Healing Conversations: developing a practical framework for clinical communication between Aboriginal patients, their families and healthcare practitioners.

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Citation List of included publications in this thesis

1. McKivett A, Paul D, Hudson N. Healing Conversations: Developing a Practical Framework for Clinical Communication Between Aboriginal Communities and Healthcare Practitioners. Journal of immigrant and minority health. 2018;3(21):596-605.

2. McKivett, A., Hudson, J. N., McDermott, D., & Paul, D. (2020). Two-eyed seeing: A useful gaze in Indigenous medical education research. *Medical education, 54*(3), 217-224.

3. McKivett, A., Glover, K., Clark, Y., Coffin, J., Paul, D., Hudson, J. N., & O'Mara, P. (2021). The role of governance in Indigenous medical education research. *Rural and Remote Health, 21*(2), 6473-6473.

4. McKivett, A., Clark, Y., Coffin, J., Paul, D., Hudson, J. N., O'Mara, P & Glover, K. (2021). Healing Conversations; guiding Aboriginal health communication in health professional education. Submitted to Qualitative Health Communication.

Abstract

Introduction

This Healing Conversations project aims to contribute to building culturally capable healthcare practitioners skilled in effective communication with Aboriginal peoples and their families.

To achieve this, the research has developed a communication framework for use in healthcare curricula. The conceptual notion of two-eyed seeing, or Etuaptmumk, put forth by Mi'kmaw elders Albert and Murdena Marshall has guided implementation of the research. This approach values Indigenous and non-Indigenous perspectives and recognises the importance of Indigenous governance in the research process.

Ontological and methodological approach

A qualitative approach was implemented to gain in depth understandings of key stakeholders. An initial framework, developed from the literature to form the basis of data collection, was refined in response to findings from the research data.

Data collection consisted of: (1) semi-structured interviews with Aboriginal community members and registered healthcare practitioners in South Australia (SA) and Western Australia (WA); (2) a workshop with a health education academic and an Aboriginal community member from SA, and two medical students (from SA and WA).

Ethics approval for this research was obtained from the Adelaide University human research ethics committee, the South Australian Aboriginal health ethics committee, the Western Australian Aboriginal Health Ethics Committee, and the University of Notre Dame Australia human research ethics committee and Community organisational support has been provided by Pika Wiya Health service, Nunkuwarrin Yunti Aboriginal health service and Kimberley Aboriginal Health Planning Forum.

Key findings

Four key themes emerged from the interviews: building the therapeutic relationship; communication in the clinical encounter; institutional and organisational factors impacting communication; and educating healthcare practitioners in communication. These results acknowledged that communication approaches need to be patient-centred, considerate of Indigenous worldviews and guided by geographical and community contexts.

The workshop validated the interview findings, recognising the Framework encompassed a broad range of cultural capabilities and required a scaffolded approach to curriculum development and implementation. The workshop highlighted the importance of quality, well-resourced teaching and assessment of Indigenous health in healthcare curricula.

Discussion

The targeted communication Framework was developed in stages in response to different avenues of feedback from Aboriginal community members, healthcare practitioners and medical students. Implementing the Framework in healthcare curricula will require close consideration to effective approaches to knowledge translation in Aboriginal health. This can include learning on Country experiences as well as supported clinical exposure, the inclusion of diverse perspectives in curricula and ensuring effective and meaningful assessment opportunities for students to demonstrate learning and identify knowledge deficiencies. This has important implications for the resourcing and governance of Indigenous health curricula.

Conclusion and future directions

Healing Conversations presents a Framework for use in healthcare professional education to better prepare students to communicate effectively with Aboriginal patients and their families (figure 1). Applying this Framework into tertiary health professional education can assist with decolonising health education academies and Indigenising health professional education. The use of the Framework in medical education and post-graduate training will provide a platform for further nuanced research into the educational impact on cultural capability outcomes for healthcare practitioners.

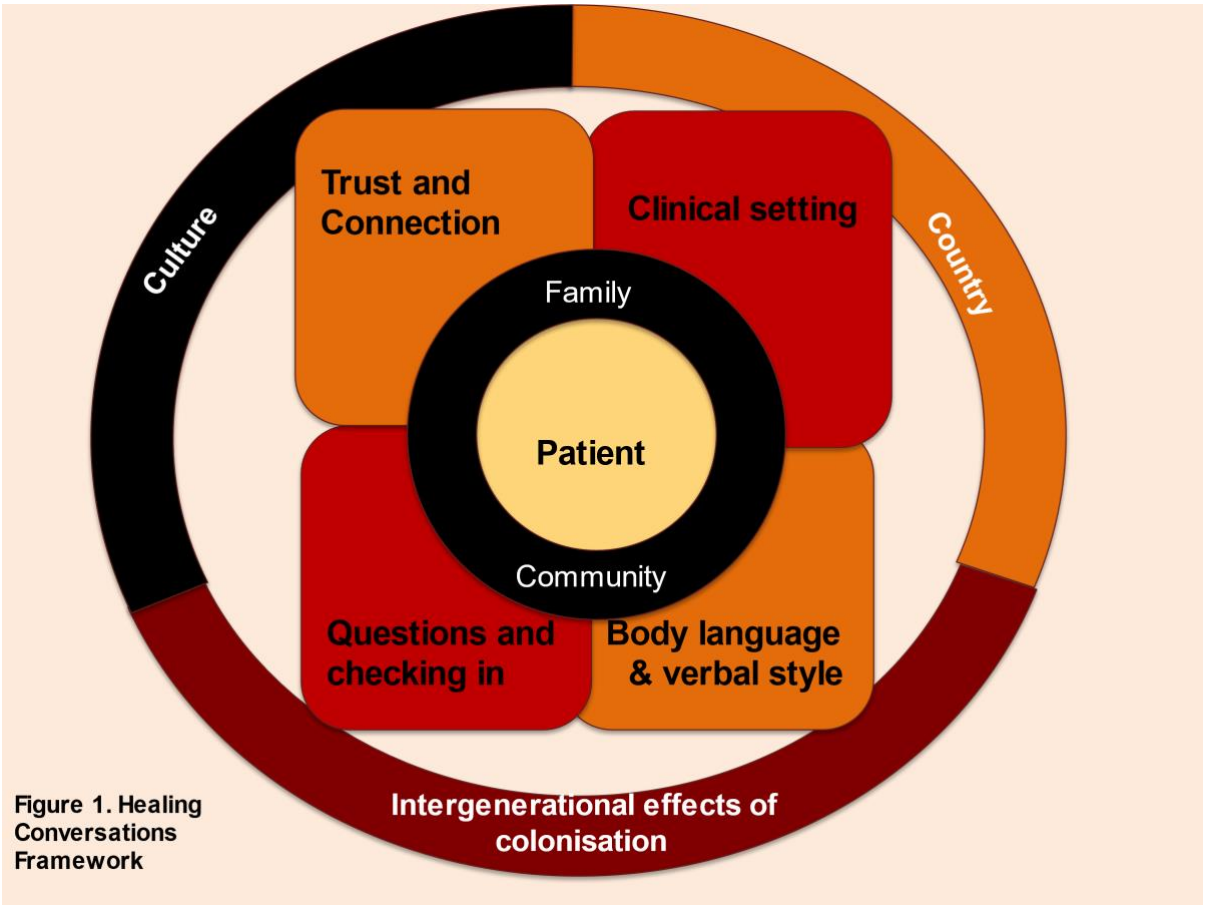

Figure 1. Healing Conversations Framework

Thesis Declaration

I certify that this work contains no material which has been accepted for the award of any other degree or diploma in my name, in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made in the text. In addition, I certify that no part of this work will, in the future, be used in a submission in my name, for any other degree or diploma in any university or other tertiary institution without the prior approval of the University of Adelaide and where applicable, any partner institution responsible for the joint award of this degree.

The author acknowledges that copyright of published works contained within the thesis resides with the copyright holder(s) of those works.

I give permission for the digital version of my thesis to be made available on the web, via the University's digital research repository, the Library Search and also through web search engines, unless permission has been granted by the University to restrict access for a period of time.

Signed: Dr Andrea McKivett, 22/02/2022

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I would like to express my deep gratitude to the Aboriginal community members, healthcare practitioners, health educators, medical student participants and community organisations that participated in and engaged with this research project. The act of sharing knowledge, experiences and support is invaluable. This project could not have been realised without this time, effort and generous acts of sharing.

I would like to acknowledge Vale Professor Dennis McDermott, a valued and respected colleague who was a member of the supervisory panel and Indigenous Governance Group. Vale Professor McDermott's contribution to Indigenous health education and mentorship of the next generation has been invaluable. I greatly appreciate the learning and wisdom he shared throughout my academic learnings.

Thank you to the University of Otago Māori Indigenous Health Innovation for generously hosting me in Christchurch for a work-shadow placement. I appreciate greatly the ready and warm welcome and the sharing of your knowledge and expertise.

I have strong respect and gratitude for the Indigenous Governance Group: Karen Glover, Yvonne Clark, Juli Coffin and Peter O'Mara who have provided a solid foundation of support and wisdom to keep the research, and the research student, on track. This has been done in the true spirit of capacity building and strengthening. Thank you for all the conversations, advice and cups of coffee.

Thank you to my research supervisors Professor Nicky Hudson and Professor David Paul. Prof Paul, your ongoing support of my career pathway from post-high school to PhD is something I value and am constantly grateful for. I have learnt a

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I would like to acknowledge my employer, University of Adelaide, for supporting me to conduct this research project as part of my employment. The financial, professional and resource support is very much appreciated. I would like to specifically acknowledge Professor Lucie Walters, Head of the Rural Clinical School, for her mentorship and support. I would also like to acknowledge Dr Helena Ward for the ongoing support, advice and mentorship throughout the entire research process.

And finally, this work could not have been achieved without the support of my family. Thank you for your guidance, wisdom, and grounding.

Two Goannas

Created in 2021 by Candice and Caitlin Swan of Ashawariya Designs, Nukunu community members from Port Augusta.

Two Goannas represents the power of connection to culture, country, and wellbeing through the gathering of traditional foods and sharing stories together.

This painting embraces concepts that are central to the Healing Conversations research of working together in collaboration and partnership to have conversations that promote health and wellbeing. The Healing Conversations

research team look forward to developing educational materials and approaches embodying the artwork by Ashawariya designs.

The digital rights for this artwork have been purchased and the image is reproduced in this thesis with permission from the artists.

> Human beings *are* because they *are in* a situation. And they will *be more* the more they not only critically reflect upon their existence but critically act upon it. (1)

Overview

This thesis details the process and findings of the research project titled Healing Conversations: developing a targeted framework for communication between Aboriginal patients, their families and healthcare practitioners. The essence of this research is grounded in the significance of critical reflexivity and praxis in driving change in Aboriginal healthcare delivery and outcomes through quality, Aboriginal community -informed health professional education.

Health professionals are key players in the collective effort to promote, strengthen and improve the health and wellbeing of Aboriginal communities in Australia(2-4). Health professionals such as doctors, nurses and allied health staff can be agents of change in addressing healthcare inequities through actions and behaviours that embody the cultural capabilities deemed necessary and significant by Aboriginal peoples(2, 4). On the other hand, health professionals can perpetuate the status quo of healthcare inequities(5). This can be enacted through the maintenance of colonial viewpoints, exhibiting paternalistic approaches to care and demonstrating an inability to work effectively alongside and in partnership with Aboriginal peoples(6).

The Queensland Cultural Capability Framework has defined cultural capabilities as the ‘skills, knowledge and behaviours that are required to plan, support, improve and deliver services in a culturally respectful and appropriate manner’(7). Health

professional educators and researchers have a core responsibility to support health professional students to develop solid cultural capabilities in Aboriginal health(4). Achieving student outcomes of becoming critically conscious of their role in both countering and maintaining healthcare inequities is a core driver of this research. This project also hopes to contribute to building a committed healthcare workforce invested in improving, promoting and strengthening health and wellbeing outcomes for Aboriginal peoples in Australia.

This thesis addresses the role of health professional education on supporting cultural capabilities, with a focus on the core skill of effective clinical communication. A lens of quality, community-informed health curricula is applied to create a framework that can help prepare health professional students to become effective communicators with Aboriginal peoples. This is done in an effort to contribute to a health workforce that is both culturally capable and able to be drivers of positive change through effective clinical interactions.

Background context

Aboriginal health disparities

Aboriginal peoples have a long history of strong connections to community, family, land and culture(8). The ongoing struggle for equity of First Nations peoples is an urgent area of action for the Australian and international community, with added responsibility of healthcare professionals given their role and power to be either drivers of change or perpetuate the status quo(4, 5). Aboriginal and Torres Strait Islander health disparities span widely from exposure to risk, burden of disease, severity of disease, life expectancy and access to quality healthcare(9-13). A

comprehensive approach towards achieving equity is required, an approach that includes a skilled and culturally capable health workforce cognisant of their role in promoting change(14).

There is increasing recognition of the need to shift away from negative and deficit-based narratives that frequently accompany Aboriginal health to strengths-based discourses that focus on solutions and positive change(15). Such efforts work to counter racialized narratives about Aboriginal health by clearly separating the discussion about structural drivers of disparities from Aboriginal peoples to avoid a victim-blaming approach (15). Activities rooted in praxis, or reflection in action, can lead to transformative change in how health professionals and the health system approach the entrenched inequities that Aboriginal people experience in health outcomes and access to quality healthcare(16, 17).

This change is being led by the growing representation of Indigenous perspectives and viewpoints in health professional education, whereby Indigenous peoples and non-Indigenous allies are reclaiming the narrative of Indigenous health being represented in curricula(18). This change reflects a slow shift in tertiary education institutions in valuing Indigenous leadership and governance to safely integrate Indigenous knowledges and perspectives into healthcare curricula.

A shifting gaze allows educators to go beyond merely describing inequities and healthcare disparities in Aboriginal health to critiquing the underlying power structures that maintain them(19, 20). Education rooted in praxis can highlight the systems of oppression that enable inequities to continue, providing the opportunity for students to develop skills and knowledges to understand and critically reflect on how to address these as individuals and members of a collective health professional identity(20). This requires solid learning in the fields of cultural safety

and understanding of the self, having a critical understanding of the roles of colonisation, marginalisation and racism in healthcare delivery, and being able to recognise the role of power in healthcare interactions(21, 22). This knowledge can inform the development of reflexive clinical skills and behaviours that promote best practice, accessible healthcare delivery(21). This works to promote an analysis of the culture of healthcare instead of presenting Indigenous culture as the problem(15, 23).

The broad constructs of understanding colonisation, racism and marginalisation form the foundation of the Aboriginal Health Curriculum(24). This thesis explores these constructs with a focus on effective communication in clinical interactions, in recognition of the salience of this clinical skill in facilitating good healthcare interactions(25). The need for targeted and sustained teaching and learning opportunities in Aboriginal health communication skills, along with the importance of regular observation and feedback from undergraduate training and beyond is explored.

Health professional education and communication

Health professional education plays a pivotal role in addressing the health inequities that are experienced by Indigenous peoples compared to non-Indigenous peoples across the globe(2). In Australia, medical education institutions are required to demonstrate committed action toward their community responsibility of providing quality education in Indigenous health(26). This aims to ensure that medical graduates are skilled and capable practitioners in the field of Indigenous health on entry to professional practice (26). Building the cultural capabilities of the future healthcare workforce to make a meaningful contribution to countering health disparities is a core responsibility for health educators (23).

A foundational skill in the provision of culturally capable healthcare is the ability to effectively communicate with Aboriginal patients in clinical interactions (27). Communication, when done well, can improve patient adherence to treatment and positively influence patient satisfaction with their doctor (28). Effective communication is valued by Aboriginal patients and seen as essential to care, engagement and the attainment of good outcomes(23). In contrast to this, ineffective communication can lead to an inability to reach shared understandings between the patient and the doctor (27). This can be a barrier to accessible, best practice healthcare.

Communication specifically in the context of Aboriginal peoples is a core graduate outcome for medical practitioners entering the health workforce, detailed as the ability to:

> Demonstrate effective and culturally competent communication and care for Aboriginal and Torres Strait Islander peoples and/or Māori. (26)

This is of significance within the Aboriginal community as there is increasing evidence which demonstrates how less than ideal communication between Aboriginal patients and health professionals is so widespread that it can be sometimes seen as the norm in clinical practice (25).

Considering the importance of this clinical skill, medical education institutions need to provide high quality teaching and learning opportunities for future healthcare providers to develop their communication skills in a way that is both acceptable to Aboriginal community members and the healthcare system. The research project Healing Conversations aims to contribute to this priority educational area.

A potential risk of creating a pan-Indigenous framework is that it essentialises Indigenous health communication, promoting a deficit-based discourse that focuses on the patient as opposed to critical reflection of the practitioner and health culture(23). This can work to create false assumptions, which could include the notion that communication barriers only occur in particularly settings such as rural and remote areas(23). This work aims to redress this risk by exploring the appropriate application of the framework to ensure that core concepts of critical reflexivity, redressing power imbalances and analysing health professional culture are not lost in curriculum implementation. This research project has been located in South Australia and Western Australia to explore the presence of commonalities and distinctions for consideration when delivering communication skills education in different geographical communities with distinct historical and cultural contexts.

Meihana Model and Hui Process

I was extremely fortunate to participate in a peer-learning and work shadow experience with Professor Suzanne Pitama at the University of Otago Māori Indigenous Health Innovation (MIHI) in 2018. During this placement I was able to observe implementation of quality health education initiatives in cultural safety and best practice Māori healthcare delivery with year 3 and year 4 medical students. This was a highly valuable learning experience in observing educational innovations in Māori health and communication skills that centre Indigenous experiences, worldviews and knowledges in design, delivery and assessment.

I was first introduced to the Meihana Model and Hui Process at a Leaders in Indigenous Medical Education (LIME) conference as an innovative approach to building the cultural capabilities of healthcare practitioners in Māori Health(29). The Meihana model draws on the Māori Health model to describe the compenents

of whanau, wairua tinana, hinengaro, taiao and iwi katoa. These components are overlaid with Māori beliefs, values and experiences and explored within a clinical assessment environment(30). Education initiatives using the Meihana model have shown to increase quality health interactions between healthcare practitioners, Māori patients and whanau(30, 31). This concept of this research project has been inspired from the approach taken to develop the Meihana model and its success in promoting culturally safe healthcare interactions(31).

Researcher positioning and educational experience

As a Gija woman, medical educator and researcher, it is my experience that learning and teaching communication skills can be a challenging task. This challenge becomes more complex as health professionals learn to communicate with peoples who present with diverse worldviews, perspectives and values in comparison to themselves as current or future healthcare practitioners.

As a medical student, learning the medical interview was a structured and closely guided activity. A checklist, rote approach to learning was useful in the early years to ensure core concepts were addressed in every clinical interview, such as the family history, medication history and presence of known drug or other allergies. This was re-enforced in clinical assessment approaches and the allocation of marks to ensuring core content was addressed. The Calgary-Cambridge guide was often referenced as a useful guide when shifting from learning core content to ensuring communication skills were appropriately implemented(32, 33), the importance of which became more and more obvious to me as a future practitioner as clinical placements and patient interactions began.

The importance of effective communication skills was further reinforced through a qualitative research project I conducted as part of a Masters in Aboriginal health, which explored factors influencing best practice health care delivery in Aboriginal health (34). Communication was a central influencing factor in clinical decision-making processes, interpretation of patient symptoms, patient engagement and healthcare accessibility(34), all of which can be either barriers or facilitators to good healthcare outcomes.

As a medical educator, I have facilitated learning in communication skills in the field of Aboriginal health. The education sessions have been developed from personal experience, clinical experience, wider expertise from mentors and colleagues supporting by existing evidence in the literature. For some students in my experience as an educator, there appeared to be a desire for more nuanced, specific teaching in the field of Aboriginal health communication to better prepare them for future clinical interactions. However, on review of the existing evidence there was no specific or targeted educational framework for learning clinical communication in the field of Aboriginal health in Australia that also considers the needs and perspectives of Aboriginal community members. As with clinical practice, best practice medical education is grounded in the evidence, and I sought through this research to ground Aboriginal communication skills curriculum in evidence that has been guided by appropriate knowledges and perspectives.

There are key leaders and role-models in this field internationally who have successfully accomplished the aim of community-informed, evidence-based clinical frameworks in Indigenous health. As already discussed, I have been motivated and inspired by the work of Māori academics and healthcare educators in their work to develop the Hui Process and the Meihana Model in Māori Health.

This innovative approach to learning and teaching has proven to be useful in facilitating better clinical interactions between Māori patients and healthcare practitioners and is being extended beyond medical education into the realm of postgraduate training(35). It is hoped this project will follow in the footsteps of this landmark work in being able to create useful and meaningful educational experiences that translate to positive health outcomes for Aboriginal peoples.

I acknowledge my positioning first as a Gija Aboriginal medical practitioner. On my mother's side, my family are Gija from Halls Creek in the northern Kimberley of Western Australia. On my father's side I have Scottish and Irish ancestry. I was brought up in the regional town of Carnarvon with a strong sense of Aboriginal identity and belonging. On transitioning through medical school and clinical practice, I remained comfortable communicating with other Aboriginal peoples in a clinical setting. Living in two-worlds had likely and unknowingly prepared me for reflexive and adaptative communication skills, and the real challenge was learning the medical culture and formalised structure of medical interviewing that formed a large part of my clinical skills education.

I value inclusion and privileging of Indigenous perspectives and am unsettled with the power imbalances that continue to exist between Aboriginal peoples and mainstream society. I strive to contribute to social justice and equity through recognising the rights of First Nations peoples and the interconnected way in which we live with each other and our environment. I value partnerships and working together with diverse perspectives, as I feel that long-term sustainable change requires a collective approach from Indigenous and non-Indigenous peoples. These values have informed my methodological approach to this research, which is described in more detail later in the methods chapter.

Research aim and approach

As discussed, Healing Conversations has developed a targeted communication framework to prepare future healthcare practitioners to have more effective clinical conversations with Aboriginal patients and their families. An initial framework was developed from the literature as a foundation for adaptation and development through the research process.

Initially the data collection was to consist of three phases; the first semi-structured qualitative interviews with Aboriginal community members and healthcare practitioners, and the second workshop with Aboriginal community members, healthcare practitioners and medical students. The third proposed phase was a testing of the finalised workshop with medical students in an educational setting. Given the time, scope and student researcher capacity within the PhD, along with the impact of the COVID-19 pandemic, the first two phases have been completed and form the body of this research work. The final test phase of the Framework will form future research in health professional education separate to this PhD thesis.

A key overarching aim of this work is to contribute to the decolonisation of healthcare professional curricula whilst concurrently integrating Indigenous knowledges, perspectives and values into teaching and learning in a way that is safe and meaningful. Reflections of the underpinning ontology, axiology and epistemology of the research process proved a pivotal part of this work. Such reflections helped bring clarity to ensuring the research being done in Aboriginal health is safe, effective, inclusive and considerate of the strength of Aboriginal

ways of knowing and doing, whilst recognising the ongoing role of colonisation in how Aboriginal peoples interact with the world every single day.

Research Team

The research team for Healing Conversations consisted of a supervisory panel and Indigenous Governance Group. The Supervisory panel included, Professor Nicky Hudson, Professor David Paul and Associate Professor Peter O'Mara. Vale Professor Dennis McDermott unfortunately passed away in April 2020. Vale Professor McDermott was a respected and valued member of the supervisory panel and Indigenous Governance Group, as well as colleague and friend. The Indigenous Governance Group consisted of Professor Juli Coffin, Dr Yvonne Clark, Ms Karen Glover and Associate Professor Peter O'Mara. Further details of the research team are provided in chapter 4.

Community engagement

The Healing Conversations research has been conducted in South Australia and Western Australia, given the connections and networks of the researchers. Community engagement occurred throughout the duration of the project; 2017-2022. This included Aboriginal community organisation consultation, engagement within the University of Adelaide medical education faculty, and a facilitated work-shadow placement at the University of Otago in Christchurch with the Māori Indigenous Health Innovation (MIHI) in 2018 for three days.

The PhD student researcher was physically located in Adelaide (SA) in 2018-2019, in Broome (WA) 2020, in Port Augusta (SA) 2021, and is currently residing in Adelaide (SA) for 2022. The varied location of living allowed for community engagement and connection of the researcher with both SA and WA communities, and facilitated participant recruitment and data collection. Employment with the University of Adelaide Rural Clinical School facilitated a mobile living arrangement across SA and WA whilst maintaining employment in medical education.

Aboriginal community consultation in South Australia occurred with Nunkuwarrin Yunti Aboriginal medical service, and the Pika Wiya Aboriginal health service in Port Augusta, SA. Both organisations reviewed the research and provided formal letters of support for ethical approval. Regular 6-monthly research updates have been provided to the Nunkuwarrin Yunti research team for the duration of the research project. Letters of support can be found in Appendix I.

Engagement occurred in Western Australia with Derbarl Yerrigan Health Service representatives and the Kimberley Aboriginal Health Planning Forum. The Kimberley Aboriginal Health Planning Forum consultation included presentation of the research project and early findings from South Australia data collection to a wide clinical reference group, prior to endorsing the project and providing a letter of community support, which can be found in Appendix I.

Local engagement with Broome Aboriginal community organisations occurred whilst the student researcher was located in Broome in 2020, including with Nulungu Research Institute and the Kimberley Stolen Generations organisation.

Ethics Approvals

Ethics approval for this research was obtained from the Adelaide University human research ethics committee (2019-001), the South Australian Aboriginal health ethics committee (04-18-787), the Western Australian Aboriginal Health Ethics Committee (976), and the University of Notre Dame Australia human research ethics committee (2020-091F). Ethics approvals can be found in Appendix II. Participant information sheets for stage 1 and 2 can be found in Appendix III, and data collection questionnaires for stage 1 can be found in Appendix IV.

Informal and ongoing knowledge translation efforts

The PhD student has maintained lecturing roles throughout the duration of the PhD at the University of Adelaide, University of Newcastle and Flinders University in the space of Aboriginal health and rural & remote health. This has provided opportunities for knowledge translation of the research findings into health education curricula through lectures, tutorials, workshops and assessment design focusing on Aboriginal clinical capabilities and cultural safety.

The PhD student researcher also has had the opportunity to contribute lessons learnt through the Governance process into recommendations for inclusive governance in a new medical school proposal for the Australian Remote Medicine Academy.

A medical education podcast was developed by the PhD Student in partnership with Professor David Paul and Associate Professor Lilon Bandler in the field of

medical education in 2021. Core themes from the research are discussed to support medical student learning, such as the importance of therapeutic relationships and appropriate research conduct in Indigenous health. Podcast link: https://indigenousmedicaleducation.podbean.com

A website was developed and maintained for this research, as a means for wider knowledge translation. The website includes short blog posts around core research themes and updates of the research progress. All research participants and community organisations have been provided with a link to the website.

The website can be found here: https://www.healing-conversations.net

The PhD research work has been presented in 2018 at the PRiDOC conference in Hawaii and the 2019 Leaders in Indigenous Medical Education Conference in Christchurch. An oral abstract was accepted for presentation at the 2020 ASME conference in Liverpool, which was subsequently cancelled due to the COVID-19 pandemic. Copies of the conference presentations can be found in Appendix V.

Language and terminology

Appropriate language use in Aboriginal and Torres Strait Islander health is fundamental as there is great diversity within the collective community. Appropriate recognition of the complexity of the historical, geographical and cultural context in which Aboriginal and Torres Strait Islander peoples live in as members of a local and collective community is essential. This thesis and the accompanying publications use the terminology of Aboriginal, Aboriginal and

Torres Strait Islander, Indigenous and First Nations according to the context and subject of the commentary to maintain respectful language use.

The term Aboriginal is used in reference to the Healing Conversations research study population, which has taken place in South Australia and Western Australia. As outlined in the South Australia Health and Medical Research Institute Cultural Protocols document:

> Aboriginal is used when referring to the First Peoples of mainland Australia and those of surrounding islands who identify as Aboriginal. Aboriginal is always used in South Australia(36) .

The Aboriginal Health team in the Department of Health, Western Australia also outline the use of Aboriginal as a preferred term of reference in the 2015-2030 WA Aboriginal Health and Wellbeing Framework:

> Within Western Australia, the term Aboriginal is used in preference to Aboriginal and Torres Strait Islander, in recognition that Aboriginal people are the original inhabitants of Western Australia(37)[i] .

The terms Indigenous and First Nations are used when referring to Traditional Custodians from across the globe, and when referring to Aboriginal and Torres Strait Islander communities collectively within the global context. The term Aboriginal and Torres Strait Islander peoples is used when referring to collective Australian First Nations peoples in an Australian national context. Indigenous is capitalised out of a sign of respect throughout this thesis(36). At times, more localised descriptors of populations are used such as Kaurna, Yawuru, Maori, Mi'Kmaw and Canadian First Nations. This is done to acknowledge the origins, context and diversity of First Nations communities and their contribution to this

work. The range of descriptive terminology reflects the diversity of Traditional Custodians both within Australia and across the globe and the community connectedness that exists at local, national, and international levels.

Thesis Outline

This thesis includes three publications that have been published by peer review and one publication that is currently being peer reviewed at time of submission. Three additional chapters are included to provide information not included in depth in the publications, including this introductory chapter, a chapter detailing the Healing Conversations workshop findings and a conclusion chapter detailing translation and next steps for this research.

This chapter, **chapter 1**, has provided an introduction to the research topic by detailing the need for evidence-based, community-informed health curricula that is grounded in praxis and transformative learning. Contextual background information has been provided in this chapter, to orientate the reader to the published literature review which forms **chapter 2.**

The scoping literature review provides an evidence-based grounding to the initial framework used in the first stage of data collection. **Chapter 3** introduces the ontological, axiological and epistemological underpinnings of this research to explain the methodological approach that has been implemented for Healing Conversations. The Canadian conceptual notion of Etuatpmumk, or two-eyed seeing, put forth by Mi'kmaw elders Albert and Murdena Marshall, has guided the

implementation of this research and is presented in more depth in this paper**.** **Chapter 4** summarises the importance of Indigenous Governance in the research process and how it has been implemented in Healing Conversations, as effective and ethical research processes in Aboriginal health are as important as the research outcomes.

Chapter 5 is a manuscript that is being peer reviewed at time of submission details the qualitative data analysis findings from the first stage of data collection in WA and SA for Healing Conversations. **Chapter 6** details the workshop findings for Healing Conversations which have not been published. **Chapter 7** concludes this thesis presenting the final Framework with considerations for curriculum implementation and assessment. Recommendations are outlined along with a path forward for planned future research work in relation to the Framework. A shortened version of this chapter will form the basis for a future submission to an appropriate health professional education journal for peer review and publication.

Publication Description

The first publication included in this thesis is a scoping literature review exploring clinical communication in culturally diverse settings locally and internationally, along with key concepts of Aboriginal health in South Australia, Central Australia and Western Australia. Literature was sourced through library database searching of key terms ‘clinical communication’, ‘Indigenous health’, ‘Aboriginal and Torres Strait Islander Health, ‘cross-cultural clinical communication’, ‘Indigenous medical education’ which identified further studies for review. Salient evidence in the field, including literature exploring the Meihana Model were reviewed and included. Grey literature was sourced through the Leaders in Indigenous Medical Education site. Literature was included if it provided a relevant insight into key qualities and

considerations for effective clinical communication in Aboriginal and Torres Strait Islander Health.

The second publication outlines the methodological approach underpinning this thesis, in recognition of the importance of research processes in contributing to knowledge that is both meaningful and translatable in clinical practice. This publication provides a grounding of the solid contribution of the Canadian conceptual notion of Etuatpmumk, or two-eyed seeing, put forth by Mi'kmaw elders Albert and Murdena Marshall, in guiding the research approach. This publication also provides guidance on how researcher knowledge paradigms were examined and positioned the importance of Indigenous Governance in this work.

The third publication provides an insight into the fundamental role that Indigenous Governance played in this research, offering a case-study to outline the approach, strengths and limitations in this work. This publication was an invaluable opportunity to think deeply about the importance of doing research in a respectful and collaborative way, and offer our learnings to promote further discussion and learnings in the wider medical education community.

Finally, the fourth publication presents the qualitative data analysis findings from the first stage of data collection in WA and SA for Healing Conversations. This publication aims to provide the thesis findings of this stage of the project in a widely accessible and translatable way.

Summary

In summary, this thesis describes the research and findings of the Healing Conversations project aimed at developing a clinical communications framework to assist healthcare practitioners to engage in more effective clinical communication

with Aboriginal patients and their families. Presented in the next chapter is the literature review that guided the development of the initial proposed communication framework which formed the basis of the first round of data collection. This paper is titled: Healing Conversations: Developing a Practical Framework for Clinical Communication Between Aboriginal Communities and Healthcare Practitioners and was published in 2018.

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REVIEW PAPER

Healing Conversations: Developing a Practical Framework for Clinical Communication Between Aboriginal Communities and Healthcare Practitioners

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Abstract
In recognition of the ongoing health disparities experienced by Aboriginal and Torres Strait Islander peoples (hereafter Aboriginal), this scoping review explores the role and impact of the clinical communication process on Aboriginal healthcare provision. A medical education lens is applied, looking at the utility of a tailored clinical communication framework to assist health practitioners work more effectively with Aboriginal peoples and communities. The initial framework, building on existing communication guides, proposes four domains: content, process, relational and environmental. It places emphasis on critical self-reflection of the health practitioner's own cultural identity and will be guided by collective Aboriginal worldviews in select Australian settings. Using a two-eyed seeing approach the framework will be developed and tested in health professional education. The aim of this research journey is to enable health practitioners to have more effective healthcare conversations with Aboriginal peoples, working toward more socially just and equitable healthcare interactions and outcomes

Keywords Aboriginal health · Indigenous health · Clinical communication · Health disparities

Introduction

Australia, as a nation, embodies a richness in community belief systems, life perspectives and shared values stemming from a variety of historical backgrounds. Central to the Australian identity are the Aboriginal and Torres Strait Islander peoples as First Peoples and caretakers of the land many of us are privileged to call home.

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Daily demonstrations of solidarity, survivorship and resilience exhibited by the Aboriginal and Torres Strait Islander community are closely entwined with ongoing marginalisation from societal structures, restricted access to basic resources and inter-generational impacts of destructive historical policy stemming from colonisation [1–3]. Colonisation, the colliding of two worlds and the meeting of different systems of knowledges and beliefs, marked the beginning of a long struggle for many Aboriginal and Torres Strait Islander peoples (hereafter Aboriginal) to reclaim individual and group identity, connection to country, family and spirit [1, 2, 4].

The combined effects of colonisation, the social determinants of health and competing belief and knowledge systems are evident in the continuing health outcome disparities between the Aboriginal and non-Aboriginal populations in Australia. Aboriginal communities are striving to maintain collective values, traditions and beliefs whilst also coping with high burdens of chronic disease, reduced life expectancies and the impacts of grief, loss and trauma [2]. Health disparities faced by the Aboriginal populations include, but are not limited to, up to an 11-year gap in expected age of death, a tripled prevalence rate of type 2 diabetes and doubled rates of tobacco smoking [5, 6].

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In light of this ongoing struggle there is increasing recognition within the health community to advance and enable best practice care provision for Aboriginal peoples [7, 8]. This is on a background of international evidence demonstrating a lower quality of healthcare provision for ethnic and minority groups across the globe [9]. Leadership must be demonstrated in the health community to challenge the status quo of Aboriginal health disparities and responsibility owned and actioned [3].

In accepting the need to advance the capacity of the health system to deliver best practice care, this article is a scoping review of current evidence looking at clinical communication skills and their potential impact on healthcare delivery for Aboriginal peoples. Given the diversity of Aboriginal communities within Australia, this review, whilst also drawing on the international literature, focuses on key concepts of Aboriginal health in South Australia, Central Australia and Western Australia. Conclusions drawn from the review and its associated research, led by an Australian Aboriginal medical academic supported by two non-Aboriginal medical practitioners with Aboriginal health expertise, will provide a guide for future work aiming to explore the utility and acceptability of a more broadly applicable framework that can be used nation-wide. The future work will draw on valuable knowledges and perspectives from both the Aboriginal and health practitioner communities to create shared solutions and a path forward.

An initial approach is outlined proposing a tailored clinical communication framework for use when working with Aboriginal peoples, accompanied by a closer look at the role of medical education in developing the communication skills of the future healthcare workforce. The ability of the healthcare workforce to enable action to better address health inequities, rather than perpetuate them, is a critical long-term goal in assuring the ongoing health of Aboriginal peoples [3]. A key stakeholder leading this charge is the Australian Medical Council who state within their accreditation requirements for medical education providers that the:

> … clinical learning environment provides students with experience in the provision of culturally competent health care to Aboriginal and Torres Strait Islander peoples and/or Maori … [10] (p. 3)

What this means in practical terms for Aboriginal people's health outcomes needs further enquiry. In order to do this, a better understanding of the meanings of the term cultural competency, what it infers and the role played by communication in this process is needed.

Culture and Competency

> The only true voyage of discovery…would be not to visit strange lands but to possess other eyes… [11] (p. 657)

Whilst the concept of cultural competence is commonly espoused in healthcare and the health education literature and is often proposed as the solution to ethnic health disparities, there are limitations associated with the term 'competence' [12]. Despite its prominence in the conversation around Aboriginal health inequities, a clear definition of cultural competency and ways to measure it is lacking in the literature, along with evidence to demonstrate it holds beneficial impacts on health outcomes [12–14]. It is suggested that cultural competency as a singular skill is really an unachievable goal, as it fails to recognise the ongoing learning process required to effectively care for people from different cultural backgrounds [14]. There are many variants of the term in the literature including cultural safety, security, humility and responsive which provides an indication of how educators and researchers are still seeking a more suitable descriptor [15]. For medical education providers there is a logic to building the knowledge and skills of future practitioners to work with culturally diverse patients, however the language used to denote this along with evidence to show translational impact to patient outcomes must be carefully considered [12, 14, 16].

The focus on communication skills training in medical education to explore whether a tailored clinical communication framework provides the opportunity to improve healthcare interactions between Aboriginal peoples and health practitioners, and must include recognition of the continuum of learning and the need for measurable and definable education interventions in this space [12]. Such a tailored communication framework would ideally have applications as a learning, assessment and reflective tool for training health practitioners that can be evaluated through implementation within Aboriginal communities. There is a requirement for effective interactions with Aboriginal communities to shift away from a check-list approach of knowing an individual's culture to addressing imbalances of power that exist within healthcare interactions [17]. A closer look at the integration of culture into communication provides an insight into the appropriate application of culture in the clinical context.

Culture

Commencing a journey of cultural learning and understanding, its influences on health and wellbeing, requires an understanding of what culture is and how health is

defined. Developing a deeper understanding of Aboriginal health requires an acknowledgment of the diversity in Aboriginal definitions of health amongst different community groups and the limitations of the English language to effectively translate Aboriginal meanings of health [18, 19]. In recognition of local variations, the 1989 Aboriginal Health Strategy Working Group provided a collective definition that addresses core concepts of culture, social determination and role of the community in health, defining Aboriginal health as:

> … not just the physical well-being of an individual but refers to the social, emotional and cultural well-being of the whole Community in which each individual is able to achieve their full potential as a human being thereby bringing about the total well-being of their Community. It is a whole of life view and includes the cyclical concept of life-death-life [20] (p. x).

As noted above, culture forms a central component of the health experience for Aboriginal peoples [20]. Whilst many definitions of culture exist, the onus is on the health practitioner to acknowledge that in regard to health, culture can influence communication, beliefs about disease and wellness in addition to values that guide health-related behaviour [21, 22]. In reviewing the literature one definition states culture to be "an accumulated pattern of values, beliefs, and behaviors shared by an identifiable group of people with a common history and verbal and nonverbal symbol systems" [23] (p. 16) and another the "integrated pattern of human behaviour which includes, but is not limited to, communications languages, beliefs, values, practices, customs, rituals, roles, relationships and expected behaviours of a racial, ethnic, religious, social or political group" [13] (p. 253).

Often time, culture and ethnicity are used synonymously, as they can be closely related and strongly linked in particular contexts. It is salient to note that whilst populations with the same ethnic background often share a collective culture, culture can exist beyond the bounds of ethnic heritage. The presence of a collective approach to worldviews and beliefs within a community, coupled with individual-level variations, lends itself to a patient-centered approach that considers broad contextual factors adapted to suit patient needs [24].

Notable in the area of cultural learning is that the journey must begin with an understanding of the self, and the practitioners own cultural identity [25]. This can form the basis of critical self-reflection and reaffirms the complexity of suggesting cultural competence can be mastered by understanding the 'other' when our own identities and experiences of the world are constantly evolving. Critical self-reflection also lends itself to fundamental considerations of power and positioning of the health practitioner in relation to the patient [17].

Adding to the complexity here, a false dichotomy exists in health curricula between self-reflection and clinical competence, given the two are seen as inseparable entities [26]. A new framework for thinking has been called for in health curricula that challenges existing beliefs leading to a process of 'unlearning' [26]. The proposed clinical communication framework could be one answer to this call, provided it stimulates practitioners to consider their own cultural identity and positioning in relation to the environment and those around them, and the impact this has on clinical communication interactions. Extending this thinking requires a closer look at the communication process and how communication modalities may differ between population groups who share collective worldviews and values.

Communication

Like many medical terms 'communication' has a Latin origin 'communicare' which means 'to share' [27]. In essence, communication is the act of conveying meanings from one entity or group to another through the use of verbal, nonverbal and written mediums. Intercultural communication, or communication between members of different cultural groups, explores how collective beliefs, values and worldviews influence communication discourse at a group level [23, 28].

Identifying commonalities at the population level increases the risks of inappropriate application of stereotypical characteristics at an individual level [29, 30]. It also risks representing cultures with supposedly fixed characteristics that may be in opposition with each other [31]. Effective communication requires a reflexive and critically conscious practitioner to ensure group-level knowledge of culture is appropriately applied to individuals. Despite the risks, population commonalities may provide insight to where communication mismatches can occur more broadly, enabling a reflexive practitioner to navigate ways to address this in their communication approach.

A key concept used to explain variations between different cultural groups when studying communication is individualism–collectivism [28]. Simplified, individualistic-oriented cultures place priority on the needs and goals of the individual, in contrast to collectivist cultures that weight preference to the broader needs of the entire community. Whilst no culture exhibits one set of values exclusively, where they sit on the spectrum can vary. Individuals within more collectivist cultures may purportedly give priority to the collective self over their own individual needs [28].

Western cultures can be thought of as being geared towards individualism with the presence of collective values such as individual achievement, personal development and

independence [23, 31]. In contrast are the collective values of the Aboriginal population whereby community and family priorities take precedence, and a strong connection to land is maintained [32]. A simple example of where conflict may arise between the two orientations is in the agreement of management priorities, and understanding what obligations must be met in order for an individual to engage effectively in a treatment plan. Another is the distinction between Aboriginal community-controlled health service values and how these might differ to mainstream health services [31].

Another concept raised in the literature is that of high-context and low-context cultures and the relation this has to individualism–collectivism [28]. Information transfer in a high-context culture is explained to predominate both through the physical environment and the internal behaviour of the person, and less so on explicit communication approaches such as verbal and written language. In contrast, a low-context culture prefers more explicit forms of communication such as verbal exchanges, placing less emphasis on physical and symbolic methods of information sharing [33]. In general terms, collectivist oriented cultures tend towards high-context communication modalities, and the opposite for individualistic cultures [28].

The relevance of high and low-context theories to Aboriginal health is supported in research that indicates relationship building and feelings of trust between Aboriginal peoples and health practitioners extends beyond what is spoken in the clinical encounter, to how welcoming the environment is and how safe people feel in their identity [22, 34, 35]. The importance of body language when working with Aboriginal communities also supports the significance of non-verbal techniques in clinical encounters [22, 36]. This can be relevant when looking at healthcare delivery if services are designed to cater for individualism and low-context styles of communication, inadvertently marginalising collectivistic-oriented populations groups.

Reflections of group-level preferences for communication raises questions around the practical approach to addressing these within the clinical communication encounter. Strategies that may enable predominant communication styles exhibited within the community to flourish, or multiple styles to be catered for within a given environment, may be a useful step forward in enabling effective communication in the healthcare setting. The way communication skills are taught in the medical curricula can provide a platform for further inquiry to assist practitioners navigate and prepare for this delicate situation.

Communication in Medical Education

> …the delivery of medical care is fundamentally a communicative enterprise in which clinicians, patients, and (when appropriate) families discuss a patient's health, decide on the best therapeutic action, and make plans for follow through on those decisions [37] (p. 287).

The ability to communicate effectively with patients, their family and other health professionals is a required competency of medical graduates on entry to professional practice [10]. Effective communication is also linked to improved patient outcomes, satisfaction and treatment adherence [37]. A skilled communicator in the clinical setting elicits and provides essential information in a way that builds trust and empowers the patient to achieve their health goals. As each individual is unique in their needs and preferred way of communicating, practitioners are required to have a flexible approach that is responsive to the needs of the person in front of them [38].

Communication skills training is a core component of medical education and deals with a variety of communication scenarios including intercultural communication, breaking bad news, communicating with families, communicating with other healthcare professionals, discussing end of life care choices and others [37, 39, 40]. Frameworks are often tailored to specific scenarios to include clinical interviewing guides, patient-centred care guides and approaches to motivational interviewing [37, 41–43].

Communication skills require both a cognitive understanding of the required content to be addressed in the clinical encounter coupled with sound process skills in eliciting required information. Subsequently, medical curricula often categorise communication skills into these two distinct processes and the ability to integrate these is an essential part of becoming an effective health practitioner [42, 44]. Interventions to improve clinical communication skills must be mindful of the different domains that make up effective communication and how these apply to diverse clinical scenarios.

A widely used guide for teaching and learning communication skills is the Calgary-Cambridge guide to the medical interview which outlines five key steps for practitioners to undertake that integrates both process and content domains [42, 45]. The five steps include initiating the session, gathering information, providing structure, building the relationship and explanation and planning [42]. The Calgary-Cambridge approach to history gathering and information sharing lays the foundation for clinical communication skills in healthcare interactions and is an ideal place to start when thinking about the effectiveness of Aboriginal health communication interventions. Whilst it does not provide a platform for more specialised clinical scenarios it may offer considerations and components for adaption in these situations.

Landmark work in New Zealand has demonstrated the successful adaptation of the Calgary-Cambridge guide to create the Meihana model, which aims to assist health

practitioners in their clinical interactions with Maori patients. The Meihana model draws on the analogy of the culturally significant waka haoura (double hulled canoe) voyaging from one destination across the moana (ocean) to another, and how this relates to the journey of a Maori patient through the healthcare system [46]. As the health journey can be influenced by a range of important factors, the Meihana model integrates colonisation, marginalisation, migration and racism (along with other key components) to clarify and deepen the content of the medical history to promote implementation of best clinical practice within the Maori community [46].

Effective application of the Meihana model is guided by the Hui Process of Mihimihi (initial greeting engagement), Whakawhānaungatanga (making a connection), Kaupapa (purpose of the encounter) and Poroporoaki (closing the session) and has been shown to improve the ability of healthcare practitioners to provide more effective care when working with Maori patients [47, 48]. This innovative research provides a leading example of how established communication frameworks can be adapted to suit the needs of targeted population groups [48].

The Calgary-Cambridge guide and the Meihana model provide a foundation for improving best practice communication with Aboriginal peoples via clinical interviewing processes. Arguably many of the existing guides allow for effective communication within Aboriginal populations, however exactly what this looks like is not necessarily explicit. A key task when developing a framework tailored to meet the needs of Aboriginal Australians will be in striking the balance of applicability across the community as a collective, without compromising its utility when working with Aboriginal people from distinct cultural groups or as individuals.

Ongoing evidence of communication gaps for Aboriginal peoples in healthcare interactions warrant careful attention and evidence-based action. This action needs to be led and role-modeled from within the healthcare system in accepting the responsibility to provide meaningful healthcare to Aboriginal communities. Understanding current intricacies in achieving effective communication processes in Aboriginal health directs attention toward salient areas in need of further action.

Communication in Aboriginal Health

> People know what they do; frequently they know why they do what they do; but what they don't know is what what they do does [49] (p. 187).

There is increasing evidence which demonstrates how ineffective communication between Aboriginal patients and health professionals influences the ability of community members to make informed decisions about their health [50, 51]. Less than ideal standards of communication can be so widespread that they are sometimes seen as the norm in clinical practice [50]. Many factors are raised in the literature that contribute to current 'less than ideal' communication standards.

A relative lack of knowledge of Aboriginal history and the impacts this has on contemporary health can be a barrier to effective communication [52]. The historical, social, political and environmental context of communities influence the resources and opportunities people have access to as well as playing a role in shared meaning-making [52, 53]. The role of trust is clear when understanding the impact marginalising historical policy continues to have on Aboriginal communities [17]. A contemporary impact of these policies can be found in individuals feeling less able to advocate for their needs in a healthcare interaction [52, 53]. Experiences of disempowerment are then further compounded by the relative lack of control a patient has to determine the time, place, participants and purpose of a clinical communication encounter [50]. An individual's communication preference could add to this complex space if it leans toward a non-verbal and symbolic approach, as the spoken word may not be enough to facilitate the building of trust and rapport.

Further, differences in first spoken language are one part of the miscommunication story and this is compounded when highly specialised medical language, or 'medical jargon' is used [29, 54]. Interpreters can provide a solution to this challenge, however there is an under-utilisation of interpreters in clinical settings [50, 54], and when used, their services are not always appropriately applied to the benefit of the patient and/or their family [55]. The connection between language and identity can also influence clinical communication encounters. Appropriate and respectful integration of te reo Maori is detailed in the Meihana model signalling the importance of language in Maori health and wellbeing [46]. An innovative study that aims to measure the impacts of language reclamation on health outcomes within a South Australian Aboriginal community will provide further evidence to the role language has on empowerment, health and wellbeing [56].

Style of communication and the mode, approach and timing of information delivery is another challenge to more effective health communication when working with Aboriginal peoples [57]. Question–answer approaches may be incompatible with an Aboriginal knowledge discourse, and interrogational questioning can consolidate power imbalances [21, 50], This can result in gratuitous concurrence (repeating responses believed to be desired by the provider) [50], or 'agreeableness in the face of authority', further compounded by direct yes/no questioning and the absence of confirming patient understanding [58].

A health practitioner working from a predominantly biomedical model can risk sidelining significant priorities held by patients [50]. The opportunities for sharing knowledge and understanding are greatly reduced when only one domain of health is explored. There is also an identified need for health information to be provided to the wider family and community to enable a more supportive environment for people when unwell [51]. Access to supplemental health resources targeted toward specific Aboriginal communities is an additional barrier, both in availability and in staff knowledge of where to access and when to use [51]. This may be one example of the intersection between collectivist and individualistic -oriented cultures whereby the role of the wider community and preferred methods of information sharing are not considered in the clinical encounter.

And lastly, time is a fundamental contributor to health communication. Time is needed to build trust and allow stories to be shared [21]. Effective use of time requires a balance of practitioner and patient needs being addressed [22]. In addition to the availability and use of time, perceptions of time within Aboriginal communities may not align with that of the health practitioner. How time is perceived varies across cultures [59]. Some Aboriginal communities embrace more circular perceptions of time in contrast to the dominant western discourse of linear time [59].

Given the complexity of the communication process and the need for interventions to work towards improved health communication, a tailored framework may better prepare practitioners to communicate more effectively with Aboriginal peoples and their community. This framework must be cognizant of the identified barriers and enablers to effective healthcare provision, providing practical solutions that can be implemented by healthcare practitioners and organisations.

A Path Forward

> Everything I do, I do with respect. Father used to say, believe in all people. It's not we and them. It's us [60] (p. 8).

Addressing communication shortfalls in Aboriginal health requires the targeted building of knowledge and skills of the health care provider, guided by the values and goals of the Aboriginal community.

Building a potential framework for improved communication with Aboriginal patients in the clinical setting should begin with an understanding of the roles colonisation, racism and marginalisation have on the four domains of content, process, relational and environment. The further development of this model will be guided by Aboriginal community members, health practitioners, medical educators and medical students in two select Australian settings, drawing on both traditional knowledge and lived experiences fused with western medical knowledge and experiences to create new understandings (Fig. 1).

Though not explicit, the medical practitioner has a central role in the framework, as achieving health equity relies on the ability of the medical practitioner to communicate with people from different cultural backgrounds. Whilst a challenging task, critical reflection by medical practitioners of their own positioning in relation to each domain when working towards health equity will likely enhance the effective implementation of this process. This starts with an understanding of the self and how the practitioner's own cultural identity influences each domain, encouraging the practitioner to re-discover their own beliefs, attitudes, values and communication style and how these might complement or contest with patient care. Acknowledging personal biases and the role of ethnocentrism on interactions with others can work toward the development of a critically conscious health practitioner [21, 31, 61]. The goal of enabling health equity is centred to ground the model with the ultimate purpose of this work.

The community and patient surround the medical practitioner to guide the adaptation of the communication approach in each of the surrounding domains. Considerations of the patient cannot be done in isolation from the community, given the very definition of health for Aboriginal peoples is one that considers and is influenced by the wider community to which people belong [20]. Components of this framework may require skills and actions to be taken on by the healthcare practitioner and organisation, both prior and during the communication encounter. Actions may include recognising group-level values and preferred styles of communication, incorporating these into organisational

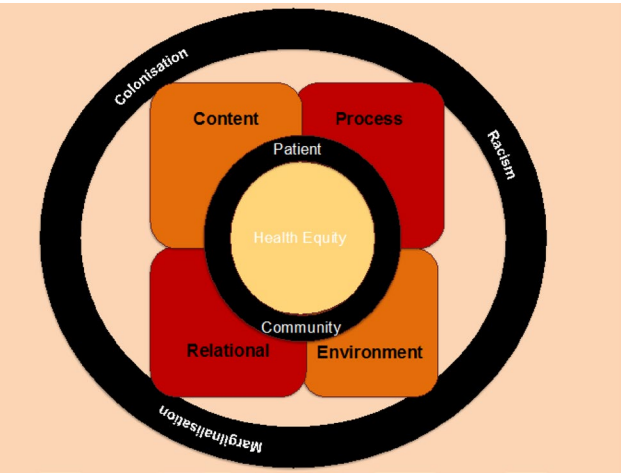

Fig. 1 Proposed initial clinical communication framework

structures and policies and then tailoring each to the individual during the communication interaction.

Given the diversity of Aboriginal communities and cultures within Australia, exploring the utility of a model within a small number of settings will guide planning for a more broadly applicable tool that can be contextualised to local community needs. This is in recognition of the importance of place-based care; health care that is considerate of the local priorities, expectations and ways of being of the community served [7]. A focus on literature detailing knowledges from Central Australia, South Australia and North Western Australia guide the following domain considerations.

Content

Understandings of content will require an approach to clinical interviewing respectful of both Aboriginal ways of life and evidence-based medical teaching. Content considerations within a clinical communication framework might include traditional medical history-gathering and information-giving steps interwoven with appropriate questions that target core concepts of Aboriginal life.

When exploring Aboriginal worldviews, the importance of family, country, beliefs and spirituality are common threads [2, 36, 62]. In Central Australia this is outlined by Kanyini, the principle of connectedness that underpins Aboriginal life, made up of Tjurkurrpa (beliefs of creation and the right way to live), Ngara (belonging to place), Waltja (family/kinship), and Kurunpa (spirit, soul) [36, 63]. The significance of kinship roles, described as "the means by which belief and action work together in harmony" [36] (p. 37) are further supported by notions of family in Northwest Australian Aboriginal communities, described as "transcending the barriers of immediate blood relations" [64] (p. 317) to govern social and cultural exchanges as well as confirm connections to place [64]. The interconnectedness of family, place, spirituality and identity is described in Northwest Australia as Liyan;

> Liyan is the center of our being and emotions. It is a very important characteristic that forms our wellbeing, keeping us grounded in our identity and our connection to country, to our family, our community and it is linked to the way we care for ourselves and our emotions [62] (p. 4).

Thus incorporating family and community structures, the impact of history, beliefs about health and wellness along with sense of belonging to place and strength of spirit will be important. In addition, including the determinants of health as identified by Aboriginal communities, such as notions of self-determination, agency, experiences of racism, opportunities to engage in cultural practices and feelings of connection to country are also relevant inclusions [64, 65]. Having a meaningful level of knowledge of the epidemiological disease and risk burden experienced by Aboriginal peoples will also help to ensure salient medical presentations and preventative measures are communicated within the clinical encounter. This demonstrates the importance of fusing Western medical knowledges and Aboriginal knowledges to create shared understandings of health and wellbeing [60].

Process

Process considerations refer to the way in which content is delivered and received to reach a shared understanding of health and treatment pathways. This can involve reflections on approach to asking questions and accommodation of a shared dialogue [65]. Yarning has been raised as an effective communication style that is characterised by its informal, conversation qualities [22, 66]. Such approaches may work toward addressing power imbalances and making people feel more able to contribute to the communication dialogue. Effective means to achieve shared understandings could include the use of storytelling, metaphors and visual representations of health concepts, as the literature shows the utility of sharing meaning between Indigenous populations and medical practitioners/researchers [51, 66, 67]. This aligns with a high-context communication style [23].

Non-verbal skills including body language, eye contact, use of silence and deep listening are also of relevance when further developing the framework. Dadirri, or deep listening and quiet stillness, reflects an important process for some Aboriginal peoples [68]. Listening without interruption and being comfortable with silence may be an essential process component, along with open, attentive and non-confrontational body language [7, 66].

The appropriate use and integration of trained interpreters could also form a key component of this section, in recognition of the important role interpreters play as facilitators in achieving effective clinical communication. Attention to the use of audiovisual aids within the clinical communication encounter to enhance co-creation of shared understandings will also be explored as a potentially central aspect of the process domain.

Process skills can influence the quality, acceptability and outcome of clinical interactions which require attention and reflexive action as practitioners adapt their communication style to suit that of their communication partner [69, 70]. Having an understanding of ones own personal communication preferences and how these may differ to others can be the beginning point for practitioners to be more attentive to processes that might be otherwise deemed insignificant.

Relational

In order to connect with another, strong relationship building skills are required. Often in Aboriginal communities, connections are built through identifying where someone belongs, what country they identify with and who their family is. Being able to participate in this process should enhance the ability of a health practitioner to establish a stronger clinical relationship with Aboriginal patients, and work towards better understanding their contextual background. Additionally, establishing common ground between practitioners and their patients is a key process that can assist forming connections [66].

Unconditional acceptance, affirmations of the positive and providing opportunities for intervention that affirms Aboriginal life, such as collaboration with traditional healers and discussing the role of traditional medicines, hold significance in the relational domain [71]. Recognising the value of different knowledge systems and working in partnership with peoples who have expertise in areas beyond the medical domain is fundamental [72]. Collaboration with community leaders and Aboriginal professionals, including Aboriginal liaison officers, transport workers and health workers is essential to providing appropriate care. This may require a shift in how the boundaries of the clinical interview are perceived and operationalized to include inter-professional practice in preparing and engaging in clinical communication.

Gender provides another area of attention in the relation component. A potential for communication conflict may arise when discussing topics that may be seen by community as inappropriate with particular genders due to local customs and practices [22, 73]. Understanding potential gender impacts will vary according to the local context, and having set strategies to manage this can ensure more effective communication encounters in the clinical environment.

Environment

The immediate physical environment can be symbolic to patients, influencing how a person engages in a communicative process. A welcoming environment is identified in the literature to improve engagement and feelings of safety for Aboriginal peoples, and now forms one of the standards set out by the Australian Commission on Safety and Quality for healthcare services [74]. This standard states:

> The health service organisation demonstrates a welcoming environment that recognises the importance of cultural beliefs and practices of Aboriginal and Torres Strait Islander people [74] (p. 3).

Further, cross-cultural interactions can be influenced by the political and organisational structure of the service in which the encounter occurs [31, 75]. Environmental considerations take these different system levels into account, requiring the practitioner to have an understanding of the nuances of the environment in which they work and the potential influence this has on the communication encounter.

Enabling patient control over where communication encounters occur may be challenging but thought needs to be given as to how to cater for this [50]. Strengths based affirmations of Aboriginal identity within the physical environment can demonstrate respect and promote attempts to build trust on the background of historical wrongs. Simple steps such as flying the Aboriginal Flag, having Aboriginal artworks and displays of commitment to Aboriginal values and priorities all contribute towards building a symbolic environment which can facilitate more effective clinical communications. Additional thoughts around how the physical environment caters to Aboriginal collective values, such as importance of family and capacity for family to be involved in the clinical encounter, are also important factors. This domain signifies the responsibility of the organisation, and its members, to ensure it actively promotes effective communication encounters rather than providing additional barriers or perpetuating less than ideal clinical environments.

Conclusion

This review marks the beginning of a research journey to develop, elaborate and test a tailored communication framework in Aboriginal health. To be effective, the framework must be appropriate to both the community served and those required to implement it, identifying the need for dual collaboration moving forward. The framework is driven by the need for health equity and provides a guide for approaching the content of clinical conversations, the way in which meanings are created and shared, the environment in which conversations take place underpinned by the salience of developing solid therapeutic relationships between the practitioner and their patient. A dedicated plan for evaluation and outcome measurement will be required in order to strengthen the translational impact this work may have on community and healthcare providers. A two-eyed seeing approach that utilises the strength of both traditional and western knowledges coming together to create new understandings, will mark the next stages of this research inquiry to develop and refine the framework as guided by the Aboriginal and health practitioner communities [60].

Aboriginal health inequities are a multidimensional challenge that demands an equally multi-dimensional approach. In this paper, the focus has been on the factors that influence the quality of the clinical interaction with a particular

interest on communication. It is proposed that a targeted framework for communication when working with Aboriginal patients may provide a platform for increased knowledge and skill of healthcare providers to meet the needs and priorities of their Aboriginal patients.

Addressing Aboriginal health disparities requires ongoing action and effort to create change, both at an individual and system level. Recognition and understanding of the role healthcare providers play in both advocating for change and shifting ways of working is essential to achieving better health outcomes from clinical interactions. When working towards health equity and the ensured wellbeing of future generations of Aboriginal communities, a long-term vision coupled with sustainable action are called for:

> When we…get impatient for 'results'…Elder Albert likes to tell us about the ash tree. Every year, the ash tree drops its seeds on the ground. Sometimes those seeds do not germinate for two, three or even four cycles of seasons. If the conditions are not right, the seeds will not germinate. Sometimes, Elder Marshall says, you have to be content to plant seeds and wait for them to germinate. You have to wait out the period of dormancy. Which we shouldn't confuse with death. We should trust this process [60] (p. 8).

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RESEARCH ARTICLE

Two-eyed seeing: A useful gaze in Indigenous medical education research

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Abstract

Context: Medical education has a role in preparing future health care practitioners to have the skills to meaningfully address health disparities while providing effective clinical care considerate of diversity in our societies. This calls for medical education researchers to approach their craft in ways that prioritise and value inputs from a broader range of perspectives and worldviews in an effort to redress the negative impacts of social, political and structural forces on health outcomes.

Methods: Given the entrenched health inequities experienced by Indigenous populations across the globe, this paper details an approach to medical education research put forward by Canadian Mi'kmaw Elders Murdena and Albert Marshall and named 'two-eyed seeing'. This approach provides the opportunity for medical education researchers to address the ongoing impacts of colonisation, racism and marginalisation on health outcomes by prioritising Indigenous worldviews in medical curricula. The need for researchers and medical academies to critically consider Indigenous governance and processes of respectful knowledge sharing within the wider institutional and societal contexts is addressed.

Conclusions: The benefits of two-eyed seeing in the context of better preparing the future workforce to effectively meet the needs of those most vulnerable, and to action change against health inequities, situate it as a promising research approach in medical education.

1 | INTRODUCTION

Medical education is a dynamic field tasked with the role of preparing future health care practitioners to meet the current and ongoing health needs of society.[1,2] The development of individuals to become effective, responsive and responsible medical practitioners is a lifelong commitment that begins with the primary medical learning and extends to postgraduate supervised training, specialist training and ongoing professional development.[3-5] Primary medical education serves as the foundation for knowledge building, importantly shaping the qualities of future health care practitioners who will practise in diverse areas of need.

The diversity that exists in our societies draws attention to the variable contexts and worldviews experienced by both patients and health care practitioners who engage within the health care system. Such worldviews, or the sets of beliefs and assumptions that provide the lenses through which experiences in health are interpreted and reasoned,[6] require close inquiry as to their influences on health outcomes and health care access for different cultural groups. This calls for a critical consciousness within medical education to ensure research does not further marginalise or oppress those with diverse worldviews within the community, and that knowledge of the social and structural drivers of health is directly translated into clinical practice frameworks.[7]

The designing of educational activities that better represent and align with diverse community worldviews is a complex task that is considered in this research approaches paper. One promising approach to enable the achievement of this is through the application

of the conceptual notion of 'two-eyed seeing'.[8] Two-eyed seeing is an invaluable approach put forward by Canadian First Nations Elders that offers opportunities to include, represent and value contributions from a wider range of worldviews and perspectives in medical education research and curriculum development.[4,9,10]

The urgency behind the need for medical education academies to consider diverse perspectives in the design and delivery of education research is demonstrated by the stark inequities faced by minority and Indigenous populations across the globe.[4,11-13] The inclusion of diverse worldviews may also have utility outside Indigenous medical education. This particularly applies when approaching complex topics that involve marginalised or disempowered cultural groups, whose experiences and worldviews can provide alternative solutions and perspectives when working towards more equitable health care systems and outcomes. With the need to address entrenched health disparities experienced by Indigenous populations in mind, this paper explores the two-eyed seeing approach in the context of Indigenous medical education research and draws on an Australian research project as an example of its application.

2 | ADDRESSING INDIGENOUS HEALTH DISPARITIES THROUGH MEDICAL EDUCATION RESEARCH

> *Racism against Indigenous Australians permeates the very fabric of contemporary Australian society …*[14]

Indigenous health disparities stem from the ongoing impacts of colonisation, racism and marginalisation on Indigenous peoples' experiences of well-being.[4,15-18] Educational initiatives in Indigenous health must address these processes in a collaborative manner.[19] As Indigenous communities are often, if not always, accessing care in racialised environments and societies,[14] a two-eyed seeing approach can provide a breadth of viewpoints and understandings to enhance the opportunity for education initiatives to be directly translated to real-life clinical practice.

In Australia, two-eyed seeing is being used to guide primary medical education research seeking to develop a more effective and culturally sound communication framework to assist medical student learning.[20] This research, titled 'Healing Conversations', aims to bring together different perspectives to facilitate improved Indigenous clinical communication skills education in medical curricula.[20] This project draws on key medical education innovations in Indigenous health that are improving quality of care and communication outcomes for Maori patients in New Zealand.[20-22]

This paper draws on the early learnings from Healing Conversations and international examples in the literature to discuss the benefits and challenges of the effective implementation of two-eyed seeing in medical education research. It aims to stimulate discussion within the medical academy around effective research approaches to curriculum delivery and design that counter colonisation and distribute power in a more equitable manner while bringing forward the voices of those least heard.

3 | COLLABORATION WITHOUT ASSIMILATION

> *… only when knowledge is conditioned by respect can it be truly shared.*[23]

As marginalised groups become empowered to share their knowledge, respectful processes around knowledge ownership that safeguard contributions to research need to be carefully considered. Promoting the health and well-being of Indigenous peoples within medical education systems centres the experiences, interests and worldviews of Indigenous peoples in all aspects of curriculum development and delivery. Such attempts, however, need not exclude mainstream approaches to knowledge and health care provision. Valuing different perspectives does not lead to their fusion into one entity; rather, it ensures that their differences and strengths are respected and preserved alongside each other in efforts to negotiate critical challenges faced by society.[24,25]

Such preservation and co-positioning have long been recognised by the Australian Yolngu people in their description of *Ganma*, which refers to the meeting of two water systems (fresh and salt water) to create foam, an entirely new and distinct entity.[26,27] Although the mixing of the waters creates the new entity, they each retain memory of what they are, and where they have come from.[26,27] This ability to integrate different perspectives closely aligns with the process of shared decision making and the balancing of patient and provider priorities when negotiating management plans in the clinical setting.

Balancing different perspectives warrants careful attention towards the distinction between the inclusion and exploitation of Indigenous knowledge. Any research in Indigenous health must be careful not to contribute to a 'global hunt' for Indigenous knowledge that creates a threat to First Nations communities and their right to knowledge ownership.[28] Medical educators and researchers hold important responsibilities when negotiating between knowledge systems and have an obligation to ensure that processes and strategies are in place for effective and respectful integration of different viewpoints, such as solid governance and accountability mechanisms, as well as to foster safe environments for critique and debate. This needs to be done in a way that allows contributors to maintain their individual integrity, preventing the domination of one discourse over the other,[24] a key characteristic of two-eyed seeing.

4 | TWO-EYED SEEING

> *… we learn to see from one eye with the best in Indigenous ways of knowing, and from the other eye with the best in the Western (or mainstream) ways of knowing… and moreover, that we learn to use both these eyes together, for the benefit of all.*[10]

Two-eyed seeing is a guiding principle brought forward by Canadian Mi'kmaw Elders Murdena and Albert Marshall that

draws together the strengths of different knowledges and cultural paradigms when devising solutions to complex challenges.[10,25,29] Two-eyed seeing enables medical educators to respectfully and effectively work with different epistemologies and ontologies, finding the strengths of each while developing new and innovative medical curricula initiatives.[10] Two-eyed seeing embodies acceptance and inclusion to promote mutual cultural respect,[8,30] and offers the opportunity to value and prioritise Indigenous ways of knowing in medical education research.[31]

Two-eyed seeing has guided health and education research in Canada.[8,10,25,29,30,32-35] Using this approach, Canadian Aboriginal and mainstream knowledges have been woven together to address such issues as the role of traditional healing in intergenerational trauma and cancer care for Aboriginal people,[8,30] to explore experiences that support a positive identity for Aboriginal men,[32] and to increase access to and engagement with science education that recognises the legitimacy of Indigenous knowledge.[10,25] Two-eyed seeing has contributed to the grounding of Canadian First Nations culture and worldviews in addictions and mental health research, in a manner that fosters cultural renewal while promoting Indigenous governance.[29]

As Indigenous knowledge has often been represented in a deficit-based frame,[36] reclaiming and revitalising Indigenous science challenges the notion that Indigenous peoples are void of scientific traditions[36] and counters the marginalisation of Indigenous knowledge in mainstream education academies. By way of contrast, in principle, two-eyed seeing can be applied to different research methodologies that will benefit from the inclusion of diverse worldviews to maximise research outcomes. As an example, it can help mitigate untoward consequences of critical participatory action research outcomes that are irrational, unsustainable and unjust[37] by promoting solid relationships, fostering the self-determination of participants and prioritising the expression of key stakeholders.[37]

Two-eyed seeing has applicability in Australian medical education research despite its distinct cultural and political context, with respect to Canada, as Australia and Canada share a history of colonisation and an ongoing struggle for the self-determination and empowerment of First Nations peoples.[18,38,39] Utilising this approach enables research teams to critically appraise the positioning and cultural context of the research to empower oppressed stakeholders.[39,40] Two-eyed seeing provides the opportunity in Australian medical education research to reconcile the conflict between Indigenous worldviews and mainstream perspectives in the medical discipline[38] and to incorporate Indigenous ways of knowing, being and doing into medical curricula activities.[41]

5 | POWER IN MEDICAL EDUCATION

Incorporating diverse worldviews into medical curricula is important as mainstream medicine has historically embraced a positivist paradigm favouring the scientific method and the search for a single, objective truth.[5,40] Indigenous peoples have often been the objects of scientific inquiry that promoted and justified racially driven practices and dehumanising behaviours.[40,42] These practices created negative population stereotypes and attitudes that have influenced Indigenous health outcomes.[38,40,43] These attitudes are further compounded by research methods that lack transparency, inclusion and collaboration.[44] Consequently, there remains considerable opportunity for transparent, inclusive and flexible approaches to knowledge sharing to become the norm in medical education.[39]

Flexibility and inclusivity are important aptitudes as knowledge is not created in isolation, but is closely shaped by particular rules, beliefs and values[28] within medical disciplines. The ways in which people and communities think about a particular issue (epistemology), perceive their reality (ontology) and the set of morals and values held when engaging in knowledge construction (axiology)[45] guide actions to create and share knowledge (methodology). When combined, these form the core aspects of a knowledge and research paradigm[46] within which medical educators work every day, whether they are conscious of it or not. Added to this, colonisation has resulted in established power relationships between Indigenous peoples and societal structures,[15] including in research and education, which are embedded in elements of power and control.[30,47] Power differentials are enacted according to whose knowledge is valued, who determines the importance of ideas and who has the final say with respect to the rules by which knowledge is evaluated.[9]

This can impact the safety of incorporating Indigenous perspectives into research as previous applications of two-eyed seeing have required researchers to challenge Western concepts of time and research timeframes in addition to advocating for resources that maximise Indigenous contributions to knowing.[8] As some Indigenous health curricula rely solely on the goodwill of Indigenous communities,[48] the appropriate resourcing of research and education activities would enable more effective and safer knowledge translation.[48]

Successful implementation of two-eyed seeing requires a critically conscious and reflexive research team as transparency around individual positioning provides a lens through which we can better understand our responsibilities and how we relate to others and our research practices.[49] Such a skill, of being able to critically reflect on one's own positioning, is essential in all facets of Indigenous health practice,[50] but it has its origin in the praxis of medical educators themselves, with reference to both their educative and research roles. Once we have a better understanding of ourselves as researchers, we can begin to collaborate with the necessary stakeholders to create needed change.

A spirit of co-location and collaboration is embedded in the two-eyed seeing approach that promotes reciprocity: a give-and-take in the learning process, and a fair distribution of power.[9] This can counter the damaging effects of colonisation, racism and marginalisation through narratives that promote the reclamation of Indigenous rights and ways of being while affirming Indigenous governance over the research process.[31]

In Australia, Aboriginal leadership and ownership are supported by the medical deans of Australia and New Zealand (Medical Deans Australia and New Zealand, Inc.), who endorsed the Indigenous Health Curriculum Framework (IHCF) in 2004.[51] This seminal framework advocates for the inclusion of Aboriginal peoples' focus on collectivity in their definitions of health when compared with mainstream populations,[52] which is harmonious with the two-eyed seeing approach.[8] Key health distinctions around the significance of cultural well-being, and the roles of family and community combined with the importance of self-determination,[53] must drive discussions and considerations of research design and knowledge translation. The gift of two-eyed seeing is the value it places on embracing differences and divergent viewpoints as platforms for discussion and innovation, and its non-avoidance of these difficult conversations and potential sites of struggle.[32]

6 | TWO-EYED SEEING: GUIDING INDIGENOUS MEDICAL EDUCATION RESEARCH IN AUSTRALIA

In the same manner in which medical education institutions require their graduates to maintain a duty of care to their patients, within an Indigenous perspective teaching institutions must acknowledge a similar duty to serve as agents of change in addressing Indigenous health inequities.[4] This can be realised through the delivery of curricular activities that address core learning areas in Indigenous health, including knowledge around the drivers of inequity of health care access, and demonstration of effective communication skills[54] in clinical encounters.

The Healing Conversations project offers an example of how two-eyed seeing can be applied in a medical education context.[20] The project aims to develop a practical, tailored communication framework to better prepare medical students to have more effective clinical conversations with Australian Aboriginal patients and their families. Communication is a praxis point in medical education, whereby medical students draw on theoretical understandings of Indigenous history, culture and communication styles to implement effective clinical practice skills such as those of conducting a medical interview.

Given the diversity within Australian Aboriginal communities, this research will be conducted across two geographical settings, South Australia and Western Australia, to determine whether the framework will have broad utility without compromising patient-centred approaches. The initial framework that will inform the first stage of consultation with the research stakeholders has been published elsewhere.[20]

In Figure 1, we summarise our suggested steps to embed a two-eyed seeing approach in Indigenous medical education that is guiding the design and implementation of Healing Conversations. This pictorial representation highlights the importance of a reflexive research team that: engages and partners with necessary stakeholders; has a collective understanding of two-eyed seeing; aligns research methods to this approach in a flexible manner, and then engages in activities of praxis, overseen by an Indigenous governance group (IGG) with clarity around power distribution in the research context.

Indigenous governance and oversight are fundamental to the two-eyed seeing approach and effective Indigenous health curricula implementation, and strategies that enable these must be integrated

FIGURE 1 Steps to embed a two-eyed seeing approach in Indigenous medical education

into the structure of the medical education academy.[52,55] Research processes that retain power imbalances are meaningless to the Indigenous community[34] in that they do not lead to meaningful and sustainable change.

Effective application of two-eyed seeing in Healing Conversations will require careful attention to ensure Indigenous governance is not dislocated from the research process, and that all stakeholder perspectives are brought together in a way that reclaims and maintains and embeds Indigenous understanding and worldviews.[29] This will be aided by having Indigenous and non-Indigenous research team members, with collective experience in Indigenous health, overseen by an experienced IGG that represents the communities involved in the research and pays attention to ensuring a fair age and gender balance.

The inherent risk in this process pertains to the power afforded to the IGG, whose offered knowledge and wisdom may regrettably go unheard by the research team or the medical academy. Healing Conversations researchers view governance as representing innovative and progressive ways to think about social coordination and patterns of rules in society[29] and therefore recognise the need for all actions, motivations and belief systems to be transparently communicated with the IGG, reconsidering dominant ideals of leadership and accountability.[56] This includes strategies to be placed at the disposal of the IGG to halt or alter the course of the research trajectory, through informal and formal mechanisms and relationships, accessible at both the institution and community levels.[56]

7 | TWO… THREE… FOUR EYES?

> *… a diversity of perspectives and opinions is valued, since it is believed that no one perspective is right or wrong; all views are seen to contribute something unique and important …*[35]

More effective research outcomes depend on the ability of the research team to engage key stakeholders throughout the research stages.[39] In Healing Conversations, the Indigenous community is a key research stakeholder group in partnership with health care practitioners, medical educators and medical students. Data collection around effective communication in an Indigenous clinical context will take part in three stages using methods tailored to each stakeholder group, which will include semi-structured interviews to develop and refine the communication framework, a workshop to finalise the pedagogical approach to delivering the framework in an education setting, along with focus groups and a survey evaluation to be carried out subsequent to the testing of the education initiative. This will facilitate multiple points of stakeholder input to the research findings, enabling the threading, revisiting and reinforcement of perspectives throughout the research process (Figure 2).

In Healing Conversations, medical students are research stakeholders to facilitate co-creation and value learning as a two-way process.[57] Co-creation can promote communication amongst stakeholders and foster productivity growth,[58] potentially influencing student satisfaction, loyalty and perceived value of education.[57] This can have possible impacts on subsequent scaffolded learning across the Indigenous medical curriculum by enhancing commitment to ongoing learning in Indigenous health.

Research outputs will draw on all perspectives as valid and valued knowledge in the development of the final recommended framework and educational approach. Any conflicts in perspectives gained will be negotiated and further explored amongst research stakeholders, guided by the IGG. The final research phase involves a pilot of the developed educational initiative to enable active knowledge translation within the research process. This recognises the need to move past descriptive research to research that appraises action and intervention.[59]

Opportunities to embed active knowledge translation and role modelling of two-eyed seeing need to be considered in the forefront of the research design. Praxis, or informed committed action,[47,60] will allow research findings to be translated directly into medical curricula to bridge the gap between knowing and doing. This will also require the use of collaborative educational pedagogies that empower Indigenous

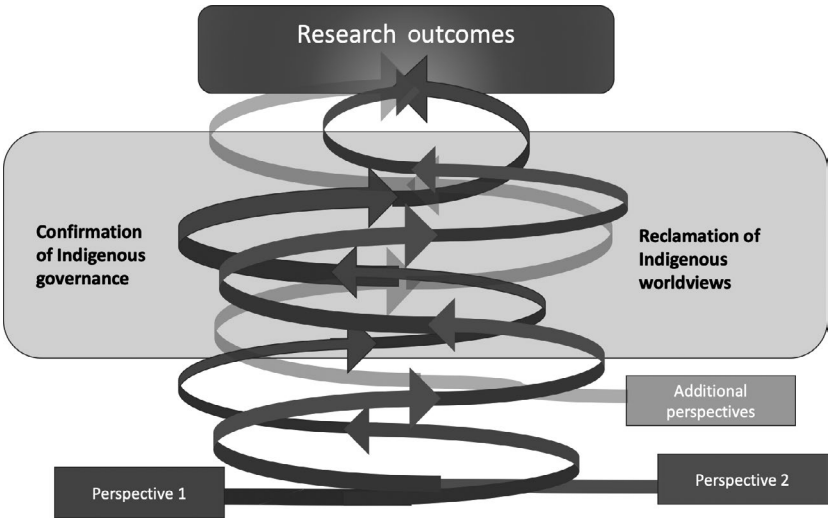

FIGURE 2 Multiple points of stakeholder input to the research findings enable the threading, revisiting and reinforcement of perspectives throughout the research process

perspectives while building the skills and capacity of the future health care workforce to provide best practice care to Indigenous communities. The ability to counter historical legacies of health research that have not yielded significant improvements in Indigenous health outcomes[59] is another requirement of this field and of two-eyed seeing, which advocates for moving past talk to productive action.[8]

The outer ellipses of Fig. 1 refer to the roles of the combined institutional and societal contexts of the research as these can influence the success of approaches to education delivery.[43] Confronting the contextual social-political influences of Indigenous health research will work to strengthen research outcomes[40] and must be embraced by the research team. This also provides the opportunity for the research team and IGG to assess whether research outcomes and Indigenous ways of knowing can be shared in a respectful environment, or whether further negotiation and action need to take place before the institution is safely ready to be a conduit of knowledge.

8 | SEEING THAT WHICH IS HIDDEN IN INDIGENOUS MEDICAL CURRICULA

> *If the conditions are not right, the seeds will not germinate.*[10]

Medical curricula can be delivered formally through stated learning objectives and scheduled activities, informally with unscheduled, unplanned conversations and interactions, or in a hidden manner, under the influence of institutional norms, policies and morals,[61] which themselves are ever-changing. The maintenance of a colonial agenda is an identified limitation to the effective implementation of Indigenous medical education[48] and can be found with the reinforcement of negative stereotypes and blaming of individual choices rather than a critique of the ongoing impacts of colonisation.[48] This agenda often exists within the bounds of the hidden curriculum[48] and potentially influences curriculum acceptability and learner knowledge.

Key challenges in the Indigenous hidden curriculum include the capacity to develop effective instructional activities, the appropriate allocation of time and space to enable scaffolded and deep learning, the prevailing of a biomedical paradigm that can delegitimise other approaches to knowing,[4] and a context in which responsibility often falls to individual Indigenous medical academics as opposed to a collective accountable team.[62] The knowledge and skills of the wider medical academic body also have the potential to influence the informal curriculum in an unpredictable way, raising the need for increased training and skill building within the medical academy around Indigenous health.[62] This can be an overwhelming task when the resourcing of Indigenous health curricula may already be limited.

Maori health medical education initiatives in New Zealand have identified a challenge in being positioned as 'cultural education' rather than as an academic health science discipline,[52] which can infer a view of 'soft science' as opposed to 'real medicine'.[52] Additional identified barriers in the informal curriculum include blurred boundaries between 'Maori health' and 'Maori culture', which can discount formal curricular initiatives and expertise.[52] This is of significance when reviewing health practitioner contributions to health inequity, which do not stem from a lack of specific cultural knowledge,[36] but, rather, from the perpetuation of colonial practices that maintain power imbalances and result in the provision of variable access to health care.[4,52] Such impacts on the delivery of medical education need to be considered carefully when researching approaches to knowledge delivery.

Greater alignment of the hidden and formal curricula can be promoted through two-eyed seeing by providing alternative perspectives to the biomedical paradigm and critiquing colonial impacts on education through multiple lenses.[63] It will require commitment and ownership of the research process from medical education institutions themselves to enact institutional change where necessary.[52] Although the hidden curriculum poses a great threat to the effective implementation of two-eyed seeing, a two-eyed seeing approach to research and education holds the potential to redress hidden curricular influences if it is embraced by the medical academy leadership group and role modelled in education practices.

9 | CONCLUSIONS

> *For apart from inquiry, apart from the praxis, individuals cannot be truly human. Knowledge emerges only through invention and re-invention, through the restless, impatient, continuing, hopeful inquiry human beings pursue in the world, with the world, and with each other.*[47]

In summary, two-eyed seeing, as demonstrated by the Healing Conversations example from Australia, offers an approach for medical education researchers to design and implement medical education initiatives guided by diverse perspectives and ways of knowing. The effectiveness of this approach will rely on the ability of the research team to establish open, reflexive and transparent research practices when engaging with diverse research stakeholders, while remaining accountable to an empowered community governance group. Informed, committed action in medical curricula is not a recommendation of two-eyed seeing research: rather, it is a fundamental component within this approach.[8] In doing this, medical educators must be cognisant of the institutional context and wider society within which they are working and facilitating learning. This includes accounting for structural barriers and advocating for the dismantling of these, identifying and promoting facilitators of curriculum implementation,[48] and assessing the readiness of the institution to serve as a platform for knowledge sharing.

Finally, researchers in this field must strongly own their responsibility and obligation to maintain the integrity of Indigenous contributions in research and knowledge translation. In turn, this must be supported by reflexive institutional structures that acknowledge the need for Indigenous ownership and governance in medical education research and curriculum implementation. This provides the way for new solutions to be created by having the necessary tough conversations around points of differences that can counter

historical practices of marginalisation and oppression. The effective integration of two-eyed seeing can provide opportunities for education systems to nurture and support the expression of Indigenous perspectives and ways of life, moving towards the creation of a more equitable society for future generations of Indigenous peoples. Future research will demonstrate if the lessons from Indigenous contexts can inform wider action in medical education research.

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CONFLICT OF INTEREST

There are no competing interests for this paper.

AUTHOR CONTRIBUTION

AM is a PhD student who researched, prepared and further edited the current paper and will act as lead researcher in the research described in the present review. JNH and DP reviewed the paper and provided expert comments and academic guidance on its direction. DM reviewed the paper and provided expert comments, and cultural and academic guidance on its direction. All authors contributed to the editing of the paper and approved the final manuscript for submission.

ETHICAL APPROVAL

Ethical approval was not sought for this paper as it details review of current literature and considerations to research approaches. Ethical approval for data collection as per the broader scope of the project to which this paper refers has been granted in South Australia.

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Overall percentage (%)	70%		
Certification:	This paper reports on original research I conducted during the period of my Higher Degree by Research candidature and is not subject to any obligations or contractual agreements with a third party that would constrain its inclusion in this thesis. I am the primary author of this paper.		
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By signing the Statement of Authorship, each author certifies that:

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REVIEW ARTICLE

The role of governance in Indigenous medical education research

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McKivett A, Glover K, Clark Y, Coffin J, Paul D, Hudson JN, O'Mara P. The role of governance in Indigenous medical education research.

ETHICS APPROVAL

This is a review article on the role of Indigenous governance in medical education research. The Healing Conversations project does have ethical approval in WA and SA, however this article does not report on data collected as per the research project.

ABSTRACT:

Context: This article considers the role of governance in Indigenous medical education research through the lens of an Australian Aboriginal research project titled Healing Conversations. The Healing Conversations project is developing and testing a targeted educational framework for improved clinical communication between healthcare practitioners and Australian Aboriginal peoples in regional and urban locations. It is proposed that an effective governance approach can support Indigenous and non-Indigenous stakeholders to work together in decision-making structures to enable outcomes that promote and prioritise Indigenous worldviews and values in medical education research.
Issue: The case study explored here puts forth the notion of effective governance as one practical way to decolonise medical education research structures in both the urban and regional setting. The importance of relationships between Indigenous and non-Indigenous stakeholders is supported in tailored governance structures, as knowledge translation efforts are situated in mainstream tertiary education structures that hold collective responsibility and accountability for change in this space.
Lessons learnt: Reflections from the Healing Conversations research case study are outlined for future consideration regarding sustainable and effective Indigenous governance initiatives in medical education and research structures. This includes the importance of an Indigenous governance structure within the research team and a strong understanding of the roles and contributions of each research team member, along with the required humanistic qualities to action effective governance in Indigenous medical education research. Collaborative governance structures are fundamental as the inclusion and prioritisation of Indigenous worldviews and values is a key step in redressing Indigenous healthcare disparities and providing culturally safe healthcare institutions.

Keywords:

Australia, communication skills, Indigenous governance, Indigenous health, medical education, research approaches.

FULL ARTICLE:

Context

> *We as Indigenous people live out our lives in two worlds according to our custom and tradition and the modern reality*[1].

Governance is the collective organisation of a group of people within a commmunity or society to make decisions about an issue important to the group[2]. Governance includes the processes, relationships, insitutions and structures that evolve as decisions within the group are made[2]. Effective governance in Indigenous medical education research aims to facilitate an approach whereby Indigenous and non-Indigenous peoples work collaboratively in decision-making structures[3]. Such an approach aims to assist research outcomes that promote and prioritise Indigenous worldviews and values[4]. A clear goal of Indigenous medical education research is to implement medical curricula that are effective in building workforce capabilities that can meaningfully improve Indigenous health outcomes[5]. As a result, inclusive governance values and supports the nurturing of relationships between Indigenous and non-Indigenous stakeholders to create meaningful praxis in the medical education research process. Key points regarding governance in Indigenous medical education research are shown in Box 1.

Effective Indigenous governance is a fundamental component in the decolonisation of both medical education and medical research institutions and requires meaningful Indigenous representation and inclusion[6,7]. Decolonisation is concerned with the long-term process of divesting colonial power and working to redress colonial legacies that negatively influence the health and wellbeing of Indigenous peoples[8]. Decolonisation of medical education research structures is required to facilitate the better preparation of the future healthcare workforce as skilled clinicians, health advocates and respectful researchers with a critical consciousness of their own cultural positioning and power[9].

Solid collaborative governance structures are important in the context of the ongoing struggle for social justice and recognition of the rights of Indigenous peoples in the Australian community. This struggle is apparent in the refusal to implement the recommendations of the Uluru Statement from the Heart[10], and in the absence of a treaty between the Commonwealth and First Nations Peoples[11]. These circumstances highlight the importance for medical education and research structures to take meaningful action in being responsive to the rights of Indigenous peoples and become agents of social justice change within their organisations and local communities[12].

This article provides a rationale behind the Healing Conversation

research project's current governance approach, noting that this may change over time, in an effort to contribute to the ongoing discourse regarding effective governance approaches in medical education structures in both urban and regional settings.

Inclusive governance is of significance to rural and remote communities that have diverse population demographics, varied experiences of accessible health care and different exposures to structures and conditions that faciliate good health and wellbeing[13]. The Healing Conversations research project addresses this by having research team members based in regional locations and performing data collection within regional South Australia and Western Australia, concurrent with urban locations. This works to ensure the experiences of Indigenous peoples in rural and remote locations are included and represented in Indigenous medical education research, reflecting the diversity of geographical locations in which Indigenous communities live, and the larger proportion of Indigenous peoples living in regional Australia when compared to non-Indigenous Australians[14].

The Healing Conversations research team consists of three key entities that contribute to the overall implementation and accountability of the research process through an inclusive governance approach. These entities are the Indigenous Governance Group (IGG), Research Supervisory Panel and the PhD student as the lead researcher. The research team are located in urban and regional areas across South Australia, Western Australia and New South Wales.

Healing Conversations forms part of a PhD student research project by an Indigenous medical academic supervised by Indigenous and non-Indigenous medical practitioners with expertise and experience in Indigenous health and medical education. The IGG comprises four Indigenous health academics with diverse knowledges and expertise. One of the IGG members is also a member of the supervisory panel to ensure effective integration and communication of ideas, perspectives and concerns between the IGG and supervision entities. Effective collaboration and communication among the entities underpin efforts to guide meaningful action in this space[15] and this is done by phone, online conferences and face-to-face meetings coordinated by the PhD student, who is based in a regional setting.

The roles and interactions of the Healing Conversations research team are outlined in Figure 1, noting the foundational role of the IGG in providing expert cultural knowledge, guidance and oversight to the implementation of the research project.

The described approach to inclusive governance is cognisant of the hierarchal and power-laden environment that accompanies medical education and research[7]. It is proposed this approach can assist authoritative structures conceptualise how they can be more responsive to Indigenous worldviews and knowledges, given the contemporary and historical context of colonisation in the heathcare system.

Characterised by Indigenous and non-Indigenous peoples working collaboratively in decision-making structures in medical education research.

Nurtures relationships among stakeholders with a clear understanding of boundaries and roles.

Works to create meaningful praxis in addressing Indigenous health disparities.

Actions reflect a shared commitment and accountability to achieving and sustaining change in Indigenous health through medical education.

Box 1: Key points relating to governance in Indigenous medical education research.

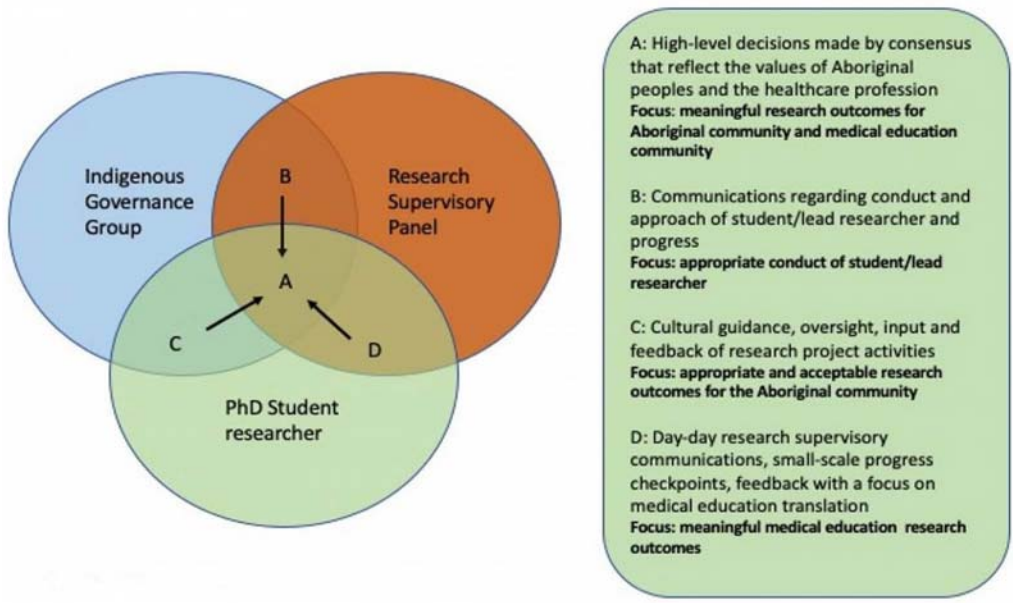

Figure 1: Actions and social coordination of the Healing Conversation's research team resulting in consensus decision-making (A).

Issue

The torment of powerlessness

> *Indigenous peoples, in exercising their right to self-determination, have the right to autonomy or self-government in matters relating to their internal and local affairs, as well as ways and means for financing their autonomous functions*[16].

Disparities in healthcare outcomes for Indigenous peoples when compared to non-Indigenous populations are well known and researched in the international medical literature[17,18]. Reduced life expectancies, increased exposure to environmental and social risk factors for disease and reduced access to opportunities that facilitate good health, combined with reduced quality of healthcare provision, form the daily lived experienced for Indigenous communities living in Australia[18-22]. The complex ecosystem of health inequities illustrates why a multidimensional approach is needed to shift health disparities and promote healthy, strong communities for current and future generations of Indigenous peoples[18,22,23]. Indigenous medical education researchers are one part of this ecosystem. They can begin to challenge health inequities through sustained efforts to build responsive and capable health systems able to counter the effects of colonisation, racism and marginalisation on health outcomes[24,25].

In order to achieve responsive and capable health systems, effective governance structures must embed Indigenous voices in medical education and research, prioritising a spirit of agency and ensuring structures are reflective of the contemporary needs of the Indigenous community[26,27]. This calls for a dynamic approach to governance to ensure medical education and research are effective and aligned to current trends and emerging evidence according to the voices and knowledges of Indigenous peoples[7,26,28]. Such emerging trends include the growing discourse around the integration of the cultural determinants of health into clinical care[29] and the need for clinicians to be skilled and knowledgeable in addressing the impacts of colonisation and racism on Indigenous health outcomes[20,30-32]. Research methods and medical institutions that fail to address and counter the effects of colonisation, racism and dispossession are unable to make a meaningful contribution to improving Indigenous health[7,24,32].

Healing Conversations is contributing to the evidence base. The project documents effective ways to build the skills and capabilities of healthcare practitioners, including the capability of practitioners to be responsive to experiences of racism and the role of cultural determinants within a clinical encounter[33]. The research has developed and is in the process of validating an alternative lens regarding capacity development of healthcare practitioners in Indigenous clinical communication skills in urban and regional settings. The inclusion of non-Indigenous partners is important to ensuring the translation of research outcomes to daily clinical practice, given the current diversity of the Australian healthcare workforce[34] and the collective responsibility of this workforce to redress health inequities[35,36]. As knowledge translation is situated within mainstream academies, effective collaborative approaches are needed. Achieving this requires clear recognition of the roles of Indigenous and non-Indigenous partners in medical education research and practice, which can be achieved through a collaborative governance approach. This can work to ensure mainstream approaches are adapting to Aboriginal community contexts and needs, and not the other way around[7].

Interconnectedness and governance in Indigenous medical education research

> *Whatever affects one directly, affects all indirectly. I can never be what I ought to be until you are what you ought to be. This is the interrelated structure of reality*[37].

The relevance of an inclusive governance approach is reflected by

the dual worlds in which Indigenous peoples live in every single day[3]. Indigenous peoples in medical education research must balance maintaining their internal governance legitimacy with their external governance legitimacy demands[3,38]. Internal legitimacy is maintained through the support of peoples who share their cultural values[38]. External legitimacy requires Indigenous peoples' contributions to be effective and credible to the medical academy and its wider stakeholders. Both legitimacies need to be balanced to enable useful change[3]. Achieving a workable balance in maintaining cultural integrity, maximising self-determination while also allowing for praxis within the medical academy can be facilitated through an effective governance approach[3].

Figure 2 demonstrates the relationship between Indigenous and non-Indigenous partners in creating culturally responsive medical curricula through medical education research. The qualities of effective non-Indigenous partners to listen, facilitate, support and work alongside Indigenous pedagogies and knowledge paradigms to be included in the medical education research can begin to shift institutions from within to be more responsive to the needs and priorities of Indigenous peoples[12]. This shift ideally will be inclusive of high-level structures guiding research implementation to the connections and partnerships formed during day-to-day research activities[39]. Nurturing relationships among partners can foster a vision for change that not only relies on external directives but is owned by the institutions themselves[12].

Institutional ownership for change reinforces the notion that improving Indigenous health outcomes is a united responsibility[36]. Non-Indigenous partners have a role in Indigenous medical education research given their positioning in healthcare provision[40], medical education delivery[41] and in contributing to the culture of healthcare institutions[36]. Non-Indigenous partners are well placed to support Indigenous medical education research by realising the rights of Indigenous peoples to self-determination[42]. They can facilitate the inclusion of values and worldviews into research processes by respecting Indigenous ownership and control of research outcomes[24,25,43]. Engaging in activities of praxis guided by an inclusive governance structure provides a useful lens in which to approach knowledge translation efforts in research. It emphasises that activities need to be inclusive of Indigenous and non-Indigenous partners while preserving and promoting Indigenous worldviews and values when enacting change.

Non-Indigenous partners, also known as allies, are characterised by their humanistic qualities of understanding patterns of marginalisation and how oppression is maintained[44]. A demonstrated ability to work alongside Indigenous researchers in a way that does not perpetuate oppression or enact paternalism[44] is quintessential in effective governance. This is a key component of the conceptual notion of two-eyed seeing, which values the strengths of different knowledge systems to create new and innovative solutions to complex problems[45]. Embracing effective governance could provide a structure to support and facilitate non-Indigenous partners to build capacity in being able to respectfully contribute to Indigenous health advancement. It also provides the opportunity to review and be accountable to the humanistic qualities that are expected when working in Indigenous medical education and research.

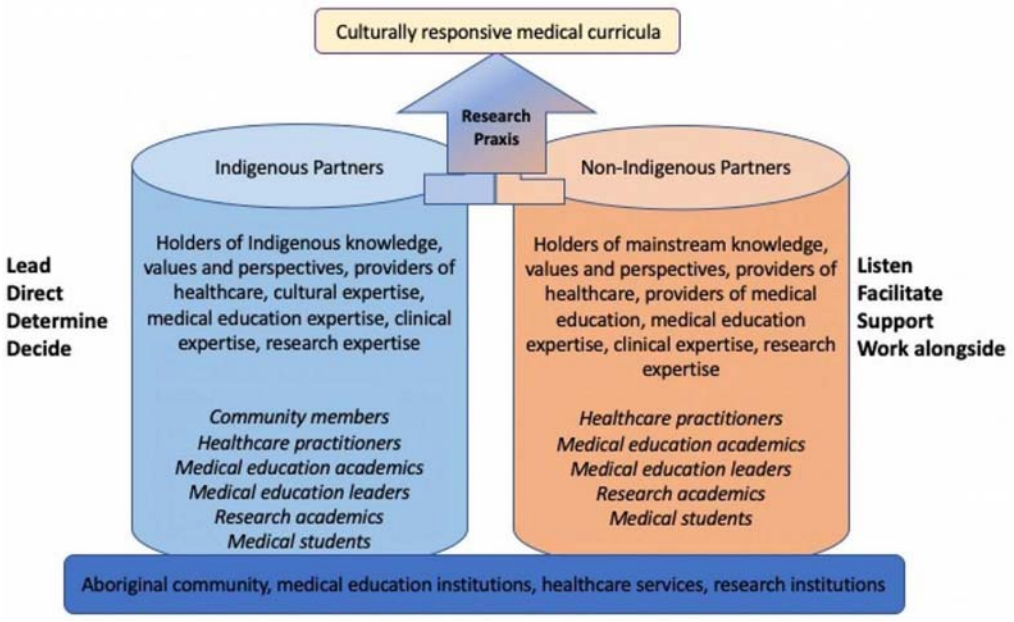

Figure 2: Partners in Indigenous medical education research and their roles in governance.

Legitimacy in two worlds

Defining parameters of effective governance can be a contested space[46], particularly when governance involves the coming together of different knowledge paradigms and worldviews. Also, the right way to do things in research can be guided by cultural values[43,46]. When implementing change that draws on the

knowledge and perspectives from two worlds, close negotiation and respect for differences is required[4]. A consensus must be reached on how decisions will be made, how accountability is enacted and how the legitimacy of different knowledge systems is handled – along with a clear outline of the resource availability to facilitate these processes[46,47].

The notion that effective governance requires positions of power to be perceived as having been acquired legitimately[48] can be a challenge in Indigenous medical education practice and research. There might be conflicting worldviews and notions of who holds the authority and knowledge to make decisions[42]. The legitimacy of Indigenous knowledge and its place within mainstream medical education and research need to be acknowledged and embraced for a collaborative governance approach to be effective[38]. To support this there needs to be a willingness to accept that individuals will have different criteria to meet when defining their capacity to contribute to the research based on their role, experiences and expected scope of contribution. This is enabled in the Healing Conversations research team through relationship building that recognises and values Indigenous approaches to knowing, doing and being[49].

Decision-making regarding Indigenous governance, knowledge and capacity needs to be led by the Indigenous members of the research team to ensure respectful and appropriate decision-making is enacted, and to prevent further oppression and the maintenance of a colonial agenda[27,47]. This can be achieved through a number of approaches. In Healing Conversations, the IGG have a critical role in shaping the research outcomes in partnership with the wider research team[50]. The establishment of a dedicated Indigenous governance structure both empowers the Indigenous voice and facilitates accountability of the research process beyond the medical research institution. Indigenous representation is balanced with non-Indigenous representation, shifting away from a population parity approach. This works to facilitate effective consensus decision-making and prevents burden of advocacy being placed onto a lone Indigenous voice.

Lessons learnt

Implementing governance in Healing Conversations

To establish the IGG, the student researcher identified suitable individuals in Indigenous health research and education using information obtained through existing work relationships and networks. Suitability drew on factors including experience and known expertise in the field, geographical location, gender and availability to contribute to the project. The shared goal of increasing workforce capabilities to work effectively with the Indigenous community unites the research team. This is guided by shared values of respect for the role and knowledge each person brings, and an understanding of our own boundaries within the research process, negotiated through discussion and relationship building. Figure 1 demonstrates these boundaries, notably the space for the IGG and student researcher to have conversations and decision-making processes independent from the supervisory team when needed.

Defining community can be challenging in Indigenous health given the diversity within the collective Indigenous population[51]. The difficulty in being able to generalise what an entire nation of people thinks[44] must be considered in governance approaches. The Healing Conversations research team address this by shifting away from a majority rule approach, to considering how to build consensus in the research outcomes[52]. Research outcomes from this process, given the tensions around defining community, further reinforce the importance of and need for Indigenous representation in governance structures to be maintained throughout knowledge translation efforts and into the structure of the medical academy. This will enable ongoing debate and discussion to ensure appropriate and meaningful inclusion and representation of Indigenous perspectives that is aligned to the local context[15].

Research praxis is addressed in Healing Conversations through the development and maintenance of a research website, regular updates of participants and research stakeholders, presentation at international medical conferences, and community engagement in the research sites (South Australia, Western Australia). Additionally, early research findings are being integrated into medical education initiatives in clinical communication that are implemented using a collaborative approach with Indigenous and non-Indigenous medical academics. The overarching governance approach ensures that accountability of the research process is owned and shared by the entire research team.

Strengthening capacity and sustainability through governance actions

Capacity-strengthening is a fundamental process of effective governance[38,46,47] and can be viewed through a collaborative lens. The capacity of Indigenous community members to contribute to change in positions from on-the-ground education activities to leadership opportunities within the medical academy can be strengthened through governance activities. Similarly, non-Indigenous contributors can strengthen individual and organisational capacities to support Indigenous leadership, include Indigenous knowledge structures and address organisational culture through their involvement and the nurturing of relationships within the governance process[12].

The terminology regarding 'strengthening capacity' as opposed to 'building capacity' recognises the capacity to thrive, lead and govern that has existed within Indigenous communities for generations[46]. Strengthening the previously eroded capacity of Indigenous peoples to contribute meaningfully to improving health outcomes is what is now needed[46] and is a fundamental reporting aspect of good research in this space[24,47].

Capacities can involve technical skills, infrastructure, financial resources and equipment[46], which all reflect the non-human structures that contribute to the governance community[53]. This can influence the sustainability of governance mechanisms at all levels[54]. The Healing Conversations research is strengthening the skills of the research team, Indigenous and non-Indigenous, in facilitating effective and evidence-based Indigenous clinical

communication programs for medical students. Given the scope of the PhD project, no financial resources or equipment have been gained by the research team. However, this will become a key focus for negotiation when the project shifts to integrating research findings into medical curricula activities to ensure knowledge translation and praxis activities are appropriately resourced in the medical academy[15].

Development of human-related capacities, although often not given high priority[46], are fundamental to ongoing success in Indigenous medical education research and praxis. Such human capacities involve skills such as confidence, morale, values and motivation[46]. Without individuals who are skilled, confident and motivated to contribute to Indigenous medical education research, and subsequent medical education curricula activities, change cannot be sustained. Healing Conversations brings together motivated researchers in Indigenous medical education in both urban and regional settings. A shared vision for change is held regarding the capabilities of the future healthcare workforce to implement best practice and address the ongoing effects of colonisation in clinical encounters suited to the local context. The possible institutional benefits that can be gained from effective and inclusive governance structures support the consideration of this to be implemented widely in the medical education academy.

Effective governance in medical academies as a driver to institutional change

> *… stop talking, start listening, and work with us to deliver*[55].

Implementing the structure of governance as described in Healing Conversations offers a useful approach to conceptualising the roles of non-Indigenous and Indigenous stakeholders in Indigenous medical education research. It allows a structure that guides relationship-building and outlines the necessary human qualities and capacities to create and sustain meaningful change in Indigenous medical education research. It also requires collective responsibility and accountability for change in this space[56].

It can be difficult to separate entities responsible for medical education research and medical education curriculum given the interwoven nature of the two. The next step in reflecting on governance in research is to consider how this approach transitions into medical curriculum implementation. In medical institutions, a multidimensional approach to enabling Indigenous agency is needed[15]. Indigenous representation is necessary in day-to-day curriculum activities, medical education leadership structures, the student cohort, organisational hierarchies and in ongoing external community engagement efforts[15]. This approach shifts away from having a single, standalone structure for Indigenous voices to be heard and included in medical education organisations to prioritising efforts to include Indigenous representation at all levels of the institution that are respectfully supported by non-Indigenous partners.

This poses a call to action to medical academies and their leadership structures to consider their commitment to addressing Indigenous health disparities by facilitating Indigenous self-determination at all levels of the institution[54]. This requires medical academies to:

- commit to a clear vision for action in Indigenous health
- work with Indigenous communities to embed collaborative governance approaches
- own their role in supporting, listening and facilitating Indigenous knowledges and perspectives into the academy
- outline their approach to capacity strengthening of all partners
- own their collective accountability to address Indigenous health inequities.

This will require firm commitment to the human and material resources needed to provide a sustainable and effective governance approach[15], with a prioritisation to the development of the Indigenous medical education workforce.

Conclusion

> *Colonisation is a fundamental determinant of Indigenous health. Medical education institutions must acknowledge their historical and contemporary role in the colonial project and engage in an institutional decolonisation process*[35].

Meaningful inclusion of Indigenous peoples in governance plays a fundamental role in the development and maintenance of culturally safe individuals, organisations and institutions[15]. When done effectively, Indigenous representation in governance can serve as an expression of agency and self-determination within the community and can work to facilitate the multilevel capacity of institutions to respond to Indigenous health inequities[12]. The inclusion and prioritisation of Indigenous voices in the design and shaping of vital institutions such as medical education and health care can work towards enhancing the collective wellbeing of the Indigenous community[38,39].

Medical education academies must now look to prioritise and embed Indigenous governance structures within curriculum and research activities and commit to capacity-strengthening initiatives that will sustain Indigenous representation over time in both urban and regional environments. This approach acknowledges the collective responsibility and accountability of healthcare systems to action and redress Indigenous health inequities in a way that fosters self-determination within the community and the medical academy.

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Chapter 5 – Results Stage 1

Statement of Authorship

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Principal Author

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Contribution to the Paper	Researched, prepared and edited the research paper. Collected the data through semi-structured interviews. Held data analysis meetings with the research team. Provided first drafts for critical revision and feedback by supervisory team, and incorporated feedback into final draft.		
Overall percentage (%)	70%		
Certification:	This paper reports on original research I conducted during the period of my Higher Degree by Research candidature and is not subject to any obligations or contractual agreements with a third party that would constrain its inclusion in this thesis. I am the primary author of this paper.		
Signature		Date	04/02/2022

Co-Author Contributions

By signing the Statement of Authorship, each author certifies that:

i. the candidate's stated contribution to the publication is accurate (as detailed above);
ii. permission is granted for the candidate in include the publication in the thesis; and
iii. the sum of all co-author contributions is equal to 100% less the candidate's stated contribution.

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Healing Conversations; guiding Aboriginal health communication in health professional education

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Abstract

Background

In Australia, healthcare practitioners are required to demonstrate capabilities in effective clinical communication with Aboriginal patients and their families.

Aim

This paper presents interview findings from the first stage of data collection in South Australia (SA) and Western Australia (WA) for the qualitative research project Healing Conversations, which is developing a targeted communication framework in Aboriginal health for use in health professional education.

Methods

Healing Conversations is guided by the concept put forth by Mi'kmaw Elders Murdena and Albert Marshall of 'two-eyed seeing'. Semi-structured interviews were conducted with Aboriginal community members (six in SA and three in WA) and healthcare practitioners (six in SA and six in WA) to inform development of the framework. Thematic analysis was conducted by the research team which identified four key themes.

Results

The four key themes emerging from the Aboriginal community and healthcare practitioner interviews in WA and SA comprised: building the therapeutic relationship; communication in the clinical encounter; institutional and organisational factors impacting communication; and educating healthcare practitioners.

Discussion

These results acknowledge that learning communication approaches need to be patient-centred, considerate of Aboriginal worldviews and guided by geographical and community contexts. A final working framework is presented in this paper, modified in response to the findings emerging from the interviews in SA and WA.

Conclusion

The next step in this research is to workshop the framework with Aboriginal community members, healthcare educators, healthcare practitioners and medical students. This framework aims to contribute to evidence-based and Aboriginal community informed healthcare education curricula.

Introduction

Communication is a cornerstone skill(1) that needs to be developed in primary healthcare education through to postgraduate training and beyond(2, 3). In Australia healthcare practitioners are required to demonstrate capabilities in effective communication with Aboriginal and Torres Strait Islander patients(4, 5). This paper presents interview findings with key stakeholders for the project Healing Conversations, to inform the development of a targeted communication framework for use in health professional education.

Healing Conversations is a qualitative research project guided by the concept of 'two-eyed seeing', developed by Mi'kmaw Elders Murdena and Albert Marshall which draws on the strengths of Indigenous and mainstream knowledges to create new solutions to complex challenges(6, 7). 'Two-eyed seeing' values the co-existence of different knowledge systems working to create new approaches(8). Importantly, when different knowledge systems are co-located they retain their identity, countering assimilation or domination of one knowledge system over the other(9). This guiding principle is fundamental for Indigenous perspectives to safely co-exist in health professional curricula(10).

The targeted communication framework aims to build healthcare practitioner capabilities in effective clinical communication with Aboriginal patients and their families. The first phase was to develop an initial framework (published elsewhere), based on the literature and informed by the innovative work in New Zealand to improve Maori health through clinical assessment(11-13). The next step was to refine the framework in collaboration with Aboriginal community members and healthcare practitioners in two different contexts in Australia(7). This paper explores perspectives on the framework, in specific regards to the

framework details and educational approaches, from Aboriginal community members and healthcare practitioners in South Australia (SA) and Western Australia (WA).

Methods

A qualitative approach was chosen as it provides the ability to gather deep understandings of effective clinical communication with Aboriginal patients from the perspective of all participants(14). As clinical communication occurs between Aboriginal community members and healthcare practitioners, participants were selected from both groups. A more detailed description of the methodological approach, which has drawn on the conceptual notion of 'two-eyed seeing' put forth by Canadian Mi'kmaw Elders Murdena and Albert Marshall, has been published elsewhere (7).

Participants in the first phase of data collection in SA and WA were purposefully selected from two groups; healthcare practitioners registered with the Australian Health Practitioner Regulation Agency (AHPRA) (six in SA and six in WA) and Aboriginal community members over the age of 18 (six in SA and 3 in WA). Participants in the healthcare practitioner group included medical practitioners and Aboriginal health workers, with WA healthcare practitioners representing a larger proportion of Aboriginal members compared to SA particpants. Those eligible for both groups were able to choose which group to represent. Formal written consent was provided prior to semi-structured interviews which were audio-recorded and transcribed, with transcribed data returned to the participants for review and approval. The interview questions are included in appendix 1 and 2. Participants

in the healthcare practitioner group included medical practitioners and Aboriginal health workers. No further demographic data was collected to ensure anonymity of participants in the research.

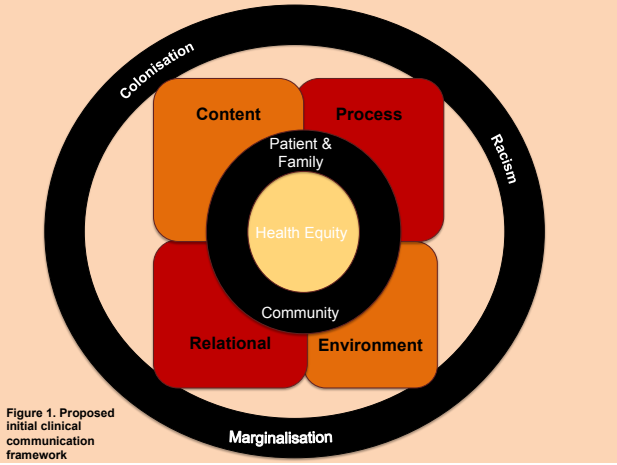

Figure 1. Proposed initial clinical communication framework

SA data collection and analysis occurred in 2019, and WA in 2020. The research was led by a doctoral researcher, an Aboriginal medical academic, conducted and transcribed the interviews, allowing for deep immersion in the data. The lead researcher values the inclusion of diverse perspectives as legitimate knowledge to be afforded power and opportunity to shape future approaches to knowing, being and doing.

Interviews took place in home and work settings depending on participant preference. The initial framework(11) (figure 1) was refined in response to SA data analysis, and then further refined through interviews with WA participants. The second and finalised frameworks are presented in the discussion section of this paper (figure 2 and 3).

Thematic analysis was used to code the transcribed interviews which were reviewed to reveal key themes. Aboriginal community members and healthcare practitioner transcripts were coded separately, and then reviewed together to refine the overarching themes. These themes were reviewed by the research team consisting of an Indigenous Governance Group (IGG) and a supervisory panel, details of these groups published elsewhere(15). Each team member received a copy of six de-identified transcripts for review from SA. Due to a delay in transcript approval, the research team received four de-identified transcripts from WA. Two meetings were held to discuss the transcripts and initial coding from SA and WA

and final themes were agreed upon by the research team. Data saturation was reached on analysis of the transcript data.

Results

Four key themes emerged from the Aboriginal community and healthcare practitioner interviews in WA and SA, comprising: building the therapeutic relationship; communication in the clinical encounter; institutional and organisational factors impacting communication; and educating healthcare practitioners in communication. Each theme along with the underpinning sub-themes are presented below.

Building the therapeutic relationship

Trust and connection

> He would talk to me about his country, his culture and his family… It is about having that sort of preliminary conversation so that you actually feel like you have got a relationship with your doctor.
>
> Aboriginal community interview D (SA)

A key aspect of good clinical communication encounters identified in the interviews was the ability to develop trust and connection. Building a good therapeutic relationship were seen to set-up effective clinical conversations where healthcare practitioners can elicit accurate information from their patient. Without this foundational relationship, technical skills and knowledge were viewed to be inconsequential.

> …you can't get anywhere unless you've got the relationship… if people don't trust you, your cleverness is useless.
>
> Healthcare practitioner interview L (SA)

Participants considered that establishing trust increased Aboriginal patient's comfort in sharing details about themselves. Trust and connection could be achieved through a reciprocal relationship when the practitioner approached the patient as an individual and shared something of themselves. This was seen as a balancing act between how much personal information to share as a healthcare practitioner, to maintain a professional therapeutic relationship.

> … it's a balancing act … something not too familiar, but to say this is a little bit about me, and that opens people up to trust and open up about themselves as well.
>
> Healthcare practitioner J (SA)

Gender also influenced trust in the interaction. Some participants identified that discussing particular healthcare issues with practitioners of a certain gender may result in the patient choosing not to share information.

> … communicate with me in a sense of asking me first if I want to see a male doctor or a female doctor first.
>
> Aboriginal community interview S (WA)

Respect and Authenticity

The ability to demonstrate respect for Aboriginal peoples underpinned the likelihood of building effective therapeutic relationships. Respect could be demonstrated through the practitioner having an open, caring and friendly

approach, remembering the patient on subsequent presentations, listening to the patient, being honest, kind and empathetic.

> Respect. I think respect underpins it all.
>
> Healthcare practitioner interview N (WA)

Respect shown in the clinical conversation was closely aligned to the need for practitioners to approach each patient as an individual. Practitioners should see people with a clear lens, unbiased by population stereotypes or previous patients they have seen.

> … another important aspect … is not to assume, generalise and stereotype.
>
> Healthcare practitioner interview J (SA)

Authenticity was discussed with the need for practitioners to communicate in an open and honest way. This includes practitioners being genuine and comfortable with not knowing everything about local Aboriginal cultural practices or Aboriginal health. Practitioner qualities of being willing to learn and generate new understandings was viewed as a positive attribute.

> … being able to communicate openly and honestly is really important.
>
> Aboriginal community interview T (WA)

> I think being genuine is important. Not pretending to be someone that you are not.
>
> Healthcare practitioner interview L (SA)

The next theme focuses on skills within the clinical encounter that were seen as important for healthcare practitioners to implement when communicating with Aboriginal patients.

Communication in Clinical Encounters

Content of clinical encounters

The necessity to address patient concerns in a respectful and appropriate way in clinical encounters was raised by participants. Practitioners needed to have the ability to follow this up with appropriate strategies to address identified concerns. The way in which questions are asked by healthcare practitioners was viewed as fundamental.

> I need to feel safe that they are competent in asking me those questions in the right way, and they know a little bit about the Aboriginal community … I need to be comfortable they have got strategies to look after my illness, given my personal situation.
>
> Aboriginal community interview C (SA)

Having the capability to respond to information provided by patients was considered important in conversations about racism in clinical encounters. If experiences of racism have an impact on someone in ways that were relevant to their clinical presentation, the conversation and an opportunity to share this was seen as important. Some participants identified the ability to ask open questions and listen deeply to the patient as one way to gather and act on clinical information related to racism. Targeted and direct questioning about experiences of racism could be interpreted as inquisitiveness without clinical relevance. Different approaches for providing open opportunities to share versus letting the patient instigate the conversation were suggested.

> Has this got something to do with health? Because racism can make you sick. … And you got to talk to people about it …
>
> Aboriginal community interview B (SA)

> …it is about leading from the patient… If the patient brings it up, then you talk about it.
>
> Healthcare practitioner interview L (SA)

Practitioners believed they should have the tools and advocacy skills to deal with information gained in relation to racism.

> … if people are going to talk about institutionalised racism, you need to teach them advocacy skills.
>
> Healthcare practitioner interview L (SA)

Colonisation was not often discussed directly in clinical consultations, as it was seen as a deep impacting factor that was addressed more superficially through acknowledgement of patient context. Understanding colonisation and its impact on current healthcare outcomes was seen as important, particularly around intergenerational trauma and social determinants of health.

> What might come up, is trying to make connection in the consult, as opposed to historical context … where are you from, who are your family…as opposed to going so deep …
>
> Healthcare practitioner interview N (WA)

> … the doctor used to just say 'this is a white man's disease. Aboriginal people never had this disease'. So right there and then, highlighted one of the impacts of colonisation and settlement …
>
> Aboriginal community interview E (SA)

The ability to have conversations about racism or the impact of colonisation came back to the importance of trust in the therapeutic relationship. The positioning and colouring of racism and colonisation in the outer circles of the framework received comments regarding them being factors that cause harm, being inclusive of more determinants such as poverty, and lacking positive and strengths-based determinants of health.

> … the difficulty with addressing in conversation a lot of these issues highlighted in the black, colonisation, racism, marginalisation … there probably does need to be quite a bit of trust behind it before you ask somebody that.
>
> Healthcare practitioner interview J (SA)

> … darker colours are a bit more scary. … not to make anything lighter of it but to represent a model that is really positive and strengths based.
>
> Healthcare practitioner interview O (WA)

The social, financial, spiritual and family context of patients were viewed as essential knowledge for healthcare practitioners to grasp. This was supported by the notion that having an accurate contextual understanding of patients can assist in accessible therapeutic management planning. Understanding a patient's wider context was seen to help practitioners learn more about their patient's values and how this might influence their healthcare.

> … finance of our accommodation … if we need to go away for further medical treatments. I don't mind talking about finances … because sometimes we can't really afford to do these things. But if there is some sort of system that can support us as a family …
>
> Aboriginal community interview S (WA)

Checking in and ensuring patient understanding in clinical encounters was another key theme in the interviews. Checking-in can work to identify and address any communication barriers and misunderstanding that may have occurred in the clinical interaction. The importance of empowering the patient through opportunities to ask questions, give feedback and share their thoughts on the clinical encounter was conveyed in the interviews.

> Take time to say … 'do you understand what I am saying'… They confirm with you.
>
> Aboriginal community interview F (SA)

> I'm usually checking with the person a lot with what they would like, the direction that we are going in, what we are deciding to do.
>
> Healthcare practitioner interview H (SA)

Supporting and allowing patients to advocate for their healthcare needs and have the skills to feel confident to ask questions and seek a second opinion was raised as important. Being able to advocate was seen to require patients and practitioners to remove notions of authority and superiority, viewing each other as on the same level.

> I think it is about teaching our mob as well … to ask the question and know what our rights are … even getting a second opinion.
>
> Aboriginal community interview T (WA)

Process skills in the clinical encounter

The importance of a practitioner's style in relation to verbal and body language was mentioned in the interviews. The ability to be responsive to the communication needs of the individual patient was seen as important. This was

supported by the view that medical students could approach non-verbal language styles in a stereotypical manner. Checking in to ensure the interpretation of body language aligns with what the patient means is important, such as head nodding, as a misinterpretation can result in a barrier to shared understanding. The ability to adapt and take cues from the individual patient's body language and mirror their preferences was raised as an important skill.

> … they are not nodding and saying yes because they understand. They are nodding and saying yes because 'I hear you'. So, it is OK for someone to nod and say yes. But it is also OK to say: 'I know I have said that, but if I put it this way, that might also help you'.
>
> Aboriginal community interview D (SA)

> … the students, they tend to be very black and white. Because they will say 'oh OK, because they are Aboriginal people you don't … do direct eye contact' … you have to see who the person is in front of you… be sensitive to the culture, but not stereotype the person.
>
> Healthcare practitioner interview H (SA)

Negative healthcare practitioner body language that could signal unwillingness to engage or give the appearance of not listening was raised in the interviews. Such active listening skills were recognised as providing space for the patient to share information, feel seen and heard, and to develop trust. Participants considered that active listening skills were difficult to learn and hard to implement in clinical environments. Factors impeding listening included time pressure and a need to reach a diagnosis or management plan quickly.

> If I go into a clinical setting, and a doctor hasn't turned to look at me, or engaged in conversation with me … I feel … not like going any further … you don't feel like this person is listening to you at all.
>
> Aboriginal community interview E (SA)

> …shutting up and listening. We are not very good at that collectively with everybody. But it is just so important with Aboriginal people. … The value of silence and getting people to practice that.
>
> Healthcare practitioner interview M (WA)

The ability to sit and be comfortable with silence was considered critical, allowing Aboriginal patients time to contemplate and plan their responses to questions asked in the clinical interaction. An inability to be comfortable with silence was described as a behaviour that could risk relevant clinical consultation being withheld.

> … why ask a question if you are going to cut them in half when they are trying to talk.
>
> Aboriginal community interview B (SA)

> … the waiting means that the person has gone through that thought process, and gone, this person really wants to hear what I have got to say. Because they have waited. And then they will say 'I accidentally took too much insulin this morning'. And you think, whoa, I nearly missed that …
>
> Healthcare practitioner interview L (SA)

Verbal language

Similar to the findings of body language, there was a need for practitioners to be responsive to the language and literacy requirements of the patient. This included avoiding medical jargon and terminology that the patient might not understand, whilst at the same time avoiding patronising language. Also discussed was the need for practitioners to consider the use of an interpreter in the conversation.

> People think they are talking in simplified language that people might understand. And they are either patronising, or they really don't understand what simplified is.

Healthcare practitioner interview M (WA)

> … it is kind of two-ways, it is not just the patient needing the interpreter, if you can't understand the patient, you might need the interpreter …

Healthcare practitioner interview O (WA)

Working with Aboriginal health services

The importance of a collaborative approach in communication and healthcare delivery with Aboriginal patients was acknowledged. This could involve Aboriginal health workers or family members to support the patient and assist in management plans. This can work to ensure institutional barriers to care are recognised and addressed, and power is effectively shared within the clinical setting.

> …that is where having another worker, a bicultural worker, having someone, a family member or someone else that can be a support for that person, asking what would make it easier for them.

Healthcare practitioner interview H (SA)

Communication skills in the clinical encounter address the importance of practitioner knowledges and skills in verbal and non-verbal language, as well as working with a team approach that enables patient's right to self-advocacy. Implementing these skills were seen to be impacted by the institutional and organisational environment of the communication encounter.

Institutional and organisational factors

Safe environments

Having a welcoming environment was considered critical to ensuring patients felt comfortable to access healthcare services. This included the physical environment and the conduct of staff. Participants commented on the need for clinical environments that ensure privacy and confidentiality, as well as the importance of having adequate time to engage in communication.

> … the biggest limitation is time.
>
> Healthcare practitioner interview Q (WA)

> Being mindful of where we are talking to patients and what we are talking about. Because a lot of patients do have that uncertainty of confidentiality.
>
> Healthcare practitioner interview P (WA)

Some participants noted the impact that settings could have in developing institutional trust and in empowering patients to engage in communication.

> …in a big tertiary city hospital, it may be you start with the process. And say 'look this is not the best place to do this right at this moment, before we even meet … is there a place where you might feel more comfortable to talk?'
>
> Healthcare practitioner interview K (SA)

> … if you are working in an organisation which is trusted, you have got a step up the ladder.
>
> Healthcare practitioner interview Q (WA)

The ability of organisations to make available Aboriginal health workers, provide follow-up to treatment, and be culturally secure commonly emerged in the interviews. Having policies and adequate funding to enable quality healthcare provision was considered important. This includes having supportive mentors for

healthcare practitioners while they are building and consolidating their capabilities to work effectively with Aboriginal peoples.

> … there is the other side of compliance. The service must be compliant as well. So, they provide follow-ups to my treatments. They must ensure that staff are going to treat me nice when I come in and look after my cultural needs and the obligations that may attached to it.
>
> Aboriginal community interview C (SA)

> … have really good supportive mentors, people who could help me through … because sometimes I guess it is hard to ask a patient 'I'm sorry. Did I do that wrong?'
>
> Healthcare practitioner interview I (SA)

The importance of support and mentorship for healthcare practitioners is fundamental. This is needed across continuum of learning and professional development from student to practitioner and beyond. The final theme explores approaching education of healthcare practitioners in communication.

Educating Healthcare practitioners

Foundational knowledge

In the interviews, participants commented on the importance of practitioners possessing broad knowledge of colonisation and the ongoing intergenerational impacts this process has on current health outcomes for Aboriginal peoples. A participant commented that acknowledgement of Australia's history can work to promote two-way understandings in health.

> What happened to my generation and the next generation is still relevant … your family structures, how you were brought up, they all have an influence on your health.
>
> Aboriginal community interview C (SA)

> …pull up for a minute, acknowledge a little… Australia is a first nation country…Get over it. And start looking at it in a two-way sense. And not nonsense.
>
> Aboriginal community interview S (WA)

Having knowledge of determinants of health was seen as invaluable. Presenting information respectfully and appropriately was commented on, to avoid tokenistic approaches to learning that devalues important knowledges. This requires careful consideration to authentic, situated learning opportunities for students to ensure appropriate and respectful learning.

> You don't want to cheapen it, for want of a better word … it has got to be done in a respectful way, and at the right place … take people out on country and teach them.
>
> Aboriginal community interview T (WA)

Learning about Australia's colonial history and legacy surrounding marginalisation and racism were frequently commented on as having the potential for learners to experience emotions of discomfort and guilt. Being able to manage this was seen as a necessary component of effective educational approaches in Aboriginal health clinical communication. The potential for learners to disengage due to being unable to manage these feelings well was seen as a risk to the success of the framework being learnt in healthcare education.

> … there is the forever challenge of people automatically assuming you are accusing them of personal guilt.
>
> Healthcare practitioner interview M (WA)

> …one of the things that happens for a lot of medical students is that they get overwhelmed with guilt, feel blamed, and they feel terrible, and then they don't learn anything.
>
> Healthcare practitioner interview L (SA)

The importance of integrating Aboriginal perspectives and worldviews into healthcare curricula was commented as vital. The need to challenge dominant paradigms of knowledge legitimacy was raised. This was seen as being able to work towards addressing the dominance of mainstream biomedical approaches to knowing which on their own cannot address Aboriginal health inequities.

> It is not all about academics. And it is not all about getting that ticket. Getting that piece of paper to become a doctor or a nurse. That is one way of learning … there is the other side too. Have they learnt the other side? No.
>
> Aboriginal community interview S (WA)

Teaching approaches

Participants commented in the interviews that the framework needed to be grounded in reality and be presented from a position of strength. This can work to challenge deficit narratives of Aboriginal peoples that are perpetuated through negative, inaccurate stereotypes and assumptions that ignore Aboriginal voices and the context in which patients live in contemporary Australian society.

> …building a story that is not all negative but has got a mix of lots of reality.
>
> Healthcare practitioner interview M (WA)

This was seen to be possibly achieved through personal storytelling, engaging authentically with local Aboriginal community members and having exposure to contemporary media that represents diverse community perspectives. Experiences and interactions with Aboriginal community members outside of the healthcare setting were seen to be vital, as this can allow healthcare practitioners

to relate to people when they are in positions of strength and wellbeing as well as positions of sickness and vulnerability.

> Don't live in the clinic … make a bond and a relationship with people that live in the community … They might start teaching them, it is not all about medicine in the non-Indigenous world.
>
> Aboriginal community interview S (WA)

> I think hearing Aboriginal people's stories are probably the most important bit.
>
> Healthcare practitioner interview H (SA)

Engaging local Aboriginal community members to share their stories was seen to be a potentially burdensome request, particularly if the activity occurs frequently. This raises important considerations around appropriate resourcing and support of the Aboriginal health curriculum, and support of staff and community members who contribute to teaching and learning.

> It is a tough audience … some of them will be quite resistant, defensive. That is tough and not everybody can cope very well with that. Nor should they have to cope with it on a regular basis.
>
> Healthcare practitioner interview M (WA)

Opportunities to practice communication skills through observed role-plays were seen to be pivotal in developing skills in alignment with the framework. Participants commented on the need for an integrated approach to teaching communication capabilities. Case-scenarios were seen to be important in challenging stereotypes and providing deeper understandings around determinants of health.

> Case scenarios … is really important, and then role-playing …

Healthcare practitioner interview N (WA)

> …practice is the thing that makes any skill better, So, role-playing it.

Healthcare practitioner interview L (SA)

The need for solid student support when learning to communicate well with Aboriginal patients in clinical settings was addressed in the interviews. This includes having mentors in the clinical setting, both clinical and cultural, to help healthcare practitioners navigate this area of clinical practice. Teaching was seen to be needed across the continuum of healthcare practitioner professional development, from students to experienced health practitioner supervisors. The potential for the framework to explicitly articulate elements of practice that might otherwise be implemented without conscious thought or reflection was discussed.

> … a big part of that is having mentors … then I could go back to work next day … people who could help me through …

Healthcare practitioner interview I (SA)

> … build it into the professional development of your established clinicians … they are the clinical placement supervisors … so it helps them to deconstruct … their behaviour as a way of training the young healthcare professionals …

Healthcare practitioner interview J (WA)

Capabilities in managing mistakes that challenge expectations of perfection in communication encounters with Aboriginal patients emerged as a key thread in the interviews. The ability to acknowledge mistakes and take steps to maintain or rebuild a therapeutic relationship was seen as a key skill for healthcare practitioners. This reflects the humanity of healthcare practitioners and the inevitability of making mistakes in clinical communication. Removing expectations

of perfection in clinical practice with Aboriginal patients was seen to encourage engagement and authenticity in clinical practice.

> You will stuff up, you will do stupid things. As long as you realise you did it, and apologise if you realise in time, and … just not doing it again in the future.
>
> Healthcare practitioner interview I (SA)

Contextualised teaching

The diversity of the Aboriginal communities across Australia was seen to require contextualised teaching specific to the local community culture, context and needs. This is a process that requires ongoing reflection and learning, regardless of time spent in the profession.

> … cultural awareness training … I don't think you will ever give it justice if people are not learning about the individual context of where they are learning and working.
>
> Healthcare practitioner interview N (WA)

This was seen to be achieved through understanding local Aboriginal communities, making local connections, as well as having knowledge about the local resources and healthcare supports available. The need for authentic Aboriginal health experience for healthcare practitioners was commented on. This was seen to allow healthcare practitioners to appropriately contextualise patient presentations and be able to make acceptable and accessible clinical decisions.

> Some of the students have commented … 'I have learnt more in this one week, because … I have seen it with my own eyes, I have heard it, and I have put it into context.'
>
> Healthcare practitioner interview N (WA)

> …we school down in metro areas … we don't really see many Aboriginal patients come through hospitals … we just don't have that experience through internship, through residency.

Healthcare practitioner interview P (WA)

Practice-specific

The diversity in practice regarding Aboriginal health communication was noted. This was seen to require the healthcare practitioner to understand the organisation they are working in and whether additional considerations and effort need to be made, with trust used as an example. The ability to work collaboratively was seen as important, but not be a replacement of the healthcare practitioner to maintain responsibility for care and demonstrate effective capabilities in Aboriginal health.

> … having the health worker there to help facilitate conversation or the discussion … not to say that we shouldn't be working on our own skills …

Healthcare practitioner interview O (WA)

To conclude this section, participants mentioned the need to consider the bigger context of education when considering knowledge translation of the framework. The notion that skills in the framework require deeper commitment at an institutional and societal level was mentioned.

> For all this to happen as a framework, it is deeper than that. It is about funding, more Indigenous roles, and policies to support doctors … so they can have two-way learning.

Aboriginal community interview S (WA)

Discussion

The four key themes arising from the interviews help to identify relevant factors influencing effective communication in clinical encounters. There was general alignment in responses between Aboriginal community members and healthcare practitioners regarding the key principles of effective communication, such as the importance of trust and respect, the value of appropriate verbal and non-verbal language styles of the practitioner, asking questions in a skilful way with clinical relevancy, and recognising the institutional impact the clinical setting can have on communication.

There were different perspectives regarding ways to ask about the impact of racism and colonisation in healthcare. However, there was agreement in responses that good understandings of the impact these processes have on Aboriginal patients is important. Understanding and acknowledging colonisation and racism can be achieved through open enquiry, responding to patient cues and being skilled in strategies such as patient advocacy to address issues when appropriate.

As colonisation and racism have ongoing intergenerational impacts on healthcare outcomes, upskilling the workforce to acknowledge and address them should enhance acceptability and accessibility of healthcare services. This was seen to require realistic educational narratives that are grounded in a strengths-based discourse. This cannot be achieved in clinical environments alone, and requires strong leadership and guidance from Aboriginal academics, experienced clinicians and Aboriginal community members at all levels of health professional education.

There was broad consensus that authentic and respectful education in Aboriginal health requires consideration to the local context to ensure knowledge is not devalued or presented in a tokenistic way. This requires effort on behalf of educators who are building cultural capabilities to ensure teaching and learning experiences do not promote stereotypical assumptions and approaches to practice. The complexity of emotion that accompanies Aboriginal health education provides a challenge to implementing this framework in health curricula. Educators need skills in facilitating clinical communication skills whilst also being equipped to address and manage potential student feelings of guilt and shame. This can be burdensome on Aboriginal academics and community members, risking curriculum sustainability if there is not adequate support and a totality of effort approach within the education institution.

The need to manage and support students through making mistakes and shifting away from goals of perfection is a key domain that arguably needs to be integrated into formal curricula. Providing effective support and mentorship to ensure mistakes and perceived failures do not become a barrier to engagement, but an opportunity for professional development, will likely work towards a more engaged healthcare workforce in Aboriginal health.

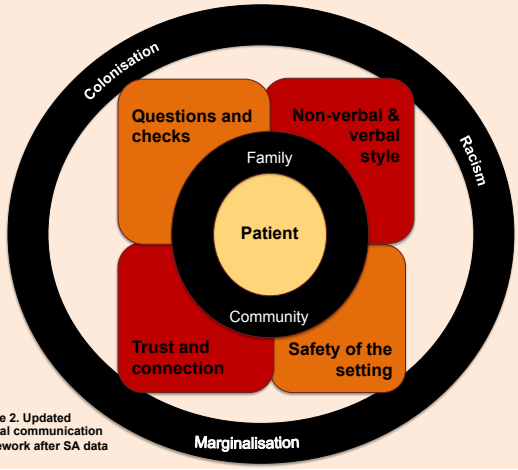

Figure 2. Updated clinical communication framework after SA data

Considering the interview evidence, the communication framework was developed in stages in response to different avenues of feedback. The initial framework (figure 1) was modified after the first round of interviews in SA. This reflected the need for a patient-centred approach and formed the basis of the second framework (figure 2). The changes

also highlight the need for practitioners to avoid using stereotypes and assumptions when communicating with Aboriginal peoples, and instead be responsive to the communication style and health needs of the individual. The language of the framework regarding ‘content’ and ‘process’ drawn from the Calgary -Cambridge model of clinical communication, were amended to ‘questions and checking in’ and ‘body language and non-verbal style’. This was done to reflect the language used within the interviews to increase clarity of intent and to promote the importance of sharing power and providing opportunities for the patient to contribute to the conversation. ‘Environment’ was changed to ‘clinical setting’ to promote clarity of meaning and the importance of having effective clinical settings when engaging in communication.

This updated framework (figure 2) formed the basis of the WA interviews. The responses from WA further refined the framework (figure 3) to remove marginalisation and racism from the outer rings. These determinants will remain significant components to be addressed in the educational details of the framework, particularly regarding the process of colonisation. Colonisation was shifted to ‘intergenerational effects of colonisation’ to further ground the clinical relevancy of colonisation as an ongoing contemporary process that impacts people’s health and access to care. Culture and country were added to the outer rings to ensure the communication approach was considerate of Aboriginal worldviews and grounded in the relevant geographical and community context of the patient and the healthcare organisation.

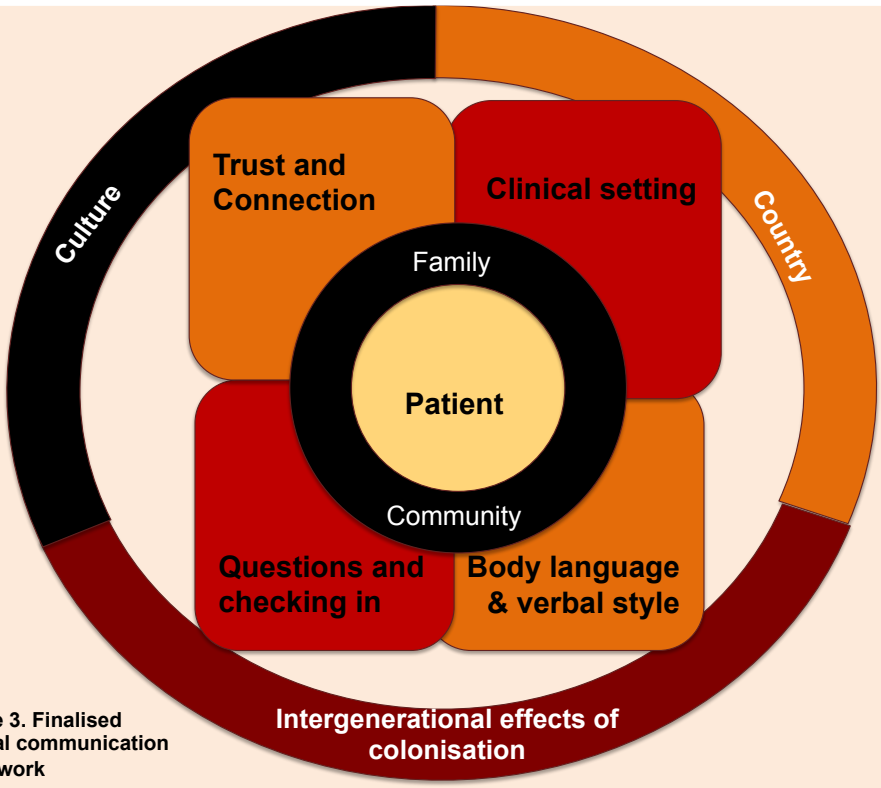

Figure 3. Finalised clinical communication framework

Strengths and Limitations

The research findings are strengthened through the use of both Aboriginal community member and healthcare practitioner perspectives, with the sample size resulting in data saturation. Having Indigenous Governance Group oversight of the data analysis and framework development reinforces the findings and enhances acceptability with Aboriginal communities. This research acknowledges the difficulty of generalising information obtained from the interviews to all clinical consultations in Aboriginal health given the diversity of experiences and cultures in the Australian Aboriginal community. Further consultation and development of the framework is planned in different educational contexts, with a view for education to gradually become more contextualised to the local community as healthcare

practitioners advance in their career. This will enable more nuanced perspectives to inform the framework in specific geographical areas.

Conclusion

On completion of data collection in two geographically distinct areas of Australia, a working framework has been developed for use in health professional education. The next step in this research is to workshop this framework with Aboriginal community members, healthcare educators, healthcare practitioners and medical students. This will be a step forward in providing evidence-based and Aboriginal community informed healthcare education curricula to better prepare the healthcare workforce to meaningfully engage in Aboriginal health and address healthcare inequities. While this research continues towards building meaningful curriculum in this space, a continued commitment to a scaffolded and sophisticated approach to knowledge translation is required, given the complexity and ongoing nature of learning in this space.

> ... I am talking about the physical, spiritual and environmental side of things… it is a simplified package and that fits in with the model that you have provided but, communication as you know, is extensive, non-ending, and ongoing.
>
> Aboriginal community interview C (SA)

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Chapter 6 – Results Stage 2

This chapter outlines the findings from the research workshop that formed the second and final stage of data collection for this research. The research workshop was held in November 2021. These findings have not been published or submitted for publication.

Workshop Methods

The research workshop was held online via the platform *Zoom* and was attended by four research participants: one Aboriginal community member, one healthcare academic, and two medical students. Three participants were from South Australia, and one from Western Australia. All participants provided written consent to participate in the workshop. The workshop ran for 2 hours in duration.

Workshop contributions were recorded via written notes taken by the research team and from written contributions made during the workshop. The workshop was not recorded. During the workshop, participants were introduced to the framework and asked to reflect on their thoughts and feedback of the workshop, ways to approach teaching the framework in health curricula, and to provide their perspectives on assessment. The outline of the workshop can be found in Appendix VI.

The student researcher summarised the workshop findings and provided these to each participant, which can be found in Appendix VII. The Indigenous Governance Group for Healing Conversations reviewed the findings and contributed to developing the final themes, in concordance with the approach taken for the first stage of data collection. The supervisory team attended the workshop to assist the

process. The Indigenous Governance team members were unable to attend due to other work commitments.

Workshop findings

The framework

In the workshop, the relevance of the framework to both Aboriginal patients and medical practice was commented on as holding the potential for students to learn about how Indigenous and non-Indigenous approaches can work together in partnership. The framework was seen to have utility in demonstrating the need to resource appropriate learning spaces and staff to facilitate meaningful inclusion of Aboriginal and Torres Strait Islander peoples and perspectives in health curricula.

In the experience of workshop participants, Indigenous health can in some settings be an after-thought which is under-resourced, leading to staff burn out and an unsustainable curriculum. This is important as workshop participants commented on the fact that Indigenous representation is needed when determining student capabilities as outlined in the framework. Reciprocity when involving Indigenous peoples in assessment and teaching of the framework was seen to be critical needed, ensuring people involved are remunerated in a fair and appropriate way.

Teaching Indigenous health

In the workshop it was discussed as important to situate the learner within the curriculum through acknowledging the diversity in experiences, cultures and pre-existing knowledge that people bring. This was seen to be a challenge for both educators and learners. Getting all learners to a common starting point can be

difficult when some students come well-equipped with knowledge and others are novices as a result of varied exposure to Australian history.

A key consideration raised in the workshop was the safety and wellbeing of Indigenous students learning in the health curriculum course. The need to provide safe learning spaces for students was seen as fundamental to ensure students are not unfairly forced into a role of educator.

The importance of identifying, challenging and preventing common stereotypical assumptions and perspectives regarding communication in Aboriginal health was discussed in the workshop. The example of students becoming hyper-fixated on whether to make eye-contact with Aboriginal people was raised. This was seen to be a common stereotype in Aboriginal health communication learning that could prevent students from developing reflexive skills considerate of a wide range of patient preferences and needs.

Having your worldview both brought forth and challenged was seen as important in Indigenous health education and in developing cultural capabilities. Being able to self-reflect in a critical manner was discussed as an important skill to foster when exploring one's own positioning and worldview critique. Having safe spaces to ask questions without burdening patients was discussed as important.

When discussing teaching approaches, conversations were seen as an important way to share knowledge. The value of building reciprocal relationships between students and key educational stakeholders was raised. Indigenous ownership and leadership of the curriculum were discussed as being important. Indigenous governance was seen to work to minimise racially driven narratives in curricula.

The workshop participants addressed the importance of contextual learning when implementing the communication framework in an educational setting. Contextual considerations were mentioned as becoming more nuanced and localised as students progress through their education and participate in clinical placements in different settings. One participant suggested that using specific terminology, such as local community names and language groups, could guide targeted educational sessions using the framework. For example, instead of teaching 'Aboriginal and Torres Strait Islander health', there may be more nuanced teaching on placement – 'Kaurna Health' or 'Yawuru Health'.

Assessing Indigenous health

In the workshop, participants viewed assessment as a fundamental component to the Indigenous health curriculum. It was also commented that it is a very difficult area to assess. Assessment was discussed as being expected by students, and when it does not occur in an integrated and aligned way, this can potentially devalue the curriculum. There was seen to be a place for both formative and summative assessment. The benefits of formative assessment were discussed as being able to allow students to participate in an honest and authentic way without fear of failure.

Assessment that encourages critical reflection was raised as important. The ability of curriculum and assessment to be authentic and not faked was discussed, whereby students are able to share a true reflection of their thoughts, skills and experiences as opposed to performing in a manner that is viewed to be desired by the assessor. Participants felt that it was essential that students were able to see the worth and value of the curriculum and assessments.

Strengths & Limitations

The workshop provided further validation of the third and final framework developed from the first stage of data collection. Having student input strengthens the utility of the framework to be effectively translated into clinical practice. The workshop output also provided additional support to the core findings of the first stage of data collection with additional insights into approach to knowledge translation. The workshop findings are limited by the small number of participants, impacting generalisability of the output to the wider medical student, healthcare practitioner and Aboriginal communities. Further work is needed to research and validate the findings from this research regarding framework implementation in various educational contexts.

Conclusion

Authentic and respectful education in Indigenous health requires consideration to the local context to ensure knowledge is not devalued or presented in a tokenistic way. It also requires effort on behalf of educators who are building cultural capabilities to ensure teaching and learning experiences do not promote stereotypical assumptions and approaches to practice. Contextual teaching was a key thread and supports the diversity of Aboriginal peoples and healthcare organisations within Australia. This demonstrates the need for education of this framework to extend beyond university into postgraduate clinical practice and work placements, incorporating local distinctions and considerations.

The complexity of emotion that accompanies Indigenous health education provides a challenge to implementing this framework in health curricula. Educators need skills in facilitating clinical communication skills whilst also being equipped to address and manage potential student feelings of guilt and shame. This can be burdensome on Indigenous academics and community members, risking curriculum sustainability if there is not adequate support and a totality of effort approach within the education institution. The need to provide safe learning spaces for students, staff and patients demonstrates the importance of practicing the framework in low-risk settings with simulated patients and quality supervision.

The need to manage and support students through making mistakes and shifting away from goals of perfection is a key domain that arguably needs to be integrated into formal curricula. Providing effective support and mentorship to ensure mistakes and perceived failures do not become a barrier to engagement, but an opportunity for professional development, will likely work towards a more engaged healthcare workforce in Aboriginal health.

Effective assessment is arguably as important as delivering quality education. The workshop confirmed the need for quality assessment in Indigenous health that is both formative and summative. Allowing the opportunity to make mistakes and fail and be guided through this with effective feedback will be a core part of effective knowledge translation of this framework. As supporting and allowing students to not be perfect is a key finding in this research, the opportunity that formative assessment can provide to nurturing clinical capabilities in Aboriginal health is significant.

Considerations for applying the findings from the research data collection are outlined in the next chapter**, Chapter 7.** In this chapter recommendations from the research are made along with future directions for research.

This chapter presents the findings from the Healing Conversations research project. Considerations for applying the Healing Conversations Framework to Aboriginal health professional education are presented along with future directions for this research. Final recommendations regarding knowledge translation are outlined in an effort to contribute to more meaningful and impactful health education that centres the voices and experiences of Aboriginal peoples. A shortened version of this chapter will be submitted to an appropriate health professional education journal for peer review and publication.

Aboriginal health professional education

Aboriginal health is an essential component of health professional education that meets the needs of contemporary Australian society and is a key accreditation requirement for health professional programs and capability expectation for practitioners(1, 2). A core component of Aboriginal health curriculum focuses on building and strengthening student capabilities in effective clinical communication (1, 2). Communication skills can be a facilitator or barrier to the provision of effective, accessible healthcare and the attainment of equitable health outcomes for Aboriginal peoples(3). Communication in the clinical setting can take many forms ranging from patient-practitioner clinical interactions, health advocacy efforts and interprofessional team care(4, 5). Given the saliency of this clinical capability, the Healing Conversations research project has developed a targeted communication framework to help prepare health professional students to communicate more effectively with Aboriginal patients. The provision of culturally safe and accessible healthcare that meets the needs of Aboriginal peoples is a key driver of this research.

Knowledge translation of the Framework will require consideration as to how information is safely scaffolded into the wider health curriculum. Institutions must be cognisant of the required human and structural resources that support effective learning in Aboriginal health curricula(6). As a result, this chapter presents considerations for educators and tertiary health academies looking to include the Framework into health professional education. By exploring the appropriate application of knowledge created through Healing Conversations, the aim is to ensure important concepts are not missed to promote the attainment of quality educational outcomes (7). A potential risk in knowledge translation lies with the readiness and capacity of education institutions to provide culturally safe learning environments for Aboriginal health communication skills learning. This chapter also outlines how the Framework could be used by organisations to explore their own readiness for engaging in educational efforts in this space.

There is a call for explicit and rigorously developed Aboriginal health curricula that co-locates Indigenous perspectives, worldviews and values alongside mainstream knowledge paradigms(6). Healing conversations has sought input from a range of key stakeholders regarding the Framework, including Aboriginal community members, registered healthcare practitioners, medical students, and healthcare educators from two Australian jurisdictions(8). This approach, which included semi-structured interviews and a workshop, has been guided by the conceptual notion of Etuaptmumk, or two-eyed seeing, put forward by Mi'mkaw First Nations Elders Albert and Murdena Marshall (9). As discussed earlier in Chapter 3, two-eyed seeing embraces the strengths of different knowledge systems in co-existing and contributing to new ways of knowing, being and doing (9).

Knowledge translation approaches for the Framework can benefit from the guiding principles of two-eyed seeing(9). Valuing the strength that diverse knowledges bring to health education can work to create safe spaces for the co-existence of Indigenous and mainstream perspectives in health curricula(9). The creation of safe spaces for both Indigenous and mainstream knowledges to contribute to teaching and learning will require a collective approach from the academy leadership and staff to respect and value the importance and legitimacy of Indigenous knowledges in health professional education(10). In the absence of a safe institutional environment, applying the Healing Conversations Framework in health professional education could have unintended negative results. This might include reverting to stereotypical narratives around communication(11), engaging in deficit-based commentary that does not challenge the structural drivers of inequity, avoiding uncomfortable conversations about colonisation and racism along with failing to reflect on the role of power in healthcare(12, 13). The creation of safe learning environments will require informed, committed action around Indigenous governance implementation, critical reflexivity regarding institutional culture and solid commitment to resourcing education efforts in this space(14).

The Framework

The Healing Conversations Framework (figure 1) pivots around the importance of patient-centred care to redress the use of stereotypes and assumptions in clinical practice and to ground clinical interactions in meeting the needs and priorities of the patient. The salience of family and community on health and healthcare interactions is represented, followed by key domains in communication requiring student capability. These include building trust and connection, being mindful of

the role the clinical setting has on communication, being skilled in appropriate, reflexive body language and verbal styles, asking appropriate, tailored clinical questions and checking in with patients to confirm their understanding and satisfaction with the direction of the clinical encounter.

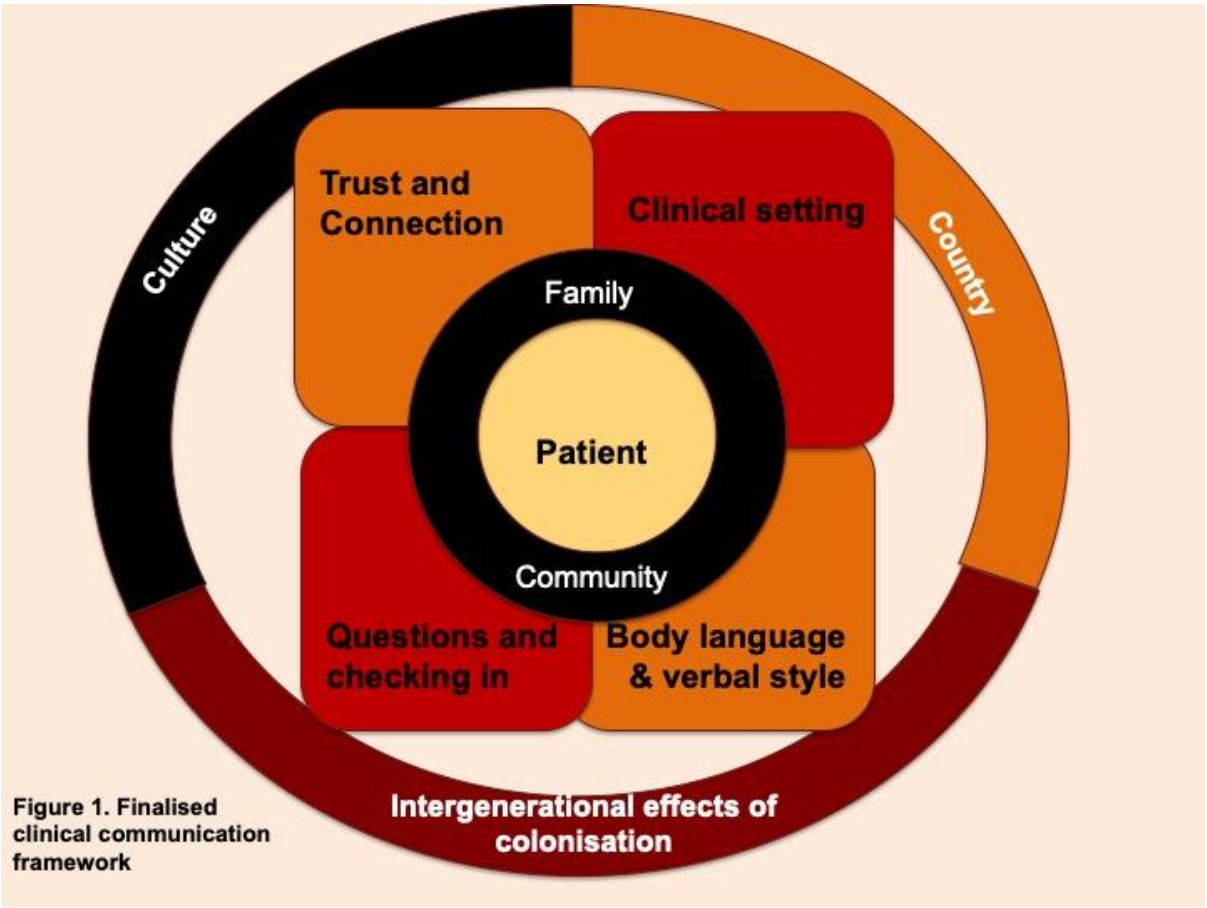

Figure 1. Finalised clinical communication framework

The outer rings provide opportunity for broader critical self-reflection and reflexivity, by asking student healthcare practitioners to identify and apply knowledge of the cultural contributors to the consultation. This includes relevant cultural considerations of themselves as the practitioner, the patient, the local community and the organisation in which they are working. A two-eyed seeing and praxis-based approach when utilising the Framework can assist students in reflecting on domains in relation to themselves as healthcare practitioners and the settings in which they work, as opposed to focusing on the patient only. Country

reflects the local contextual determinants that impact health and healthcare delivery, whilst the intergenerational effects of colonisation centre this fundamental determinant of health as essential knowledge when developing Aboriginal health clinical capabilities(15). This will require learning about the pervasive effects of racism and unexamined privilege on healthcare and developing capabilities to counter these through health advocacy and reflexive practice(16).

The Framework offers one approach to assist with decolonising and Indigenising health professional curricula in Australia. A suite of tools to achieve this are needed in curricula that aim to promote equity and social justice, particularly when delivered in institutions built on settler colonialism(6). This is due to the pervasive nature in which colonisation, racism and privilege manifests in curricula through invisible and embedded norms, structures, systems and values(6). Efforts to decolonise curricula are distinct from efforts to Indigenise it. Decolonisation involves the ongoing divesting of colonial power through governance, culture, linguistic and psychological processes(17). In health professional education this can be evident through the dismantling of colonial knowledge systems as the dominant perspective that guide values, practices and norms in healthcare practice(6). Indigenisation of curricula occurs concurrently with decolonisation as spaces are created where Indigenous values and worldviews can safely co-exist with mainstream perspectives in health(6), something the Framework can offer.

A constructively aligned Aboriginal health communication curriculum

Constructive alignment theory provides a useful lens for conceptualising scaffolded teaching, assessment and learning approaches for the communication

framework into healthcare curricula(18). Clear articulation of student learning outcomes ensures expectations regarding Aboriginal health communication capabilities are widely understood. Aligned assessment can then be designed to determine student capabilities and learning needs guided by key concepts presented in the Framework. Authentic learning activities, that adequately prepare students to demonstrate capabilities in communicating with Aboriginal patients appropriate to their skill and knowledge level, can then follow(18). Approaches to developing learning outcomes, assessment and learning activities are outlined below in this order recognising the effect of 'backwash' in higher education(19). A focus on assessment can promote a well-aligned Aboriginal health communication skills curricula whereby learners are encouraged to maintain engagement in complex situations(19). Assessment that does not clearly align to the learning outcomes risks student disengagement in the learning process, whereby learners determine what their 'minimum effort' is that does not sacrifice reward(19). This highlights the importance of curriculum that promotes student engagement through effective design(18, 19).

Learning outcomes

As the communication framework can be applied to both individual patient interactions and broader population-based issues, scaffolded learning outcomes can become more targeted as students progressively develop their Aboriginal health capabilities. Box 1 includes a sample representation of learning outcomes to support inclusive learning experiences in Aboriginal health communication skills.

These learning outcomes should sit within broader, higher level program learning outcomes and can be adapted to ensure vertical and horizontal alignment.

Box 1 – Example learning outcomes

Novice

Discuss the intergenerational impact colonisation has on health for Aboriginal peoples and outline the role of the healthcare practitioner to address this.

Discuss the importance of a patient-centred approach when communicating with Aboriginal patients in a clinical setting.

Intermediate

Demonstrate the capability to develop trust and connection with a diverse range of Aboriginal patients in a simulated clinical setting.

Demonstrate the use of appropriate body language and verbal styles when communicating with a diverse range of Aboriginal patients in a simulated clinical setting.

Entry to Practice

Demonstrate health advocacy skills in communication encounters with Aboriginal patients that can work to redress the impact of institutionalised racism on healthcare access.

Using clinical examples, distinguish between clinical settings that promote and hinder effective communication with Aboriginal patients and hypothesise the structural drivers of these differences.

Ongoing Professional Development in Practice

Critically analyse the role played by your local organisation in promoting best practice communication with Aboriginal patients and their families.

Identify your own strengths and knowledge gaps when communicating with Aboriginal patients in your current clinical setting and formulate a professional development plan to build and strengthen these.

The outcomes in Box 1 demonstrate the breadth of content that could be explicitly addressed in the Aboriginal health professional curricula from novice through to ongoing professional practice, guided by the Framework. Relevant learning outcomes also hold the potential for the development of Entrustable Professional Activity (EPA) statements (20), allowing for practitioner supervision to be tailored to the individual to ensure safe patient care (21). In Aboriginal health communication skills, the use of EPA statements could flag the importance of communication capabilities and the need for ongoing professional development to ensure practitioners maintain professional standards in this space(22). Appropriate use of EPA statements will however require careful construction to ensure they do not exclude the importance of working in interprofessional teams and the saliency of Aboriginal health input to care. Any developed EPA statements will need to

ensure they do not inadvertently oppose the concept that communication skills require ongoing development and reflexivity rather than mastery. An example EPA statement for a medical graduate might include:

> *Demonstrate the capability for critical reflexivity when gathering a medical history from an Aboriginal patient whilst working within a larger multidisciplinary team.*

Assessing EPA statements requires strong knowledge and capabilities on behalf of the supervision team, which ideally will include a range of expertise that centres both Aboriginal and clinical perspectives working in partnership. This holds potential for the Framework to be translated into assessment innovations that can determine capabilities and foster student learning in Aboriginal health (23). Considerations regarding effective assessment are required in order to determine student success of achieving the desired learning outcomes associated with the Framework.

Assessment

There is a need for quality assessment in Aboriginal health communication skills given the deficiency in rigorous assessment in this space (24). Quality assessment can signal to students what content is considered core knowledge, impacting student perceptions of the value and worthiness of Aboriginal health learning experiences (25). Meaningful representation of Aboriginal health communication capabilities in assessment can work to align the formal, informal and hidden curricula in Aboriginal health professional education (25)

Assessment provides the opportunity to identify capabilities requiring improvement and support which can be fed back to students to ensure they are meeting

professional standards(26). It is recommended through this research that communication skills assessment embrace both formative and summative approaches to maximise student learning. Formative assessment items will assist educators and learners identify where students might be experiencing difficulties, allowing for remediation and tailored learning efforts to follow (27). Formative assessment tasks can provide students the opportunity to practice and receive evaluation without fear of failure, arguably promoting more authentic engagement with communication skills learning.

Effective assessment in Indigenous health tasks should include assessments that integrate self-assessment, foster student agency and leadership, have a practice-based element, foster collaboration and engagement with other students and stakeholders, and have a focus on communication and other non-written skills(24). This can be readily applied to the Healing Conversations Framework with assessment that focuses on the role of the social determinants of health, safety of healthcare delivery and actions to counter marginalisation and institutionalised racism through effective service delivery.

When assessing the Healing Conversations Framework concepts, novice learners might engage in written activities demonstrating knowledge and understandings of the process of colonisation along with oral presentations exploring key concepts in communication such as avoiding stereotypes, recognising power and privilege in healthcare and the use of appropriate language in clinical communication. Intermediate learners will ideally shift into clinical simulation settings with Aboriginal patients and interdisciplinary team members, such as Aboriginal healthcare workers and allied health professionals, to role-play sections of the Framework using authentic case scenarios. This might include scenarios focusing

on relationship building, respectfully eliciting Indigenous status, practicing checking-in with patients, and learning health advocacy skills in responding to conversations about racism and the intergenerational impacts of colonisation. When engaging in clinical simulation activities, the Aboriginal health team needs to lead the recruitment of simulated Aboriginal patients to ensure patients have the opportunity to be involved in the scenario design(28). This will ensure scenarios are authentic and do not compromise the individuals simulating them in any way(28).

Entry to practice and ongoing professional development assessment will preferably be practice-based and lever from clinical experiences and interactions relevant to the individual practitioner and their organisation. This might include guided case-based discussions from practitioner's clinical placement, preparation of health advocacy resources tailored to their local organisation and community (podcasts, community health promotion event planning) and the preparation of learning plans relevant to communication with Aboriginal patients, their families and the local communities. Practitioners with highly developed capabilities might extend these through the co-development of educational resources for junior colleagues with local Indigenous community members and Indigenous healthcare professionals as a platform for ongoing assessment and development.

Examples of scenarios for different learners are provided in Box 2, along with possible domains for assessment. Scenarios and tasks will need to be adapted to the local context as guided by Aboriginal health experts and community members before implementation. This can ensure curricula reflects local values, healthcare needs and community priorities instilling the importance of responsive healthcare practice(29). Ideally, students will have the opportunity to practice their skills in

multiple diverse case scenarios in Aboriginal health across multiple years of their practitioner training and be observed by a wide range of Aboriginal health experts.

Box 2: Example scenario and assessment domains for novice, intermediate and entry to practice learners.

Novice learner

Scenario *Mr R is a 23 -year- old male presenting to an Aboriginal community-controlled health setting for an annual health check. You are shadowing Ms Jen (who is an Aboriginal health practitioner) and Dr Barry (the GP) at the practice. Ms Jen and Dr Barry want to discuss with you the role of effective communication in promoting good health outcomes for Aboriginal peoples.*

Student Task

1) Outline to Ms Jen and Dr Barry key knowledge and capabilities that healthcare practitioners need to develop to be able to communicate well with Aboriginal peoples.
2) In your discussion, outline the role that colonisation has on healthcare delivery for Aboriginal peoples.
3) List some ways that healthcare practitioners can develop their capabilities in effective communication with Aboriginal peoples.

Assessment guide for expert feedback

- Student articulates the importance of key domains such as understanding the local Country, culture and historical context of where communication occurs
- Student expresses the importance of patient-centred care that avoids stereotypes and considers individual needs.
- Student is able to discuss respectfully how colonisation influences care delivery, exploring concepts of marginalisation, racism and the importance of partnership with Aboriginal peoples
- Student provides a good outline of communication skills learning that focuses on practitioner critical reflexivity and understanding themselves and their own culture and health professional culture.
- Student uses appropriate and respectful language and terms of reference throughout discussion

Intermediate learner

Scenario: *Mrs G is a 45-year-old female presenting to a private general practice in an urban setting for the first time. Mrs G requires her pharmacy scripts to be renewed to ensure ongoing access to her medications. Mrs G has a large family and works part time, and at times experiences financial stressors. Mrs G currently feels well in herself and has been living with chronic obstructive airways disease for some years.*

Student Task:

1) Gather a detailed clinical history from Mrs G.
2) On conclusion of the clinical encounter, outline possible strategies to the interprofessional team that could alleviate Mrs G's main concern regarding accessible medication.

Assessment guide for expert feedback

Clinical interview

- Student provides the opportunity for the patient to identify as an Aboriginal and/or Torres Strait Islander person.
- Student provides the opportunity for the patient to share about their family and community context in the communication encounter.
- Student demonstrates skills in building trust and connection with the patient.
- Student provides evidence of reciprocity in the communication encounter through active listening and/or sharing something of themselves.
- Student avoids closed, dominating or disengaged body language. Student demonstrates skills in open attentive body language.
- Student avoids complex medical jargon where appropriate. Student engages in respectful conversation that is acceptable to the patient.
- Student considers the setting of the communication encounter and takes action where appropriate to ensure patient privacy and comfort.
- Student takes an appropriate medical history and provides opportunities for the patient to ask questions and express concerns, particularly around financial accessibility of medication.

Management planning with interprofessional team (must include an Aboriginal health professional)

- Student articulates underlying drivers to inequities in access to financial resources for Aboriginal and Torres Strait Islander peoples
- Student demonstrates knowledge of local and national policies and systems that can alleviate barriers to accessible medication.
- Student proposes practical steps to address medication access for the patient that considers the roles of the interprofessional team in Aboriginal health

Assessment will require co-location of perspectives, ensuring clinical and Indigenous viewpoints are included in supervision and feedback that includes the patient perspective.

Box 2 continued.

Entry to Practice learner

Scenario: *Mr R is a 23 -year- old male presenting to an Aboriginal community-controlled health setting for a wound review. Mr R explains during your consultation that he was in the local hospital a few days ago with a wound infection and discharged himself because he did not feel comfortable in the ward. He has presented today to have his wound checked and dressed.*

Student Task:

1) Gather a targeted clinical history from Mr R regarding his wound.
2) During your conversation, explore Mr R's recent hospital experience
3) Discuss your findings with the team and outline the health setting's role in Mr R's early discharge

Assessment guide for expert feedback

Clinical interview

- Student provides the opportunity for the patient to identify as an Aboriginal and/or Torres Strait Islander person.
- Student provides the opportunity for the patient to share about their family and community context in the communication encounter.
- Student demonstrates skills in building trust and connection with the patient.
- Student provides evidence of reciprocity in the communication encounter through active listening and/or sharing something of themselves.
- Student avoids closed, dominating or disengaged body language. Student demonstrates skills in open attentive body language.
- Student avoids complex medical jargon where appropriate. Student engages in respectful conversation that is acceptable to the patient.
- Student considers the setting of the communication encounter and takes action where appropriate to ensure patient privacy and comfort.
- Student takes an appropriate medical history and provides opportunities for the patient to ask questions and express concerns, particularly around financial accessibility of medication.

Discussion with interprofessional team (must include an Aboriginal health professional)

- Student articulates the role of the health structure in Mr R's early discharge, focusing on structural barriers to accessible care
- Student proposes practical steps the health structure could implement to enhance culturally safe communication and healthcare practices for Mr R
- Student avoids deficit-based narrative and does not blame Mr R for discharging early, rather focuses on management going forward

Ongoing professional development

Scenario: Healthcare practitioners form a key component of culturally safe healthcare structures for Aboriginal peoples. The role of the healthcare practitioner is not limited to patient and community care; it extends to include advocate and educator roles. Your clinical workplace is creating educational resources for junior healthcare professionals about engaging in effective communication with Aboriginal peoples.

Healthcare Professional Task

- Create a 15-minute educational podcast that contextualises effective communication with Aboriginal peoples within your clinical workplace for junior healthcare professionals.
- Privilege local Aboriginal community perspectives and knowledges in your podcast content
- Include strategies that junior healthcare professionals in your workplace can readily implement to strengthen their cultural capabilities
- Reflect on power and privilege in healthcare delivery and communication

Assessment guide for expert feedback

- Podcast demonstrates effective health advocacy skills in Aboriginal health
- Podcast includes salient elements of the Healing Conversations Framework that is contextualised to the local clinical setting and community
- Podcast privileges local Aboriginal community perspectives through direct interviews or citation in content
- Podcast avoids deficit-based narratives and stereotypes to promote strategies that embody partnership, collaboration and power-sharing.

Assessment will require co-location of perspectives, ensuring clinical and Indigenous viewpoints are included in supervision and feedback that includes the patient perspective.

A key issue is assessment expertise in Aboriginal health. Assessment activities need to be appropriately evaluated by a range of co-positioned experts in Aboriginal health and healthcare practice, reflecting a two-eyed seeing approach(9). This could be achieved through the provision of qualitative expert subjective feedback and/or objective feedback through the use of targeted rubrics. Qualitative feedback can be guided by key themes emerging from the Healing Conversations research framework and tailored to the level of the student, as outlined in the assessment guides for Box 2. Multiple feedback opportunities will be required to ensure judgments about student capabilities are useful and considerate of varying contextual circumstances in which capabilities need to be demonstrated(26). This challenges tertiary health academies and training organisations to invest in providing extended opportunities for learning and observation in Aboriginal health throughout health career pathway training(26).

Effective assessment of the Framework might involve a shift from a reductionist approach to skill building to one that makes complete assessments of Aboriginal health capabilities for each individual student (23). A holistic assessment of student capabilities could be achieved through a programmatic assessment approach if there is adequate faculty capacity, knowledge, partnership and communication regarding student performance in Aboriginal health domain. To be effective, a programmatic approach will require strong representation of Aboriginal perspectives and knowledges across the program to ensure student capabilities are assessed from appropriate lenses at each point. This could prove difficult in an education environment that has minimal available Aboriginal health expertise. In this scenario, the concept of a programmatic response might need to be limited to the domains of Aboriginal health where appropriate expertise and input is available.

Teaching and Learning Activities

Translation of knowledge from the Healing Conversations research into teaching and learning activities will need to closely relate to the assessment task, level of learning and career pathway of the student. Activities will ideally provide students the opportunity to practice transferring their skills in an authentic way aligned to their current capability and their future professional practice(30). As demonstrated in the Framework, students will require foundational knowledge of how colonisation, racism and marginalisation impact health and healthcare delivery in order to work effectively with Aboriginal patients. Foundational skills of critical reflexivity and critical reflection will provide students with the capabilities to be successful in learning about Aboriginal health and working with Aboriginal patients(22).

This raises the need for education institutions to make the distinction between cultural safety curricula and Aboriginal health curricula(16). Though complementary, building the skills of the healthcare workforce in understanding and knowing themselves benefits diverse cross-cultural work and deserves its own curriculum space. Clearly distinguishing the two learning domains requires a whole-of-curriculum commitment to realise the interconnected nature of learning and the necessary qualities that can support capability building in Aboriginal health. Done well it can alleviate the academic burden on the Aboriginal health staff and provide another point of capability assessment in a programmatic assessment approach.

As student's progress in their clinical capabilities and begin clinical placements, independent learning approaches regarding the Framework could be useful, reflecting an andragogical approach to learning(31). This might involve students

critically reflecting on their own practice and critically analysing models of care they have experienced on work experience placements. Discussions can be guided by the Framework, incorporating student's prior knowledge and experiences(31). Through discussion, self-learning plans could be designed to further develop strengths and address any communication skills needing support as outlined in Box 3.

Box 3. Example learning activities for novice, intermediate, entry to practice & ongoing professional development learners.

Novice

Location of teaching and learning activity:

Teaching space that is deemed an appropriate learning environment by the local Aboriginal health team.

Required staff:

Staff with skills and expertise in Aboriginal health communication, healthcare delivery and Aboriginal health education to engage in team teaching.

Activity description:

Students observe a diverse range of communication interactions between healthcare professionals at different learning stages and Aboriginal community members that demonstrate best-practice for the current capability of the healthcare practitioner.

Discussion prompts

- Discuss the communication skills scenarios using the Healing Conversations Framework as a guide. What was done well? What could be improved?
- Discuss the different communication capabilities between the different healthcare practitioner. Reflect on your current capabilities and the learning pathway that you are on regarding effective communication in Aboriginal health.
- Reflect on your own style of communication.
- What strategies and approaches can you implement if you are experiencing difficulties in communication with Aboriginal peoples or make a mistake during a clinical communication interaction?

Intermediate

Location of teaching and learning activity:

Teaching space that is deemed an appropriate learning environment by the local Aboriginal health team.

Required staff:

Staff with skills and expertise in Aboriginal health determinants, healthcare delivery and Aboriginal health education to engage in team teaching.

Activity description:

Students engage in a guided discussion with the Aboriginal health team about key points raised in the case scenario. Students could be tasked to research one of the discussion prompts using evidence-based approaches that privilege Indigenous perspectives through citation, with findings presented in a follow-up session with guided feedback.

> *Mrs G is a 45-year-old female who recently presented to a private general practice (Practice A) in an urban setting for the first time. This was due to a negative experience at a healthcare organisation (Practice B) recently where a healthcare practitioner made a disrespectful comment about her appearance and was unable to process her request for medication assistance. Mrs G lives with her mother, husband and three children. Her mother was a member of the stolen generations and has been politically active until recently, as her health has*

Box 3 continued.

Entry to Practice

Location of teaching and learning activity: Various settings deemed appropriate learning environments by the local Aboriginal health team; clinical placement setting, university or online.

Required staff: Staff with skills and expertise in Aboriginal health and clinical practice

Activity description:

Critically reflect on a recent clinical communication encounter you have engaged in with an Aboriginal patient. Drawing on the Healing Conversations Framework, identify communication capabilities of strength and those that require further development. (*Students might choose to reflect on different components of the framework throughout a longitudinal placement.)*

You can use the following prompts as a guide for your reflection.

- Where was your patient from and did you get an insight into their family and community context relevant to their health presentation?
- How effective were your efforts to develop trust and connection with the patient?
- Did you check in with the patient during the conversation, and did they have any difficulties understanding you?
- Did you have any difficulties understanding the patient, and what steps did you take to address this?
- Did you have enough time and privacy for your conversation?
- Could the communication interaction have gone better in a different clinical setting?
- What was your body language throughout the communication encounter?
- Did you get enough information required for your specific task?
- Were other healthcare professionals involved in the communication encounter?
- Were other Aboriginal healthcare professionals involved in the communication encounter?

Learning Plan

On reflection, develop a professional learning plan for the next 3 months that draws on the evidence base privileging Indigenous perspectives in citation. Consider strategies to have your communication skills observed for feedback from Aboriginal health academics and from Aboriginal patients directly receiving your care. Discuss how you will achieve this plan with the Aboriginal health team.

Ongoing Professional Development

Location of teaching and learning activity: Workplace setting deemed an appropriate learning environment by the local Aboriginal health team

Required staff: Staff with skills and expertise in Aboriginal healthcare delivery and Aboriginal health education, as well as senior staff representing the workplace, to engage in team teaching.

Activity description:

Engage in advanced clinical simulation scenarios tailored and targeted to health professional field of practice and clinical setting. Scenarios will focus on advanced communication skills including navigating barriers to healthcare access, engaging in health advocacy to address experiences and impact of racism, communicating with family members and engaging in health literacy efforts. Scenarios to be developed in partnership with local Aboriginal community representatives and Aboriginal health experts in the relevant field for the practitioner (general practice, surgery, palliative care).

Undergraduate health professional students with minimal prior education in Aboriginal health will benefit from learning activities that draw on appropriate pedagogical approaches to learning. This will require strong guidance by experienced health educators who can position and contextualise learning experiences based on the Framework effectively. Learning activities might involve

Aboriginal community members engaging in knowledge-sharing with novice learners in environments deemed locally appropriate. Case-studies and role-play scenarios that advance and develop in complexity alongside the capabilities of the student could support a scaffolded approach where students can contextualise broad concepts into daily work-related activities. For example, case studies in Box 3 could be used as a teaching and learning activity that develops in complexity across multiple years of a health professional curriculum.

Experiential, community-based learning in Aboriginal health can be successful in fostering student capabilities (28, 32). However, this approach to learning can be limited by community capacity, supervisor capability, curriculum time and allocated resources(32). Clinical simulation can be a useful tool to further experiential learning(32) and supplement precious human and organisational resources, such as placements in Aboriginal health organisations and on-Country learning experiences.

There is a tension in Aboriginal health clinical capabilities education if delivered in a culture of perfectionism and low tolerance of failure(33). This requires careful consideration by health educators in setting realistic expectations for students and ensuring regular opportunities for practice and feedback in safe settings. Early exposure to clinical simulation with experienced Aboriginal community members in controlled settings can work to provide safe learning spaces(28, 34). Addressing fear of making mistakes will be an important task to promote ongoing engagement of healthcare professionals in the field of Aboriginal health.

Finally, a heutagogical approach to using the Framework in health education might be useful in ongoing professional development(35), particularly with the recent shift to online teaching and a ready uptake of telehealth due to the COVID-19 pandemic(36). This approach might encourage students to draw on the Framework and engage in an ongoing reflective learning process in Aboriginal health capabilities, supported through effective digital platforms(35). This highlights the need for considering what Aboriginal health capabilities are required in an online clinical environment and how the Framework could be applied in university and post-graduate training programs building skills in digital health(36).

Who teaches, where and how?

Two-eyed seeing provides a useful lens in which to consider who is best positioned to engage in curriculum activities related to the Framework(9). The co-location of Aboriginal perspectives alongside mainstream knowledge paradigms will be essential to guide students through capability building that is informed by dual perspectives in health. Educators who are good role-models, create welcoming learning environments and have skills in facilitation and mediation can promote learner satisfaction(29). Educator skills and preparedness to teach communication skills in Aboriginal health will have a key impact on learner outcomes(29). This could be assisted through drawing on the research findings of Healing Conversations and forming solid relationships with local Aboriginal health organisations and expertise.

Vital members of the Aboriginal health team are Aboriginal community members engaging with students as simulated patients or as patients in clinical practice(28). This requires health educators to consider innovative ways to safely provide regular opportunities for students to receive useful and supportive feedback from Aboriginal patients about their communication skills and cultural safety capabilities(28). This could be achieved through regular sustained simulation experiences, and/or having dedicated Aboriginal health ward rounds where patient feedback is sought with the support of expert clinicians and Aboriginal health professionals. Having a dedicated educational unit for Aboriginal health in clinical teaching environments, such as teaching hospitals, could open many possibilities for sophisticated professional development in clinical environments during longitudinal placements for health professional students. This will require strong capabilities in the Aboriginal health team when working in partnership to respect and value the perspectives of all team members.

When considering the dynamics of the Aboriginal health team, racialised power imbalances need to be removed to ensure Aboriginal knowledges are not sidelined in the educational team (37). This requires a reflexive approach on behalf of all educators. Partnership and collaboration between Aboriginal and non-Aboriginal experts can work to reduce the heavy burden Aboriginal academics can experience when playing multiple roles in the health education institution (37). Key takeaway points for educators looking to apply the Framework into health professional education are summarised in Box 4.

The act of sharing knowledge cannot be done in isolation of a conscious awareness of the ontological, epistemological and axiological positioning of the knowledge holder and receiver(38). This asks educators to develop a critically

reflexive approach to designing and implementing curriculum that is considerate of their own positioning in the world and cognisant of their knowledge strengths and limitations(7). Critical reflection on behalf of educators is necessary work to ensure teaching and learning activities regarding the framework are aligned to essential shared values that emerged in the research of mutual respect, partnerships, equity, social justice and self-determination.

Box 4.
Key takeaway points

- The communication Framework can be used to guide targeted learning outcomes and assessment innovations in Aboriginal health curricula.
- Co-location of Aboriginal and mainstream perspectives in teaching and assessment is essential.
- The patient perspective is critical to developing reflexive communication skills.
- Fear of failure needs to be addressed through practical support and attainable expectations
- Multiple and sustained opportunities for feedback are required.
- Health education academies can use the communication Framework as a guide to reflect on their readiness to engage in Aboriginal health learning.

A commitment to shared values in Aboriginal health needs to be extended to the academy itself. The Framework provides a platform for reflection for health professional education academies to review their collective capabilities in Aboriginal health and identify areas in need of strengthening. For example, drawing on the outer rings, reflections regarding acknowledgement and respect of Country, safe inclusion of Aboriginal culture in the curriculum and efforts to decolonise the institution can help academies to reflect on their readiness to safely include teaching and learning in this space. Academies can also reflect on their own institutional culture to identify facilitators and barriers to Aboriginal engagement in health education, from both a student and staff lens.

Strong relationships with the local Aboriginal community will be pivotal to the success of this Framework being implemented in healthcare curricula. This can work to develop responsive and contextualised curricula in Aboriginal health with

multiple and sustained opportunities for learning, observation and feedback. This will require strong commitment and executive support from the academy to Aboriginal health to own and be accountable to Aboriginal health as a priority educational area. A lack of institutional investment in Indigenous health poses a strong risk to implementing comprehensive curricula(32). Resource allocation will need to be negotiated and addressed if meaningful educational outcomes are to move from rhetoric to reality.

Summary Recommendations from the Healing Conversations Research

The appropriate implementation of knowledge gained through this research project will be fundamental in successfully applying the Framework to practice. To assist with this, six recommendations are outlined below for health professional education programs and relevant organisations looking to translate the findings from the Healing Conversations research project into action.

1. Health professional education programs provide frequent and sustained learning opportunities in Aboriginal health communication capabilities that are targeted and scaffolded to the level of the learner. This will include regular opportunities for observation and feedback by experienced Aboriginal community members and healthcare practitioners as guided by the Healing Conversations Framework.
2. Health professional education programs invest in Indigenous Governance structures in their institution. This will work to ensure appropriate representation of Aboriginal perspectives and knowledges in health

education and to provide accountability mechanisms for curricula to the Aboriginal community.

3. Health professional education programs work to create safe learning environments whereby Aboriginal and mainstream knowledges and perspectives are valued and able to effectively co-exist in curriculum activities. This can be realised through the learning from the conceptual notion Etuaptmumk, or two-eyed seeing, put forward by Mi'mkaw First Nations Elders Albert and Murdena Marshall(39).
4. Implementation of the Healing Conversations Framework in education is locally contextualised as guided by Aboriginal community members and Aboriginal health professionals. This will work to avoid a stereotypical, pan-Indigenous approach to communication skills learning and ensure activities are considerate of the local historical, cultural and geographical context.
5. Learning Aboriginal health communication capabilities spans the trajectory of healthcare professional development, from undergraduate learning to post-graduate speciality training and beyond.
6. Health professional education programs embrace the principles of constructive alignment when delivering education in Aboriginal health communication capabilities to ensure quality educational outcomes are achieved and student engagement is promoted.

Strengths and Limitations

Strengths of this research project include the consideration of diverse contexts in the data collection approach, along with the inclusion of diverse perspectives in the research team and the research participants. The Indigenous Governance Group provide strength to the findings being accountable and acceptable within

the collective Aboriginal community. The study is limited in its ability to be generalised to all areas of clinical practice and Aboriginal health and will require work and effort to adapt and further explore contextualised approaches to communication skills education. The research is also limited in its application in being guided by perspectives from Western Australia and South Australia which may not be applicable to the broader Aboriginal and Torres Strait Islander communities in other regions.

Impact of Covid-19

The covid-19 pandemic began in 2020 as the student researcher was based in Broome, Western Australia. Research translation activities were impacted due to lockdowns and border restrictions, including an accepted conference presentation at the Australian Medical Education Europe Conference in Liverpool. This had been scheduled for November 2020 and was to centre on Indigenous Governance in medical education. Fortunately, semi-structured interviews were still able to be conducted in a delayed timeframe in Western Australia given the student researcher was living in Broome. This meant the student researcher was able to meet with research participants in person in abidance with local border restrictions once they eased later that year. By this time, South Australian semi-structured interviews had already been completed. On reflection, potential negative outcomes of the covid-19 pandemic border restrictions had been mitigated by the student researcher living in WA during this period of time.

Supervisory and Indigenous Governance Group meetings occurred in person where possible. Group meetings were predominantly moved to online platforms which allowed everyone to meet in real-time despite geographical isolation and travel restrictions.

Conclusion

The Healing Conversations research has developed a Framework to assist healthcare practitioners have more effective clinical conversations with Aboriginal patients and their families. Applying this Framework into tertiary health professional education has the potential to contribute to decolonising health education academies and Indigenising health professional education. A committed institutional environment that values Indigenous health knowledges and perspectives and develops and maintains local relationships with Aboriginal community members and organisations is essential. This can work to support the Aboriginal health team deliver a constructively aligned Aboriginal communication skills curriculum that is contextualised to the local community, environment and culture. Opportunities exist for innovation in education delivery of the Framework through sustained clinical simulation opportunities, student-led learning initiatives and organisational commitment to supporting Aboriginal health capability development in clinical placement settings. A strength of this Framework is the potential for knowledge translation to be contextualised through participation of local Indigenous community members and Aboriginal healthcare professionals.

Future research in this space will need to explore specific teaching, learning and assessment innovations of the Healing Conversations Framework within health professional programs, to identify useful initiatives that promote quality educational outcomes. Further research into the process of local adaptation of the Framework to be contextually responsive can work to ensure wider utility of this work across different parts of Australia. This will need to be done across the continuum of health professional development to postgraduate training and beyond, given the dynamic and evolving nature of communication capabilities in Aboriginal health.

Considerations regarding the potential application of the Healing Conversations Framework have been provided in this chapter along with recommendations from this research. This has been done with the ultimate aim to contribute to a healthcare workforce able to communicate well with Aboriginal peoples in the healthcare system. Redressing health disparities and improving the quality of care received by Aboriginal peoples is an urgent priority for our healthcare system. Enhancing communication capabilities is one useful step forward in this work that requires solid commitment and ongoing effort from all levels of tertiary health education.

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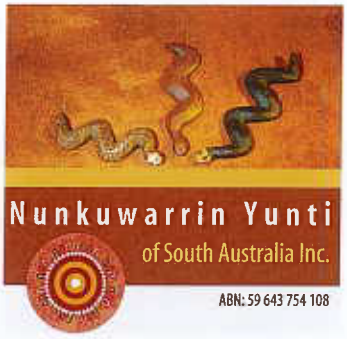
Appendix I

Letters of Support



Dr Andrea McKivett
The University of Adelaide
Level 4 Adelaide Health & Medical Sciences (AHMS) Building
North Terrace
Adelaide SA 5000

07 August 2018

Re: Healing conversations: a practical framework for clinical communication between Aboriginal communities and healthcare practitioners

Dear Andrea,

On behalf of Nunkuwarrin Yunti of South Australia Inc. I am writing this letter to confirm our in principle support for the above named research.

We provide in principle support to provide information about the research to potential participants by placing advertising materials for the study, such as flyers, brochures and posters, within our organisation. We understand the research aims to develop, trial and evaluate a clinical communication framework for use in healthcare interactions between Aboriginal community members and healthcare professionals. We understand the research will:

1) Seek Aboriginal community and health practitioner input and involvement in developing the initial framework
2) Involve Aboriginal community members, medical educators and medical students to critically evaluate the developed framework and plan the educational intervention strategy
3) Test the framework in two select medical education settings with medical students, supervised by trained clinicians and/or medical educators

Our in principle support for the 'Healing conversations' study is pending unconditional approval for the project from the Aboriginal Health Research Ethics Committee.

On behalf of Nunkuwarrin Yunti of South Australia Inc., I wish you all the best on your research journey and look forward to being involved in this work in the future.

Yours sincerely,

Vicki Holmes
Chief Executive Officer

Subject: Letter regarding support for research
Date: Monday, 18 June 2018 at 4:13:09 pm Australian Central Standard Time
From: Alan Morris
To: Andrea McKivett
CC: Cindy Koolmatrie

Good afternoon Andrea. I refer to your recent correspondence to the Chairman of the Board of Directors of the Pika Wiya Health Service Aboriginal Corporation seeking support for your PhD research into Healing Conversations.

Board Members discussed your request at the last Meeting of Directors and supported your request for support, citing the research to be important. I have referred the information you forwarded to the Board Chair to the Clinic Services Manager so that she is included in any subsequent contact. Cindy Koolmatrie can be contacted on

Thank you for thinking of us and we wish you well in your research

Regards

Alan Morris JP
Chief Executive Officer
Pika Wiya Health Service Aboriginal Corporation
Ph 08
Email:

Broome
Regional Aboriginal
Medical Service

P 08
F

PO Box 1879,
Broome WA 6725
ICN 12 ABN 23 750 533 168

4 December 2019

Dr Andrea McKivett
Adelaide Health and Medical Services

By email:

Dear Andrea,

RE: Healing Conversations Project

I confirm that Broome Regional Aboriginal Medical Service (**BRAMS**) supports the Healing Conversations Project.

Please don't hesitate to contact me if you require any further information.

Yours sincerely,

Cassie Devereux
CEO

From: Emma Carlin
Date: Friday, 7 February 2020 at 11:37 am
To: Andrea Jane McKivett <
Cc: Ethics
Sub Committee
Subject: KAHPF Research, Evidence & Data Subcommittee Application: 2020-001: Healing Conversations

Dear Andrea,

Thank you for submitting your proposal to the KAHPF Research Subcommittee. The Subcommittee is supportive of the project: 2020-001: Healing Conversations

When you obtain ethics approval for this project please forward to me and let the Subcommittee know when the project is due to commence.
The Subcommittee requests that you provide half page progress reports every 12 months and a final report once the project has been completed (forms are available on the Subcommittee website:http://kams.org.au/research/kimberley-research-subcommittee/). Progress reports are due on the 30th June each year and the final report is due once the project has been completed. Please note that the Subcommittee will not accept a final report from any other institution and the Subcommittee's final report form must be used.

If the Subcommittee does not receive annual progress reports within four weeks of the due date we will contact your institutional ethics committee and WAAHEC and let them know that you have not adhered to the conditions of the Subcommittee.

The Subcommittee also requires that you provide an electronic copy of any publications that arise from this research.

To help coordinate research across the Kimberley the Subcommittee lists the projects carried out here on the Subcommittee website (http://kams.org.au/research/projects-supported/). We will use the summary section of your form for this purpose. We can post the final plain language report on this website to increase dissemination of the results.

Please note that the Subcommittee does not provide formal letters of support and this email can be used for this purpose – I have cc'd the secretariat from WAAHEC into this email

Kind Regards
Emma Carlin

Emma Carlin
Research Fellow| The Rural Clinical School of Western Australia, The University of Western Australia
Senior Research Officer| Kimberley Aboriginal Medical Services Ltd
Secretariat| Kimberley Research Subcommittee | Kimberley Aboriginal Health Planning Forum
Postal Address: PO Box 1377, Broome WA 6725 | Street Address: 12 Napier Terrace, Broome WA 6725
Phone:

Appendix II

Ethics Approvals

RESEARCH SERVICES
OFFICE OF RESEARCH ETHICS, COMPLIANCE AND INTEGRITY
THE UNIVERSITY OF ADELAIDE

LEVEL 4, RUNDLE MALL PLAZA
50 RUNDLE MALL
ADELAIDE SA 5000 AUSTRALIA

TELEPHONE +61 8 8313 5137
FACSIMILE +61 8 8313 3700
EMAIL hrec@adelaide.edu.au

CRICOS Provider Number 00123M

Our reference 33245

07 January 2019

Professor Nicky Hudson
Medicine

Dear Professor Hudson

ETHICS APPROVAL No: H-2019-001
PROJECT TITLE: Healing conversations: a practical framework for clinical communication between Aboriginal communities and healthcare practitioners

The ethics application for the above project has been reviewed by the Human Research Ethics Committee and is deemed to meet the requirements of the *National Statement on Ethical Conduct in Human Research (2007)*.

You are authorised to commence your research on: 07/01/2019
The ethics expiry date for this project is: 31/01/2022

NAMED INVESTIGATORS:

Chief Investigator:	Professor Nicky Hudson
Student - Postgraduate Doctorate by Research (PhD):	Dr Andrea Jane McKivett
Associate Investigator:	Professor David Paul
Associate Investigator:	Dennis McDermott

CONDITIONS OF APPROVAL: Thank you for your considered responses to the matters raised. The revised application provided on 11/12/2018 has been approved.

Ethics approval is granted for three years and is subject to satisfactory annual reporting. The form titled Annual Report on Project Status is to be used when reporting annual progress and project completion and can be downloaded at http://www.adelaide.edu.au/research-services/oreci/human/reporting/. Prior to expiry, ethics approval may be extended for a further period.

Participants in the study are to be given a copy of the information sheet and the signed consent form to retain. It is also a condition of approval that you immediately report anything which might warrant review of ethical approval including:

- serious or unexpected adverse effects on participants,
- previously unforeseen events which might affect continued ethical acceptability of the project,
- proposed changes to the protocol or project investigators; and
- the project is discontinued before the expected date of completion.

Yours sincerely,

Professor Paul Delfabbro
Convenor

25 October 2018

Principal Researcher (as per the AHREC application form):	Dr Andrea McKivett
Organisation:	University of Adelaide
Via email to corresponding researchers:	

RE: Healing conversations: a practical framework for clinical communication between Aboriginal communities and healthcare practitioners

AHREC Protocol #: 04-18-787

Dear Andrea,

Thank you for your submission and requesting ethical review from the Aboriginal Health Research Ethics Committee (AHREC). Thank you also for your response clarifying the minor queries raised by the Committee, which was reviewed out-of-session and met with support.

I am pleased to advise that the study was granted final ethical approval by AHREC. We wish you well with the studies and look forward to receiving your progress reports. Please be advised that, in accordance with the National Statement, AHREC requires researchers to submit reports for monitoring purposes on an annual basis. Regardless of the approval date, AHREC implements a streamlined annual reporting deadline for all studies and requires researchers to submit their annual reports every November. Given the short timeframe, please be advised that the first annual report or the final report of the study is due by 30 November 2019. Please plan for any subsequent reporting deadlines accordingly.

Please also be advised of the standard conditions of approval below.

If you require further information, please do not hesitate to contact the Executive Officer, Dr Gokhan Ayturk, from 08

Sincerely yours,

Dr Gokhan Ayturk on behalf of

Amanda Mitchell
Chairperson, AHREC

Aboriginal Health Research Ethics Committee (AHREC)
Street Address: 220 Franklin Street, Adelaide SA 5000, Mailing Address: PO Box 719 Adelaide SA 5001
Tel: (08) 8273 7200 Email: gokhan.ayturk@ahcsa.org.au Website: http://ahcsa.org.au/research-overview/ethical-review-ahrec/

Standard Conditions

1) The approvals are granted based on the documentation and scope outlined by the researcher at the time of the review. AHREC must be notified of, and, approve, any changes to the study including minor or major changes to the study parameters, personnel updates and extension requests.
2) Where applicable, the onus of following the appropriate procedure for obtaining informed consent and protecting the well-being of a participant lies solely with researcher(s).
3) AHREC approvals are valid for three years from the date of the approval letter unless up to a maximum of 5 year approval timeframe is specifically requested, for example, in case of longitudinal studies and research projects conducted under Centres of Research Excellence. AHREC does not grant approvals on an indefinite basis and requires the submission of an extension request before its approval expires. The aforementioned study is approved until 1/9/2023 as requested.
4) Studies aiming to involve an Aboriginal organisation, e.g. an Aboriginal Community Controlled Health Service, should adapt a partnership approach and go through a meaningful engagement process evidenced by an in-principle support letter or appropriate agreement.
    a. This letter or agreement should clearly articulate the time, expertise and resources required to support the study.
    b. Study timeframes and tools should be implemented with respect to the characteristics of each context engaged without an adverse impact on the quality of care and capacity of service.
    c. The Committee recognises that this process may not always be possible to finalise ahead of the ethical review process and advises that its approval is conditional upon the consultation process occurring to the satisfaction of the Aboriginal organisations and people whose support is sought to achieve study goals.
5) Where studies are granted approvals on the basis of the need to source ongoing advice from an established Aboriginal governance structure (e.g. Aboriginal advisory group, steering committee) or, where researchers indicated that it will be established, studies should be implemented as such. Should the ongoing monitoring of a study find that the original approval parameters were not adhered to by researchers, AHREC may further deliberate on the continued ethical acceptability of the study.
6) All adverse events to participants or local organisations and communities must be reported to AHREC immediately. These may include any serious or unexpected effect, unforeseen events and information that may invalidate the ethical integrity of the study.
7) Where possible, research participants should be supported for their time attending research activities. If the researchers will provide gift cards to incentivise participation, these should be gift cards that cannot be utilised for the purchase of alcohol or tobacco.
8) Research participants should be offered support for transportation to the location where research activities will take place and/or reimbursed for costs incurred e.g. parking, travel costs. This support should ideally be provided to participants up-front.
9) AHREC requires researchers to submit their annual reports every ***November***, by the end of the month, throughout the approval timeframe. Final reports can be submitted at any time. Please find the reporting template at: http://ahcsa.org.au/research-overview/ethical-review-ahrec/
10) As part of AHREC's monitoring function and in accordance with the NHMRC Guidelines, where the Committee identifies that a study is high risk due to its interest in issues that are highly sensitive to Aboriginal communities or has become high risk due to its overall code of conduct; it requires researchers to submit their manuscripts for review and approval before publication. The researchers are notified of this advice specifically during the approval timeframe.

Aboriginal Health Research Ethics Committee (AHREC)
Street Address: 220 Franklin Street, Adelaide SA 5000, Mailing Address: PO Box 719 Adelaide SA 5001
Tel: (08) 8273 7200 Email: gokhan.ayturk@ahcsa.org.au Website: http://ahcsa.org.au/research-overview/ethical-review-ahrec/

WAAHEC Western Australian Aboriginal Health Ethics Committee

Approval Letter

Date: 10/07/2020

Dear Dr McKivett

HREC Reference number: 976

Project title:

Healing conversations: a practical framework for clinical communication between Aboriginal communities and healthcare practitioners

Thank you for submitting the above research project for ethics approval. The research project was considered by the WA Aboriginal Health Ethics Committee (WAAHEC) at the meeting held on 10/07/2020 . I am pleased to advise that the WAAHEC has reviewed and approved the following documents submitted for this project:

Document(s):

McKivett WAAHEC with appendices (final)
McKivett WAAHEC with appendices 2 (final)
waahec amended participant info sheets

450 Beaufort Street, Highgate WA 6003 / PO Box 8493, Stirling Street, Perth WA 6849
Phone: (08) 9227 1631 **Fax:** (08) 9228 1099 **Email:** ethics@ahcwa.org **Web:** www.ahcwa.org.au **ABN:** 48 114 220 478 **ACN:** 114 220 478

The WAAHEC has granted approval of this research project from <date of the meeting held>, pending your agreement of the following conditions:

Conditions

- The WAAHEC will be notified in writing, giving reasons, if the project is discontinued before the expected date of completion.
- The Chief Investigator will provide a Progress Report by 30 June each year in the specified format. This form can be found on the AHCWA website (www.ahcwa.org.au).
- The approval for research projects is three years. Research projects should commence and conclude within that period of time. Projects must be resubmitted if extension over three years becomes necessary.
- Information about publications and/or conference presentations may be incorporated into Progress and Final Reports. This enables the WAAHEC to maintain a record of publications. Researchers can contact the WAAHEC if they require support or feedback prior to publication.
- Aboriginal and Torres Strait Islander communities are formally acknowledged for their contribution to this research project.
- If amendments to the research project become necessary, these should be submitted using the form provided on the AHCWA website (www.ahcwa.org.au).

Please contact ethics@ahcwa.org if you have any queries about the WAAHEC's consideration of your project.

The WAAHEC wishes you every success in your research.

Kind regards

Erica Lewin

For, Vicki O'Donnell
Chairperson, WAAHEC

450 Beaufort Street, Highgate WA 6003 / PO Box 8493, Stirling Street, Perth WA 6849
Phone: (08) 9227 1631 **Fax:** (08) 9228 1099 **Email:** ethics@ahcwa.org **Web:** www.ahcwa.org.au **ABN:** 48 114 220 478 **ACN:** 114 220 478

THE UNIVERSITY OF NOTRE DAME AUSTRALIA

19 Mouat St (PO Box 1225) Fremantle WA 6959
+61 8 9433 0555 | enquiries@nd.edu.au

15 June 2020

Professor David Paul
School of Medicine
The University of Notre Dame Australia
Fremantle Campus

Dear David,

Reference Number: 2020-091F

Project title: "Healing conversations: a practical framework for clinical communication between Aboriginal communities and healthcare practitioners."

Thank you for submitting the above project for review. It is noted that you have ethics approval for this project from W.A Aboriginal Health Ethics Committee, reference number 892. Your application has been assessed as qualifying for a Cross-Institutional approval and is therefore exempt from HREC review. I am pleased to advise that ethical clearance has been granted for this proposed study.

Other researchers identified as working on this project are:

Name	School / Centre	Role
Dr Andrea McKivett	University of Adelaide	PhD student
Prof Nicky Hudson	University of Adelaide	Supervisor

All research projects are approved subject to standard conditions of approval.

Please read the attached document for details of these conditions.

Should you have any queries about this project, please contact me at #2964 or

Yours sincerely,

Dr Natalie Giles
Research Ethics Officer
Research Office

Cc: Prof Kathryn Hird, Acting SRC Chair, School of Medicine

Appendix III

Participant information sheets

PARTICIPANT INFORMATION SHEET
Aboriginal Community consultation

Healing conversations: a practical framework for clinical communication between Aboriginal communities and healthcare practitioners

HUMAN RESEARCH ETHICS COMMITTEE APPROVAL NUMBER: H-2019-001
ABORIGINAL HEALTH RESEARCH ETHICS COMMITTEE APPROVAL NUMBER: 04-18-787
WAAHEC APPROVAL NUMBER: 976
NOTRE DAME HREC APPROVAL NUMBER: 2020-091F
PRINCIPAL INVESTIGATOR: Professor Nicky (JN) Hudson
STUDENT RESEARCHER: Dr Andrea McKivett
STUDENT'S DEGREE: PhD of Medicine

Dear Participant,

You are invited to participate in the following research project titled 'Healing Conversations'.

What is the project about?
Communication (talking and body language) in health is important, and we would like to help healthcare professionals (such as doctors, nurses and physiotherapists), have better conversations with Aboriginal community members.

Who is undertaking the project?
This project is being conducted by Dr Andrea McKivett under the supervision of Professor Nicky Hudson and Professor David Paul.

Why am I being invited to participate?
You are being invited to participate as you identify as an Aboriginal person and we would like to talk with you about a framework for conversations in health we have developed.

What am I being invited to do?
You are being invited to participate in a 30-minute interview to discuss conversations in health interactions (such as a doctor's visit). The interview will be audio-recorded if you agree to this. If you do not wish to be audio-recorded, the interviewer will take written notes from your interview.

The interview will be held at a place suitable for you, such as your home or workplace.

How much time will my involvement in the project take?
The interview will take at about 30 minutes, but it can be longer or shorter if you wish. You will only need to do one interview.

Are there any risks associated with participating in this project?
It is unlikely that you will experience any risks from participating in this project.

If your talk with the interviewer evokes memories or thoughts that might be, the interviewer will provide details of services available that can support you.

What are the potential benefits of the research project?
There are no direct benefits from you by participating in this research project. Rather, the benefits are in helping to better prepare the health workforce (such doctors and nurses) to work well with Aboriginal communities. The potential benefits are at the community level.

Can I withdraw from the project?
Participation in this project is completely voluntary. If you agree to participate, you can withdraw from the study at any time.

If you withdraw after your contributions have been published or submitted as part of the final report for the student's PhD in medicine, Andrea McKivett, your published contributions will not be able to be withdrawn. Note the final report is also termed a 'thesis'.

What will happen to my information?

Your information will have your name removed after the interview, and your name will not be published in any material associated with the research. Direct quotes may be used in materials related to the research project, but you will not be named with the information. This includes writing of the final thesis (report), powerpoint presentations, conference presentations, journal article publications and teaching materials associated with the framework. While all efforts will be made to remove any information that might identify you, as the numbers of people in the study is small, complete anonymity cannot be guaranteed. However, the upmost care will be taken to ensure that no personally identifying details are revealed.

You will receive a copy of either the interview transcript or notes taken from the interview.

Your information will only be used as described in this participant information sheet and it will only be disclosed according to the consent provided, except as required by law.

Who do I contact if I have questions about the project?
If you have any questions please contact
Dr Andrea McKivett (Lead researcher):

What if I have a complaint or any concerns?
The study has been approved by the Human Research Ethics Committee at the University of Adelaide (approval number H-2019-001). This research project will be conducted according to the NHMRC National Statement on Ethical Conduct in Human Research (2007). If you have questions or problems associated with the practical aspects of your participation in the project, or wish to raise a concern or complaint about the project, then you should consult the Principal Investigator. If you wish to speak with an independent person regarding concerns or a complaint, the University's policy on research involving human participants, or your rights as a participant, please contact the Human Research Ethics Committee's Secretariat on:
Phone:
Email:
Post: Level 4, Rundle Mall Plaza, 50 Rundle Mall, ADELAIDE SA 5000
Any complaint or concern will be treated in confidence and fully investigated. You will be informed of the outcome.

If I want to participate, what do I do?Please contact Dr Andrea McKivett on if you wish to participate in this study, or email

PARTICIPANT INFORMATION SHEET
Healthcare Practitioner consultation

Healing conversations: a practical framework for clinical communication between Aboriginal communities and healthcare practitioners

HUMAN RESEARCH ETHICS COMMITTEE APPROVAL NUMBER: H-2019-001
ABORIGINAL HEALTH RESEARCH ETHICS COMMITTEE APPROVAL NUMBER: 04-18-787
WAAHEC APPROVAL NUMBER: 976
NOTRE DAME HREC APPROVAL NUMBER: 2020-091F
PRINCIPAL INVESTIGATOR: Professor Nicky (JN) Hudson
STUDENT RESEARCHER: Dr Andrea McKivett
STUDENT'S DEGREE: PhD of Medicine

Dear Participant,

You are invited to participate in the following research project titled 'Healing Conversations.'

What is the project about?

Communication in health is important, and we are developing a tailored clinical communication framework to assist healthcare professionals have better conversations with Aboriginal community members. We have developed an initial framework that we would like your feedback and advice on, to see if it is acceptable for the Aboriginal and healthcare community.

A pictoral overview of this framework is shown here in Figure 1

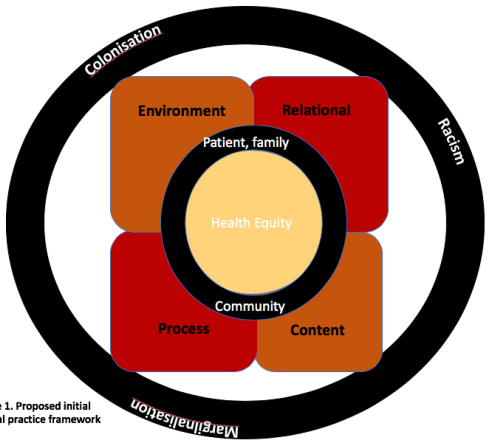


Figure 1. Proposed initial clinical practice framework

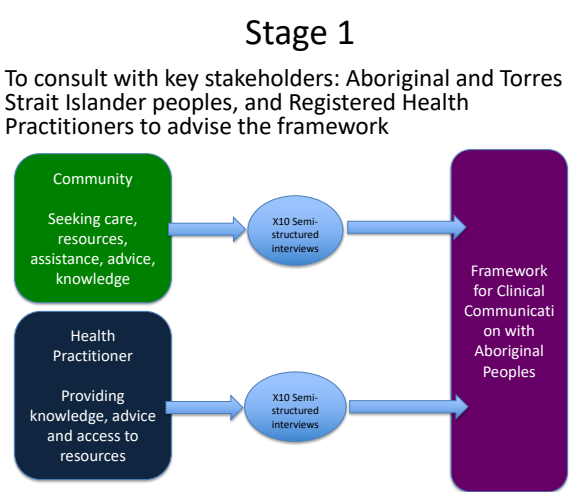
Who is undertaking the project?
This project is being conducted by Dr Andrea McKivett and will be the basis of a PhD in Medicine at the University of Adelaide under the supervision of Professor Nicky Hudson, Professor David Paul and Professor Dennis McDermott.

Why am I being invited to participate?

You are being invited to participate in this research project as you have experience in clinical communication processes, and you may have experience in medical education and/or Aboriginal healthcare.

We would like to interview you to gain your thoughts and perspectives around the initial framework and its contents, to see if you think it is appropriate and feasible for use within a clinical encounter.

This is the first stage in the research process, and we will also be interviewing Aboriginal community members. Once we have developed the final model, we will test it with training medical students.



What am I being invited to do?

You are being invited to participate in a 30-minute interview to discuss communication in healthcare interactions to gain your thoughts and ideas around the initial framework and considerations for further development.

The interview will be audio-recorded if you agree to this. If you do not wish to be audio-recorded, the interviewer will take written notes from your interview.

At the end of the interview, the researcher will type up the interview and provide you with a copy of what was discussed. You can have any part of the interview removed from the research if you like, and you can withdraw from the research study at any time.

The interview will be held at a time and place suitable for you, such as your workplace.

How much time will my involvement in the project take?

The interview will take at a minimum 30 minutes but it can be longer if you wish. You will only need to do one interview.

Are there any risks associated with participating in this project?

It is unlikely that you will experience any risk from participating in this project.

Discussions around health and healthcare interactions can evoke memories or thoughts that might be uncomfortable for some peoples. If this occurs, the interviewer will provide details of services available that can support you.

What are the potential benefits of the research project?

There are no direct benefits from you by participating in this research project. Rather, the benefits are in helping to better prepare the health workforce to work effectively with Aboriginal communities. The potential benefits are at the community level and health workforce level.

The research team will provide you with information and updates on the research process and outcomes, for they may be of use to you in your clinical practice.

Can I withdraw from the project?

Participation in this project is completely voluntary. If you agree to participate, you can withdraw from the study at any time.

If you withdraw after your contributions have been published or submitted as part of a thesis, your published contributions will not be able to be withdrawn.

What will happen to my information?

Your information will be de-identified immediately after the interview, and your name will not be published in any material associated with the research. Information you contribute may be used to develop the clinical communication framework, and direct quotes may also be used in materials related to the research project, however you will not be identified with the information. This includes writing of the final thesis (report), powerpoint presentations, conference presentations, journal article publications and teaching materials associated with the framework. While all efforts will be made to remove any information that might identify you, as the sample size is small, complete anonymity cannot be guaranteed. However, the upmost care will be taken to ensure that no personally identifying details are revealed.

Your information will be securely stored in a password protected computer and locked cabinet that the lead research will have access too.

You will receive a copy of either the interview transcript or notes taken from the interview. You can choose to have any or all of the information removed from the project.

Your information will only be used as described in this participant information sheet and it will only be disclosed according to the consent provided, except as required by law.

Who do I contact if I have questions about the project?
If you have any questions about the project please contact:

Dr Andrea McKivett (Lead researcher)

Professor Nicky (JN) Hudson (Principal Supervisor)

Professor David Paul (Co-Supervisor)

What if I have a complaint or any concerns?
The study has been approved by the Human Research Ethics Committee at the University of Adelaide (approval number H-2019-001) This research project will be conducted according to the NHMRC National Statement on Ethical Conduct in Human Research (2007). If you have questions or problems associated with the practical aspects of your participation in the project, or wish to raise a concern or complaint about the project, then you should consult the Principal Investigator. If you wish to speak with an

independent person regarding concerns or a complaint, the University's policy on research involving human participants, or your rights as a participant, please contact the Human Research Ethics Committee's Secretariat on:
Phone: +61 8
Email:
Post: Level 4, Rundle Mall Plaza, 50 Rundle Mall, ADELAIDE SA 5000
Any complaint or concern will be treated in confidence and fully investigated. You will be informed of the outcome.

If I want to participate, what do I do?
Please contact Dr Andrea McKivett on if you wish to participate in this study

Yours sincerely,
Dr Andrea McKivett
Professor Nicky (JN) Hudson
Professor David Paul

PARTICIPANT INFORMATION SHEET
Workshop

Healing conversations: a practical framework for clinical communication between Aboriginal communities and healthcare practitioners

HUMAN RESEARCH ETHICS COMMITTEE APPROVAL NUMBER: H-2019-001
ABORIGINAL HEALTH RESEARCH ETHICS COMMITTEE APPROVAL NUMBER: 04-18-787
PRINCIPAL INVESTIGATOR: Professor Nicky (JN) Hudson
STUDENT RESEARCHER: Dr Andrea McKivett
STUDENT'S DEGREE: PhD of Medicine

What is the project about?
Communication (talking and body language) in health is important, and we would like to help healthcare professionals (such as doctors, nurses and physiotherapists), have better conversations with Aboriginal community members.

A framework has been completed after consultation with the Aboriginal community and healthcare community. We would like to invite you to be involved in a workshop to talk about the framework and the approach to using it in an educational activity in medical curricula.

Who is undertaking the project?
This project is being conducted by Dr Andrea McKivett under the supervision of Professor Nicky Hudson and Professor David Paul.

Why am I being invited to participate?
You are being invited to participate in this workshop as you have one or more of the following:

- Lived experience as an Aboriginal community member who has used the healthcare system
- Health Professional experience in either Aboriginal communities, Aboriginal health, medical education
- Student experience in the medical education system as a current student to facilitate co-creation.

What am I being invited to do?
You are being invited to participate in a workshop to discuss the framework and some additional materials for suitability and approach to implementation in medical education. The session will be recorded through notes and participant written activities. At the end of the workshop, the researcher will type up the workshop findings and provide you with a copy of what was discussed.

How much time will my involvement in the project take?
The workshop will take approximately 2.5 hours however you can choose to leave the workshop at any stage.

Are there any risks associated with participating in this project?
It is unlikely that you will experience any risk from participating in this project. Discussions can evoke memories or thoughts that might be uncomfortable for some peoples. If this occurs, the interviewer will provide details of services available that can support you.

What are the potential benefits of the research project?
There are no direct benefits from you by participating in this research project. Rather, the benefits are in helping to better prepare the health workforce to work effectively with Aboriginal communities. The potential benefits are at the community level and health workforce level.

Can I withdraw from the project?
Participation in this project is completely voluntary. If you agree to participate, you can withdraw from the study at any time. If you withdraw after your contributions have been published or submitted as part of a thesis (final report), your published contributions will not be able to be withdrawn.

What will happen to my information?
Your contribution to the workshop will be as per a group process, any individual contributions will be linked to your role only (ie medical student, Aboriginal community member) and your name will not be published in any material associated with the research. Information you contribute may be used to develop the clinical communication framework and educational approach, and direct quotes may also be used in materials related to the research project, however you will not be identified with the information. This includes writing of the final thesis (report), powerpoint presentations, conference presentations, journal article publications and teaching materials associated with the framework. While all efforts will be made to remove any information that might identify you, as the numbers of people in the project is small, complete anonymity cannot be guaranteed. However, the upmost care will be taken to ensure that no personally identifying details are revealed.

You will receive a copy of the workshop outcomes. Your information will only be used as described in this participant information sheet and it will only be disclosed according to the consent provided, except as required by law.

Who do I contact if I have questions about the project?
Please contact: Dr Andrea McKivett:

What if I have a complaint or any concerns?
The study has been approved by the Human Research Ethics Committee at the University of Adelaide (approval number H-2019-01). This research project will be conducted according to the NHMRC National Statement on Ethical Conduct in Human Research (2007). If you have questions or problems associated with the practical aspects of your participation in the project, or wish to raise a concern or complaint about the project, then you should consult the Principal Investigator. If you wish to speak with an independent person regarding concerns or a complaint, the University's policy on research involving human participants, or your rights as a participant, please contact the Human Research Ethics Committee's Secretariat on:
Phone:
Email:
Post: Level 4, Rundle Mall Plaza, 50 Rundle Mall, ADELAIDE SA 5000
Any complaint or concern will be treated in confidence and fully investigated. You will be informed of the outcome.

If I want to participate, what do I do?
Please contact Dr Andrea McKivett on if you wish to participate in this study

Appendix IV

Questionnaires for stage 1

Semi-structured interview – Aboriginal Community Members

Question 1
When you visit a doctor or healthcare professional, how do you like them to communicate with you? What do you want them to ask you about?

Question 2
Do you want your doctor to ask you about things like racism, education and/or financial resources for example? If yes, how?

Question 3
What makes a doctor a good communicator with Aboriginal peoples and their families? Are there any particular factors that influence good communication with doctors?

Question 4
How do you think doctors should go about considering the cultural determinants of people's health, like connection to land, family and spirituality?

Question 5
Have you ever had a doctor address the role of history and colonisation of our country really well in a clinical consult? If yes, how did they do this? If no, would you like them to and how?

Introduce Aboriginal community members to the initial framework developed from the literature review including the prepared questions attached to the framework.

Questions 6
Is there anything in the framework that you think should be removed? Anything that should be added?

Question 7
Do you have ideas for what we could call the framework and how we might draw it better?

Question 8
Do you have any further advice or comments?

Thank you for your time

Semi-structured interview – Healthcare Practitioners Questionnaire

Introduce health practitioners to the initial framework developed from the literature review.

Question 1
What are your thoughts regarding this framework? Is it useful?

Question 2
Is there anything missing from the framework that you think is critical to enabling health practitioners communicate more effectively with Aboriginal peoples?

Question 3
What do you think is the most important aspect of effective communication with Aboriginal peoples and is it included in the framework?

Question 4
What do you think will enable this framework to be implemented easily in clinical practice?

Question 5
Do you have practical suggestions for how aspects of this framework can be accomplished in a clinical encounter, for example, asking about racism and cultural determinants of health?

Question 6
Do you have practical suggestions for how doctors can address Aboriginal patients historical context/impact of colonisation in a clinical encounter?

Question 7
Would you like to change anything about the framework?

Questions 8
Do you have any further comments or advice about effective clinical communication with Aboriginal peoples?

Thank you for your time

Appendix V

Conference presentations

i) 2018 PRIDOC conference – oral presentation
ii) 2019 LIME conference – oral presentation

Healing conversations

Developing a tailored practical framework for clinical communication between Aboriginal peoples and healthcare practitioners …

….With a focus on medical education…

Dr Andrea McKivett and Professor David Paul

Acknowledgement of place

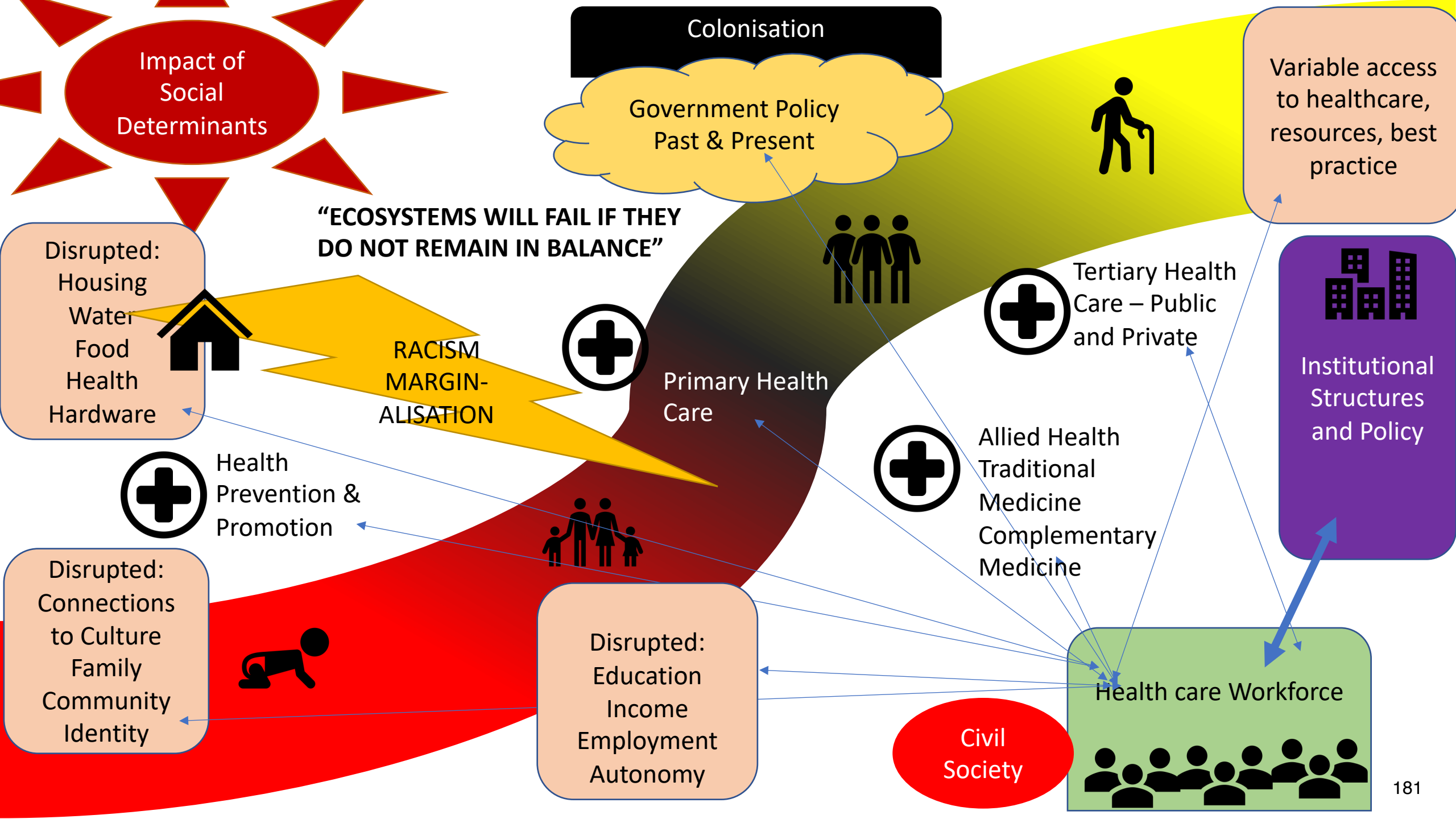
“I am, by calling, a dealer in words; and words are, of course, the most powerful drug used by mankind.

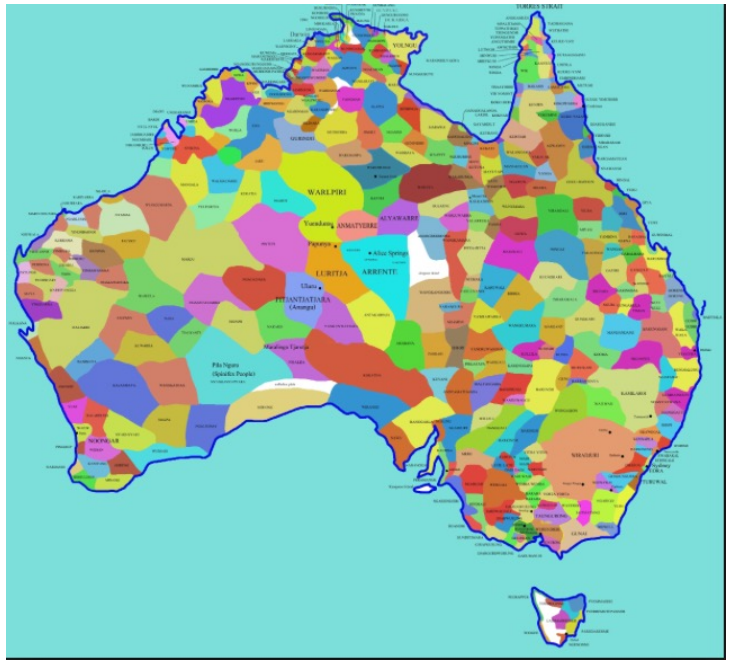
Not only do words infect, ergotise, narcotise, and paralyse … they enter into and colour the minutest cells of the brain …”

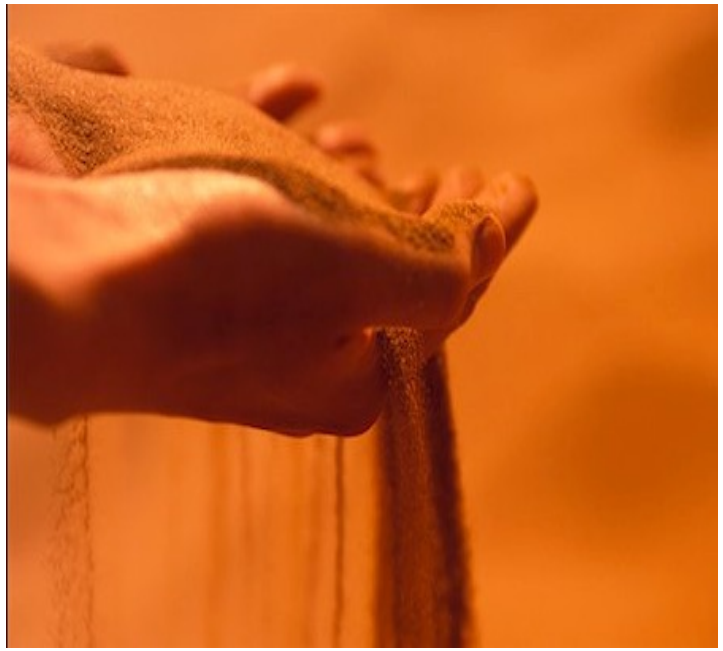
- Rudyard Kipling,

Address to the Royal College of Surgeons, February 1923

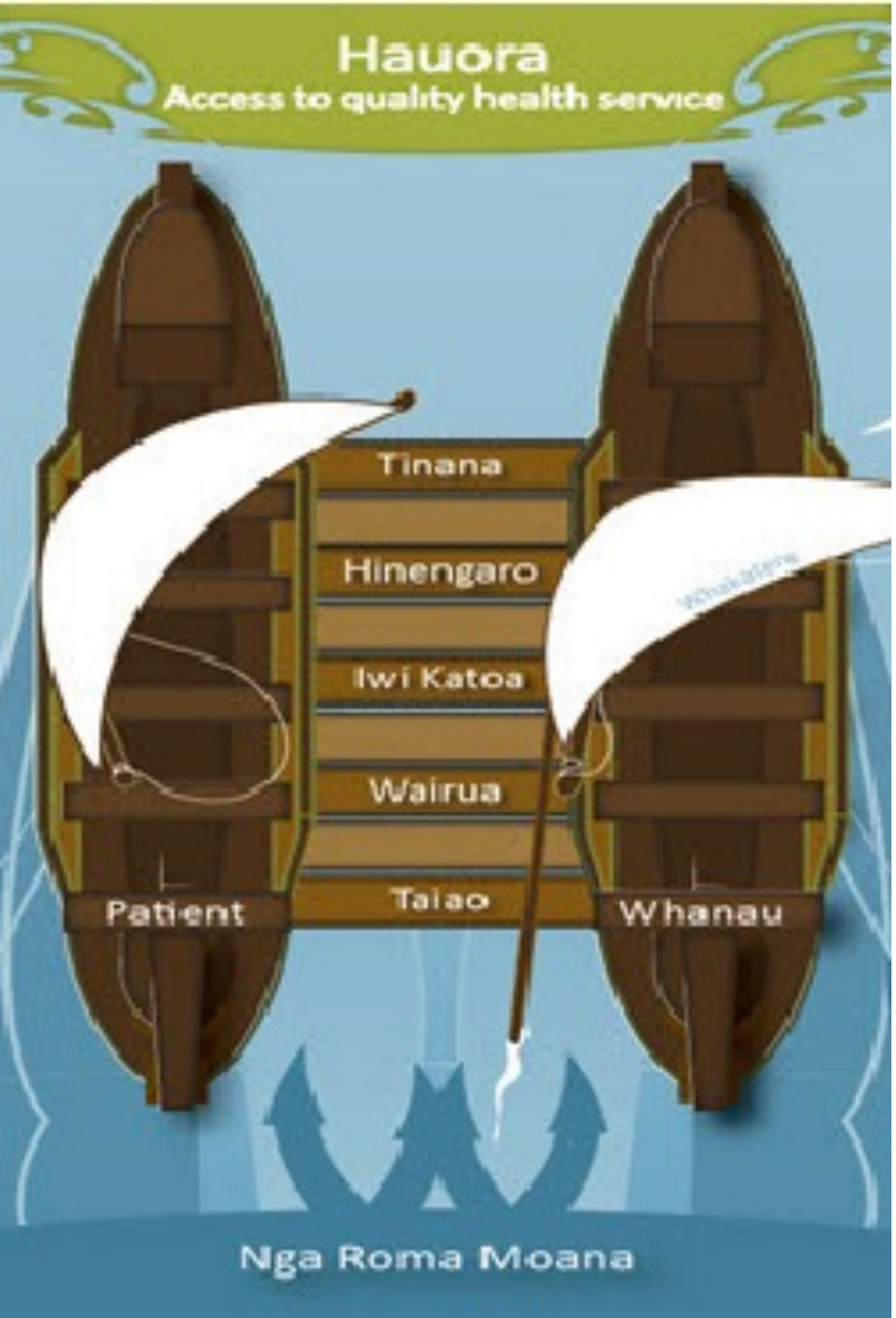
If there is an ecosystem of health inequity…can we disrupt it?


Impact of Social Determinants
Colonisation
Government Policy Past & Present
Variable access to healthcare, resources, best practice
"ECOSYSTEMS WILL FAIL IF THEY DO NOT REMAIN IN BALANCE"
Disrupted: Housing Water Food Health Hardware
RACISM MARGIN-ALISATION
Primary Health Care
Tertiary Health Care – Public and Private
Institutional Structures and Policy
Health Prevention & Promotion
Allied Health Traditional Medicine Complementary Medicine
Disrupted: Connections to Culture Family Community Identity
Disrupted: Education Income Employment Autonomy
Health care Workforce
Civil Society





"…in diversity there is beauty and there is strength"
Maya Angelou



Great steps forward: learning from our colleagues

"We are inclined to think of reflection as something quiet and personal. My argument here is that reflection is action-oriented, social and political. Its 'product' is praxis (informed, committed action), the most eloquent and socially significant form of human action."

- *Stephen Kemmis "Action Research and the Politics of Reflection" in David Boud, Rosemary Keogh and David Walker, eds., Reflection: Turning Experience into Learning (New York: Kogan Page Ltd., 1985) 139 at 141.*

Pitama, S, Huria, T, Lacey, C. Improving Maori health through clinical assessment: Waikare o te Waka o Meihana. The New Zealand Medical Journal 2014; 127(1393): 107-119.

Foreseeable Challenges and risks

Diversity of contexts

Broad utility with individual-level applicability

Negotiating knowledge boundaries

Hidden & Informal curricula

Building better practitioners

- Consistent message across curriculum
- Effective communication framework that is applicable
- Constructive alignment
- Clarity around expected standard for assessment of medical student skills and knowledge
- Specific examples of appropriate questions and styles of communication
- Focus on developing critically conscious practitioners who are aware of their own cultural identity

Ways forward

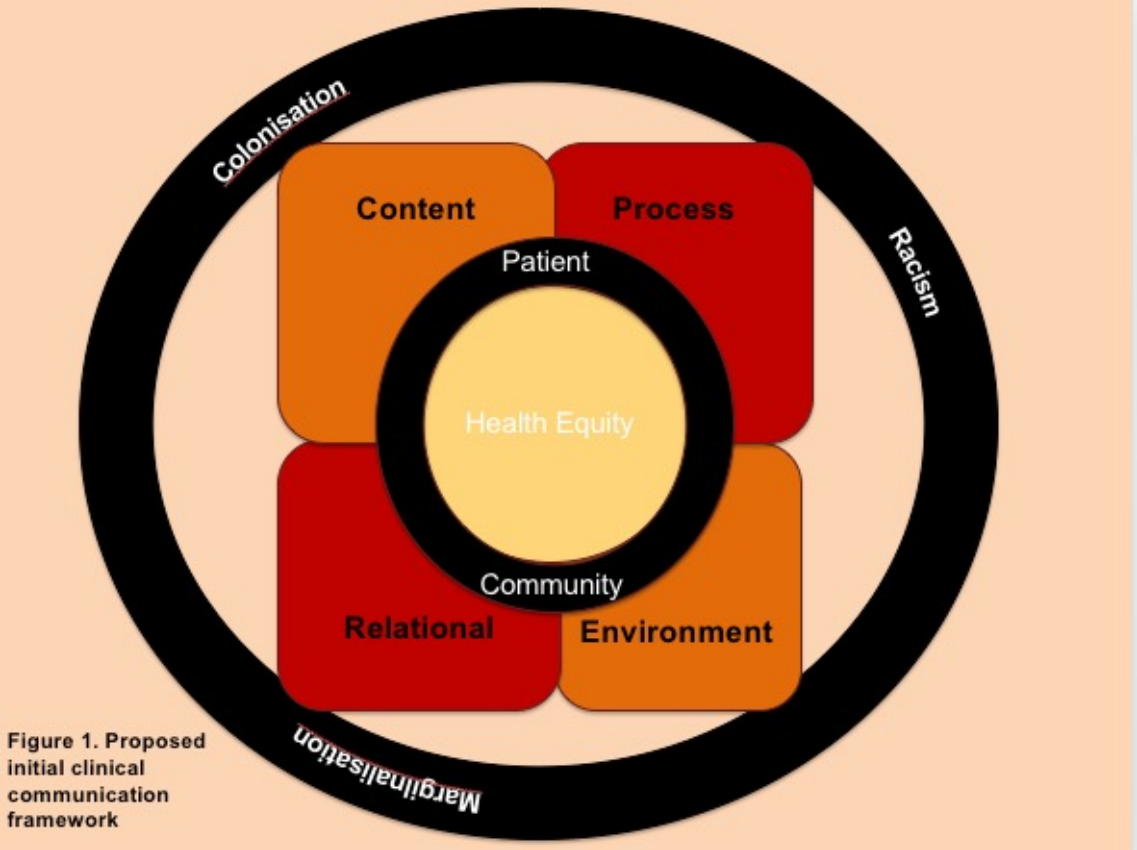


Figure 1. Proposed initial clinical communication framework

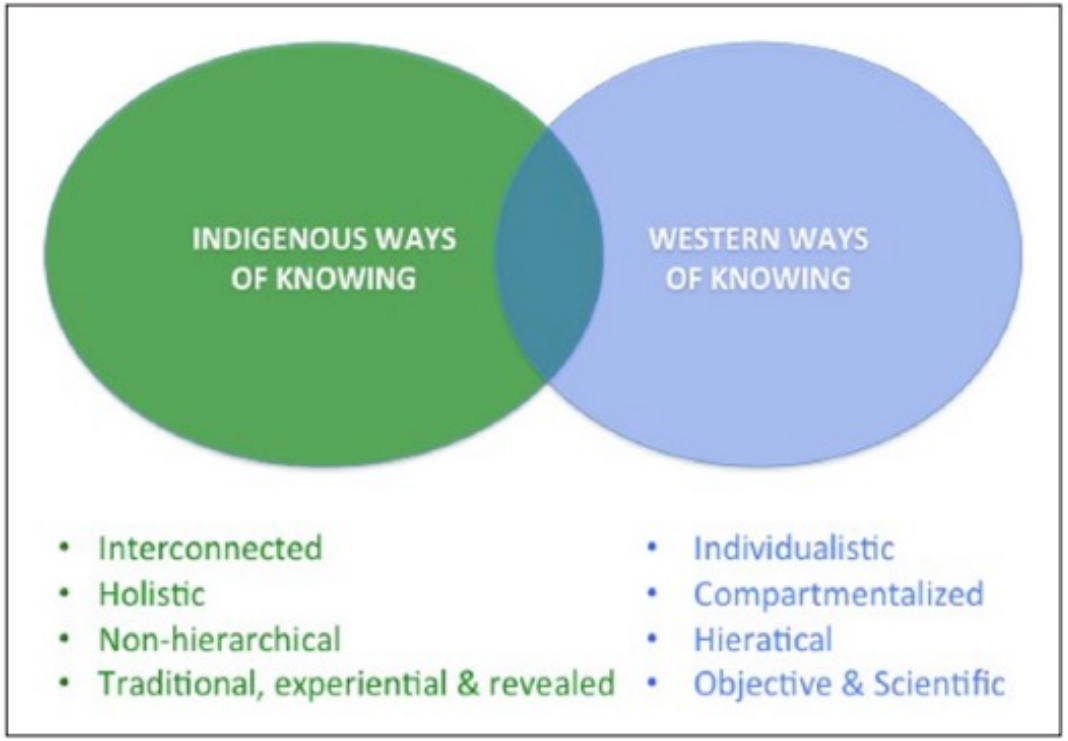


Figure 1. Two-Eyed Seeing.
Note. Adapted from Bartlett and Marshall (2010).

“When we … get impatient for ‘results’ … Elder Albert likes to tell us about the ash tree. Every year, the ash tree drops its seeds on the ground. Sometimes those seeds do not germinate for two, three or even four cycles of seasons. If the conditions are not right, the seeds will not germinate. Sometimes, Elder Marshall says, you have to be content to plant seeds and wait for them to germinate. You have to wait out the period of dormancy. Which we shouldn’t confuse with death. We should trust this process”

- Bartlett, C et al. 2012

1

2

"if your actions inspire others to dream more, learn more, do more, become more, you are a leader" - John Adams

Pitama S, Robertson P, Cram F, Gillies M, Huria T, Dallas-Katoa W. Meihana model: A clinical assessment framework. *New Zealand Journal of Psychology*. 2007;**36**(3):118-25.

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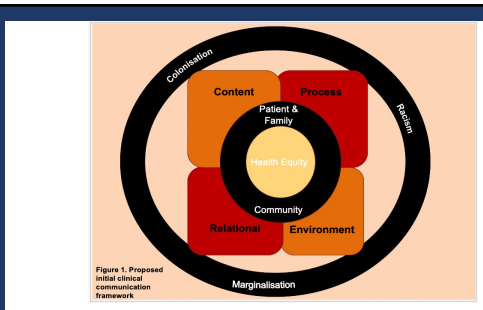


Figure 1. Proposed initial clinical communication framework

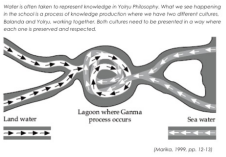
McKivett A, Paul D, Hudson N. Healing Conversations: Developing a Practical Framework for Clinical Communication Between Aboriginal Communities and Healthcare Practitioners. *Journal of immigrant and minority health*. 2018:1-10.

4

Integrative methodology

"We cannot solve our problems with the same thinking we used when we created them."
Albert Einstein

- Value of different knowledge systems
- Inclusion without fusion



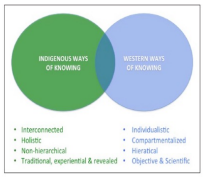


Figure 1. Two-Eyed Seeing.
Note. Adapted from Bartlett and Marshall (2010).

Bat, M, Shore, S. Listening differently: An exploration of grey literature about Aboriginal teacher education in the Top End of the Northern Territory. MATSITI, Charles Darwin University, Haymarket, New South Wales. 2012.

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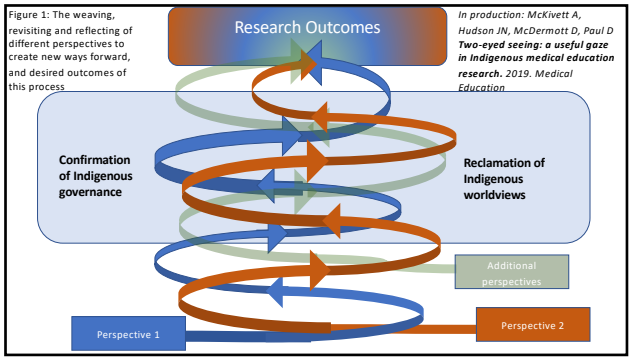


Figure 1: The weaving, revisiting and reflecting of different perspectives to create new ways forward, and desired outcomes of this process

In production: McKivett A, Hudson JN, McDermott D, Paul D ***Two-eyed seeing: a useful gaze in Indigenous medical education research.*** *2019. Medical Education*

6

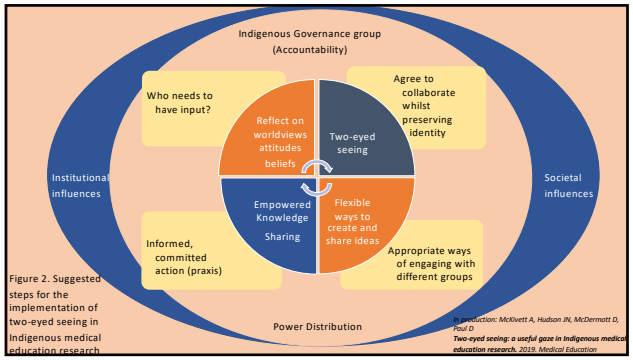


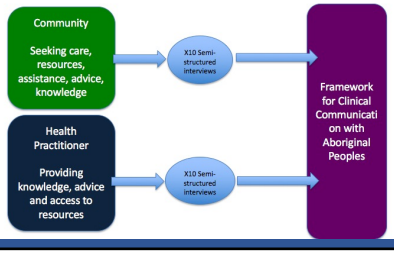
Figure 2. Suggested steps for the implementation of two-eyed seeing in Indigenous medical education research

In production: McKivett A, Hudson JN, McDermott D, Paul D ***Two-eyed seeing: a useful gaze in Indigenous medical education research.*** *2019. Medical Education*

7

Stage 1

To consult with key stakeholders: Aboriginal and Torres Strait Islander peoples, and Registered Health Practitioners to advise the framework



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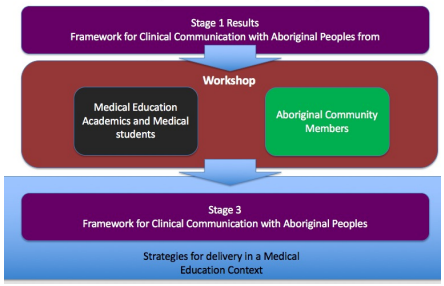
Stage 2 - Workshop



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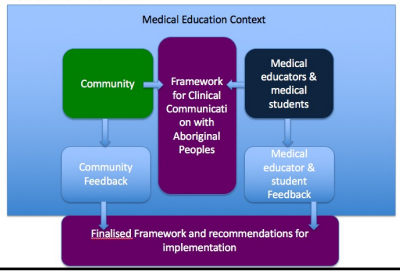
Stage 3

Trial and evaluate framework in a medical education context



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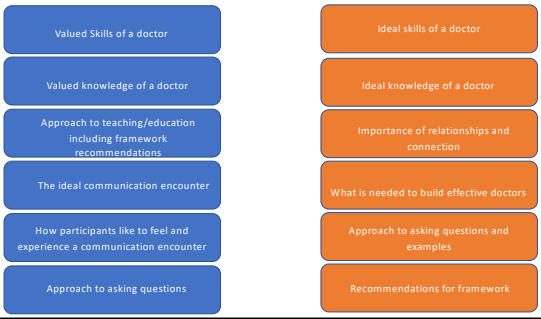
Early findings from Phase 1 SA



11

"a comfort zone is a beautiful place, but nothing grows there" - unknown

I wonder whether changing the colour… Identify the influences there, but not have people drawn to them.

…one of the things that comes out about discussing those outer rings is, the lack of safety for many Aboriginal people sitting down with a doctor.

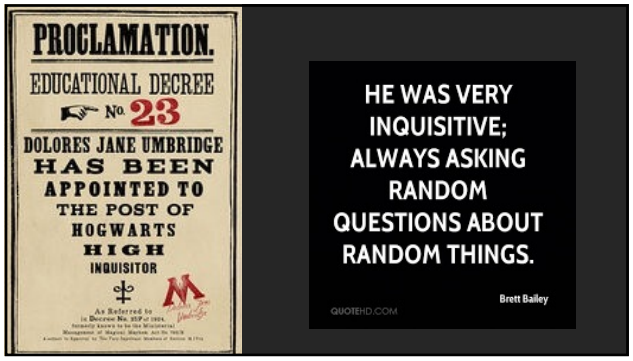
… much as we know that how it is, is that colonisation, racism and marginalisation are just sitting there always, in the background of whatever we do. The health equity is what we want. And part of me would like that to sit on the outside… when I look at it, I just feel a bit … I know that is how it is, but it's not how it should be.

I guess one of the things that struck me. It's in all negative, the black is all negative. The circle. There is a movement at the moment to really respect Aboriginal culture and the past …. I just wondered about whether we could have some more positive aspects as well.

I also like that it acknowledges potentially some more, well, depending on who is involved, uncomfortable talking points. And we are talking about racism. We are talking about marginalisation. We are talking about inequality here. I think it's good, that that is quite clearly represented in the diagram here. It's not shying away from that.

It almost gives permission that they can, not just think about it, but ask about it and find out about it. I feel like that step from knowing it impacts on health, then knowing what to do about it.

12



13

" a prudent question is one half of wisdom" – Francis Bacon

Give them the opportunity to voluntarily say something. They could say no, I don't want to talk about that, or it is not something that I want to talk about. But you give them the opportunity

There is also the process with their communication so that it must be delivered in a meaningful way that I feel comfortable, and I can expand upon that.

…some people need to have those conversations. But for me, no, it hasn't been necessary…But I certainly see the value in doctors asking about those things. When we go to the doctor, there are other things that are happening in our lives that we may need to talk about…

I suppose it has to be … knowledgeable on how they are presented. So, the right way to frame those particular questions, to gauge or to get some understanding, is that you definitely need to have the right questions asked. If it is not the right questions, then it makes it feel a bit intrusive.

…if somebody asked me that, I would be responsive but, the response would totally depend on how the question is framed.

I think they should ask before they want to know something.

[The doctor] will say, 'can I ask you something?'. I said, 'Ah yeah, I suppose go for it'.

14

In brief…

Managing discomfort is growth

Outer circles can trigger discomfort

Deeper conversations can be achieved when working with this discomfort for the interests of the patient

How can we empower doctors to manage their discomfort for the betterment of their patients?

Its not about the what, its about the how

Participants discussed the need for questions to be framed appropriately, to enable sharing of what was important to them

Questions can be asked when relevant, purposeful with associated action

Quality of response can be dependent on previous factors; relationships, trust, rapport

15

You are actually having a conversation with someone who is actually interested in you as a person. I like that. As I said, I would go back. I was lucky….

…[[the doctor] was interested in what I was working on, interested in the study, all of those things. And [the doctor] would ask 'so, how is that going?' And I would be able to tell [the doctor] something. So, we already had something that was there, that you could build on if the opportunity presented itself. But I have to say [they were the] only doctor I have had that has been like that. And it was a really good experience.

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Appendix VI

Workshop outline

Participatory Workshop Program

Session 1 (30 min)

Introduction of framework to workshop participants seeking feedback

Session 2 (1 hour)

Workshop the structure and content of the framework for suitability for medical education curricula

Session 3 (1 hour)

Workshop the design for curriculum delivery and assessment for medical educational curriculum

Thank you for your time

Healing Conversations Research Workshop

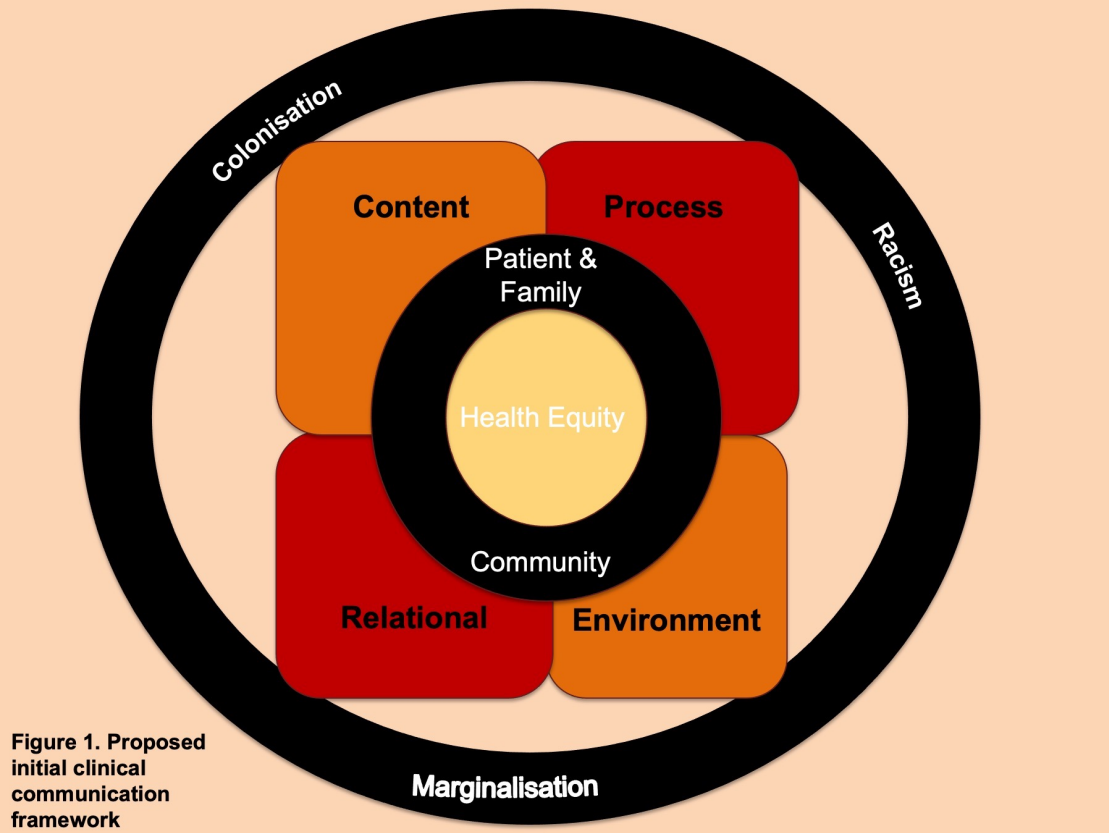
Overview of today

12.30-1.00 PERTH	2.00-2.30pm ADELAIDE	Introductions + Overview	Outline expectations of the workshop Framework details Present stage 1 findings Provide draft paper?
1.00-1.30 PERTH	2.30-3.00pm ADELAIDE	Feedback and thoughts on the framework	What are your thoughts on the framework? How might we teach this effectively? What learning materials do you think would be useful to support the framework in a teaching setting?
1.30-1.45 PERTH	3.00-3.15pm ADELAIDE	BREAK	BREAK
1.45-2.15 PERTH	3.15-3.45pm ADELAIDE	Feedback and thoughts on the framework	What might assessment of this framework look like?
2.15-2.30 PERTH	3.45-4.00pm ADELAIDE	Wrap up, summary and conclusion	Present final findings and overall themes drawn from the group

Aims and expectations

- To hear your thoughts, perspectives, experiences and views on a communication framework in Aboriginal health
- You can utilize the chat function if you prefer to provide written comments and feedback
- The zoom session is not recorded – we will be taking written notes and monitoring the chat function.
- You will not be identified by name - only representation (medical student, health educator, Aboriginal community member)

Where we started….



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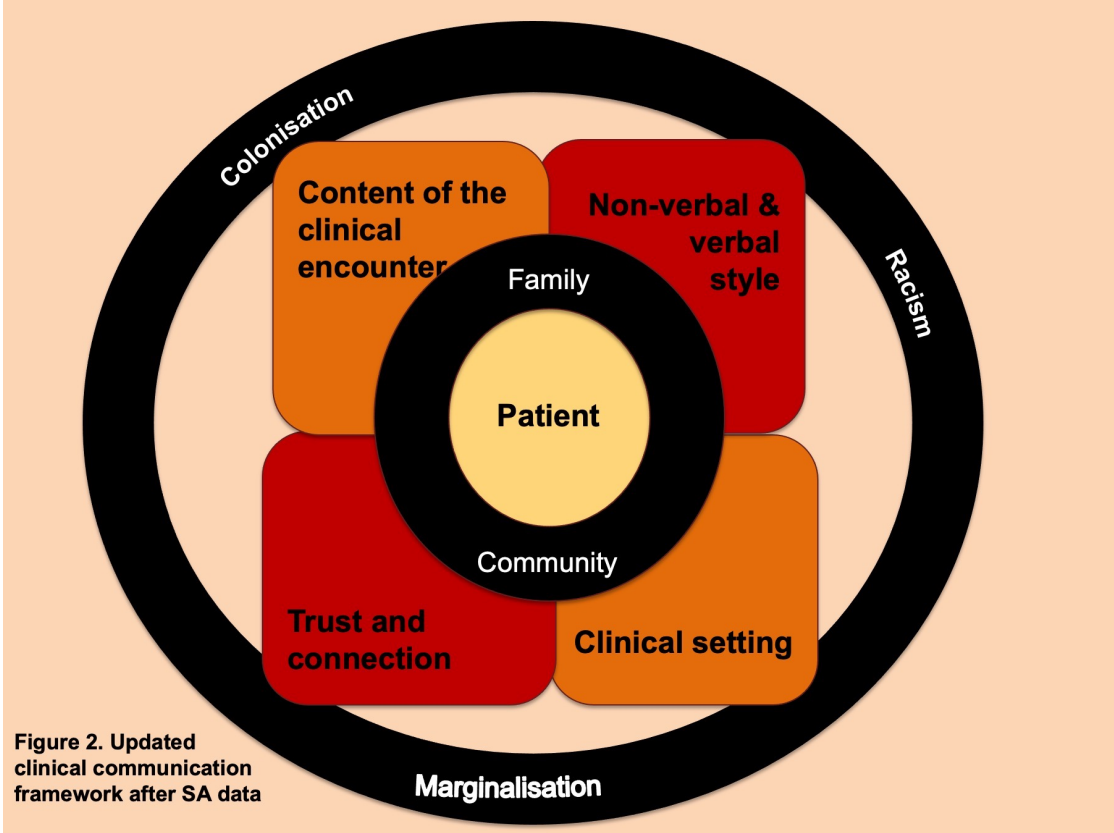
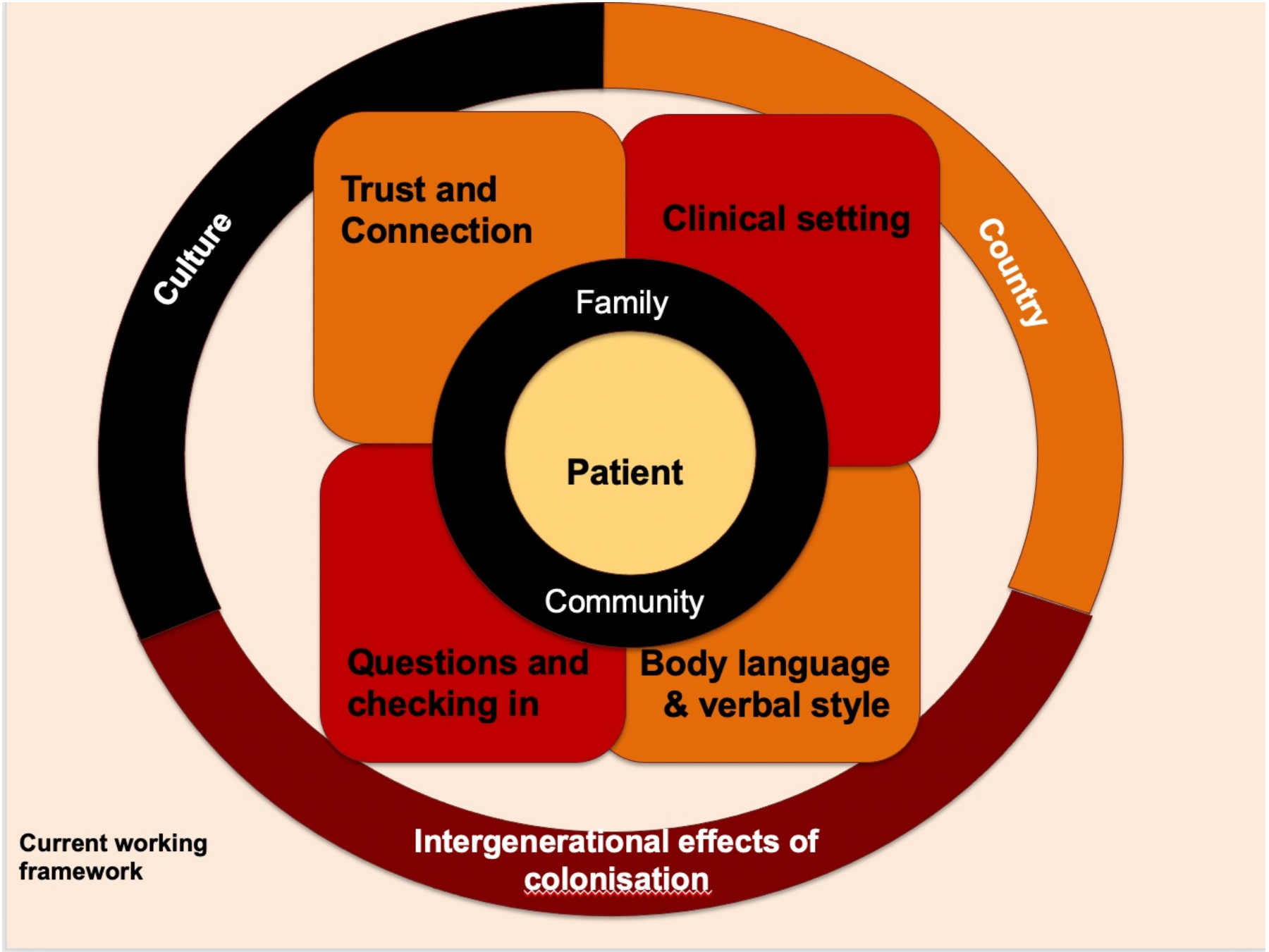


Figure 2. Updated clinical communication framework after SA data

Four key themes emerged from the Aboriginal community and healthcare practitioner interviews in WA and SA;

1) building the therapeutic relationship;
2) communication in the clinical encounter;
3) institutional and organisational factors impacting communication;
4) educating healthcare practitioners in communication.

These results acknowledge that communication approaches need to be patient-centred, considerate of Indigenous worldviews and guided by geographical and community contexts.



Current working framework

Trust & Connection

He would talk to me about his country, his culture and his family… It is about having that sort of preliminary conversation so that you actually feel like you have got a relationship with your doctor.

Aboriginal community interview D (SA)

Clinical Setting

… if you are working in an organisation which is trusted, you have got a step up the ladder.

Healthcare practitioner interview Q (WA)

Questions and Checking in

I'm usually checking with the person a lot with what they would like, the direction that we are going in, what we are deciding to do.

Healthcare practitioner interview H (SA)

I think it is about teaching our mob as well … to ask the question and know what our rights are … even getting a second opinion.

Aboriginal community interview T (WA)

Body Language and Verbal Style

… they tend to be very black and white. Because they will say 'oh OK, because they are Aboriginal people you don't … do direct eye contact' … you have to see who the person is in front of you… be sensitive to the culture, but not stereotype the person.

Healthcare practitioner interview H (SA)

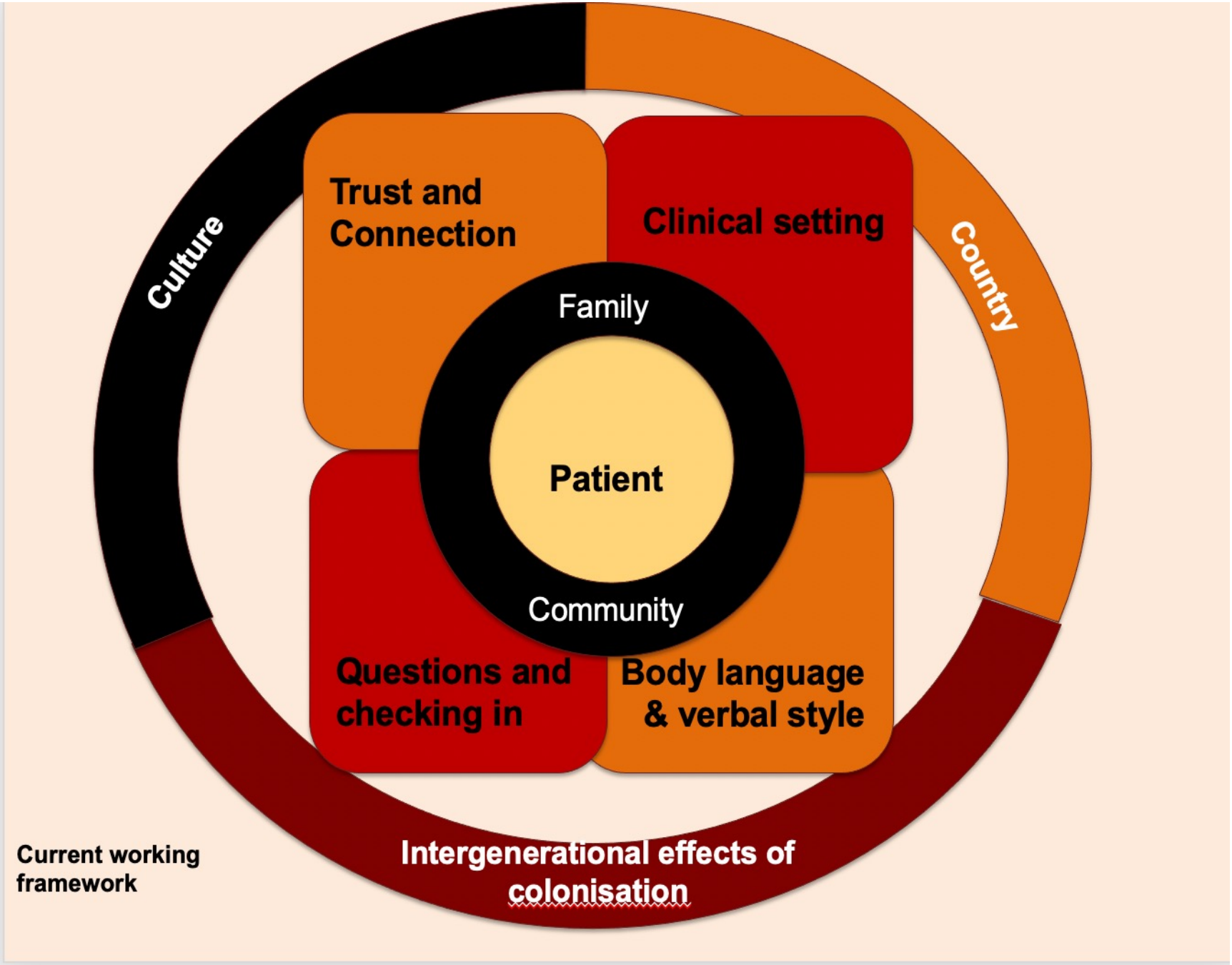
…shutting up and listening. We are not very good at that collectively with everybody. But it is just so important with Aboriginal people. … The value of silence and getting people to practice that.

Healthcare practitioner interview M (WA)

Colonisation was shifted to ‘intergenerational effects of colonisation’ to further ground the clinical relevancy of colonisation as an ongoing contemporary process that impacts people’s health and access to care.

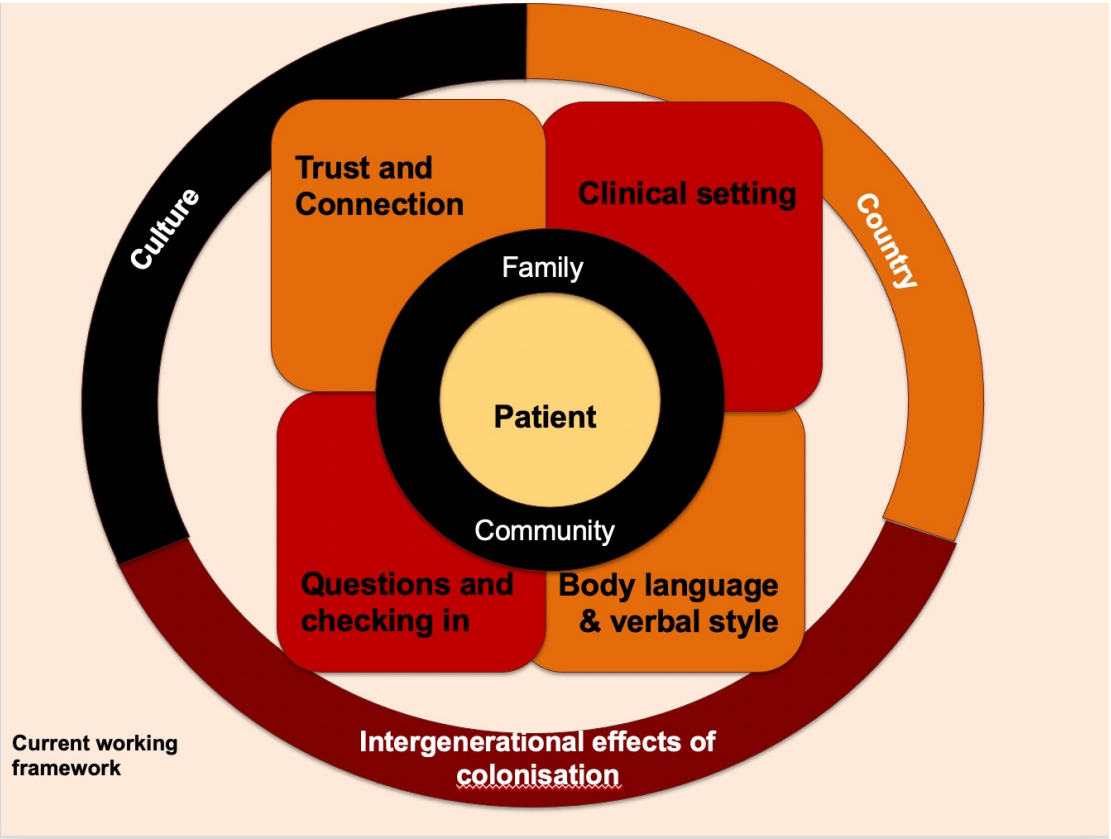
Culture and country were added to the outer rings to ensure the communication approach was considerate of Indigenous worldviews and grounded in the relevant geographical and community context of the patient and the healthcare organisation.

Racism and colonisation were from the outer rings. These determinants will remain significant components to be addressed in the educational details of the framework.



Sub- themes related to education

- Broad knowledge (colonization, history)
- Local knowledge and contextualized teaching (on-country, site specific)
- Teaching approaches (reality, guilt, discomfort, practical and authentic experiences)



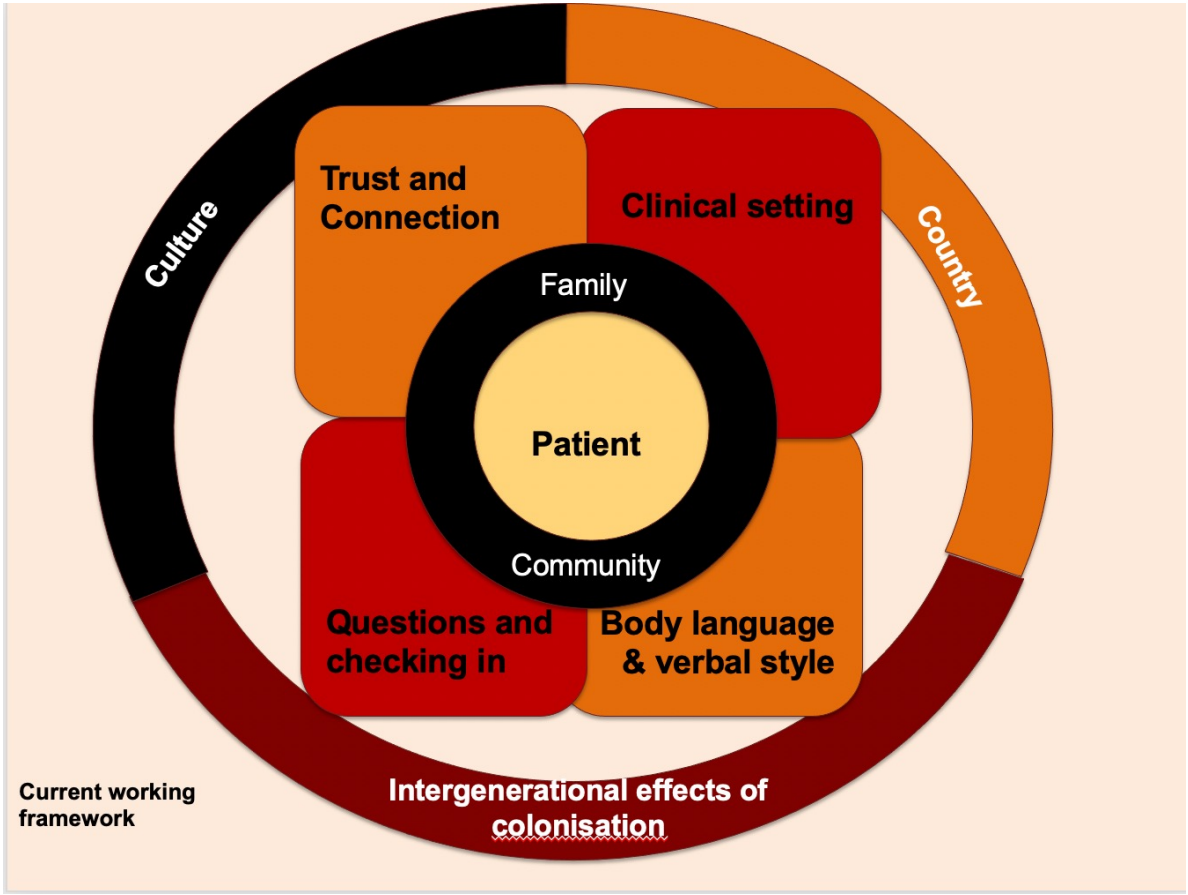
1. What are your thoughts on the framework?

2. How might we teach this effectively to health professional students?

3. What learning materials do you think would be useful to support the framework in a teaching setting?

BREAK

What could assessment of this framework, or elements of this framework, look like?



Wrap up and Conclusion

- Key takeaways
- Future directions
- Thank you for your valued participation!!

Appendix VII

Copy of feedback provided to workshop participants

Participant Feedback – Workshop findings

The framework

At the workshop, participants reviewed the proposed communication framework. One participant commented that it broadly captured elements of current related health curriculum frameworks. It was seen to be very broad and needing some detailed and specific guidance as to what lies under each domain. This will require a scaffolded educational approach to introduce learners to the broad components as well as the specific details that lie within each component, to be revisited and re-enforced across learner's progression through a health-related course.

The framework can be interpreted and presented in educational settings through a two-eyed seeing lens, and relates to both Indigenous peoples and health, and mainstream peoples and health, and medical culture. It provides the opportunity for students to learn about how Indigenous and non-Indigenous approaches work together and in partnership.

The framework can demonstrate to universities and training organisations the need for resources and appropriate teaching structures, learning spaces and inclusion of Aboriginal and Torres Strait Islander peoples and perspectives in curriculum. Because it is so broad and requires a sophisticated and complex approach that builds each year, this needs to be resourced and supported appropriately for it to be taught well.

Context will be a required foundational part when implementing the communication framework in an educational setting. Contextual considerations may become more nuanced and localised as student's progress their education and beginning clinical placements in different settings. It was suggested that using specific terminology, such as local community names and language groups, can guide targeted and locally contextualised educational sessions using the framework. For example, instead of teaching 'Aboriginal and Torres Strait Islander health', there may be more nuanced teaching on placement – 'Kaurna Health' or 'Yawuru Health'.

The framework was seen to identify many important components of the cultural safety and cultural capability model that fit within the Indigenous Health Curriculum.

Teaching Indigenous health

In the workshop, discussions about implementing the communication framework in an educational setting linked back to core issues of Indigenous health education. The importance of situating the learner within the curriculum, acknowledging the diversity in experiences, cultures and pre-existing knowledge, can be a challenge for both educators and peers. Getting all learners to a common starting point can be a challenge when some students come well-equipped with knowledge and some are novices who may express

undesirable viewpoints. Teaching Indigenous health must ensure core considerations for the safety and wellbeing of Indigenous students learning in the health curriculum course, to protect them from unsafe conversations and actions, and prevent them from taking on role of the educator instead of the student.

The importance of identifying, challenging and preventing common stereotypical assumptions and perspectives regarding communication in Aboriginal health was discussed. This supports the interview findings of promoting skills in reflexivity, as the example of students becoming hyper-fixated on eye-contact for example was raised in the workshop. This requires management to ensure students are demonstrating good clinical capabilities in practice, and the framework needs to work to ensure it does not promote stereotypical assumptions in learning.

When discussing teaching approaches, conversations were seen as an important way to share knowledge. The value of building reciprocal relationships between students and key educational stakeholders was raised. Indigenous ownership and leadership of the curriculum was discussed as being important. Indigenous governance can work to minimise racially driven narratives in curricula and can begin to identify and address hidden and informal teaching and learning activities that do not align with the values and goals of the Indigenous health curriculum.

Having safe spaces to ask questions without burdening patients was discussed as important. Having your worldview both brought forth and challenged was seen as important in Indigenous health education and in developing cultural capabilities. Being able to self-reflect in a critical manner was discussed as an important skill to foster when exploring one's own positioning and worldview critique.

All of this is critical considering the point raised that Indigenous health curriculum can in some settings and institutions be an after-thought and can be under-resourced so that staff responsible burn out, and the curriculum becomes unsustainable. This can be reflected in a totality of effort of a range of contributors towards the curriculum and the necessary relational and physical structures in which the curriculum is delivered.

There was a conversation and written commentary regarding bridge building and jigsaw solving. How do we figure out how we can work together in a complementary way?

This requires an important reflection point as an educator – how do you foster strong, reciprocal relationships with your students? How can this be done effectively?

Assessing Indigenous health

Assessment was seen as a fundamental component to the Indigenous health curriculum by all workshop representatives. It was also seen as a very difficult area to assess.

Assessment is expected by students, and when it does not occur in an integrated and aligned way, this can potentially devalue the curriculum. There was seen to be a place for both formative and summative assessment, so that students could participate in the assessment in an honest and authentic way without fear of failure.

The need to support students through the complexities of group work was raised. Disengagement and disinterest can be seen to impact on the experience of group assignments. Assessment needs to be fairly weighted for amount of effort, and considerations around highly engaging material is important.

The ability of curriculum and assessment to be authentic and not faked was discussed, whereby the students share of true reflection of their thoughts, skills and experiences as opposed to performing in a manner that is desired by the assessor. Assessment that encourages critical reflection was raised as important. Curriculum and assessment needed to be engaging and seen to be worthy and valuable for the weighted grade allocated.

Indigenous representation is needed in determining capabilities. A reciprocal approach to involving Indigenous peoples in assessment and teaching is needed, and people involved need to be remunerated in a fair and appropriate way.