.

*I think that this less 'formal' teaching has proven to be very successful as a way of conveying this type of information, ie a more personal approach. I felt that I have come away with a real understanding of this issue rather than just an academic knowledge which was how Aboriginal Health etc has been taught to me in previous years.*

A number of students also stated that the pedagogical approach taken had enabled them to tackle difficult and confronting issues in a way they had not been able to achieve with more traditional approaches to teaching.

*We were able to communicate confrontational issues at an informal level - we would not be able to do this at other places.*

Small groups and talking circles with a low facilitator-to-student ratio (1:3) were important in this learning experience, and enabled contact between facilitators and students.

*The small-group discussions were fantastic as they gave us an invaluable opportunity to interact with the people on the front line of Aboriginal health issues in Victoria and an opportunity to gather information about the history of Aborigines before and after white invasion of Australia. This information was extremely important since I had not thought about or known about a majority of issues before the weekend.*

*Shared emotional stories. [The facilitators were] very patient. Invaluable opportunity to talk face to face. I felt involved.*

39 *Lousy Little Sixpence*, (1983, 56 minutes, Ronin films) and *From Sand to Celluloid*, (1996, AFI). Six short films by Indigenous film makers. Students saw 2 of these films over the weekend. *Two Bob Mermaid* (15 minutes), written and directed by Darlene Johnson and *Round Up* (16 minutes), written and directed by Rima Tamou

40 The Challenging Racism Game Kit was developed in 1987 by the South Australian Justice, Freedom and Hope Workgroup. It was written by mainly non-Aboriginal women in consultation with several Aboriginal people. A panel of Aboriginal people had monitored the running of the game on a number of occasions in its development. (Instructions for the game are included as Appendix 6)

The value in having non-Aboriginal as well as Aboriginal facilitators was also noted by some students.

*Having non-Aboriginal facilitators was also important as it aid[ed] in preventing an 'us and them' attitude.*

With respect to process, a few students commented that they would have liked more introductory sessions to work through issues such as a fear of offending, uncertainty about trusting others and how not to be afraid of making mistakes. One student commented that they would have liked to have had more 'fun time' organised, separate from the Aboriginal content, in order to have a break from the emotional impact of the weekend.

### **Content**

Overall, students found the information relevant, useful, informative and varied and that the amount given was appropriate.

*All the content was valuable and tackled many facets of Aboriginal life - history, culture, family, identity, beliefs, health etc.*

Comments from students about each session (detailed in Appendix 8) demonstrate how the progression of material from an historical overview through to a range of contemporary issues was very successful for students. Many students also commented on how they appreciated the way the program moved between the university-organised sessions and the cultural activities organised by Brambuk staff. In addition, students appreciated the pre-reading as a way of supporting and expanding on the material covered over the weekend.

### **Process evaluation - the urban tour (students)**

Students found that the urban tour gave a good overview of the services and support structures operating in Melbourne. Many commented on the value of visiting the different agencies after the experience of the weekend, as they came to them with a greater understanding of the broader issues and with a newly gained framework from which to understand the practical information given.

*The urban tour was extremely relevant and comprehensible. Due to the weekend, I could understand why these services had been initiated and could understand their immense importance to the Aboriginal people living in Melbourne. I think that all the destinations were very interesting and I felt that I learnt more easily about Aboriginal services after the weekend in the Grampians than in previous times.*

*The urban tour was also a time of excitement for me as well as concern. It was exciting to see some of the facilitators who I had met at Brambuk in their occupations in the city caring for their community. The familiarity with them gained over the weekend aided the discussions at each destination.*

Students found that a good range of places had been selected and some were shocked that they had no prior knowledge of such services and of their work. Students also gained a greater sense of the Koori community in Melbourne, the community's achievements and struggles, and responses by mainstream services and the government.

*It was exciting to see many initiatives for Aboriginal people managed by Aboriginal people, but at the same time it worried me to see actually how little they had compared to mainstream society. The tour brought home to me how much is stacked against the Aboriginal community and how helpless they must sometimes feel. The urban tour was yet another awakening for me, and also another emotional day.*

The tour also gave students more contact with Aboriginal people working in health and related fields. The main problem again related to time constraints. One student in particular really felt they were rushing from place to place and couldn't take everything in. Finally, the social gathering was enjoyed by all students, enabling them to continue to make contact with a wide range of Koori people, whilst also being informative. Students also appreciated the chance to have a more celebratory closure.

### **Process evaluation (facilitators)**

Facilitators unanimously described the project extremely positively. Many were quite inspired by the process and all were keen to be involved with further programs if they were taught in a similar manner to the pilot project.

Having Brambuk as the location for the weekend away supported the facilitators in their preferred orientation to teaching and helped create significant 'cultural safety'. Placing such a weekend program before any visits with urban organisations also made it easier for the facilitators to talk with students back in Melbourne. All facilitators who were involved with both the weekend and the urban tour and social gathering expressed their enjoyment at meeting the students again and being able to develop connections at a less superficial level than is often possible.

All facilitators felt well-supported by being able to bring family and friends away for the weekend and were appreciative that the accommodation arrangements included a separate place where they could socialise as a group. A number of facilitators would not have been able to come if such arrangements had not been made, while others would have found the process more difficult or more tiring if they had not been supported in this way. The majority appreciated this opportunity to meet with other facilitators and spend extended time together.

The orientation and development of the program's content, the use of predominantly small-group work and the more informal and flexible approach to both the structured and unstructured parts of the program had all been based on various models of Koori teaching in the Aboriginal community. All facilitators appreciated this approach to teaching and the flexibility to run sessions in their own way. Facilitators also liked working in pairs or threesomes in the small-group work. Not having to do the work as a single Koori representative, fielding questions on a wide range of topics, made an enormous difference for many.

*A number of facilitators also commented on the enthusiasm of the students and the respect they received from the students. These facilitators generally put this down to the fact that the students were there voluntarily.*

*The students were respectful and helpful. I feel they were encouraged to own the weekend and do the dirty work rather than to expect a 'service'. All were enthusiastic and willing to learn. Many were very honest and truthful.*

### **Impact evaluation**

Whilst no formal pre- and post-evaluation was undertaken, it was clear to the organisers, through comparing students' comments in the pre-planning meetings with those in the evaluation after the project, that significant changes had occurred in students' attitudes. This student-reported impact of the project will be briefly discussed in general terms followed by an evaluation of the project's specific aims.

### **Changes in knowledge, attitudes and practice**

The majority of students described changes in their thinking about a number of issues that occurred through being involved with the Brambuk teaching process.

For all students the process was eye-opening, challenging, thought-provoking and extremely moving. Many described it as 'life-changing' on many levels, but particularly with respect to their attitudes towards Aboriginal people and their culture, and towards their own cultural origins and sense of self. Students' comments included:

*When you suddenly go click or bang, 'I suddenly dramatically realise how important this all is to me living on this land', your mind is changed forever. This is the change in mind-set which will make the difference to how we practice as doctors (apart from how we live as Australians and as people). And the bang requires quite an intense encounter, I think probably only possible on a weekend like this one, difficult or impossible in the classroom with a hundred people sitting listening to a lecture.*

*I think we were all so affected by the weekend that our approach to Kooris as a whole and to those we may meet in a health context, and our perception of Koori well-being, will be radically and positively shaped by this experience. So many barriers, blinkers, fears, prejudices, stereotypes, misconceptions and lies were shed at Brambuk. This is only the beginning I hope of an ongoing process of learning and commitment and acknowledgment, feeling and thinking and empowerment.*

*Of the many weekends that I remember, this Brambuk weekend is one which will always hold a special place in the heart. [Its] styles and approaches clearly provided a thought-provoking and stimulating basis for others and my own identity.*

### **The project's aims: were they achieved?**

*The Brambuk experience deserves more praise than words can offer - it has set a precedent for future years of understanding and learning by others and if not this, then at least the foundations for all those involved this year in making for a better (world) for Aboriginal people. This weekend was not merely 'food' but a 'banquet' for thought and I thank the organiser and all the facilitators for offering their time, their soul bearing, their stories to total strangers and for allowing us all this priceless opportunity and experience. If only the rest of the nation could participate in such a project, Australia would be a far less ignorant, far more human kind of place.*

### **1. To provide a series of opportunities to meet and build relationships with a wide range of Aboriginal people**

Students appreciated the facilitators, particularly their patience, respectfulness, knowledge, openness and honesty. Many students described being quite overwhelmed by how friendly and approachable the Koori facilitators were, directly contradicting their own experience of considerable cultural separateness and division. The project clearly provided students with the opportunity to meet a large number of Aboriginal people from different backgrounds.

*The information was astounding and would lose its impact if it were printed on a slide or crammed into a book... The personal contact is essential; even though I was petrified at first, I'm glad I have [had] an experience that will lead to other similar experiences in the future.*

*As Aboriginal issues and health care are full of stereotypes built up over the years of experience of our lives, the only way to challenge those stereotypes is through personalised experiences. The weekend provided that...as the knowledge gained was personalised. Small facilitator–student ratio allowed a more meaningful and permanent growth in knowledge and sharing ideas. It allowed relationships to be made and Aboriginal people were in control.*

### **2. To develop a range of learning processes that would facilitate this contact between students and facilitators and be a positive and empowering experience for the Aboriginal and non-Aboriginal people involved**

A number of facilitators stated that often at such events they have felt drained or robbed of information. On this occasion, however, they felt that the process that we used had been a very enabling and replenishing one. A few of the Aboriginal facilitators also commented that the weekend had helped rekindle a cultural vitality and a strengthening of their Aboriginal identity.

Many spoke about the impact they saw the weekend having had on the students also. The following comment is from one of the non-Aboriginal facilitators who had significant cross-cultural training experience:

*To take a group of people into an Aboriginal space and then watch the transformation which can take place is inspirational. An openness occurs which I believe is impossible to recreate in the formal setting of a university. A greater understanding about the interrelationship between our shared history and the effect this had on the current health and well-being of Aboriginal people can only be gained by a willingness to examine our own place in Australia. I have worked with students in a uni setting before and have never seen such deep work being done.*

### **3. To encourage students to reflect on their own cultural heritage and cultural practice.**

For a number of students, the weekend was a significant turning point in a realisation of their personal need to understand their own cultural background or heritage. For most students, this was the first time they had been confronted with the importance of this for all people.



*The things I got from the weekend were on lots of different levels... On a personal level I really got thinking in a big way about what a sense of belonging is. I left the weekend strongly wanting to find out more from my family about our history and establishing my sense of belonging more than I have before.*

*I realised too that I missed the family and cultural history that the Aboriginal people share and now feel a need to explore the history and culture of my own family further than my grandparents' immigration to Australia.*

*I found the Aboriginal issues discussed to be personally confronting, questioning 'Where do I really come from?' and 'What is my role here today?' and 'How can I help?' I know many students felt like likewise.*

#### **4. To develop a broader and more personal understanding of Aboriginal issues in general**

All students commented in some way about how their overall understanding had been altered through participating in this experience. Many students began to question old beliefs or found that the process enabled an appreciation and increased understanding of new perspectives.

*Changed the way I will see myself in this country forever. Gave me respect for the land and Aboriginal people.*

*I went to the weekend with what I thought was a relatively good understanding of Aboriginal issues. What I came away with was a real and more personal understanding of issues. It made me realise how, as a generation, most people with 'knowledge' intellectualise the problems rather than feel any real passion for the people. Here's to a new generation!*

#### **5. To gain a greater understanding of both the diversity and the strength of the Victorian Aboriginal community**

Most students commented on how the project enabled them to appreciate, generally for the first time, both the diversity of experience and backgrounds of the Koori facilitators and the wide range of views expressed.

*The range of Kooris from different walks of life meant we were presented with multiple points of view, rather than a (single) viewpoint.*

#### **6. To gain an understanding of the role of history, racism (particularly institutionalised racism), culture and land rights in Aboriginal health both in terms of the causes of health problems faced by Aboriginal people and possible strategies for change**

We spent most of the introductory and planning meetings explaining the reasons why we would not be dealing with health issues directly. This had been difficult for a number of students, but by the end of the project many students described their greatest learning as being some kind of reshaping or recontextualising of Aboriginal health.

*I don't think we learnt much about Aboriginal health but I don't think we need to in that strict sense. What we need as doctors (what every single Australian really needs) is to discover a connection with Aboriginality. It's hard to describe because it's a deep experience but elements of it are learning the true history of the last 200 years, realising the length of Aboriginal history, acknowledging how destructive non-Aboriginals have been and are, seeing the meaning in Aboriginal spirituality and their connection to the land, feeling the sense behind many Aboriginal beliefs like the family stuff, land use, laws etc.*

Students described gaining this perspective because the teaching had a broad focus on Aboriginal issues, focussing particularly on cultural, historical and contemporary issues. The students could then make the connections with Aboriginal health.

*I think this weekend was a great new experience in that it exposed us to many Aboriginal issues we as students would not get a great deal of exposure to. Although the focus of this weekend was not totally set on Aboriginal health, I believe having a firm understanding of Aboriginal issues such as culture, history etc is important if we are to do something about Aboriginal health. Only when 'white people' can understand the Aboriginal people more, could we effectively develop management plans which are culturally compatible and sensitive to the Aboriginal people's needs.*

*As future doctors we also naturally tend to concentrate on purely medical issues and define problems in western medical terms. I think that the conference wisely resisted this and concentrated on wider issues. The main message for me was the need for a holistic approach to Aboriginal health which embraces past, present and future, and which encompasses the critical issues of Aboriginal culture and identity. I felt that some of these concepts were very effectively conveyed in the group sessions - for example, [the] importance of extended family in Koori society - but I also realised just how little we know about Koori people and culture. From the group sessions I gained a better understanding of the Koori perspective, particularly the crucial importance to them of an honest reappraisal of history by whites.*

Students were particularly overwhelmed by Australia's post-contact history, particularly in Victoria, and were often rather startled by their own past lack of exposure. Many had heard very little of the massacres in Victoria; of Aboriginal resistance post-contact; of government practices and past legislation; of the specifics about mission life and of the overall impact on Aboriginal people.

*The videos were useful in bringing the sins of the past (not so distant) into the foreground. I think the tendency of many well-intentioned whites to focus on the future is to consign history or at least compartmentalise the past.*

*I guess I didn't realise the extent to which Aborigines have been persecuted throughout the past 200 years and this camp certainly made me question and re-think some of my earlier beliefs.*

## **7. To develop an increasing understanding of the importance of the reconciliation process and a sense of such relationships between Aboriginal people and themselves as being possible and potentially positive and rewarding**

As has been discussed earlier, students unanimously said that they had benefited from the chance to work together with Aboriginal people and to begin to make connections. Many also spoke of the need to reconcile the past for themselves.

*It brought home for the very first time how inhumane man can be; always inhumanity has seemed to hold a place elsewhere but never here on our own shores. This is what I learnt from this weekend: the injustice and cruelty of man, the need for us to recognise our own faults in the past, our errors in the present and once having achieved this understanding, to get off our backsides and do something to rectify the circumstances.*

This opportunity to meet with and talk to a wide range of Aboriginal people gave all students a sense of the possibility of forming future relationships with Aboriginal people and a very different sense about what this might entail.

*Meeting and talking with Koori people. Discovering the positive things happening in the Aboriginal community and meeting with some of the people involved in various initiatives. I came away with a much more optimistic outlook for the future of Aboriginal people, and reaffirmed my desires to get involved in Aboriginal health.*

Others spoke about the realisation that the process of learning and working on these issues would be life-long and that the project was just a beginning.

*I felt I gained a great deal from the pilot program - particularly realising that this is just the beginning of a life-long learning experience. It was by far the best teaching experience I have had of Aboriginal culture and health.*

The majority of students were keen to have some follow-up so that they could continue this reconciliation process. There has been no follow-up evaluation of the students involved, but since the project a number of students have, in fact, been active in the University's rural club. These students have organised several activities with Aboriginal people and, as a result, have introduced the issues to a broader group of students.

### **Unexpected outcomes**

Several additional or unexpected outcomes emerged. One unexpected outcome was that many students commented that the project had restored their faith in the exciting possibilities of learning in a course such as Medicine.

*People who think that this sort of learning is an unnecessary luxury are completely wrong. I found the weekend just as relevant as anything I had been taught already in the medical course, and it was more relevant than an awful lot of things. I've been getting cynical about the medical course, (but) over the weekend I couldn't help but think, 'Hey, this is what Medicine should be about!' We had laughter, learning, fun, a few tears and a total broadening of horizons. [Student's emphasis]*

Another unexpected outcome was simply the extent to which students wanted to see the project offered to many more students and to become a permanent feature of the course.

*Without a doubt...the Brambuk weekend offered an experience no lecture, no mere teaching could ever achieve and for that reason I urge that this type of weekend be continued, be expanded for the benefit of future students and inevitably, for the betterment of society itself.*

Another unexpected outcome was the way in which teaching a small group of volunteer students can have a 'flow-on' effect to the larger group. In many cases, individual students felt more confident to discuss Aboriginal issues with their contemporaries and their newly attained enthusiasm generated an increased interest in Aboriginal health amongst other students.

*During this weekend I learnt more compared to other weekends in my medical student career. This way of learning really stay[s] in the mind. We did not take any notes, but we remember everything. We had a very good conversation on our way to Melbourne in the car because this way of learning is so powerful... I have already educated three of my medical colleagues about Aborigines... Now I have a better understanding about Aboriginal people.*

A final unexpected outcome related to students' own thinking about curriculum and how Aboriginal health should be framed. It appeared from the post-pilot project meetings that the students who had participated in the pilot project had, as a result of their participation, an increased development in their thinking about curriculum. Comments about current curriculum and future teaching made by these students were considerably more developed than those in the surveys. A measure had not been designed to compare these particular students' comments in these discussions with those that they had made earlier in the survey, but the overall difference was striking. This observed difference was also consistent with the self-reported changes outlined by the students themselves.

## 7.5 Discussion

This pilot project involved thirty-two medical students in a two-phased learning process in cross-cultural teaching in Aboriginal health. The qualitative process and impact evaluation indicates that it was a positive and constructive experience for both students and facilitators and that we succeeded in achieving our aims. This obviously needs some qualification. Evaluation from students and facilitators was gathered immediately or soon after the intervention. For the majority of students, the Brambuk experience had been like an epiphany and the intensity of students' comments need to be read in this context. Such levels of attitudinal change brought about by significant events are obviously not just simply sustained. Rather, such an event may provide a major catalyst for change from which attitudes continue to shift and develop over a period of years. As has been mentioned previously, we were not able to evaluate these students for any significant period of time after the project except to note that the majority of these students were informally followed up later in their course and the ongoing impact of the project - how it had shaped students' attitudes and their decisions to take on particular challenges or to pursue this area further - was notable.

Also, there were limitations to using students' and facilitators' own reflections as the primary evaluation method. Whilst students' responses could be quantified and major themes identified, clearly not all students achieved the same level of attitudinal change. Nevertheless, this evaluation process helped us to fairly confidently determine the specific aspects of the project that achieved the attitudinal change that students reported. While the project only involved thirty-two students, this was a larger student group than most previous immersion projects or field trips with medical students and its findings are of significance for future projects.

### **7.5.1 Features which contributed to the project's success**

#### **Focussing on making connections between Aboriginal people and students**

Focussing on the development of connections between Aboriginal people and students was a key feature behind the project's success. Having students come away to a place of special significance to Aboriginal people and bringing students and facilitators together over a range of formal and informal activities helped break down various fears on both sides. Other projects have also found this particular focus to be key to successfully breaking down barriers (Garvey and Hazell, 1997; Kaufman, 1984),

#### **Facilitating an examination of students' own backgrounds.**

As organisers we had always felt that the 'unexaminedness' of people's own issues around their cultural heritage functioned in an unconscious way as barriers to any learning about Aboriginal health. If students feel culturally marooned themselves or have little access to or knowledge of their own history, it is very difficult for them to begin to appreciate Aboriginal issues without feeling, for example, considerable anger or a sense of loss. As these processes are often not conscious, such strong and negative emotions are often projected onto Aboriginal people per se. The weekend was remarkably successful in indirectly allowing students to begin to understand the relationship between their own identity and sense of self and their emotional reactions to Aboriginal issues.

#### **Voluntary student involvement**

Voluntary participation meant that those present were willing to change and experience different perspectives. It also enabled the facilitators to enter the relationship more easily and helped with the successful facilitation of group dynamics. Whilst the majority of the students mentioned that they would like to see the pilot project offered to all students, most conceded that they could not envisage it being as successful if involvement was not voluntary.

#### **Mixing year-levels**

We found that the benefits of including a mix of year-levels outweighed the disadvantages. We were not able to find any examples of this approach in the literature. Kamien had involved fifth- and sixth-year students but did not comment on this aspect of the project (1975). Significant learning occurred simply through sharing knowledge and experiences within the mixed group and students were able to form additional connections across year-levels.

### **Conducting the program over two phases**

The design of an initial immersion process followed by consolidation via exposure to Aboriginal services was another aspect of the project's success. Other projects surveyed had largely involved a single field trip and had not followed this up with further work with the particular group of students involved.

I would argue that it is essential that the first phase of any program involves some kind of 'immersion' phase such as a weekend away. The second phase can then be somewhat more flexible. Our students found it very valuable visiting Aboriginal-controlled services, once they had done the work of the weekend.

I would suggest that the more intensive part of any project is no more than 2–3 days. A number of students requested that the weekend away involve more time, with more opportunities to learn and to get to know the facilitators better. This is not realistic for facilitators given other commitments and work-loads, and the demands that such work invariably entails. In fact, part of our overall goal was to help students realise that they cannot learn everything in one go and that one process cannot immediately 'make up' for students' lack of contact with Aboriginal people in the past. I believe that students need to develop the capacity to bear a sense of 'not knowing' and to come to grips with their past lack of relationships with Koori people. More time could be spent on these issues in the orientation process and some changes could be made to the program to utilise the time better. Any changes or additions, however, would need to be done with care, so that students did not feel too overwhelmed or rushed. For example, utilising the first day of the camp better by starting earlier with a range of introductory sessions and conducting separate debriefing sessions for facilitators and students in the evening, could help maximise the value of a weekend away.

### **Orienting students and facilitators before their involvement in the pilot project**

Whilst having a different focus, these observations of the importance of thorough student orientation to any project mirrored those of Kaufman (1984). Having two orientation sessions with students prior to the pilot project was essential. These sessions ensured that most students felt they had been listened to from the outset; were clear about what the project could achieve; had some input into the program; felt involved with the process; and had begun learning through discussion and prior reading. This also meant that student expectations were, by and large, in tune with the project.

No studies in the literature had looked at facilitator orientation, which this project found to be as important as student orientation. We found that it was important to conduct facilitator orientation very flexibly. A mixture of group and individual discussions were necessary to fit in with other demands. There was also a need to allow for some facilitator orientation immediately prior to the first phase of the project, given inevitable last-minute changes. This helped to ensure that the whole group felt comfortable with the process.

As organisers, we felt that we could have given the facilitators more preparation or specific facilitator training time, particularly to help clarify specific roles and responsibilities. This will always be difficult, however, when working with a large number of facilitators with different levels of specific experience in teaching and different facilitation styles.

### **Adopting particular teaching principles and processes throughout**

In general terms, our experience supported a number of teaching processes used by others. Kamien (1975) and Garvey and Hazell (1997), for example, have also spoken about the importance of ensuring ample unstructured time and of creating a fairly informal learning environment. While some students asked for more formal teaching time, this lack of 'formal teaching time' was precisely what we were wanting to encourage students to 'bear' and, instead, to 'risk' making connections with as many Koori people as possible. The use of 'talking circles' as a model was extremely successful, though adjustments might need to be made to allow more time with each 'circle', so that discussion can develop more fully.

Using both Aboriginal and non-Aboriginal facilitators gave us a valuable opportunity to model to students how Aboriginal people and non-Aboriginal people can work together and for students to see Aboriginal and non-Aboriginal people who have known each other for significant periods of time and have had positive histories together.

We found that it was also essential that there was plenty of time for all people involved to deal with emotional issues as they came up. It is important to commence this in the orientation work and to continue it throughout both phases of the program using a variety of methods. For the majority of students this was all dealt with fairly well, but a handful of students commented that they would have liked more debriefing. These particular students felt very constrained by a fear of offending, and experienced difficulty, or felt that others were experiencing difficulty, in voicing particular opinions. While such issues may take a lifetime to resolve, there is scope for developing the program in a way that would contribute to that progress. Some suggestions would be to include additional formal debriefing work with students and facilitators separately on the evening of the first full day of the weekend program and to work at intervals throughout the program with students talking in pairs about their own emotional reactions.

It is important to carefully consider and formally address difference within the non-Aboriginal group and to be mindful of not creating two polarised groups in discussion of Aboriginal versus non-Aboriginal Australia. While this distinction is an extremely important one in this work, it needs to be done in such a way that doesn't simply 'lump' all non-Aboriginal cultures together. One student in the pilot felt that non-Aboriginal people were grouped together in this way, and this point needs to be carefully considered in any future programs.

The following figure gives a summary of the key approaches and teaching methodologies found to be useful in the evaluation (Figure 7-1).

**Figure 7-2. Key approaches and teaching methods found to be useful in the immersion-style pilot project**

GENERAL

- Conducting the project as a two-phased learning program (Brambuk program as phase one, and an urban tour as phase two)
- Formally orienting both students and facilitators to the program and enabling a process whereby both facilitators and students could develop a sense of ownership of the project
- Conducting formal follow-up with both students and facilitators after the program's completion
- Involving a mix of students from different year-levels
- Involving students on a voluntary basis only
- Having a flexible program so as to respond to any evaluation by students and facilitators during the process
- Focussing throughout the program on building relationships and making connections between Aboriginal people and students
- Facilitating an exploration and reflection on the part of the students of their own backgrounds
- Having the program content reflect the histories and experiences of local communities
- Involving both students and facilitator from the outset in the development of evaluation processes and the development and subsequent modification of the program
- Developing different systems of evaluation for facilitators and students



**Figure 7-2. (cont.) Key approaches and teaching methods found to be useful in the immersion-style pilot project**

#### BRAMBUK PROGRAM

- Taking students away from their usual teaching environment to a place of special significance for Victorian Kooris
- Conducting the program over two-and-a-half days
- Having a facilitator:student ratio of 1:3 or 1:4
- Incorporating a wide range of activities and different teaching methodologies into the process
- Developing a range of teaching material that took students from an historical overview through to a range of contemporary issues
- Interspersing this teaching with a range of cultural activities
- Including both structured and unstructured time in the program
- Using 'talking circles' as one of the primary teaching processes
- Allowing ample time for debriefing throughout
- Enabling facilitators to bring family and friends
- Arranging accommodation so that students and facilitators could have time apart, to socialise and to debrief

#### URBAN TOUR

- Conducting an urban tour as phase-two of a learning program
- Introducing students to a range of community-controlled services in their local area
- Involving facilitators who already knew the students through phase-one

In conclusion, this pilot project was a significant step in further developing cross-cultural training in the undergraduate medical curriculum and hopefully it provides some sound stepping stones for future projects.



# Brambuk pilot teaching project

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Students and Facilitators involved in the Brambuk Pilot Project



Ian Anderson and Nikita Tabuteau at the Brambuk Project dinner

# Brambuk pilot teaching project

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Facilitators and family members on a walk in the Grampians/Gariwerd National Park



Brambuk Cultural Officer Mark Mathews talking to students about Indigenous plants

# Brambuk pilot teaching project

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## Talking Circles





## Section 4:

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### Conclusion





# Chapter Eight: Conclusion and Recommendations

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This project was conceived in order to address difficulties experienced by staff, students and the Aboriginal community in relation to Aboriginal health teaching in the Faculty of Medicine at the University of Melbourne.

The findings of the needs assessment and pilot teaching project demonstrate that teaching medical students about Aboriginal health does matter and that, within the confines of a demanding course, there is significant potential for focussed and effective teaching to overcome existing problems. From the needs assessment I was able to formally identify a series of barriers to learning and factors that could facilitate learning in this area. This has clear relevance for future curriculum development. The pilot teaching project subsequently put this theory into practice and successfully demonstrated the way in which one intervention can have a significant and far-reaching impact on teaching and learning.

As a result of this work, I would argue that there is a need for the development of two types of teaching in Aboriginal health: firstly, an improved, coordinated and integrated core curriculum; and secondly, elective processes for smaller groups of interested students. Both these forms of teaching need to be adequately resourced and properly supported. Institutions have a primary responsibility to ensure that all students receive a certain amount of teaching about Aboriginal health. However, as this study has demonstrated, this does not necessarily need to involve a lot of teaching. What is required is that significant attention be paid to various structural and pedagogical processes to ensure that the teaching achieves its objectives. The development of elective teaching is vital in providing processes for interested students to develop their knowledge further. This pilot project demonstrates how important these elective processes can be, not simply for those directly involved but also in fostering a more positive climate for curriculum development and a flow-on effect where knowledge is passed on to non-participating students.

As a result of this work I have proposed a number of recommendations for Aboriginal health teaching in undergraduate medical curricula. These recommendations have been organised according to structural, teaching and student factors. It is important to remember however, that curriculum development is an evolutionary process. These recommendations have been written at a particular time in history and will need to be reviewed on an ongoing basis.

These recommendations have relevance for all people involved in teaching Aboriginal issues to medical students. It does need to be acknowledged, however, that they have been specifically written to address issues around teaching at the University of Melbourne. Each institution clearly has its own context for addressing these problems, and needs to develop its own specific curriculum.

**Figure 8-1. Primary recommendations in relation to Aboriginal health curricula in the undergraduate medical course**

- That two types of teaching be developed in Aboriginal health: an improved, coordinated and integrated core curriculum; and elective teaching processes for smaller groups of interested students.
- That the development and delivery of core and elective teaching be adequately funded and appropriately resourced.
- That core and elective teaching be developed in accordance with the structural, teaching and student recommendations as outlined below. [see Figures 8-2, 8-3, 8-4]

One specific responsibility of medical schools is to provide the optimum environment for educational change to occur. Such structural factors set the tone for student learning and can create a climate that either fosters or undermines the learning process. With respect to these structural factors, the needs assessment identified the importance of devising a properly integrated and coordinated course, where Aboriginal health is taught as a theme throughout and where broader social and cross-cultural understandings of health are a central part of the course. The needs assessment also identified the importance of developing partnerships and appropriate consultative mechanisms and providing adequate training for staff in this area. It is important to note that many of these recommendations are consistent with the changes currently taking place within the new undergraduate course at the University of Melbourne and with many other undergraduate courses in the country.

**Figure 8-2. Structural recommendations in relation to Aboriginal health curricula in the undergraduate medical course**

#### INTEGRATION AND COORDINATION

- That the study of social, historical, political and economic understandings of health and illness be incorporated throughout the undergraduate medical course.
- That a broadly based cross-cultural program be developed as part of the core teaching, with teaching in Aboriginal health and related issues being part of this program.
- That teaching in Aboriginal health and related issues be embedded as a theme throughout the course.
- That teaching methodologies used in Aboriginal health teaching be institutionally supported and, as much as possible, reflect those used elsewhere in the course.

#### PARTNERSHIPS

- That formal and informal partnerships be established between local Aboriginal communities and the university involved.
- That the different universities involved with developing and delivering undergraduate medical teaching about Aboriginal health and related issues work together collaboratively as much as possible to avoid duplication of resources.
- That partnerships be established with key postgraduate courses, such as general practice registrar training, which also delivers core Aboriginal health teaching, in order to enhance development and avoid repetition.

#### CONSULTATION

- That the specific content and priorities for Aboriginal health teaching be developed collaboratively by the Indigenous communities, the university involved with teaching, and students.
- That mechanisms be established to ensure that Aboriginal people are meaningfully involved with the design, development and delivery of the Indigenous health curriculum within the course.
- That mechanisms be established to ensure that students are involved with the design, development and delivery of curriculum.

#### STAFF TRAINING

- That cross-cultural training on Aboriginal issues be developed for all staff who have a major teaching role in the medical course.

Just as structural change is important in enabling changes in teaching practice, changes in teaching practice can support significant change in the student population. The pilot project demonstrated that creating a particular teaching environment gave students the opportunity to respond to the issues and to do the work to develop their skills and knowledge and achieve significant attitudinal change.

The following teaching recommendations relate to both core and elective teaching, though obviously content and teaching methods will vary somewhat.

**Figure 8-3. Teaching recommendations in relation to Aboriginal health curricula in the undergraduate medical course**

TEACHING METHODOLOGIES

- That teaching on Aboriginal issues be multidisciplinary in its approach, drawing on a range of disciplines within the humanities, social sciences and biomedical sciences.
- That Aboriginal health teaching be largely locally based and, in Victoria, focus primarily on rural and urban Koori communities.
- That there be a wide range of Aboriginal facilitators (taking into account such factors as age, experiences, expertise and views) involved in teaching.
- That non-Aboriginal facilitators with experience working with Aboriginal people be involved in teaching.
- That teaching be undertaken in such a way as to foster constructive experiences between Aboriginal people and students.
- That teaching methodologies which enable students to examine their own cultural backgrounds be developed and implemented.
- That teaching methodologies which allow for students to constructively engage with the range of emotions that they bring to the area and that arise during the teaching, be developed and implemented.
- That teaching methodologies recognise and utilise the specific cultural experiences of Indigenous medical students and the range of cultural experiences of other students within the group.
- That the various methodologies utilised in elective teaching remain flexible and specific to different institutions.
- That teaching methodologies which include a solution-focussed approach be developed and implemented.
- That a range of teaching methodologies be utilised in core teaching, including:
  - small-group tutorials;
  - judicious use of lectures;
  - the insertion of readings and examples into other curricula;
  - self-directed learning projects.
- That a range of teaching methodologies be utilised in elective teaching, including:
  - small-group tutorials;
  - self-directed learning projects;
  - immersion-style field trips;
  - placements with community-controlled organisations;
  - placements with Aboriginal Liaison Officers in mainstream organisations.

**Figure 8-3. (cont) Teaching recommendations in relation to Aboriginal health curricula in the undergraduate medical course**

#### TEACHING CONTENT

- That all the Aboriginal health content in the course be designed in a way that develops the knowledge-base, skills and attitudes of the students.
- That particular emphasis in the content be given to:
  - Aboriginal history;
  - cultural and social issues which address students' pre-existing perceptions;
  - notions of Aboriginality;
  - the particular relationships between health and self-determination;
  - land rights;
  - racism;
  - information about Aboriginal health funding and the demographics of communities.

This project's immersion-style field trip is an example of an elective teaching process that provides a model for the way that many of these broad recommendations can be implemented. The success of the field trip gives support to the idea that, provided there is some institutional support, elective processes can occur even where there is little structural change occurring. Such elective teaching processes can also provide a place to institute change and to test new pedagogical approaches (see Figure 7-2).

Students also have a key role to play with respect to their own learning. Having a student population in Medicine which reflects the diversity in the broader community, and increasing the number of Indigenous students in the course, each has obvious social significance. Both these factors also have clear relevance for learning. The pilot project and, to some extent, the needs assessment, supported the idea that diversity in the student group in general, and the involvement of Indigenous students in particular, led to greater outcomes for student learning.

In addition, future teaching in Aboriginal health needs to carefully consider how best to approach this teaching given the increasing numbers of overseas-born and international students entering Medicine. These students will bring different issues to the area and teaching may need to be contextualised more broadly so that it has relevance for students who have lived the majority of their lives outside Australia and for those who will be returning to their country of origin. These changes to the composition of the medical student body at the University of Melbourne have had a significant impact since this projects' initial needs assessment was completed and these issues may need further investigation.

**Figure 8-4. Student recommendations for Aboriginal health curricula in the undergraduate medical course**

**STUDENT SELECTION PROCESSES**

- That the medical faculty continues to work towards ensuring that selection processes reflect the diversity in the community, particularly in relation to social class and cultural background.
- That selection processes actively foster the recruitment of Indigenous students.

**STUDENT POPULATION**

- That teaching takes into consideration the increasing diversity of the student population (in particular students' cultural, educational and socio-economic backgrounds).
- That structures are established to properly support Indigenous students (culturally, academically and financially) once they are enrolled in the course.

In conclusion, this study has brought together and critically evaluated existing knowledge relevant to the field of Aboriginal health teaching in undergraduate medical courses. It has contributed to our understanding of medical students' perceptions of Aboriginal people, their understanding of Aboriginal health and their attitudes towards teaching. The project has developed a new model that articulates key barriers and enhancers in relation to learning and has demonstrated an effective approach to teaching students about Aboriginal issues. It is hoped that this body of work will contribute to existing knowledge in this important field.

# Appendices

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# Appendix 1: Steering Committee

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The steering committee was formed in 1995, primarily to oversee the development and delivery of the surveys and the pilot teaching project. It comprised six individuals, bringing together a broad range of expertise and experience within the Koori community, and within both the disciplines of Education and Medicine.

## **Associate Professor Ian Anderson**

At the time of the project, Ian Anderson was the Medical Director and Chief Executive Officer at the Victorian Aboriginal Health Service (VAHS). Ian is the first Koori to graduate in Medicine from the University of Melbourne. Prior to becoming CEO, he had worked at VAHS as both a health worker and a doctor and had taught Aboriginal health in the fifth-year program at the University of Melbourne for a number of years. Ian designed the structure of the project's focus group discussions and was involved with the initial data collection from these discussions.

## **Peter Clarke**

Peter Clarke was working as the Koori Education Officer with the Catholic Education Office at the time of the project and brought to the group extensive experience in cross-cultural teaching amongst non-Indigenous teachers and students. Peter had a strong commitment towards all Australians being better informed about Indigenous history and Indigenous culture. He was also a talented artist and had been involved for many years with the Latje Latje cultural group.

## **Ellen Herlihy**

At the time of the project, Ellen Herlihy was head of the Epidemiology Unit in the Department of Public Health and Community Medicine at the University of Melbourne and was coordinator of the fifth-year teaching program in Community Medicine. Ellen was also involved with the initial development and data collection of the focus group discussions with students.

## **Agnes Dodds**

At the time of the project, Agnes Dodds was a senior lecturer in the Centre for the Study of Higher Education at the University of Melbourne. She brought significant experience in educational initiatives and evaluation processes to the group.

## **Danni Stewart and Richard Kjar**

Danni Stewart was a final-year medical student and Richard Kjar a fourth-year student at the time of the project. Both were very interested in Aboriginal issues and in educational change in Medicine and came with a broad understanding of students and their educational needs.



# Appendix 2: Questions and Student Handouts for Focus Group Discussions

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## Stream One

1. If you were asked to describe Aboriginal people to a total outsider to the Australian community, what would you say?

### Probes

Where do they live?

What sort of lifestyle do they lead?

What sort of issues do you associate with Aboriginal people?

What sort of problems do you associate with Aboriginal people?

What are the key forces that have shaped Aboriginal life today?

What is your relationship with Aboriginal people?

2. Prior to coming to university, what sort of influences shaped your understanding of Aboriginal people or your appreciation of Aboriginal issues?

### Probes

What was the role of family and friends?

What was the role of Aboriginal people?

What was the role of education?

What was the role of text and visual images?

3. To what extent do you think your individual experience is common to non-Aboriginal Australians? What about other medical students?
4. Are there any critical incidents you remember which have been influential in shaping your understanding of Aboriginal people? If so, what?
5. Has university changed your understanding of Aboriginal people or appreciation of Aboriginal issues? In what way?
6. How do you feel about interacting socially with Aboriginal people in general?

## Stream Two

1. How important is it to you to learn about Aboriginal issues in the medical degree course? And why?

### Probes

What sort of advantages do you recognise?

What sort of disadvantages do you recognise?

2. What sort of issues, if any, do you feel need to be covered in discussing Aboriginal health in this course?
3. Aboriginal health status is lower than that of non-Aboriginal people. Why do you think this is so?
4. What sort of things must be done in order to improve Aboriginal health status?

## Stream Three

1. How likely is it that when you are doctors you will deal with Aboriginal patients?

### Probes

Why?

What is the most likely/least likely scenario?

Do you anticipate any problems under these circumstances?

How does this shape your approach to learning about these issues?

2. How would you characterise the relationship between the medical profession and Aboriginal patients in general?

### Probes

What are the factors or processes that have contributed to this?

## Handout 1: Quote

In the 1960s, the Aborigines Welfare Board<sup>41</sup> wrote to medical practitioners in Victoria requesting information on the health of Victorian Aborigines. The general practitioners were the only access to the health system at this time (apart from casualty departments). One doctor who worked in a rural practice, replied in 1966 that:

*I do think of them as 'pests' by and large because the 5% of Aboriginal patients would account for perhaps 50% of late-night calls and weekend work... In my earlier days here, I would sometimes try to collect a fee, particularly if a group arrived in a taxi from forty miles away, but now I do not. It upsets me, not them...*

*I resent them for this double imposition — this is a busy practice and sleep can be precious and I get very little time to spend with my family of five.*

How do you respond to this? Why do you think this situation had developed?

## Handout 2: Case Study

Consider the following case study, and I want your opinion on certain issues.

Amy is a 35-year-old Koori woman, with newly diagnosed NIDDM. She lives in her sister's house in Broadmeadows, having just left a town along the Murray River where most of her extended family lives. Living in this small house are her three children, her sister and nephew. Amy has her name on the state public housing waiting list. The main source of income for the household is her job as a receptionist for a Koori Co-operative in the inner city. No-one in the household has access to a car. Clinically Amy is hypertensive, smokes twenty cigarettes a day, has no history of ischaemic heart disease but is ten kilograms overweight.

This is her third visit to you after being commenced on an oral hypoglycaemic, three months previously. Interventions over the past three months:

- 11 February: RBG-15; Urea and Electrolytes-NAD; LFTs-NAD.  
Commenced on Metformin 500 mg bd.  
Referred to dietitian.
- 27 February: For review, unable to keep appointment.
- 24 March: Visited dietitian, but did not follow-up.  
Blood taken for lipids/cholesterol, RBG and HbA1C.  
Managing medications.  
Has not been able to obtain a glucometer.  
Is having problems at work (staff conflict).  
Sister's husband has moved into house.
- 15 April: RBG-14; HbA1C-13% (poor control)  
Reported central crushing chest pain on exertion (which ceases on rest) on two occasions over the past fortnight.  
Mother, who lives in Swan Hill, has been ill over the last week.  
Amy wants work certificate.

What do doctors mean by the term compliance?

How would you describe Amy's response to medical treatment?

How would you explain it?

<sup>41</sup> The Aborigines Welfare Board was created under the Aborigines Act with the function to 'promote the moral, intellectual and physical welfare of Aborigines... with a view to their assimilation into the general community'. Lyons, G. 1983. Official Policy Toward Victorian Aborigines 1957-1974. *Aboriginal History* 7:61-81.



# Appendix 3: Student survey

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**The University Of Melbourne**

**Department Of Public Health  
and Community Medicine**

## **Aboriginal Health: Innovations For Teaching Medical Students**

**Research Project  
Medical Student Questionnaire**

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### SECTION 1

This section contains a number of routine demographic questions to help us gain a profile of medical students at Melbourne University who respond to this questionnaire.

1.1 What is your gender?

- male
- female?

1.2 What age category do you belong to?

- 15-19
- 20-24
- 25-29
- 30-34
- 35-40

1.3 What is your country of birth?

1.4 If your country of birth is not Australia, how many years have you been living in Australia?

- 0-4 years
- 5-9 years
- 10-14 years
- 15-19 years
- 20-24 years
- > 25 years

1.5 In which year are you currently enrolled?

- 1st year
- 2nd year
- 3rd year
- 4th year
- 5th year
- 6th year

1.6 If you are in your clinical years, at which hospital campus are you based?

- Austin and Repatriation Medical Centre
- Royal Melbourne Hospital
- St Vincent's Hospital

1.7 Please tick the area(s) of medicine in which you would like to work in the future

- general practice
- hospital based specialist medicine
- private practice based specialist medicine
- community health
- Aboriginal health
- research
- other \_\_\_\_\_
- no preference at present



1.8 At this stage, where are you planning to practice medicine once you have graduated?  
(Please tick as many boxes as appropriate.)

- Australia
  - rural
  - remote
  - city
  - no preference at present
- Elsewhere. Please state which country

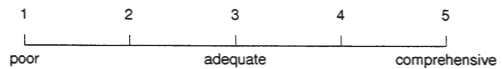
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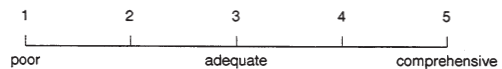
### SECTION 2

This section is to gain some understanding of your current knowledge and opinions about Aboriginal issues  
Please circle a number on the following scales.

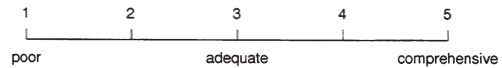
2.1 How do you rate your knowledge of issues facing contemporary Aboriginal Australia?



2.2 How do you rate your knowledge of Aboriginal history, culture and politics?



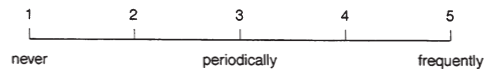
2.3 How do you rate your knowledge of Aboriginal health specifically?



2.4 The health status of Aboriginal people is lower than that of non-Aboriginal people.  
Why do you think this is so?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2.5 Do you expect to have much involvement with Aboriginal patients once you have graduated?



Please expand on why you think this.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**2.6** Can you consider the following **influences** that may have **shaped your understanding** of Aboriginal issues. Please rank the three most notable influences from (1) to (3).

- family
  - friends
  - primary and secondary school education
  - general media reportage (TV, newspaper, film, radio)
  - Aboriginal people in the media
  - Aboriginal people that you have known personally
  - Teaching in the Medical Faculty
  - Experiences at university outside of this teaching
  - other (please outline)
- 

**2.7** Please list any incidents that you think have been particularly critical in influencing or shaping your understanding of Aboriginal people.

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**2.8** In 1994-1995 approximately what percentage of the federal health budget do you think was specifically allocated to Aboriginal health?

- 20%
- 10%
- 5.0%
- 1.0%
- 0.1%
- < 0.1%

**2.9** Over the past 10 years (adjusted for inflation) do you think that Aboriginal health funding has

- decreased
- remained the same
- increased

**2.10** What do you think might be the average life expectancy of an Aboriginal male in Victoria?

- 30 years
- 40 years
- 50 years
- 60 years
- 70 years

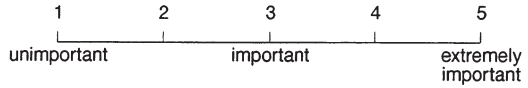
**2.11** The prevalence of diabetes in the non-Aboriginal population is approximately 2%. In comparison, what do you think the prevalence of diabetes in the Aboriginal population might be?

- the same
- twice as high
- 5-10 times as high
- 50 times as high

**SECTION 3**

This section is to determine your specific opinions about teaching Aboriginal health in the medical curriculum  
Please circle a number on the following scales.

- 3.1 How important is it for you to learn about Aboriginal health and related issues such as Aboriginal history, culture and politics in the medical curriculum?



Please explain.

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- 3.2 List possible benefits of learning about Aboriginal health and related issues as part of the medical curriculum?

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- 3.3 List possible disadvantages of learning about Aboriginal health and related issues as part of the medical curriculum?

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For the purpose of this study, our definition of **teaching** includes any situation where preclinical or clinical teachers have been involved in facilitating your learning, eg **bedside teaching, laboratory teaching, advanced study units, formal and informal tutorials or group discussions and lectures.**

- 3.4 Please list the teaching that you've had to date on Aboriginal health and related issues in the table below no matter how small it may seem. Include as much on the table as you can remember.

Some illustrative examples of more informal teaching are given.

<b>Briefly describe teaching received in Aboriginal Health or related areas.</b>	<b>Year Level</b>	<b>Teaching staff involved</b>	<b>Subject in which taught</b>
Bedside tutorial. Aboriginal patient with heart failure. Focused on causes and social issues.	4th year	Dr J. Smith	Medicine
Informal discussions on access to health care in Australia. Discussed Aboriginal people.	3rd year	Dr J. Smith	Community Medicine

3.5 With respect to this teaching, what did you find the most useful and why?

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3.6 With respect to this teaching, what did you find the least useful and why?

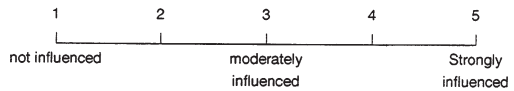
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3.7 To what extent has the above teaching at Melbourne University influenced your perceptions about the Aboriginal community and Aboriginal health?



3.8 If there has been any change in your perceptions as a result of this teaching, can you outline this in more detail?

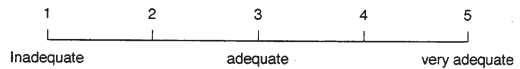
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3.9 For your level of medical training, how adequate would you describe the amount of teaching you have had up to now in Aboriginal health?



Please explain.

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3.10 What sorts of issues or topics would you like to see covered in any teaching on Aboriginal health and related issues?

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3.11 Do you think that Aboriginal health should be taught

- as a separate set subject
- as a subject area that is incorporated into a wide range of existing subjects such as general medicine, paediatrics, epidemiology etc.
- as both a separate subject and as a subject that is incorporated into a range of existing subjects.

3.12 With respect to learning about Aboriginal health and related issues as a set subject, what would be your preferred option?

- a set subject in the preclinical years.
- a set subject in the clinical years.
- a set subject incorporated throughout both preclinical and clinical years.

3.13 Are there any other ways that you think that teaching could be improved?

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**SECTION 4.**

Follow Up.

To ensure confidentiality, please detach this section for separate collection on completion of the questionnaire. Your contact details are only for the purposes of any voluntary follow up as outlined below.

4.1 We are keen to have students' involvement in the broad area of curriculum development. Are you interested in having more input in the development of an Aboriginal Health curriculum?

- yes
- no

4.2 We are planning to interview a small group of student volunteers about their teaching experiences to date. This will be done at the most convenient location for you and would involve approximately 20-30 minutes. Are you interested in being involved?

- yes
- no

We are planning a pilot teaching program in Aboriginal Health in March/April 1996.

At this stage, this will entail a weekend away at Brambuk, the Aboriginal Cultural Centre in Gariwerd Victoria, a guided urban tour of key social health and cultural centres and an evening seminar with members of the Aboriginal community.

We have yet to determine cost but there will be a small cost to participants of \$20-25

4.3 Would you consider participating? (At this stage we are looking for expressions of interest only.)

- yes
- no

If you are interested in being involved in any of the above please provide your contact details and we will get in touch with you.

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Phone no: \_\_\_\_\_

E mail: \_\_\_\_\_

**Thanks for taking the time to fill out this questionnaire.**



# Appendix 4: Pilot Teaching Project, Brambuk- Collection of Readings

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# Appendix 5: Students' Learning Requests from Pilot Project Orientation Meetings

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## GENERAL LEARNING REQUESTS:

- to get a first-hand view of their way of life;
- to hear Aboriginal people's version of more recent historical events;
- to hear specific Victorian history;
- to understand the specific significance of the land in Victoria;
- to hear from young people in the Aboriginal community of a similar age to themselves;
- to hear how Aboriginal people see things and to gain an understanding of the specific problems they face.

## INFORMATION ON A WIDE AND VARIED RANGE OF AREAS WAS ALSO REQUESTED. STUDENTS REQUESTED INFORMATION ABOUT:

- legal issues;
- structure;
- contemporary lifestyles;
- how customs and culture are passed down;
- the impact of western culture;
- ATSIC and its role and structure in the Aboriginal community.

WITH SPECIFIC REFERENCE TO HEALTH, STUDENTS ALSO REQUESTED INFORMATION ABOUT:

- remote health;
- mental health;
- the delivery of Aboriginal health care is structured across Australia;
- traditional medicines and the use of plants;
- aged care system for Aboriginal people;
- approaches to health education;
- the relationship between Aboriginal people's vulnerability to particular health problems and specific aspects of Aboriginal culture and the impact of western culture;
- compliance with medication;
- how the medical profession should approach health education with Aboriginal people;
- Aboriginal people's attitude to western health care (positive or negative) and how doctors might respond to these attitudes to better provide good health services.

# Appendix 6: The Challenging Racism Game

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*The Challenging Racism Game* Kit was developed in 1987 by the South Australian Justice, Freedom and Hope Workgroup. It was written by mainly non-Aboriginal women in consultation with several Aboriginal people. A panel of Aboriginal people had monitored the running of the game on a number of occasions in its development.

This is an edited version of the instructions that were part of the kit. They are intended to give readers an idea of how the game is run and are not intended to be a recipe for running the game. Two non-Indigenous cross-cultural workers, with experience in running the game, ran our session. They facilitated the game slightly differently to the outline that is provided below.

## Objectives

- To explore racism and non-Aboriginal people
- To highlight structural inequality and oppression
- To provide a creative and stimulating context in which to examine racism
- To avoid guilt and inertia

## Prerequisites

Facilitators need to have participated in the game previously

## Time needed

1.5–2 hours and, ideally, a group of 15–25 people

## Resources

- Armbands for half the players
- Monopoly money
- Game squares
- Game cards
- 2–4 dice
- A large room with plenty of space to spread out

## Process of the Game

### *Section 1: Introduction (30 minutes)*

Facilitator explains the objectives of the game, not the rules, including the fact that the game is played in three stages. If group members do not know each other or if the facilitators do not know the group, start with a round of introductions. Then go around the group again asking the questions, 'Why are Aborigines on the bottom of the heap?' or 'What are two stereotypes of Aboriginal people you have believed?' The purpose of this is to focus the group's attention on the issues of racism and Aborigines, and to bring out the range of attitudes that exist in the group.

### *Section 2: Playing the Game (1 hour)\**

1. Facilitator divides the group into two arbitrary groups. Team B is asked to leave the room and put their armbands on. The facilitator speaks to Team A.

2. Team A without the armbands:

- is given orientation of the game;
- is told the rules of the game;
- starts the game with \$500;
- is told to stand in line and remember the person in front of them.

3. Team B with armbands:

- is not given orientation;
- is not told the rules;
- starts with no money;
- is told to stand in line and remember the person in front of them;
- waits outside while Team A is oriented.

4. Outline of the Game

- Game squares are laid out in a circle. A Team-A member throws first, then a Team-B member. Each player throws the dice in turn and moves forward according to the number of places thrown.
- Players need to remember their own position in the order of the team.
- As players cannot move on to a square occupied by a Team-A player, they must sit out of the game until a space becomes vacant.
- Team-A players can move to a spot occupied by Team B and the Team-B player must sit out of the game until the Team-A player moves on.
- Players may borrow money from their own team members.
- Team-A players are responsible for evicting or removing Team-B players from their square.
- When a Team-B player is removed from the Jail square, they are moved out of the circle, away from other Team members.

### *Section 3: Evaluation (at least 1 hour)*

Different techniques of evaluation will be needed depending on the response of your group. We suggest a circle where everyone expresses their feelings about their role in the game. Also a circle asking the question, 'Why did Team B lose?' or 'Is this like real life?'

# Appendix 7: Evaluation forms

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## Student Evaluation Questions: 1. Brambuk Program

Students were given forms to complete at the end of Day 2 and Day 3 of the Brambuk program. On one form they were asked to complete these three questions about both the morning sessions and the afternoon sessions. On the second form they were asked to complete the same questions about the activities which had been organised by Brambuk staff.

1. What specifically did you find useful about the content and the process of these sessions?

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2. What was not useful about the content and the process of these sessions?

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3. Is there any way these sessions could have been improved for you?

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## Student and Facilitator Evaluation Questions:

### 2. Brambuk Program

At the conclusion of the Brambuk program, students and facilitators were given an additional evaluation sheet seeking their views about the overall program.

1. What are your views about this weekend as a way of learning about Aboriginal issues and Aboriginal health?

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2. Would you recommend that such weekend teaching sessions be conducted for future students?

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3. Please give any other comments you have about the three days.

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## Student Evaluation Questions: 3. Brambuk Program

We were planning to have a structured group-feedback, with both students and facilitators, as part of the final session. Unfortunately, time did not permit this. All students still completed the following form that we had devised for the process, and this was an opportunity to make additional comments about the weekend.

GOOD POINTS	BAD POINTS
About the WEEKEND	
About the TEACHING (CONTENT)	
About the TEACHING (FACILITATION)	
About us, the STUDENTS	

## Facilitator Evaluation Questions: 3. Brambuk Program

Facilitators were also invited to complete a similar form with some modifications.

GOOD POINTS	THINGS THAT COULD BE IMPROVED
About the WEEKEND (IN GENERAL)	
About the TEACHING (CONTENT)	
About the TEACHING (FACILITATION)	
About the STUDENTS	
About us, the FACILITATORS	



## **Student Evaluation Questions: Urban Tour**

Students had completed every evaluation form in great detail over the weekend and were somewhat 'evaluated out' by the completion of the urban tour. By that stage students were very familiar with the kinds of questions they were being asked. Seven students wrote out evaluations on blank cards that evening. Most students elected to speak with me personally that evening or over the phone during the following week.

The following questions were asked:

1. What did you find useful about the urban tour?
2. Were there any parts of the tour that were not useful?
3. Is there any way that the urban tour could have been improved from your perspective?
4. Do you have any further comments?

## **Facilitator Evaluation Questions: Urban Tour**

Facilitators were also invited to speak about similar questions with me personally that evening or over the phone during the following week.

The following questions were asked:

1. What do you think was good about the urban tour?
2. Were there any parts of the tour that were not so good?
3. Is there any way that the urban tour could have been improved from your perspective?
4. Do you have any further comments?



# Appendix 8: Pilot Teaching Project: Brambuk Program and Process Evaluation

PROGRAM	PROCESS EVALUATION
<p><b>Orientation (Day 1)</b> Students and facilitators gathered that evening and met informally over a barbeque.<sup>42</sup></p>	<p><b>Orientation (Day 1)</b> As facilitators arrived later than expected, Friday evening did not go as planned and student feedback was varied.</p>
<p><b>Hopes, fears and expectations (Day 2)</b> The formal program commenced with a session on hopes, fears and expectations. This session aimed at providing a reference point for the weekend by clarifying learning and personal aims. Students and facilitators alike shared thoughts in small groups. Common themes were then identified in the wider group. People's hopes, fears and expectations were anonymously written down and kept on the wall over the weekend. Participants were also encouraged to add to these lists as the weekend progressed.</p>	<p><b>Hopes, fears and expectations (Day 2)</b> Seven students spoke specifically about this session. All seven found it very useful. Starting in this manner had served as a good reference point for the whole weekend in clarifying aims and giving the group a clear, shared direction. Expressing various fears, hopes and expectations in small groups and then within the wider group, helped create a safer environment and was reassuring for these students, particularly in coming to realise how much they had in common with other students.</p> <p><i>By doing 'hopes, fears and expectations' posters we were able to get through the 'uncomfortable zone' before it was time to ask questions - made speaking up a lot easier.</i></p> <p><i>I thought it was great how we listened to our hopes, fears and expectations at the start and then reconsidered these in our de-briefing session. This was really useful for me as it compounded the huge amount I had taken in and kind of summarised it into something I could take away with me and keep forever</i></p>

<sup>42</sup> Session 1 was scheduled for the Friday evening but was postponed until the following day as many facilitators were delayed in leaving Melbourne

## PROGRAM

### FILMS AND TALKING CIRCLES (DAY 2)

This session began to explore the broader issues of Aboriginal history, culture and identity. Selected historical and contemporary films<sup>43</sup> were shown to further familiarise students with the broader history of Aboriginal people (from pre-contact, through early colonisation and to later periods of segregation and assimilation) and to show them the impact of this history on contemporary culture and contemporary Aboriginal identity. Film was used to expose students to these issues and generate and stimulate ideas and key questions prior to moving into the talking circles.

The next session was based around the idea of 'talking circles'. Facilitators took six groups of 5–6 students (ratio approx. 1:3) and students rotated through three different groups with thirty minutes in each group. The session began with a clarification of group rules for the talking circles, particularly in relation to turn-taking and confidentiality. In the groups students were free to ask any questions and to express their ideas and reactions after having seen the films. Everyone then regrouped to sum up the session

## PROCESS EVALUATION

### FILMS AND TALKING CIRCLES (DAY 2)

The films and talking circles gave students a more meaningful insight into Aboriginal history and culture than the majority had previously received. The use of both contemporary and historical films with very different styles and approaches clearly provided a thought-provoking and stimulating basis for students to move into the talking circles. Many found the historical material shocking and commented on how sheltered they had felt from Australia's past and more recent treatment of Aboriginal people. The films also helped to encourage students to frame Aboriginal issues within an historical context.

Students universally appreciated the 'talking circles' as a place to discuss the issues raised by the films with such a large number of Aboriginal people. Hearing a number of different viewpoints and experiences clearly helped students understand the complexity of the issues at a more personal level. Through this process many students quickly understood that there were many different views in the Aboriginal community and for the first time realised that asking such questions such as, 'What do Aboriginal people want?' is unhelpful and unrealistic.

*Videos presented history in an accessible, informative way. It was very overwhelming, but talking circles afterwards gave us a chance to 'debrief', discuss, ask questions — start thinking and feeling and speaking about what we'd been made aware of. Excellent forum - relatively non-intimidating and informal - fantastic opportunity to ask necessary but probably naive and potentially dodgy questions and to hear Kooris speak. Rotating facilitators provided different foci and approaches.*

*I think it was good not to dive straight into the talking circles without any informative programming and that the balance between media in this presentation — the videos, speeches, hand-outs and the museum displays around the room contributed to my rapid grasping of the facts at hand. The talking circles were of course the most memorable part of the seminar and this personal contact and frank, open discussion were excellent in stirring the heart and forming positive attitudes to supplement actual knowledge of the facts.*

Time constraints were the main difficulty with this session.

## PROGRAM

### NATURE WALK AND CULTURAL TALK (DAY 2)

Brambuk staff led the next sessions which included a nature walk, giving students some understanding of indigenous plants and their medicinal value, and a talk on the history of the local area both pre- and post-colonisation. These sessions gave students an understanding of cultural practices, both those lost and those retained over the last 200 years and some idea of the contemporary structure of communities in the area.

## PROCESS EVALUATION

### NATURE WALK AND CULTURAL TALK (DAY 2)

Fifteen students spoke specifically about this session. They found it interesting and stimulating, gaining an appreciation of the importance of local knowledge being maintained. Students described being struck by the strengths in the culture; what had survived; what had changed; and what had been lost.

Students also enjoyed learning first-hand about medicinal plants and for many, this quickly broadened their horizons with reference to how they view current curative medicine. For many, their interest in indigenous plants was stimulated and they were keen to find out more.

*Showed me how much local Kooris had lost through white man's presence and the struggle to learn it again.*

*The nature walk itself was brilliant. It's interesting to see what Aborigines used different plants for, and to see that the innocuous little plants that we would trample over unthinkingly are actually food sources or medicines.*

*Hearing the story of creation of Gariwerd was useful in the sense that it gave me some idea of how Dreamtime stories are relevant today.*

Interestingly after the experience of the talking circles, a number of students found being in the larger group less fruitful. One student would have liked more time to explore specific issues and one requested that similar talks in the future also include a female facilitator to discuss women's issues.

43 Students saw *Lousy Little Sixpence* (1983, Ronin films, 56 mins) and two films from the collection *From Sand to Celluloid*, six short films by Indigenous filmmakers (1996, AFI). The two short films were *Two Bob Mermaid* (15 mins), written and directed by Darlene Johnson, and *Round Up* (16 mins), written and directed by Rima Tamou.

## PROGRAM

### SPECIAL INTEREST SMALL GROUPS (DAY 2)

In the final session for the day, students attended one of four topic groups which dealt with various contemporary issues previously identified in the planning meetings. Topics covered were land rights and native title; working in remote Aboriginal communities; Aboriginal families; and mental health issues. These informal discussion groups focussed on what Koori people and those working in the field were doing in these areas

## PROCESS EVALUATION

### SPECIAL INTEREST SMALL GROUPS (DAY 2)

Thirteen students commented specifically on the small groups. Generally, students appreciated being able to discuss specific areas of particular interest in small groups.

The group discussing remote communities was more popular than the others and hence generated more feedback. The following comments about each small group give a sense of what students learnt by participating.

#### **Working in remote communities:**

*The session with M. and N. was also really good because they not only shared the great things about working in remote areas, but they also made us aware of the many difficulties and frustrations. It was realistic and down to earth, and it really opened up my eyes to the possibility of working in such areas. Beforehand I had some fairly glamorised ideas about what working in the outback would entail and now I'm better informed.*

#### **Koori families:**

*I personally got a lot out of this session because it grounded me in how Koori families live now. I left with a much stronger sense of what family means to a Koori.*

#### **Mental health:**

*Heard Aboriginal stereotypes of white institutions and stories to back it up. Emphasised the differences in care and healing of mental illness for Aborigines and non-Aborigines.*

#### **Land rights:**

*I attended the session on land rights/law and was made to understand the predicament and relative lack of constructive action with regard to Aboriginal Native Land Rights.*

Some students felt that these sessions did not have as much student input as earlier sessions and a few would have liked the opportunity to attend more than one session. In general, students felt increasingly relaxed and more familiar with the facilitators on Day 3 and found that this helped with the development and depth of discussion.

## PROGRAM

### VISIONS FOR THE 21ST CENTURY (DAY 3)

The morning session focussed on participants' thinking about their visions for the next century for Aboriginal and non-Aboriginal Australia, particularly in areas such as health, education and the law. In small groups, students worked through a utopian scenario for Aboriginal Australia, focussing on one of these areas, thinking through the existing barriers to such a scenario and reflecting on what they believed was needed to overcome these barriers. Complex issues and possible systemic and specific solutions were discussed in groups.

## PROCESS EVALUATION

### VISIONS FOR THE 21ST CENTURY (DAY 3)

Twelve students spoke specifically about this session. As a group, they found it positive, constructive and practical and stated that the small-group work helped to clarify their thinking both personally and at an institutional level. A number of students particularly appreciated working in groups with Aboriginal and non-Aboriginal people in modelling the reconciliation processes and working towards solutions together.

*Discussion of ways to tackle the changes needed to reach the ideal situation (equality in all areas) was great because it gave me a sense of future promise and that there are goals to achieve and these goals are very realistic and possible or achievable. This discussion was also valuable in that it showed me that I will or can play a role in striving toward many of the changes necessary to recognising the Aboriginal people and their history on this land that we share. Noting the challenges (such as prejudices and racism) that will act as hurdles to achieving showed that the discussion wasn't merely idealistic utopian talk.*

One student particularly appreciated this shared approach when considering health and realised that it was not necessary to solve problems single-handedly with very little knowledge. Four students felt that the discussion was too utopian and not completely realistic in terms of solutions and two also found that the topics were too broad and too general to meaningfully discuss them in a limited time frame.

## PROGRAM

### CHALLENGING RACISM GAME (DAY 3)

Following this orientation to contemporary Aboriginal issues, students were invited to participate in a game aimed at exploring racism, highlighting the structural and institutionalised nature of racial inequality and oppression.<sup>44</sup> This session was led primarily by the two non-Aboriginal facilitators with experience in cross-cultural work and in running the game. Other facilitators played roles in the game or acted in a more supportive capacity. The game aimed to give students an understanding of the 'wall of prejudice' experienced by Aboriginal people. It was designed to avoid reinforcing guilt by empowering students to change their understanding of and response to racism in some way. After playing the game students evaluated their responses to the process, particularly their emotional responses to the role that they had and how participating in the game had altered their understanding of the structural or institutionalised racism. This session concluded with a simple visual exercise using matchsticks, where each matchstick represented a period of time in Australia's history. This exercise powerfully contextualised Australia's post-contact history over the last 200 years.

## PROCESS EVALUATION

### CHALLENGING RACISM GAME (DAY 3)

The majority of students found this session very helpful and only two students did not find it useful, seeing the work as somewhat repetitive of the previous session. Ten students gave more detailed feedback about this session and spoke at length about its impact.

It was clear from students' evaluation comments that as a group they had gained a greater understanding of institutional racism and its impact on Aboriginal people.

*Made me examine myself dramatically because it made me aware of my basic, raw emotions and ways of reacting when removed from the complex politics of 'real life'. It was just a game but it was one of the most powerful parts of the weekend for me. It made me realise how my guilt paralyses me.*

*The game helped me to understand how it feels to be an Aboriginal person, ie how they are treated in a very prejudiced way.*

All but one student found the timing of the game appropriate: that having it on the second day provided a way of contextualising material in an experiential way. Students found the debriefing session helpful in dealing with their emotional reactions to the process and in helping make the game meaningful. Again some students requested more time especially for the debriefing and one student thought it would be very helpful to run the game twice, reversing the two teams so that all participants received a first-hand experience of institutional inequities.

Many students also commented on the power of the 'matchstick spiral' in challenging students' views of 'white' Australian culture and in assisting them to gain both a sense of the extent that Indigenous cultures have been in Australia and of the impact of colonisation in such a short period.

*(The match spiral) was really powerful. Its image will stay in my mind for a very, very long time.*



## PROGRAM

### ART SITE TOUR (DAY 3)

The afternoon session, run by Brambuk staff, involved a walk to an art site within the national park. During the course of the weekend it became clear that traditionally the site had special significance to men and would not have been visited by women. We had not been informed of this during the organisation of the program. Brambuk staff were happy for all students to visit the site but many of the Aboriginal facilitators did not see it as culturally appropriate to go. This issue exposed students to a potential conflict and gave them an opportunity to work through the issues for themselves. An alternative walk was organised for those female students and facilitators, and others, who did not wish to visit the art site

## PROCESS EVALUATION

### ART SITE TOUR (DAY 3)

Feedback was very positive and thirteen students spoke at greater length about the tour. Students found the walk relaxing, giving them time away from the more structured teaching of the weekend and time for reflection. A number of students had a sense that it helped make things 'real' for them or brought the information and things that they had learnt home for them at a different level. For others, it put things into some kind of order through appreciating the immediate environment.

*The walk to the Bunjils shelter brought the immensity and reality of Aboriginal life home to me. To walk in a place that has been used by Aborigines for that long...*

*Getting out and seeing the land. Being able to wander around the boulders and trees. Hearing the stories. Seeing what had to be done [a wire cage] to protect a sacred site from non-Koori society.*

Two students expressed difficulties with this session because of the confusion over whether or not it was an appropriate site for women to visit. Brambuk staff told students that it was OK for all students to go but that the site had in fact been a sacred men's site. As most of the female Aboriginal facilitators in the group decided not to go, students found the different messages they were getting confusing.

*I chose not to go on this walk because of the way I have learnt about women's and men's business and sacred sites up north... I feel very wrong if I go somewhere which is important without knowing the full story of the place... It was insinuated that this was a sacred men's site but then we were told that it didn't really matter if we went there. I felt like the information was conflicting and that we weren't informed properly. I don't think most people would have come across the concept before of there being places that are sacred that shouldn't be visited by everyone. I felt the situation was not well explained to a group of people who were not well informed enough to know there was a potential issue.*

*A number of students would have liked to have done much more walking in the bush, including visiting more art sites if there had been more time.*

## PROGRAM

### CLOSING SESSION (DAY 3)

The planned 'structured conversation', exploring the notion of an 'enculturated self', with a panel including Aboriginal facilitators, students and non-Aboriginal facilitators was abandoned as it was clear that there was a need for all participants to talk freely about the impact of the weekend in a confidential manner. This session gave all students and facilitators a chance to reflect on their original hopes, fears and expectations and about their own cultural identity.

## PROCESS EVALUATION

### CLOSING SESSION (DAY 3)

The confidential closing session was reported to be important and powerful for all involved. Most students did not comment on it specifically in the evaluation because they saw it as a discrete session in its own right. One student did comment:

*Good to hear what people gained from the weekend on an individual level. Very emotionally charged and it is a part of the weekend I'll never forget. I hope that future students will be given the opportunity to experience the same things and feelings that I did.*

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