Part 1: We need to close the gap in education to "close the gap"

Feb 17, 2018 | 0 | Indigenous Australians,indigenous health,Medical education,rural and remote ...

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What is 'the gap'?

Most Australian doctors know about 'the gap' between Indigenous and non-Indigenous Australians – the shortened life expectancy, poorer health outcomes and higher rates of chronic disease. But the gap is more than this; extending to the ongoing effects of colonisation, the intergenerational trauma and the lack of sufficient culturally safe clinical environments. These issues are often not discussed with our training doctors. There is a deficit in Indigenous health education and Indigenous health placements, both of which are crucial to 'Closing the Gap'.

I could go into detail here to quantify the gap – differences in life expectancy, poor educational attainment, poor living conditions and high rates of lifestyle-associated disease such as diabetes, cardiovascular disease, substance abuse and childhood infections. But this is common knowledge. We know the what, to some degree we know the why, now we need to talk about the how. How do we start reducing it?

Cultural training for closing the gap

Part of the solution starts in adequately training our future health professionals. Culturally safe environments are key, but I can hear you asking, what does that mean? How do we go about creating that? The focus of most cultural training is cultural awareness, or 'a sensitivity to the similarities and differences that exist between two different cultures, and the use of this sensitivity to facilitate effective communication with members of another cultural group' [1].

Ideally, this would start in training, in medical schools and education of other health professions. There should be sufficient education and preparation on appropriate and respectful interactions with Indigenous patients through teaching, complemented by relevant clinical experience, including placements in services and communities with significant Indigenous populations [2]. Appropriate education raises awareness regarding the holistic approach to the health of Indigenous people and facilitates reflection of one's own cultural background, biases and potential underlying stereotyping and racism [2].

Awareness of Indigenous health issues can be achieved through sound education and placements but awareness is not always translatable to the skills required to communicate in an effective and appropriate manner. In part, this may be due to 'symbolic violence' (Bourdieu, 2002: in Durey, 20103). Symbolic violence refers to the systemic discrimination that occurs when White Australian dominance, through ways of thinking and acting, is unquestionably accepted and underlying power relationships are

masked. This can often result in indirect subordination, which is by definition not pre-meditated or intentional.

Cultural training & policies are needed

You can ask any Australian and they can tell you that Aboriginal people are disadvantaged, have poorer health outcomes and higher rates of unemployment. But what many of these individuals will fail to do is turn the lens on themselves and consider the advantages that being non-Indigenous has afforded them. This ignorance masks the more subtle acts of racism that are part of daily life for minorities [3]. Even subconscious negative stereotypes may encourage marginalisation, translating to disenfranchisement, neglect and poor healthcare experiences [4].

To combat this within the healthcare system there needs to be adequate cultural sensitivity training and policies promoting cultural respect with clear guidelines for implementation. The Indigenous health education included in medical school curricula still takes the form of uninspiring lectures and superficial assignments. The negative attitude towards Indigenous health education extends into employed health professionals. For instance, in New South Wales, despite efforts to increase education, only 41,949 NSW Health employees completed face-to-face Aboriginal cultural training since its implementation in 2011 [5]. There are currently over 100,000 working for NSW Health, over 15 local health districts.

Two major flaws in medical education

There are two predominant flaws in current medical education that limit integration of cultural training and understanding. Firstly, despite Indigenous health being mandated as part of the core curriculum by the Australian Medical Council (AMC) for medical school accreditation, Indigenous health education remains poor and clinical placement opportunities are lacking. Through my medical school career, I was required to self-initiate the most rewarding clinical experiences in services and communities with significant Indigenous populations.

The second flaw is the fact that cultural awareness programs often focus primarily on the individual, in this case medical students or health workers, without incorporating the system in which the individual is working [2]. This leaves disjointed systems with no consistent evaluation to ensure good practice. More than several individuals are required to remodel a system. The rhetoric needs to change and a cultural change across the profession needs to start from the bottom up. Today's students are tomorrow's practitioners. The policy approach to Indigenous health would benefit from the addition of a grass-root approach in addition to the more traditional top-down approach. We need to modify people's perceptions, behaviours and thought patterns to ultimately change the system.

From my own experience in medical school, Indigenous health learning activities lacked student engagement, limiting their utility and impact. We need to teach better and engage our medical students.

The importance of clinical placements for closing the gap

An immersive clinical experience is key to clinical engagement. We have good data that shows that rural clinical placements increase intention to practice rurally, both for medicine and other health care professions [6, 7]. The quality of these placements is a significant contributing factor to future workplace choice [8]. There is limited data on the impact of placements in communities with a large Indigenous population, however, a study of student nurses who undertook placements in Indigenous communities demonstrated Indigenous-focused placements [9], students who participated in this clinical experience found it an enriching experience, developing a greater understanding of Aboriginal health issues and how to better and more appropriately engage with Aboriginal patients [9].

We need a 'culturally secure' healthcare system [2]. This includes a robust health policy, improving behaviours and attitudes of practitioners within the health care system, including relationships between professionals, individuals and the community. We need a way to educate healthcare workers in cultural sensitivity and motivate them to change their behaviours, recognising ingrained and unintentional biases.

But how do we create this type of environment? Identifying the issues allows change to be set in motion. In Part 2, I will explore the possible interventions to improve our understanding of Indigenous communities, health and patients.

Related Blogs:

- Part 2: Closing the 'gap' in medical education

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