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The Indigenous Health Agenda in Medical Education

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Abstract

This thesis describes the indigenous health agenda as a unique landscape located within the wider field of medical education. The indigenous health agenda offers medical educators the opportunity to contribute to indigenous health and wellbeing. The thesis reviews the commitments of medical schools in Aotearoa New Zealand and Australia to the indigenous health agenda and asks how these commitments are currently being enacted and can best be realised in future. The research identifies an indigenous rights to health approach as under-utilised and potentially beneficial. Using Kaupapa Māori methodology a research study consisting of thirty-two semi-structured interviews (28 individual, two joint, and two focus group interviews) was undertaken across two research phases. In Phase One, key informant interviews were conducted to gain insight into stakeholder perceptions of medical school commitments to the indigenous health agenda. In Phase Two, a case study was carried out at The University of Auckland Faculty of Medical and Health Sciences, in which key informants discussed the relevance and potential applications of Phase One findings. Thematic analysis was used to encode and order data. Study findings establish the viability of a rights approach, and bring into focus drivers of the indigenous health agenda, obstacles to the indigenous health agenda, and strategic pathways for the indigenous health agenda. The indigenous health agenda is redefined as building a strong indigenous presence in medical schools via four strategic pathways - indigenous knowledge and information, indigenous process and practice, indigenous personnel, and indigenous resource base - and transforming institutions to enable that presence to have impact. When the four strategic pathways are applied across the domains of clinical teaching and learning, cultural understanding and critical awareness, community relations, and indigenous leadership and organisational autonomy, a 4 X 4 table of the indigenous health agenda is developed. The indigenous health agenda is then understood to consist of ends, means, and motives. The ends are to reduce indigenous health inequities and contribute to indigenous health and wellbeing. The practical means are to develop indigenous presence within and across pathways and domains in medical education. The motives are human rights to health and more specifically and powerfully, indigenous rights to health. Developing each facet of the indigenous health agenda is a task still to be achieved, as is mastering the complex dynamics of equitable partnerships between medical schools and indigenous communities, and between indigenous leaders and their non-indigenous allies. Even so, the thesis predicts a bright future for better understanding and further practical developments of the indigenous health agenda in Aotearoa New Zealand and Australian medical schools.

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Acknowledgements

Ehara tāku toa i te toa takitahi, engari he toa takitini

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Abbreviations

AIDA – Australian Indigenous Doctors Association

AMC – Australian Medical Council

ATSIC – Aboriginal and Torres Strait Islander Commission

CANZUS – Canada, Australia, New Zealand and Australia

CDAMS – Committee of Deans of Australian Medical Schools (former name of MDANZ)

CRT – Critical Reflection Tool

HRC – Health Research Council of New Zealand

ICIHRP – International Collaborative Indigenous Health Research Partnership

KMT – Kaupapa Māori Theory

KMM – Kaupapa Māori Methodology

KMR – Kaupapa Māori Research

LIME – Leaders in Indigenous Medical Education

MAPAS – Māori and Pasifika Admissions Scheme

MDANZ – Medical Deans of Australia and New Zealand

MOUs - Memoranda of Understandings

MOAs – Memoranda of Agreements

NHMRC – National Health and Medical Research Council of Australia

THENet – Training for Health Equity Network

WGIP – United Nations Working Group on Indigenous Populations

Glossary of terms

Aotearoa	New Zealand
hapū	sub-tribe; the level at which social relationships were mostly transacted in pre-contact Māori society
hauora	Māori concept of holistic health
iwi	tribe
kai	food
kanohi ki te kanohi	face-to-face
kaumātua	esteemed elder of either gender
Kaupapa Māori	the philosophy and practice of being Māori
mana	power or influence derived from legitimate authority
manaaki	forms of generosity that enhance the mana of all those involved, e.g. providing hospitality
Māori	Indigenous peoples of Aotearoa
Pākehā	non-Māori, non-Pasifika New Zealander
Te Ao Māori	the Māori world
te reo Māori	the Māori language
Te Tiriti o Waitangi	The Treaty of Waitangi
tikanga	culturally correct way of doing things that is contextually determined
tino rangatiratanga	self-determination, sovereignty
whakawhanaungatanga	the process of identifying, maintaining or forming past, present and future relationships
rūnanga	administrative or governing body of hapū or iwi in Aotearoa New Zealand
whānau	extended family

Preface

As a Māori woman and a Māori public health graduate, my interest in how the health system can be altered and improved to more effectively support Māori health and wellbeing has underpinned all of my research efforts to date. My interest in medical education that can contribute to Māori health and wellbeing began while I was tutoring core courses in the Bachelor of Health Sciences degree at The University of Auckland. I became increasingly aware of the importance of a holistic foundation in Māori health for all health professional students, especially medical students, considering the relative power of medical professionals in health care settings. Part of our consciousness-raising as Māori has been to recognise common ground with other indigenous peoples and struggles worldwide. Given the similarities of this struggle across indigenous contexts, it seemed evident to me that the same principles of a holistic foundation would apply to medical education in other countries. This led me to consider medical education in an international context. How can indigenous health and wellbeing be improved and indigenous suffering be alleviated through medical education? Initially, the literature on social accountability seemed to offer a way forward. Medical educators were articulating the need for community engagement beyond the institution and profession, to partnership with communities themselves, of whom indigenous communities would surely be a part. It seemed plausible that the social obligation of medicine to communities themselves in the service of health equity could focus attention on indigenous health inequities in a useful way. However, what was notably missing from the social accountability literature were indigenous voices. Given the importance of partnership with communities, where was the community voice of indigenous peoples and an indigenous view of social accountability in medicine and medical education? From an indigenous perspective, the dynamics of colonisation and the need for decolonisation are central to any discussion of social accountability. This poses a major challenge. To decolonise medical education involves a dramatic transformation. This is asking medical schools to accomplish a task that society as a whole has yet to undertake, let alone achieve. On the one hand this seems entirely appropriate and called for; on the other, so ambitious a task seems nearly impossible at a practical level. So, what would lay the groundwork for this much-needed culture shift that could make partnership with indigenous communities a reality and not just a distant aspiration? What would support indigenous voices and empowerment in the medical education space?

A review of the literature on indigenous voice and power within medical education settings suggested a growing awareness of the importance of placing indigenous rights to health at the

centre of such discussions. This opens the space for indigenous voices to be heard and potentially, for indigenous health empowerment. The recognition of indigenous rights to health means acknowledgement of equitable partnership. Equitable partnership entails a reciprocal relationship with expectations, obligations and responsibilities on both sides. In making commitments to support indigenous rights to health, medical schools open themselves to the community partnerships to which socially accountable medical education aspires. Medical schools in Aotearoa New Zealand and Australia have begun making these commitments. However, these commitments currently exist mostly as statements of principle, whose pathways to realisation have only just begun to be specifically determined. How these commitments could best be fulfilled in medical schools in Aotearoa New Zealand and Australia is the focus of this research.

Chapter One: Medical education and indigenous health inequities

Introduction

The gap between the health and wellbeing of indigenous and non-indigenous peoples around the world is widely known and well documented (Anderson et al., 2016; Dew, Scott, & Kirkman, 2016; Valeggia & Snodgrass, 2015). Indigenous peoples worldwide experience significantly poorer social and health outcomes than their non-indigenous counterparts (Axelsson, Kukutai, & Kippen, 2016; King, Smith, & Gracey, 2009; Kirmayer & Brass, 2016). In Aotearoa New Zealand, the life expectancy gap between Māori and non-Māori is between 7-10 years (Whitinui, 2011). In Australia, the life expectancy gap between Indigenous Australians and non-indigenous Australians is at least 10 years, while Indigenous Australian children are five times as likely to die before the age of 5 as other Australian children (Anderson et al., 2016; Dew et al., 2016). These statistics equate to a staggering amount of human suffering, a burden of ill health referred to throughout this thesis as indigenous health inequities. Indigenous health inequities and the wider group of social disadvantages to which these health inequities belong, most notably poverty, are the final common pathway of a range of structural and systemic factors. Enduring legacies of colonisation not only account for these factors historically but also continue to maintain indigenous structural and systemic disadvantage in the present (Kirmayer & Brass, 2016).

This introductory chapter lays the groundwork for this thesis by providing the context in which the research topic and research question are framed. Indigenous peoples have a higher burden of disease than non-indigenous people. Medical schools have a responsibility to address this burden and how medical schools understand their obligations to address indigenous health inequities and what they are currently doing about them provide the context for this research. The ethical obligation and practical need to address indigenous health inequities more effectively is the impetus for this research. On the one hand, it is obvious that indigenous health inequities are largely governed by social disadvantage, not by the education of future health professionals. On the other hand, health professionals do contribute to the differential quality of care experienced by indigenous peoples and medical schools have a responsibility to mitigate these inequities (Australian Medical Council, 2010; Ewen, Mazel, & Knoche, 2012; Jones et al., 2010). Furthermore, medical schools are in a powerful position to contribute intellectual and physical resources to address health inequities through their role in educating and shaping the future health workforce, conducting research on health-related

issues, teaching the theory and practice of health services provision, and advocacy for indigenous health equity (Australian Medical Council, 2010; Haynes et al., 2013; Woollard & Boelen, 2012). Indeed, medical schools in Aotearoa New Zealand and Australia are expected to address indigenous health inequities, deliver indigenous medical education and have partnerships with indigenous communities and organisations (Australian Medical Council, 2012).

This thesis proposes that all medical schools in Aotearoa New Zealand and Australia have made commitments to a task that can summarised as the indigenous health agenda. The indigenous health agenda in medical education is medical schools' commitment to address indigenous rights to health by developing strong indigenous contributions and providing institutional support for those contributions to have impact, in the service of indigenous health and wellbeing. This agenda consists of multiple elements that include: the aspiration to reduce indigenous health inequities and contribute to indigenous health and wellbeing, developing equitable community partnerships, recognising indigenous values and worldviews, supporting indigenous rights, and ensuring cultural understanding, critical awareness, reflexivity and safe, equitable practice. How all of these elements fit together is the focus of this research.

The proposal that medical schools can advance the indigenous health agenda by making commitments to address indigenous rights to health may sound plausible, yet it does not tell us what indigenous rights to health are. Neither does it tell us how commitments to indigenous rights to health can advance the indigenous health agenda, or to what degree the success of the indigenous health agenda depends on a rights approach. To begin with then, this thesis suggests that indigenous rights to health can be located in the overlap between human rights to health and indigenous rights (see Chapter Three). As such, support for indigenous rights to health requires either support for human rights to health or support for indigenous rights or (preferably) both. Here, it may be useful to distinguish the specificity of indigenous rights to health from either indigenous rights in general, or human rights to health in general. This thesis further suggests that commitments to indigenous rights to health can advance the indigenous health agenda by developing practical action steps that realise those commitments. What those practical action steps actually consist of awaits the results of the research undertaken in this study. Finally, the degree to which advances in the indigenous health agenda depend on a rights framework or alternatively, can be advanced without it, requires

further investigation and so awaits the results of the research undertaken in this study as well. These are preliminary considerations to be developed further throughout the thesis.

The remainder of this introductory chapter offers a reflection on my positionality as an indigenous woman and Māori researcher and brings to light some of the fundamental perspectives and core assumptions that helped to shape this study. Next, the context of this study is outlined, followed by a brief discussion of the organising concepts used in this thesis. This is followed by a description of the study itself and some of the principal terms used throughout the thesis. The chapter concludes with a brief summary of subsequent chapters.

Researcher Position

>*Ko Hikurangi tōku maunga*
>
>*Ko Waiapu tōku awa*
>
>*Ko Horouta tōku waka*
>
>*Ko Pine Amine Poutu rātou ko Te Ataarangi Tukino Poutu, ko Te Oporoporo Tukino Poutu ōku tipuna*
>
>*Ko Tuwhakairiora tōku hapū*
>
>*Ko Ngāti Porou tōku iwi*
>
>*Ko Jonathan Fay tōku pāpa*
>
>*Ko Margaret Poutu Morice tōku māmā*
>
>*Ko Hemi Cumming tāku hoa rangatira*
>
>*Ko Anna Poutu Fay tōku ingoa*

I am a 31 year-old Māori woman, middle child of three with an elder brother and younger sister. I have grown up and thrived in the warm embrace of a large, unruly, close-knit Māori whānau with nine aunts and uncles and 28 first cousins. My father identifies as Pākehā and is of Irish, English and Scottish ancestry, born and raised in the USA. He has consistently nurtured my scientific interests and modelled a deep respect for empirical evidence. My mother is Māori, descended from a long line of strong Māori women. She has taught me most of my practical life skills and my strong ethic of service to others. My whakapapa is principally through my maternal grandmother and this lineage lives in me. I hold myself responsible to my people and am answerable to this felt sense of responsibility. This

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consciousness is both a privilege and an obligation; to my whānau, to the wider Māori community and to indigenous peoples worldwide. Like many Māori, I uphold a collective responsibility to address Māori needs and realise Māori aspirations. Like many other indigenous researchers, I attempt to reflect this collective responsibility in the research I undertake. In all my research endeavours, my intention is to uplift indigenous peoples and serve indigenous health and wellbeing. I do this by actively engaging in Māori principles of relationship and responsibility. I hold paramount the dignity and worth of all human beings and embrace the non-violent struggle for social change in the cause of justice. I believe that the personal is political. I describe myself as an idealist who seeks pragmatic solutions. I draw strength from the solid foundation of empirical investigation and all that it can discover. My work aims to be both theoretically sound and genuinely useful, practical tools intended for application; in this research, for use by indigenous peoples and the medical community.

A topic such as this, located at the intersection of medical education, health care and social justice, is fraught with cultural and political implications and ramifications. Institutional environments such as universities are often supportive in principle yet resistant in practice to aspirational goals that require new priorities and the re-deployment of limited resources. This is not unknown in medicine. Other social justice orientated agendas within medical education, such as social accountability, face similar challenges (see: Boelen, 2011; Boelen & Woollard, 2009; Woollard & Boelen, 2012). Although many advances have been made over the past 20 years, significant resistance inevitably arises as soon as attempts are made to implement social justice orientated aspirations within the orthodoxy of medicine and medical education. What became clear to me was that in order to progress the indigenous health agenda, there must be a way to move along the continuum from theory to action, to use what we already know and apply it more effectively. When the opportunity to carry out my PhD research as part of the Educating for Equity (E4E) project (see p. 12) arose, the idea that I might be able to explore this area across different indigenous contexts became both practically feasible, as well as theoretically challenging and exciting. Being able to explore how medical schools can contribute to reducing indigenous health disparities across both Aotearoa New Zealand and Australia has enabled a broad approach to the advancement of the indigenous health agenda; one which has potential to be applied in other indigenous settings outside of Aotearoa New Zealand and Australia. It has also identified some interesting theoretical and methodological challenges for me as an emerging researcher.

I locate myself as an indigenous researcher utilising what can be considered a 'traditional' indigenous scholarly position. That is to say, I am an indigenous researcher employing an indigenous research methodology that seeks to challenge the ongoing legacy and persistence of colonisation. I wish to make clear, however, that I am not uncritically evoking the colonised-coloniser binary. The international recognition of indigenous peoples as a legal and social identity/category, and indigeneity as a field of scholarship, represents an extraordinary achievement. To a significant extent, this is an achievement that relies on 'strategic essentialism' (Spivak, 1990). Strategic essentialism requires the simplification of indigenous identities in order to gain legitimacy and achieve its political and social goals (Hoskins, 2012). As such, indigenous peoples are sometimes considered to be bound primarily by the colonising experience. This is not the unifying feature of indigeneity, however, nor of the indigenous experience. When I speak of my experience of being indigenous, it is not the experience of being colonised that I am principally referring to, but rather, to possessing a worldview that intrinsically appreciates our deep and profound connections to one another and the Universe, and a relational orientation to others based on this understanding of interconnectedness. This is important because although inherently critical, this work strives to make clear that all peoples, both indigenous and non-indigenous, have much to offer this agenda. There is absolutely a place for non-indigenous contributions to justice for indigenous peoples. In fact, we need non-indigenous allies to engage in partnership and offer support. However, we need their support as partners and allies, not as governors or superiors. Of equal importance, I am not proposing that there are fixed positions to be assumed based on indigenous status, quite the opposite. I acknowledge the importance of more fluid, 'both/and' approaches to the indigenous health agenda, particularly in spaces where rigid 'either/or' binarised approaches are both difficult to avoid and can potentially cause conflict.

I have always believed in the power of education to ignite enthusiasm and instill a sense of purpose in those who receive it. In the medical field, this is not limited to medical students alone. It is critically important that everyone working in medicine and in health today become familiar with the realities of indigenous health status worldwide, including Aotearoa New Zealand and Australia. It is equally important that health professionals recognise their potential to contribute to the resolution of indigenous health inequities. I believe that support

for the indigenous health agenda has the power to contribute to the reduction of health inequities anywhere and everywhere that these inequities might occur.

Ultimately, Kaupapa Māori (see p. 11) approaches to research give primacy to defining best practice in Māori terms, and using this primacy to practical effect to benefit Māori communities. In this research, this primacy is used to practical effect to benefit all indigenous peoples across Aotearoa New Zealand and Australia. The strategic essentialism used here reflects my understanding of the unanimity or common purpose of indigenous peoples, rather than a false notion of indigenous uniformity or interchangeability. Thus, from the very outset, this research was guided by my worldview and by my personal commitment to justice for indigenous peoples everywhere.

Setting the scene: Indigenous health and medical education in Aotearoa New Zealand and Australia

This research began with an interest in how medical education can contribute to reduce indigenous health inequities and contribute to indigenous health and wellbeing. Initially, the focus of this research was on how the teaching and learning of health equity in medical school could influence more equitable health care delivery. The overlap between cultural competency and indigenous health curricula in medical education in Aotearoa New Zealand and Australia (see: Ewen, 2012), as well as the legacy of Irihapeti Ramsden, a Māori nurse internationally known for her development of the educational framework of cultural safety (see: Ramsden, 1993), led to a consideration of how best to teach cultural self-understanding and cultural self-awareness. Cultural self-understanding is the recognition, appreciation and understanding of personal origin and unique cultural heritage, while cultural self-awareness encompasses the awareness of both one's own culturally determined attitudes and biases and one's attitudes and biases towards people from other cultures. What was envisaged was a contribution to the discourses of cultural humility and cultural safety in medical education that was specifically focused on indigenous health and would potentially empower and inspire medical students to contribute to indigenous health equity through consciousness-raising and the development of reflexive awareness. However, while exploring these ideas, other approaches to consciousness-raising regarding health equity in medical education came into focus, some of which focused specifically on indigenous health inequities, but many of which were grounded

in Hippocratic values and medicine's historical commitment to social justice (see: Woollard, 2006; Braveman, 2006; Sandhu, Garcha, Sleeth, Yeates, & Walker, 2013).

Medicine and medical education have always had to negotiate social justice issues pertaining to health. This led me to the forward edge of how indigenous health inequities are currently addressed within a western paradigm in medical education. At the forward edge of addressing health inequities through western medical education, is social accountability in medical education. In recent years, social accountability in medical education has emphasised the aim of equipping medical students to be 'change agents'(Murray, Larkins, Russell, Ewen, & Prideaux, 2012). Social accountability in medical education denotes the obligation of medical schools to take action through education, research and service activities on the health priorities of the community, region and nation they have a mandate to serve. These health priorities are jointly identified by stakeholders such as governments, health care organisations, health professionals and the public (Boelen & Heck, 1995). For medical schools located in countries with indigenous populations, this includes the health priorities of indigenous communities (Murray et al., 2012). Community-engaged medical education has been cited as a means to meet the social accountability aspirations of medical schools (see: R. Strasser et al., 2015; R. P. Strasser et al., 2009).

However, the culture of medicine and medical education may be understood to contribute to the development of better health outcomes but also to impede their development. While it may not be easy to recognise or challenge those policies and procedures of the medical status quo that impede health equity and contribute to health inequity, these do need to be recognised and challenged(Wear, 2003). Socially accountable medical education is no exception to this. Social accountability in medical education has much to recommend it, but ultimately, fails to acknowledge the degree to which the culture of medicine itself unwittingly replicates a colonising agenda in relation to indigenous peoples. A needs-based service ethic, however noble its intentions, leaves little space for the self-determination of indigenous populations. In other words, the interface between indigenous health and wellbeing and the culture of western medicine needs to be appreciated as a site of struggle. Like any other culture, the culture of medicine and medical education is conceived of as a dynamic and evolving set of relationships, roles and rules, norms and values.

This thesis contends that indigenous health inequities are, in part, manufactured and maintained in the intersection and interaction between the culture of medicine and medical education, lack of awareness of social injustices, and lack of commitment to social justice in the health arena. The social injustices responsible for producing indigenous health inequities specifically include a lack of commitment to honour indigenous rights to health. Democratic western ideals of social justice have always been an important part of western medicine and medical education and many key figures in medicine have argued and continue to argue passionately for fair and equitable medical service, research, teaching and training. However, to date, medicine's implicit commitments to ideals of equality and fairness have neither generated support for indigenous rights to health nor resulted in the reduction of indigenous health inequities (Phillips, 2015). Indigenous rights to health could therefore be considered a relatively neglected sector of social justice in medicine and medical education. When considered from this standpoint, it is not surprising that indigenous health inequities have proven so resistant to improvement (see: Chino & DeBruyn, 2006; Mitrou et al., 2014). The challenge to the culture of medicine and medical education to provide adequate remedy for indigenous health inequities, then, includes the challenge to demonstrate commitments to indigenous rights to health and offer support and partnership for indigenous rights-orientated health initiatives in health services, health research and medical training and education.
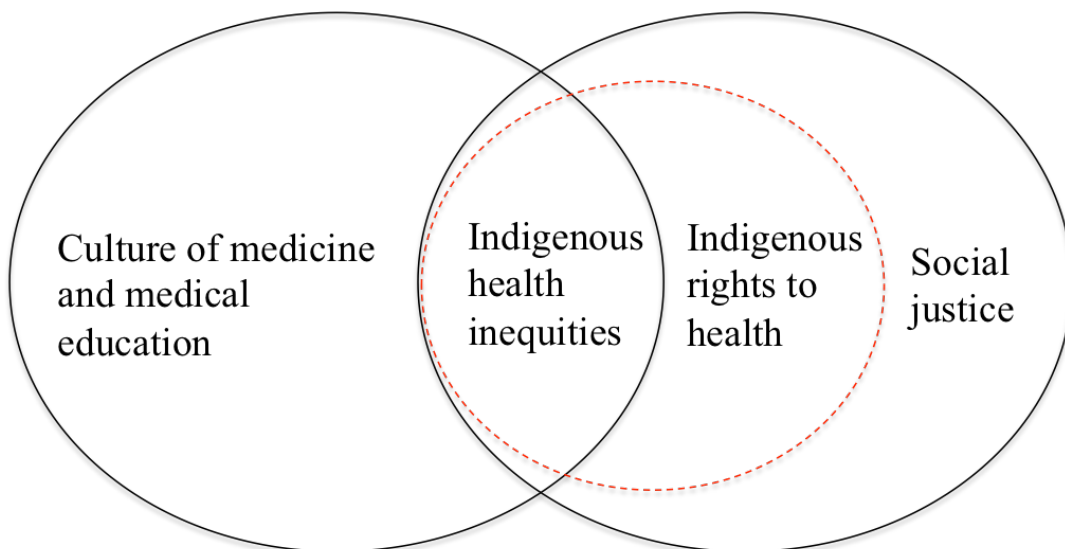
Figure 1: The intersection of indigenous rights to health and medical education

Figure 1 above is a simplified model of the intersection of the culture of medicine and medical education and social justice. While indigenous rights are not entirely subsumed by the social justice agenda, social justice has always been part of the medical agenda, hence the overlap or intersection of the two circles showing their close connection to each other. However, as indicated by large areas outside of their intersection, there are also many parts of the social justice agenda that have not yet been taken up by medicine or medical education, and many parts of medicine and medical education that have little or nothing to do with social justice. Indigenous rights to health are shown as a sector or subset of social justice. Many but not all of these rights have to do with medicine and medical education. Indigenous rights to health include the reduction of indigenous health inequities, which are located as issues of concern for medicine and medical education. These are also within the purview of social justice generally and indigenous health rights specifically, positioning indigenous health inequities as (1) a medical issue, (2) a human rights issue, and (3) an indigenous rights issue.

The study: Medical education that contributes to indigenous health and wellbeing and supports indigenous rights to health

This research is conceptualised as building on the strengths of the current commitments to the indigenous health agenda made by medical schools across Aotearoa New Zealand and Australia. As such, this research is located at the interface between indigenous rights to health, the injustice of current indigenous health inequities, and western medicine and medical education's responsibility to reduce indigenous health inequities and contribute to indigenous health and wellbeing in Aotearoa New Zealand and Australia. Given the outline and rationale provided above, the overarching research question is: How can medical schools in Aotearoa New Zealand and Australia best fulfil their commitments to addressing indigenous rights to health in the service of reducing indigenous health inequities and contributing to indigenous health and wellbeing? This question has three sub-questions:

1. What are Aotearoa New Zealand and Australian medical school commitments to the indigenous health agenda?
2. How are these commitments currently enacted?
3. How can these commitments best be realised in future?

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Overcoming indigenous health inequities is both an urgent health needs issue and an indigenous rights priority. This research takes the normative position that the medical profession and medical education have specific roles and responsibilities in the realisation of the right to health equity for indigenous peoples. This position is supported by an extensive research literature that documents medical schools' capacity to address indigenous health inequities by increasing the indigenous health workforce and producing a medical workforce that can contribute to improving health outcomes for indigenous peoples (see: Australian Medical Council, 2012, Curtis, Reid & Jones, 2014; Ewen et al., 2016). However, even when this capacity for a positive contribution is recognised, conceptual and practical challenges remain about how to fulfil these responsibilities within medical school contexts. If medical schools have already begun to make commitments to reducing indigenous health inequities, and are supportive of indigenous rights to health in principle, how might these commitments be better understood and more effectively enacted in practice? How can medical education 'walk its talk' with regard to indigenous rights to health equity? What specific changes to medical education and training will be needed to improve indigenous health outcomes and support indigenous rights to health and wellbeing?

This thesis explicitly identifies indigenous health inequities as a rights issue that must be addressed through commitments to indigenous rights to health in Aotearoa New Zealand and Australia. It calls for the commitment of medicine to support indigenous rights to health in all facets of medical education, including the formal curriculum, informal practices, and institutional arrangements. These commitments provide a context for the development of partnership relationships based on shared power and shared authority between medical institutions and indigenous peoples and communities, aimed at improving indigenous health outcomes. If support for indigenous rights to health can contribute to the indigenous health agenda in the service of reducing indigenous health inequities and contributing to indigenous health and wellbeing, then the question of how medical schools in Aotearoa New Zealand and Australia can best fulfil their commitments to addressing indigenous rights to health turns out to be a critically important question. Accordingly, this research aims to:

1. Explore how commitments to address indigenous rights to health could be more effectively demonstrated through medical education. This aim will be met by gathering key informant perspectives on medical school responsibilities to address the

indigenous health agenda and the role of an indigenous rights to health framework in medical education in Aotearoa New Zealand and Australia.

2. Synthesise these perspectives to formulate specific action steps by which medical schools might fulfil their commitments to indigenous peoples' rights to health.

3. Consider the relevance and application of these findings in a case study of the University of Auckland Faculty of Medical and Health Sciences.

Kaupapa Māori methodology

Kaupapa Māori methodology, defined in Chapter Four, provides the theoretical 'lens' for this study. In Aotearoa New Zealand, Kaupapa Māori research (KMR) is a central orientation and approach for many Māori researchers, particularly in the fields of education and health (Smith, 2012). Underpinning KMR is Kaupapa Māori Theory (KMT). Although KMT has multiple and varied definitions, it is widely acknowledged that the development and evolution of KMT originated as a response to the political, cultural, and economic marginalisation of Māori and persistent power imbalances in Aotearoa New Zealand. Furthermore, KMT is "an assertion of the right for us to be on our own terms and to draw from our own base to provide understandings and explanations of the world" (Pihama, 2010 p. 11). This statement references Kaupapa Māori itself, often described as "the philosophy and practice of being Māori" (Smith, 1992, cited by Bishop, 1998, p. 201). 'Being Māori' in this very full sense includes immersion in the worldview and experience of Te Ao Māori; an indigenous ontology in which concepts such as balance, reciprocity, and relationship are key to our understanding of the universe. Kaupapa Māori, defined in this way, will always be much more broadly conceived than any particular theory, research or method. In other words, both theory (KMT) and research (KMR) are particular applications of Māori kaupapa. Kaupapa Māori Theory guides and informs KMR, but can independent of it in the sense that KMT also guides many other forms of practice that may not include research, for example educational programmes and policy. However, the relationships between these concepts are dynamic and evolving, with KMR informed by and at times informing KMT. The term Kaupapa Māori methodology is used in this research to describe the particular framework used for this thesis.

Educating for Equity (E4E)

This research was carried out as part of the Educating for Equity (E4E) project. The E4E project is a multi-staged action research project. Educating for Equity seeks to share, compare, and build international capacity to develop new and positive approaches to the health and wellbeing of indigenous peoples through education of health care professionals who work with indigenous peoples. The project is supported by the International Collaborative Indigenous Health Research Partnership (ICIHRP) and includes partners in Canada, Australia and Aotearoa New Zealand. The Health Research Council of New Zealand (HRC), and the National Health and Medical Research Council of Australia (NHMRC) likewise support the E4E project. Being part of the E4E project presented a unique opportunity for a Joint PhD to be undertaken with a co-investigator of E4E at a partner institute. A trans-Tasman partnership offered a systems rationale, as all medical schools in Aotearoa New Zealand and Australia are accredited by the Australian Medical Council (AMC). Thus, this research has been undertaken as part of Joint PhD with The University of Auckland as the lead institute, and The University of Melbourne as a partner institute. The theoretical and methodological implications of carrying out Joint PhD research that is grounded in Kaupapa Māori methodology is explored further in Chapter Four.

Organising concepts used in this thesis

Indigenous rights

Indigenous rights refer to the rights of indigenous people to determine their own destiny and to retain or obtain an equitable share of natural and other resources. The history of colonisation is a history of indigenous struggle; rights denied, promises not kept, treaties broken, grievances unaddressed, protests ignored, and reparations yet to be made (Morgan, 2011). Indigenous peoples' struggle for social recognition and social justice might be considered a necessary and appropriate response to a history of colonisation that is still ongoing; loss of land, loss of language, loss of traditional ways of life, and a host of deleterious consequences associated with these losses (Kenrick & Lewis, 2004; Morgan, 2011). The United Nations Draft Declaration on the Rights of Indigenous Peoples (UNDRIP) asserts the right of indigenous peoples to protect and maintain control over their property, possessions, practices and knowledge, as well as representation, recognition and resources with which to address systematic and persistent dispossession and discrimination (Havemann, 1999; Hodgson, 2002;

Morgan, 2011). The UNDRIP also explicitly cites the relationship that treaties and agreements formalise as a "basis for a strengthened partnership between indigenous peoples and the State(s)" (UNDRIP, 2008, p. 3).

Formally adopted in 2007, the UNDRIP contains 46 articles covering the "inherent rights of indigenous peoples which derive from their political, economic and social structures and from their cultures, spiritual traditions, histories and philosophies, especially their rights to their lands, territories and resources" (UNDRIP, 2008, p.2). Furthermore, the UNDRIP affirms the "fundamental importance of the right to self-determination of all peoples, by virtue of which they freely determine their political status and freely pursue their economic, social and cultural development" (UNDRIP, 2008, p.3). The UNDRIP also makes explicit that in the exercise of these rights, indigenous peoples should be free from discrimination of any kind.

The past 40 years have seen the emergence and growth of varied and diverse indigenous rights movements throughout the world (Mazel, 2009; Morgan, 2011; Thornberry, 2002). The expansion of these movements has simultaneously been a local and a global phenomenon, the product of the success of groups of indigenous peoples strategically representing and promoting their own identities to defend rights, mobilize resources, and advance certain political, economic, and cultural agendas. The emergence of international indigenous rights coalitions and networks has enabled indigenous peoples to assert and lobby for indigenous interests worldwide and raised contentious issues such as the legal status of indigenous intellectual property and/or economic compensation for the collection, appropriation, and use of indigenous resources (Oldham & Frank, 2008). But indigenous rights movements seek more than reparation and recompense; they also actively seek to develop partnerships by which indigenous people might realise their aspirations to build a positive future on their own terms (Durie, 2004). As Durie (2004) notes: the UNDRIP looks "forward as well as backward and [is] as much about development as restoration" (Durie, 2004, p. 5).

Within Aotearoa New Zealand Te Tiriti o Waitangi (Te Tiriti) is acknowledged as the founding document of Aotearoa New Zealand. Drafted in 1840, Te Tiriti is a prime example of the treaties and agreements referred to in the UNDRIP (UNDRIP, 2008). Te Tiriti o Waitangi is a formal proposal by British Crown authority to engage with the indigenous peoples of Aotearoa New Zealand. Three specific articles in Te Tiriti formalise a relationship

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of partnership between Crown and indigenous (chiefly) authority; protect indigenous rights and resources, and; offer the rights and duties of citizenship to ensure indigenous participation in civil society. Te Tiriti has often been cited as an exemplar of how governments might engage with their indigenous peoples in a meaningful relationship of reciprocal expectations and obligations in which respect for the autonomy and self-determination of both parties is protected and preserved (Whitinui, 2011). Contrasting with the Māori experience in Aotearoa New Zealand, Aboriginal and Torres Strait Islander peoples' pan-tribal political organisation has been inhibited by the vastness of Australia (Havemann, 1999). While Aboriginal and Torres Strait Islander peoples' rights can be found in some Commonwealth and State land rights legislation, there are no treaty-based rights embedded in the Australian Constitution (Anderson et al., 2006; Havemann, 1999).

However, despite the existence of Te Tiriti, Māori rights are systematically undermined and denied at government level. The UN's Special Rapporteur considers that New Zealand's human rights legislation currently does not provide sufficient protection mechanisms regarding the collective rights of Māori that emanate from Article Two of Te Tiriti (United Nations, 2006). While Māori rights are enshrined in Te Tiriti, there is no entrenched constitutional recognition of Te Tiriti, or of Māori rights, in the unwritten constitution of Aotearoa New Zealand (Havemann, 1999). Despite this, Te Tiriti remains a unique document with the potential to provide a moral and ethical foundation for a bicultural society.

As this thesis takes a Kaupapa Māori approach, Te Tiriti is considered to be a blueprint for partnership at the State level, as well as for partnership in health. This does not enshrine a fixed or uniform relationship between Māori and the State. Rather, Te Tiriti is a living document. It offers the potential for continuing commitment, challenge and encounter which allows "contingent agreements [to be] made for differential constitution of shared social and political spaces in the local and lived contexts of people's lives" (Hoskins, 2010, p.3).

Human rights to health

The right to health, as defined by the World Health Organisation (WHO) Constitution, is the right to "the highest attainable standard of health" (World Health Organisation, 1948). Braveman & Gruskin (2003) propose "that the right to health can be operationalized as the

right of all social groups to attain the level of health enjoyed by the most privileged in society"
(Braveman, 2006, p.184). This is not to be confused with the right to be healthy, but rather:

> the right to a system of health protection which provides equality of opportunity to
> enjoy the highest attainable level of health… [this] includes the right to equal access to
> cost-effective medical care as well as to child care, education, housing, environmental
> protection, and other factors that are also crucial to health and wellbeing (Braveman et
> al., 2011, p.50).

This is underpinned by the consideration of all human rights as interconnected, making the
right to health inseparable from the right to a reasonable standard of living and education, as
well as freedom from discrimination and the autonomy to fully participate in society
(Braveman & Gruskin, 2003; Hunt, 2006). Human rights principles offer a universal frame of
reference that defends the need for affirmative action or positive discrimination to remedy
historic disparities that adversely impact health and health care (Braveman, 2006).

However, the use of an aspirational human rights framework and the symbolic power of
human rights discourse in international law has had a very limited impact on indigenous
peoples' health status in practice. Governments regularly refuse to redress past grievances and
often perpetuate new forms of inequity, creating further barriers to the realisation of
indigenous rights to health (Gray & Bailie, 2006). Even when international health policies
uphold human rights to health, "indigenous peoples [worldwide] might continue to be ignored
[by international health policy] simply because they do not fit into the predominant lens of
public health utilitarianism that has predominated in the creation and action of health policy"
(Stephens et al., 2006, p. 2026; Gray and Bailie, 2006).

Human rights discourses refer primarily to the rights of individuals and the relationship
between individuals and the State. The individual is assumed to be the basic social unit.
Unfortunately, this individualistic assumption means that the conception of human rights will
not match up with our social reality as human beings (Jones, 1999). The concept of collective
rights challenges and extends the traditional liberal paradigm of human rights. Human rights
are usually framed as universal in nature, but are generally assumed to belong to individuals
rather than communities. Understood as individual entitlements, universal human rights do not

easily translate into the collective orientations and communal concerns prioritised within indigenous contexts (Hodgson, 2002; Thornberry, 2002).

The UNDRIP (UNDRIP, 2008) attempts to address some of the complexities of the tension between individual and collective rights, by affirming that indigenous peoples are equal to all other peoples – as individuals – while at the same time entitled to collective rights specific to their indigenous status. Critics of the usefulness or validity of indigenous-specific rights often argue that there is no justification for specific rights for indigenous groups. They claim that universal human rights principles and existing international law are sufficient for all human beings – and all groups of human beings (Thornberry, 2002). However, this claim asserts the importance of equality as an abstract principle without providing for the conditions of equity that would make this equality possible. Any serious proposal for future equality cannot afford to ignore the principles of equity, or equality in diversity, a diversity that for indigenous peoples includes a specific history of extreme discrimination and spiritual and material dispossession in their own land. Not only have indigenous peoples faced these conditions in the past, they continue to face the ongoing consequences of discrimination and dispossession today (Kenrick & Lewis, 2004; Mazel, 2009).

For these reasons, while indigenous peoples are often grouped together with other minorities and underserved populations, the experience of being displaced and marginalised in one's own land is quite unique (Mazel, 2009). Nor is the denial of indigenous peoples' rights to self-determination limited to past injustices. Colonising policies and practices endure in the ongoing and persistent pressure to force cultural assimilation and to deprive indigenous peoples of their land rights (Kenrick & Lewis, 2004; Thornberry, 2002; Morgan, 2011). Collective injustice and individual deprivation may be understood as cause and effect. As the representative of the Aboriginal and Torres Strait Islander Commission (ATSIC) to the eleventh session of the UN Working Group on Indigenous Populations (WGIP) in 1993 explains:

> It is precisely because the collective rights have not been acknowledged that the individual rights of indigenous persons, for example the right to equality of opportunity in the provision of education, employment and health care – have not been realised in any nation in the world. Only when our collective identities have been

recognised will the appalling disadvantages that we suffer as individuals be redressed (O'Donoghue, quoted in Pritchard, 1998).

If the proposition that historical injustices perpetrated upon indigenous collectives have generated a legacy of individual deprivation, including ill-health, is accepted, then it follows that recognition and respect for collective indigenous rights to health will over time impact at the level of individual wellbeing.

Indigenous rights to health

In this thesis, indigenous rights to health are located at the intersection of indigenous rights and universal human rights to health. Indigenous rights have become increasingly important on the political agenda and legal landscape in Aotearoa New Zealand and Australia, particularly in relation to land rights, sovereignty and justice. Both countries have histories of "institutional and ideological intolerance towards indigenous peoples" (Havemann, 1999, p.4). Attempts to reconfigure the unequal power distribution between coloniser and colonised in both Aotearoa New Zealand and Australia have increased in both countries over the past 40 years (Paradies, Harris & Anderson, 2008; Havemann, 1999).

Where ill health is attributable to disparities in wealth, power, privilege and prestige, the policies and practices that seek to reduce these health inequities are consistent with principles of equity and social justice (Braveman, 2006; Peter, 2001). The ethical values of distributive justice and restorative justice have often been cited as integral to the pursuit of health equity and the remediation of social disadvantage (Sanson-Fisher, Williams, & Outram, 2008). One of the ways in which basic human rights are realised is through the right to health and healthcare. Basic human rights apply to indigenous peoples as they do to all peoples. Health is generally regarded as a fundamental human right and an essential constituent of human potential (Universal Declaration of Human Rights, 1948). Health rights encompass specific principles, such as the availability, accessibility, acceptability and quality of healthcare services. Health rights for everyone includes more than the legal protection of civil and political rights to seek or access healthcare. Social and economic rights must be realised if civil and political rights are to be defended (Farmer, 2005). Legal remedies for social disadvantage may be proposed, but they in no way guarantee the action required to realise health equity. Farmer (1999) even suggests "an exclusive focus on a legal approach to health

and human rights can obscure the nature of violations, thereby hobbling our best responses to them" (Farmer, 1999, p. 1487). Rights can be understood as "powers or instruments to secure or promote individual or group interests" (Ivison et al., 2000, p. 17). This understanding challenges a focus on formal civil and political rights, precisely because political rights are emptied of their substance without social and economic power (Farmer, 2005). Similarly, an appeal to government standards of equity or human rights fails to acknowledge that state power is responsible for many if not most human rights violations. As such, this thesis does not orient itself to the legal framework of either human rights or indigenous rights. Rather, this thesis is concerned with exploring how indigenous rights to health and health care are applied and upheld in the education and training of medical practitioners in medical education in Australia and Aotearoa New Zealand. This agenda can be located within a broader struggle for health equity, which is itself a politically and socially motivated endeavour (Starfield, 2006).

Terms used in this thesis

Indigenous peoples

Indigenous peoples across the world define and name themselves in many different ways. For purposes of this thesis, indigenous peoples are persons who identify themselves as descendants of the original inhabitants of a particular geographical region. Durie (2004) describes indigeneity as pertaining to (1) the strength of collective connections to a particular landscape or portion of the natural world and (2) cultural distinctiveness. That is, indigenous peoples have a special relationship with the land and natural resources that is fundamental to their cultural identity and to their survival. Secondly, indigenous peoples have distinct social, political and cultural identities, including languages, traditions, legal and political institutions that are distinct from those of the national society with whom they share boundaries and borders.

The term indigenous is taken to be inclusive of all First Peoples (Cobo, 1986). As each indigenous group is unique in its own culture, Smith (2012) suggests that the term 'indigenous peoples' may be considered problematic insofar as it can appear to "collectivize many distinct populations whose experiences under imperialism have been vastly different" (Smith, 2012, p. 6). However, as mentioned earlier in this chapter, indigenous unanimity relates primarily to possessing a worldview that holds certain assumptions about the interconnectedness of the

social, natural and cosmic worlds. Because indigenous groups also have common ground in the experience of conquest and colonisation, the term 'indigenous peoples' as a political category has been of enormous strategic importance to indigenous rights movements, as it has "enabled the collective voices of colonized people to be expressed strategically in the international arena" (Smith, 2012, p.7). This in turn, has afforded greater collective strength to local indigenous voices, who are often minorities as well as marginalised on a global scale (Smith, 2012). The politics of indigeneity will be explored further in Chapter Three.

The term 'indigenous peoples' is an inclusive term that refers to indigenous peoples worldwide. For the purposes of this research, however, 'indigenous peoples' will also be used more specifically to refer to the indigenous peoples of Australia and NZ, the countries where the study takes place. 'Māori' is used exclusively for the indigenous peoples of Aotearoa New Zealand and 'Indigenous Australians' is used interchangeably with 'Aboriginal and Torres Strait Islander peoples' for the indigenous peoples of Australia.

Health equity

This thesis defines equity as equality in diversity. Most definitions of justice invoke standards of fair and equal treatment, but being equal does not mean having to be the same. The remediation of disadvantage creates more equality or restores more equality amongst diverse people. This is a restorative process, different from but complementary with distributive justice. The term social justice as used in this thesis is an inclusive term that refers to distributive justice, restorative justice and the remediation of avoidable disadvantage. Braveman & Gruskin (2003) put this somewhat differently, stating that "equity means social justice or fairness; it is an ethical concept, grounded in principles of distributive justice" (Braveman & Gruskin, 2003, p.254). The International Society for Equity in Health (ISEqH) definition of equity likewise recognises that health equity is inextricably linked to the struggle for social justice (Braveman & Gruskin, 2003; Anand, 2002). Zeelerer and Cunneen (2001) describe principles of restorative justice and reconciliation governing relations between indigenous communities and government. Drevdahl et al., (2001, p. 23) suggest that social justice refers to the "equitable bearing of burdens and reaping of benefits in society." 'Distributive justice' refers to the equitable allocation of societal resources, which in the context of health means health care and the key determinants of health (Braveman, 2006). 'Health justice' is the core ethical principle of social justice applied to health. It underpins the

ethical requirement to address health disparities in the service of health equity. This thesis understands the terms 'health justice' and 'health equity' to be interchangeable; both refer to the equitable distribution of healthcare resources and the remediation of unjust and avoidable inequalities in health status. As Braveman et al. (2011) articulate: "health equity is social justice in health" (p. S150).

Indigenous health and wellbeing

The term indigenous health and wellbeing refers to the health and wellbeing of indigenous individuals, but also refers to the collective health and wellbeing of indigenous families, communities, and peoples as well as people. This thesis understands health and wellbeing to encompass a broad set of holistic connections between the health of humanity and its constituent individual human beings and the health of the planet itself. As explained in the indigenous rights to health section above, indigenous peoples hold a conception of health that is grounded in the health of humanity and the planet itself. To have 'healthy' people on an unhealthy planet is a contradiction in terms. In other words, health is understood as an encompassing term pertaining to an individual's physical, mental, social, and spiritual wellbeing.

Indigenous health agenda

The indigenous health agenda in medical education refers to all actions that medical schools take to reduce indigenous health inequities and contribute to indigenous health and wellbeing across all facets of medical education. This includes the formal curriculum, informal practices, and institutional arrangements; everything that medical schools in Aotearoa New Zealand and Australia can do to contribute to indigenous health and wellbeing. The indigenous health agenda is initially described as medical schools' commitment to address indigenous rights to health by developing indigenous contributions, and providing institutional support to enable those contributions to have impact. However, once the research study was completed, it became possible to further refine this definition as medical schools' commitment to address indigenous rights to health by transforming institutions to enable indigenous presence to have impact in the service of indigenous health and wellbeing.

Summary of Chapters

This thesis has five main sections organised across nine chapters. The first three chapters comprise the theoretical context of this research, followed by the research methodology and methods; findings; discussion, and; conclusions and future directions. **Chapter One** has provided an introductory overview of key ideas, terms, and concepts that define the research agenda. **Chapter Two** discusses health equity in the context of western medical education, showing how aspirations such as social accountability, community-engagement, and cultural competence, cultural humility and cultural safety in medicine and medical education have contributed, or could contribute to indigenous health equity. **Chapter Three** discusses how medical schools in Aotearoa New Zealand and Australia currently address indigenous health inequities and why an indigenous rights to health framework is a workable and worthwhile approach. The chapter begins with a brief description of the nature of medical schools' commitments to reducing indigenous health disparities and where support for indigenous rights to health can currently be found, followed by how medical education settings can be understood as sites of struggle. The chapter ends with the framing of the research agenda, specifically the use of an indigenous rights to health approach, and a restatement of the research rationale and key research questions. **Chapter Four** presents Kaupapa Māori methodology, which offers the theoretical lens through which this research was undertaken and forms the basis of the research methods used. **Chapter Five** describes the research methods used in this study. The chapter begins with an overview of the methods, including governance and ethical approval, followed by detailed descriptions of the two research phases. **Chapter Six and Chapter Seven** present the major findings of the research thematically; these themes are depicted in a visual model at the beginning of Chapter Six to show how the themes relate to one another across the two chapters. **Chapter Eight** discusses the major contributions of this work and presents a table that combines and organises all the primary research findings, as well as an expanded visual model of the research findings. Finally, **Chapter Nine** offers a conclusion that reflects on the research questions, discusses study limitations and researcher reflections, and considers future directions.

Chapter Two: Medical education responses to the challenge of health inequities

Introduction

This chapter will explore how medical education has attempted to address health inequities, and explore how the values and principles of medical education can provide an orientation to distributive, remedial, and restorative social justice in the service of reducing health inequities. The contribution of medical education to addressing health inequities is not a new idea. Western medicine traces its origins and aspirational ideals to the Hippocratic Oath and Hippocratic traditions of holism and humanism in ancient Greece (Miles, 2004; Tountas, 2009). Inherent in the ideals of Hippocratic medicine is the ethos of service and the concept of the social contract between medicine and society. In response to the substantial and systematic health inequities that exist worldwide, medical schools are increasingly expected to educate future physicians to be socially responsible and to be held accountable if they do not demonstrate commitment to this responsibility (Abdalla, 2012; Boelen & Woollard, 2009; Sandhu et al., 2013). Likewise, community-engaged medical education and cultural competency have emerged as approaches to equipping future medical practitioners to make a contribution to the wellbeing of all populations, particularly underserved communities (Paul, Ewen & Jones, 2014; Woollard, 2006; Kumagai & Lypson, 2009). Such assertions not only echo the original holistic and humanistic service ideal to which medicine has always aspired, but represents the explicit belief in medicine as a social good and the recognition that the medical profession has a role to play in addressing the social issues that affect peoples health (see Woollard, 2006). As Frenk and Chen et al (2010) note:

> the core space of every health system is occupied by the unique encounter between one set of people who need services and another who have been entrusted to deliver them. This trust is earned through a special blend of technical competence and service orientation, steered by ethical commitment and social accountability, which forms the essence of professional work (Frenk & Chen et al., 2010, p. 1925).

The service ethic of the medical profession itself drives a number of initiatives that include an emphasis on public health, human rights frameworks, and social accountability; all of these initiatives can have a marked positive impact on the indigenous health curriculum within medical schools (Phillips, 2004; Meili, Fuller & Lydiate, 2011). Socially accountable medical

education, community-engaged medical education, and cultural competency, humility and safety could all be considered to honour a tradition of service in medicine, as well as belong to a growing number of medical education initiatives that are oriented towards social justice. All of these approaches can be effective means of addressing indigenous health inequities and advancing indigenous health through medical education. However, such approaches may also fail to advance this agenda and in certain instances may even run counter to indigenous health priorities (see: Ritz, Beatty & Ellaway, 2014; Paul, Ewen & Jones, 2014).

This chapter discusses the responses of medical education to health inequities and their relevance to indigenous health inequities. Specifically, socially accountable medical education, community-engaged medical education and the concepts of cultural competence, cultural humility, and cultural safety will be explored. These approaches have been suggested as possible ways in which medical education might address indigenous health inequities more effectively (see: Meili, Fuller & Lydiate, 2011; Strasser et al., 2015; Paul, Hill & Ewen, 2012). The chapter begins with socially accountable medical education, followed by community-engaged medical education and cultural competency. Next, a critique of these approaches is offered, identifying ways in which these approaches may be problematic in their pursuit of health equity for indigenous peoples through medical education.

Social accountability in medical education

The ideal of socially accountable medicine is as old as the Hippocratic oath (Cruess & Cruess, 2008). Recently, however, there has been a sharp increase in the demand to focus on socially accountable medical education. Over the past 30 years, Dr Charles Boelen and other colleagues at the WHO have advanced the theory of socially accountable medical education (Preston, Larkins, Taylor & Judd, 2016). Since the 2000s, medical schools have been expected to educate their future physicians to be socially responsible (Woollard, 2006; Boelen & Woollard, 2011; Larkins et al., 2013). It has been suggested that medical schools be held accountable if they do not demonstrate their commitment to this responsibility (Dharamsi et al., 2011; Abdalla, 2012; Sandhu et al., 2013). Accordingly, many medical schools today would claim to be working hard to meet the challenge of providing socially accountable medical education, training, and research (Abdalla, 2012). This has led to developments in the measurement and evaluation of social accountability within medical schools (Preston, Larkins, Taylor & Judd, 2016). However, not only do expected standards of social accountability vary

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widely from one medical school to the next, but the criteria themselves by which social accountability is defined vary widely as well (Abdalla, 2012). Social accountability has been defined to include: accessible healthcare (McKimm & McLean, 2011), appropriate healthcare (Meili, Fuller, & Lydiate, 2011), social responsibility (Dharamasi et al., 2011; Murdoch-Eaton & Green, 2011), social awareness (Gibbs, 2011; Meili, Fuller, & Lydiate, 2011), community involvement and service (Wasylenki, Byrne & McRobb, 1997), health equity (Larkins et al., 2013), health advocacy (Gill & Gill, 2011; Irby, Cooke & O'Brien, 2010), and stakeholder partnerships (Lindgren & Karle, 2011; McKimm & McLean, 2011).

While it is likely that each of the criteria listed above can be thought of and argued for as aspects of a socially accountable medical education, it is obvious that a broad framework is needed in which the place of each of these definitions can be appreciated as significant components of the totality of socially accountable medical education and medical practice. Ritz, Beatty & Ellaway (2014) note that "until relatively recently, accountability to patients, the public, and the profession, were generally held to be the private and moral concern of individual physicians, rather than the collective responsibility of institutions or the profession as a whole" (p.152). However, as mentioned above, there has been a growing focus on institutional responsibility in medicine and medical education. Boelen & Woollard (2011) assert that if medical schools are to be considered socially responsible, responsive, or accountable (see following section), their mission must be to 'best serve' the public. This is emphasised by the WHO definition of the social accountability of medical schools: "[Medical schools have] the obligation to direct their education, research and service activities towards addressing the priority concerns of the community, region and/or nation they have a mandate to serve. These priorities are jointly defined by government, health service organisations, the public and especially the underserved" (Boelen & Heck, 1995, p. 3). In other words, action is primarily driven by health priorities, which are collectively established by stakeholders. Writing for the WHO, Boelen & Heck (1995) articulated four principles that describe the health care to which people individually and collectively have a right: (1) quality; which strives to provide citizens with "person-centered care", or the best ability to protect, restore and promote wellbeing (2) equity; which seeks to ensure that all citizens are protected from discrimination and have full access to and the opportunity to benefit from health care services (3) relevance; which tries to ensure that priority health needs are addressed, particularly of those who are most vulnerable, and (4) effectiveness; which refers to health care resources and

their use to serve public interest in effective and efficient ways (Boelen & Heck, 1995). Boelen and Woollard (2009; 20011) suggest that these four values or principles can be used as a gauge for health impacts and can therefore be used to help define and describe a socially accountable medical education (Boelen & Woollard, 2009; 2011).

A number of different frameworks, models, projects and organisations have been developed to support the implementation and evaluation of social accountability in medical education (see: Abdalla, 2012; Larkins et al., 2013; Boelen & Woollard, 2009; 2011; The Training for Health Equity Network, 2011; Preston, Larkins, Taylor & Judd, 2016). Many of these approaches to the development of socially accountable medical schools use the key principles outlined above. By exploring the possible applications of Boelen and Woollard's (2011) social accountability standards, it becomes possible to see how the values and principles of socially accountable medical education might be conceptualised in the service of reducing indigenous health inequities.

The social obligation scale

Boelen & Woollard (2011) propose that the social accountability of medical schools should be grounded in careful measurement and testing of the "relationship between inputs, processes, outputs and impact on health" (p. 614). In other words, social accountability should be assessed by demonstrable results rather than solely relying on ideology or good intentions. Boelen & Wollard's view is that in order to become socially accountable, medicine must move beyond the position of non-maleficence or 'first do no harm', to a stance of active beneficence, that is, attempting to 'do good' by honouring the broader values, ideals and priorities of the society in which it is situated. Medical education needs to progress from its past as an insular, internally referenced traditional body of knowledge and skills to a modern, multidisciplinary training, particularly in relation to its most needy, at risk, or health deprived populations. Integration with the needs and interests of community stakeholders is essential (Boelen & Woollard, 2011).

The conceptual framework that underpins the social obligation scale shown below (Table 1) includes the four principles of social accountability mentioned earlier, additionally calling for an 'explicit three-tier engagement' that encompasses social responsibility, social responsiveness, and social accountability (Boelen & Woollard, 2011, p.614). First, social

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responsibility requires that medical educators identify current and prospective social needs and challenges. Second, social responsiveness requires that medical educators adapt medical school programmes to meet these needs and challenges. Third, social accountability requires that medical educators are engaging with and being held to account by the community or communities they have a mandate to serve and that expected educational outcomes have in fact benefited these communities. The progression in medical education from responsibility to responsiveness to accountability can be considered a developmental process in which each new step builds on and extends previous steps while at the same time incorporating and integrating prior knowledge and understanding.

	Social Responsibility →	Social Responsiveness →	Social Accountability
Social Needs Identified	Implicitly	Explicitly	Anticipated
Institutional Objectives	Defined by faculty	Inspired from data	Defined with society
Educational programmes	Community-orientated	Community-based	Contextualized
Quality of graduates	Good Practitioners	Meeting criteria of professionalism	Health system change agents
Focus of Evaluation	Planning (process-focused)	Doing (outcome-focused)	Impacting (results-focused)
Assessors	Internal	External	Health partners

Table 1: Boelen & Woollard's (2011) Social Obligation Scale

As mentioned above, Boelen & Woollard (2011) have usefully defined and distinguished the tiers of the social obligation scale, depicted in Table 1 above. The social obligation scale describes the progression from social responsibility to social responsiveness to social accountability. Using the example of equity in health, Boelen & Woollard (2011) use the social obligation scale to demonstrate some of the difficulties of matching medical education to social needs. For example, socially responsible medical schools may seek to include course material on population health, or research that links health inequities to social determinants of

health. At the same time, they may fail to expose students to the groups of patients or modes of clinical practice that best illustrate these principles. A socially responsive school would take the next step beyond a socially responsible school by facilitating community engagement and community-based experience. Socially responsive medical schools would also assess students' competence to care for underserved populations, and actively encourage graduates to direct future practice to areas of need. A socially accountable school would go further still, integrating social needs as "part of the managerial loop: the school participates in needs identification, justifies action programmes accordingly and verifies whether anticipated outcomes and results have been attained in satisfying social needs, via their graduates" (Boelen & Woollard, 2011, p. 616). This commitment also applies to research outputs and service delivery. Boelen & Woollard (2011) suggest that this will require medical schools to widen their scope of duties. Frenk and Chen et al. (2010) likewise propose a shift from isolated educational institutions to integrated education and health systems through networks and alliances in the transition from "inward-looking institutional preoccupations to harnessing global flows of educational content, teaching resources, and innovations" (Frenk & Chen et al., 2010, p. 1924).

As such, socially accountable medical education and medical practice need to integrate not only an empirically derived understanding of the social determinants of health and equity, but a service driven ethos of culturally safe, competent and reflexive practice based on considerations of health equity and justice, as well as health practice initiatives based on active, ongoing partnerships with community stakeholders. The following sections briefly reflect on how the tiers of the social obligation scale, the medical paradigms that underpin them and how they may, or may not serve to address indigenous health inequities.

Social responsibility

The social responsibility of medical schools can be described as the obligation to respond to health priorities (Ritz, Beatty & Ellaway, 2014). However, as shown in the social obligation scale above, these priorities are only implicitly identified, as institutional objectives are internally defined by faculty, rather than derived from an analysis of social needs. As such, there is a high risk of mismatch between medical graduates and meeting social needs of the community or communities the medical school has a mandate to serve, particularly in the absence of any evaluation. Furthermore, although it may not be immediately apparent, social

responsibility as described in the social obligation scale is located within a biomedical paradigm. The broader implications of Boelen and Woollard's (2011) concept of social responsibility become somewhat clearer once this tier is contrasted with the two tiers that follow it, both of which are located 'outside' the biomedical paradigm and require significant modifications to it.

Because socially responsible medical schools tend to emphasise clinical accountability, rather than social accountability, socially responsible medicine can be understood as a fair and equitable application of the traditional biomedical model. Clinical accountability is traditionally dependent upon an expertise held almost exclusively by members of the medical profession (Salter, 2001). It is this expert judgment that enables an accurate assessment of what is or is not good clinical care.

A socially responsible, fair and equitable application of the traditional biomedical approach to fighting disease has much to recommend it (Engel, 1978; 1981; Pauli, White, & McWhinney, 2000). Indeed, medicine's specialised scientific expertise is what many ill people seek. However, although scientific knowledge has unquestionably brought enormous benefits to patients, it is most certainly not the only foundation necessary for clinical training (Kuper & D'Eon, 2010). Medical knowledge has come to be regarded as not merely 'cultural' knowledge but as real knowledge (Taylor, 2003). Biomedical assumptions inherent in the socialisation process of medical training become powerful norms that underpin and shape clinical practice and medical decision-making (Taylor, 2003; Boutin-Foster et al., 2008). The inherent assumptions attached to the biomedical paradigm include an emphasis on 'truth' based on scientific principles and understandings, political neutrality and fairness (Lupton, 2012). What can be observed and measured is privileged over all other aspects of reality (Crowley-Matoka, et al., 2009; Russell, 2013). In one respect, regarding all patients as objective bodies should result in a 'leveling' that could contribute to equal treatment across patients. However, this turns out to be far from the case in actual practice. There are multiple ways in which the privileging of the biomedical paradigm in practice is far from fair for indigenous peoples. When illness is viewed as separate from social context, "physicians are more likely to mislabel problems that originate in the social and economic sphere as negative characteristics of the patients themselves" (Crowley-Matoka et al., 2009 p. 1357). This clearly has a disproportionate impact on all those who are marginalised, including indigenous peoples.

The 'victim blaming' of indigenous peoples denies structural and system bias and serves to re-inscribe colonial thinking whereby indigenous peoples themselves are responsible for their unequal health status (Reid & Robson, 2000).

The privileging of what can be observed and measured in a predominantly biomedical paradigm extends to the production of medical knowledge, resulting in epidemiology and statistics on indigenous health that are often presented in a way that consolidates deficit theory analysis, and a presentation of indigenous health inequities as a 'problem' of indigenous peoples, rather than a focus on the structural bias that exists across all sectors of society (Reid & Robson, 2000). Furthermore, the study of these health disparities amongst specific clinical populations does not necessarily require engagement with patient populations themselves; what is sought is an improved scientific understanding that is only available to doctors themselves (Boelen & Woollard, 2011). Only medical training will provide the requisite expertise to evaluate what is or is not useful information. Therefore, standards of social responsibility remain internally generated, internally referenced, and internally assessed and evaluated (Boelen & Woollard, 2011). These limitations of social responsibility become clear when they are contrasted with the social responsiveness and social accountability tiers of the social obligation scale.

Social responsiveness

Consulting Boelen and Woollard's (2011) description of social responsiveness, some of the consequences of this reintegration for medical education become apparent. Feedback is actively and explicitly solicited from the patient (Boelen & Woollard, 2011), whose social as well as physical needs are explicitly identified. In contrast to the internal assessment of social responsibility, the assessment of social responsiveness is external as well because service medicine requires patient-centered care and patient feedback (Boelen & Woollard, 2011). To a very significant degree it is the patient who defines through their feedback what is or isn't 'responsive.' Within this frame, the values and virtues of Hippocratic medicine were, and still are, fundamentally humanistic. Engendering these values and virtues in future medical practitioners remains an important task. Aligned to this service ideal is the belief in medicine as a social good and the recognition that the medical profession has a role to play in addressing the social issues that affect people's health (White & Connelly, 1992; see Woollard, 2006). However, empirical evidence suggests that emphasising service values in

medical education does not necessarily result in their practice (Coulehan, 2005; Dharamasi et al., 2011; Bleakly, 2014). Considering the dehumanisation that many indigenous peoples still face, being responsive to indigenous health inequities requires more than a commitment to Hippocratic values and the ideology of humanism. Overcoming the effects of health professional bias and institutional racism requires the development of a 'critical consciousness' (Kumagai & Lypson, 2009). An emphasis on service medicine does not necessarily offer a critical analysis of the policies and practices in medicine that continue to contribute to health inequities, particularly indigenous health inequities. Beyond an awareness of the existence of health inequities, critical analysis requires a consciousness regarding structural systems of power and privilege.

Contemporary medical education often emphasises the need for future practitioners to be aware of the social determinants of health. Some authors have argued that this emphasis demonstrates a return to the historical commitment of medicine to social justice (Woollard, 2006; Braveman, 2006; Sandhu et al., 2013). Indeed, socially responsive medicine extends its focus to include not only teaching public health and epidemiology related to social determinants, but engages students in community-based activities (Boelen & Woollard, 2011). However, an awareness of the social issues that cause health inequities and an emphasis on the role of doctors in addressing these inequities in practice may not include the recognition that "paternalistic principles of responsibility and right action that while they may have been driven by consideration of social justice, have sometimes had untoward consequences in Indigenous contexts" (Hunter, 2006, p.30). Unless paternalistic attitudes towards indigenous health inequities that undermine indigenous agency are unpacked and challenged, the potential for addressing indigenous health inequities through service medicine remains limited.

Social accountability
The social obligation scale (Table 1) suggests a progression from the implicit awareness of social needs to the explicit awareness of social needs to the anticipation of social needs. 'Tier-three' or 'anticipative' social accountability as outlined by Boelen and Woollard (2011) includes the responsibility to ensure that better health outcomes actually occur. Socially accountable medicine not only seeks to match its interventions to current social needs, but extends beyond this to pursue prospective needs and possible health improvements for individuals and populations. This requires a much more thorough integration with

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communities. It is the collaborative development of community health standards that makes possible anticipation as well as responsiveness to community health needs and interests. The second key transition, from the social orientation of service medicine that acknowledges the person of the patient, to the broader community orientation of partnership medicine, is the recognition and reintegration of the realities of patient membership in multiple health stakeholder communities (Woollard, 2006; Boelen & Woollard, 2011; Boelen, Dharamasi & Gibbs, 2012). It is medical schools' capacity to engage directly with these stakeholder communities and to craft enduring partnerships with them that most powerfully supports better health for the community as a whole, and not just selected individual patients within it (Boelen, Dharamasi & Gibbs, 2012). In partnership medicine, the underlying paradigm has shifted again, from biopsychosocial medicine to a biopsychosocially-informed collaborative community medicine. Socially accountable medical education organises group-to-group relations between the medical school and the local community in which that medical school is located (Boelen, Dharamasi & Gibbs, 2012). It is the development of sustainable health partnerships at the group-to-group level that underpins and supports individual doctor-and-patient partnerships. Stakeholder communities are in the best position to anticipate their own social needs and to assist medical schools to align their institutional objectives with these needs (Sanson-Fisher, Williams & Outram, 2008).

As mentioned above, clinical accountability is traditionally dependent upon an expertise held almost exclusively by members of the medical profession (Salter, 2001). In contrast to clinical accountability, social accountability is externally referenced (Boelen & Woollard, 2011). Indeed, social accountability is specifically accountability to the Other; the non-professional, the person who is dependent upon the good judgment and goodwill of the expert, variously described as the layperson, the public, or society itself. 'Society', however, is an abstract generalisation. In each concrete instance, the relevant portion of society is the particular community within which a particular practitioner locates their practice. For social accountability to be realised, it is community standards that must be met, the standards of a group of real people and not just those of an abstract 'layperson' or 'member of the public.' Stakeholder communities are in the best position to anticipate their own social needs and to assist medical schools to align their institutional objectives with these needs (Sanson-Fisher, Williams & Outram, 2008). An empowered stakeholder community can help to contextualise and fine-tune community-based health initiatives; provide results-focused feedback to health

providers; and offer medical students opportunities for real-world experience as health system change agents (Boelen & Woollard, 2011; Frenk & Chen et al., 2010).

Despite explicit commitments such as mission statements, statements of intent, and academic values and principles, the commitment to social accountability and the service mandate has faced enormous challenges to date (Abdalla, 2012). The difference between medical schools' intent to be socially responsible or responsive and their ability to actually become socially accountable is problematic. As Woollard (2006) eloquently puts it: "In a profession claiming centuries of cohesive commitment to the welfare of others, it is increasingly urgent that the current generation of medical educators converge on a relevant set of principles and activities" (p. 301). In their conceptual framework of socially accountable medical education, Preston, Larkins, Taylor & Judd (2016) emphasise a framework that is informed by practice, rather than recommendations, but note that the 'bedrock' of socially accountable medical schools are shared values and aspirations that align with socially accountable practice.

However, as Ritz, Beatty & Ellaway (2014) note: "the challenge with such diversification of meaning is that the term 'social accountability' has come to mean so many different things to different people that its core meaning lacks coherence, and the diversity of ideologies that have been attached to the discourse has rendered the concept highly amorphous and unstable" (p. 153). Furthermore, once the challenge of defining social accountability in its values, principles, activities, and content has been met, there is still an even greater challenge in integrating these into the curriculum and developing structures and processes that emphasise their value (see: Cooke et al., 2006; Hafferty, 2008). To be successful, core values and principles must be shared across and between medical schools and the community groups with whom the school has partnerships (Preston, Larkins, Taylor & Judd, 2016). Ideally this alignment would be institutionally supported in the form of policy and funding as well. Finally, "the nature of development of social accountability is contextually dependent, politically, historically, socially, spiritually, and economically influenced" (Preston, Larkins, Taylor and Judd, 2016, p. 8). This means that what constitutes effective action will differ in different medical schools depending on context. Ultimately, the development of socially accountable medical practice and theory is iterative, rather than prescriptive, and relies on the consistent application and reflection on actions that 'walk the talk' of social accountability (Preston, Larkins, Taylor and Judd, 2016).

Community-engaged medical education: notions of partnership and accountability to healthcare stakeholders

For over half a century 'community' has featured in medical education discourse (Strasser et al., 2015). This has included the exploration of relationships between medical schools and communities through research with community groups, community-oriented medical education, community-based medical education, and community-engaged medical education (see: Wallerstein & Duran, 2010; Strasser et al., 2015; Ross et al., 2014; Hays, 2002). More recently, the developing focus on community in medical education has been linked to recommended global reforms that aim to advance health equity (Frenk & Chen et al, 2010).

Historically, scientific medical training has been systematically applied since the Flexner Report in 1910, which resulted in major educational reforms in North America (Beck, 2004). These reforms set the trend for medical education in the 20th century (Strasser et al., 2015). The Flexner legacy is often reduced to the privileging of scientific knowledge in medical training. Science privileges the teaching of an evidence-based 'best practice' that is scientifically validated and empirically shown to be clinically effective. The dominance of this approach is also aligned to the re-location of medical schools within universities. However, Flexner also emphasised the physician as a social instrument, noting that "the physician's function is fast becoming social and preventative, rather than individual and curative" (Flexner, 1910 quoted in Hodges, 2010, p. S34). By 1925, Flexner himself was critical of how positivism and the scientific aspects of medicine had become so dominant that doctors were "sadly deficient in cultural and philosophic background" (Flexner, 1925, quoted in Hodges, 2010, p. S34). The centenary of the Flexner report sparked a number of new perspectives regarding the potential direction of medical education in the 21st century (Frenk & Chen et al., 2010; Kuper & D'Eon, 2010; Hodges, 2010; Cooke et al., 2006). Indeed, over the past two decades there has been a repeated contention that social as well as technical aspects of health care should be part of health professional education (Krasnik, 1996; Cooke et al., 2006; Sanson-Fisher, Williams & Outram, 2008; Sandhu et al., 2013). The Lancet Commission on the Education of Health Professionals for the 21st Century report (see: Frenk & Chen et al., 2010) proposed that new directions should be explicitly linked to social change. Such a proposal re-positions medicine and medical education as responsible for health in a broad way, enlarging the frame of medicine beyond the one to one relationship between practitioner and

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patient. Where medical education is linked to social change and health professionals globally "should be educated to mobilise knowledge and to engage in critical reasoning and ethical conduct so that they are competent to participate in patient and population-centred health systems as members of locally responsive and globally connected teams" (Frenk & Chen et al., 2010, p.1924), the concept of community becomes central.

As a term used in medical education however, 'community,' like social accountability, can mean many different things. For some, the concept of community is limited to a locality (e.g. a neighbourhood, or school district), some understand community to be a particular patient setting (e.g. patient list of a specific practice), and others perceive it as a cultural group (see: Strasser et al., 2015; Deroo & Maeseneer, 2007). The concept of community in the Lancet Commission report is "an essential social construct that deserves as much attention as the individuals within it" (Strasser et al., 2015, p. 1-2). The movement from community-oriented medical education, to community-based medical education, to community-engaged medical education in some ways, reflects the movement from social responsibility to social responsiveness to social accountability (see: Strasser et al., 2015).

Community-oriented medical education initially described medical students learning about community contexts and their impact on patient care, particularly patients from different cultural and social backgrounds. Community-oriented medical education aimed to produce doctors who could "serve their communities and deal effectively with health problems at primary, secondary and tertiary level" (Hamad, 1991, p.15). The emphasis here is not on a new specialisation of community medicine, but rather that across all medical specialties, including research, community-oriented doctors should be able to respond to 'community needs.' Community needs can be described and measured, their causes defined, and steps to address them considered from within the medical school. Since its introduction in the 1960s and 70s, however, community-oriented medical education increasingly came to include any educational model or programme that was related to community context(s) in some way (Strasser et al., 2015). As a result, community-based medical education is sometimes seen as a subset of community-oriented medical education, but progressively became the preferred approach due to its action-orientation, that is, the implementing of community-oriented education programmes (Hamad, 1991).

Community-based medical education focuses on enhancing student learning through learning activities or programmes that take place in communities, as opposed to students learning about communities from afar (Hamad, 1991; Strasser et al., 2015). These activities or programmes can take place in a range of clinical learning environments, including remote, rural and underserved community health settings, and should ensure benefits not only to students, but to community members as well (Hunt, Bonham & Jones, 2011). Although community involvement is implied in some examples of community-based medical education programmes, few specify how community members contribute to such programmes (see: Hunt, Bonham & Jones, 2011). The relationship between community-oriented medical education and community-based medical education can be described using the metaphor of a car; community-based medical education is seen as the engine (Strasser et al., 2015) or as the driver (Hamad, 1991) of the community-orientated medical education car. However, communities tend to be the destination or passive passengers, "with medical schools referring to professional standards and quality in response to any attempts at backseat driving by communities" (Strasser et al., 2015, p. 2).

Community-engaged medical education, by contrast, emphasises partnerships between medical schools and communities and notes the importance of interdependence and reciprocity in these mutually beneficial partnerships (Strasser et al., 2015). As such, community involvement is fundamental to any learning activities, programmes, research, or community development missions. The community ceases to be a passive host of medical school initiatives and students and are instead actively involved in decision-making processes at the medical school, positioning community-engaged medical education as a "practical means by which medical education is socially accountable, communities are served, and national and international health equity agendas can be advanced" (Strasser et al., 2015, p. 4).

The emphasis on community involvement and co-creation of priorities and outcomes in community-engaged medical education represents a high level of accountability by medical schools to specific communities. This description of partnership resembles Boelen and Woollard's (2011) highest standard on the social obligation scale, social accountability. Partnership enables this standard to be met by requiring medicine and medical education to be accountable to the local communities they serve. Likewise, partnership serves as a framework for the co-creation of priorities and goals between medical schools and communities in

community-engaged medical education. But the question of how this works in practice remains. What does partnership actually consist of? What are the respective roles of medical schools and the communities they serve? How do these two groups, in the context of this study, medical schools and indigenous communities, work most effectively with one another?

Examples of community-engaged medical education that demonstrate partnerships with indigenous communities have been documented in both Australia and Canada (see: The Training for Health Equity Network, 2011; Strasser et al., 2009; Strasser et al., 2015; Reeve et al., 2017). Flinders University School of Medicine (Flinders) and James Cook University Faculty of Medicine, Health and Molecular Sciences (JCU) in Australia, as well as The Northern Ontario School of Medicine (NOSM) in Canada, are all members of The Training for Health Equity Network (THENet). Flinders, JCU and NOSM have all identified indigenous health as a priority issue, demonstrating indigenous workforce development initiatives, as well as partnerships with indigenous communities as core to their community-engaged medical education (Strasser et al., 2015; The Training for Health Equity Network, 2011). The aims of this community-engaged medical education is to produce physicians for underserved communities, using social accountability principles (see: Neusy & Palsdottir, 2008; The Training for Health Equity Network, 2011). Although THENet schools use the WHO's social accountability principles (Boelen & Heck, 1995), partnership has been added to the four principles of quality, equity, relevance and effectiveness/efficiency[1] in THENet's cited values and core 'lens' in their social accountability operational model (The Training for Health Equity Network, 2011). Partnership at the community level means "meaningful collaboration" with communities, who are "engaged and makes and receives meaningful in-kind and financial contributions" (The Training for Health Equity Network, 2011, p. 15). It is suggested in THENet's Evaluation Framework for Socially Accountable Health Professional Education (2011) that these partnerships are documented for example, in meeting minutes, Memoranda of Understandings (MOUs), or financial audits. Likewise, community engagement resources should be allocated according to priority needs within the school's

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[1] The original WHO social accountability principle of 'effectiveness' is renamed 'efficiency' in THENet set of values. However, both terms are referring to the principle of cost-effectiveness, that is, the use of health care resources to address priority health needs (see: Boelen & Heck, 1995; The Training for Health Equity Network, 2011).

reference populations, that is, the populations the school serves, and such policies should be documented.

The Training for Health Equity Network was launched in 2008 and is a "network of collaborating medical schools experimenting with instructional and institutional innovations to attract, retain, and enhance the productivity of health professionals serving disadvantaged populations, often in remote rural areas" (Frenk & Chen et al., 2010, p. 1939). Indeed, many of the indigenous communities with whom the medical schools at Flinders, JCU and NOSM – and elsewhere (see: Strasser, 2016; Hudson & Marr, 2014) – have engaged with also happen to be in rural remote regions, which means that on top of the chronic shortage of doctors experienced by many rural regions worldwide, language and trust issues as well as a lack of public transport and telecommunications may impact significantly on these communities and their ability to access health services (Phillips, 2015; Strasser et al., 2009). In addition to the recruitment and retention of indigenous medical students, partnerships between indigenous communities and medical schools can facilitate reciprocal benefits in research and service activities, as well as future health professional education to address such issues in health care access and delivery. However, caution must be taken to ensure that indigenous-specific approaches to addressing such issues are not overlooked in favour of a more general rural and remote community focus, or that rural and remote indigenous communities are not offered resources and investment at the expense of urban indigenous communities (Phillips, 2015).

Using THENet's Evaluation Framework (2011), Flinders, JCU and NOSM were all able to identify varied partnerships and relationships with indigenous communities, although there appeared to be no formal statement or identification of the 'reference population' documented at JCU or Flinders, while NOSM defines their reference population (Ross et al., 2014). This is significant because without community input, medical schools may mistakenly assign key identifying characteristics, for example, understanding geography to be the key identifying characteristic for rural communities, as opposed to culture or ethnicity (see: Strasser et al., 2015).

All three schools have indigenous community educators and/or cultural mentors involved in future health professional education and some degree of community input into decision-making processes. However, despite evidence of community involvement in school decision-

making processes, particularly at NOSM, all schools acknowledged that these processes were not well documented and often could not be located at all, or were held in memory only by key school personnel. Likewise, governance and curricula decisions were generally not well documented; limited examples of community inclusion could be found at Flinders, while JCU acknowledged limited documentation of community participation. Decisions only appeared to be collaborative and involve the "school[s] stakeholders" at NOSM (Ross et al., 2014, p. 14).

To ensure the evidence-based reform cited in the Lancet Commission (Frenk & Chen et al., 2010), assessment of the impact and effectiveness that health professional schools are having in addressing the health needs of communities they partner with is crucial. The Teaching for Health Equity's Evaluation Framework offers a practical and useful guide for assessing progress towards stated goals of social accountability and community-engagement. However, the pilot implementation of the evaluation framework indicated the need for more research and better tools and resources to assess how progress impacts school reference populations, including indigenous communities (Ross et al., 2014). Recent developments in tools that track graduate outcomes, such as the Medical School Outcome Database in Australia and New Zealand can be used to assist THENet's Evaluation Framework to advance understandings of impact (Ross et al., 2014).

Community-engaged medical education has expanded on community-oriented medical education and community-based medical education to become an important aspiration for a growing number of schools. However, although community-engaged medical education can facilitate community involvement and collaborative relationships between indigenous communities and medical schools as shown in the examples at Flinders, JCU and NOSM, whether these relationships are in fact partnerships depends upon how partnership is defined by community partners, rather than by institutions. Strasser et al. (2015) acknowledge that both existing schools that are moving to become more community engaged, such as Flinders, as well as new schools that are set up with an explicit community-engagement mandate, such as NOSM, face challenges related to historical norms and resistance to change. This is further explored in following sections (refer to section on Institutional resistance to power-sharing, p. 45).

Cultural competence, cultural humility, and cultural safety

Cultural competence is a well-established part of medical curricula across the US, Canada and Aotearoa New Zealand and Australia (Paul, Ewen & Jones, 2014). Built on the terms cultural awareness and cultural reflexivity, cultural competency refers to a set of relevant knowledge and skills that individual practitioners are expected to apply in health care settings (Phillips, 2015). The practice of these skills is carried out in the service of effective communication and quality, responsive care (Betancourt, 2006). Related to these ideas of "effective communication, and the need to be responsive and deliver quality care to all" (Betancourt, 2006, p.500) is patient-centred care, or an attempt to meet the patient in their individual culture. Cultural competence strategies intend to make health services more accessible and appropriate for patients from diverse cultural backgrounds. Within this field, culture is recognised as a "multi-dimensional construct that includes age, gender, ethnicity, spiritual beliefs and sexual orientation" (Jones et al., 2010, p. 2). However, culture is often narrowly understood as synonymous with ethnicity or race, which often fails to capture diversity within groups. This reflects the first of three categories of limitations of cultural competence; a lack of clarity around what culture means in the medical field; insufficient recognition of the 'culture of medicine', and; a lack of evidence to link cultural competence strategies to health outcomes (Thackrah & Thompson, 2013).

Nevertheless, in Aotearoa New Zealand and Australia, cultural competence forms part of the accreditation standards and is a part of medical curricula across both countries (AMC, 2012). As Durie (2004) notes: "both cultural safety and cultural competence are based on the observation that health practitioners who do not take culture into account in diagnostic and management protocols fall short of acceptable standards of practice" (Durie, 2004; p.18). However the process of learning cultural context is labeled, the importance of culture in health care and the connection between culture and health has increasingly become commonplace in medical programmes in Aotearoa New Zealand and Australia and elsewhere (Paul, Hill & Ewen, 2012). What the terms cultural competence, cultural awareness, cultural reflexivity, cultural humility, and cultural capabilities all have in common is the individual focus (Phillips, 2015; Tervalon & Murray-Garcia, 1998). By contrast, cultural safety, cultural respect, cultural literacy all extend beyond the individual to include institutional factors, processes and systems (Phillips, 2015; Ewen, 2011b). It has been argued that if cultural competence is intended to contribute to the reduction of health inequities, a more critical approach should be used to locate cultural competence within a broader social justice initiative that can consider power

relations within society, particularly in medicine and medical institutions, including medical schools (see: Gustafson & Reitmanova, 2010; Wear, 2003; Kumagai & Lypson, 2009). Implicit in these terms that encompass both individual and institutional factors is an understanding of power in partnership. At the institutional level there is an acknowledgement of the inherent power disparity between universities and indigenous communities as a result of persistent, ongoing marginalisation due to a history of colonisation. At this level, cultural safety can become a decolonising task, concerned with "values and beliefs as much as individual actions or institutional practices and policies" (Phillips, 2015, p.41).

The distinction between the individual focus and the institutional focus is critical, because as shown by the taxonomy of curricula (see p. 43), even where individual health care workers, students and educators are engaged in individual culturally safe practice, without the application of these principles at the institutional level, the hidden curriculum will continue to generate a lack of cultural safety for indigenous peoples. Cultural competence has repeatedly been revealed to be problematic due to the uncritical assumption that it is possible to be competent in understanding the culture of 'the other', and the potential of this position to reinforce imperialism through medical professionalism (Ewen, 2011). As such, it is an excellent example of a part of the medical curriculum that is specifically intended to assist future practitioners to practise equitably, but still often perpetuates a paternalistic attitude that contributes to indigenous health inequities (Ewen, 2011).

As Durie (2004) notes: "Inter-cultural misunderstandings may create barriers for effective care but unless practice is consistent with the broad aspirations of indigenous peoples, then no matter how professionally it is delivered, in the end it may hinder rather than facilitate good health" (Durie, 2004, p.18). Wherever indigenous health in medical education is framed as meeting the needs of yet another 'underserved population,' collaborations between the executive body and indigenous health staff may be undermined or become lip service (Phillips, 2015). In this respect, medical education can be seen as a microcosm of broader societal dynamics. Paternalistic approaches to solving social inequities tend to assume that agency and self-determination on the part of indigenous patients and their communities is problematic rather than seeing it as empowerment, i.e. as a problem rather than a solution (Hunter, 2006). Such approaches are located in a paradigm that promotes equality, assuming that all disadvantaged peoples have the same needs (Humpage & Fleras, 2001). Ultimately, a

paternalistic approach to indigenous health will always have difficulty legitimising indigenous aspirations (Phillips, 2015; see Farmer, 2005). This is one of the main reasons that the service medicine agenda will have limited applicability to indigenous health issues.

Critique of medical education responses to addressing indigenous health inequities

As outlined in Chapter One, health system factors, including health professional bias and institutional racism, continue to contribute to inadequate and inequitable health outcomes for most non-white indigenous minorities, including Māori and Aboriginal and Torres Strait Islander peoples (Harris et al., 2006; Reid & Robson, 2000; Burgess, 2011). Some have argued that producing socially accountable health practitioners can significantly contribute to the medical establishment's stated aspirations to address and reduce these health inequities (The Training for Health Equity Network, 2011; Meili, Fuller & Lydiate, 2011). However, much of the social accountability theory and many of the approaches to socially accountable medical education maintain an assumption that social accountability can be improved without fundamental challenges to the paradigms that underpin western medicine and medical education. For example, in their definition of the equity principle, Boelen & Heck (1995) describe the aim to ensure that all citizens are protected from discrimination and have full access and the opportunity to benefit from health care services. In order to do this, however, doctors must be able to not only recognise their own prejudices, but also understand what full access to and benefiting from health care services actually looks like to their patients. It appears that the more attempts are made to ground the aspirational principles of social accountability in educational and medical practice, the clearer it becomes that social accountability at a practical level requires real and substantial partnership. Partnership enables a reciprocal relationship, which moves beyond initial engagement at a community level to mutually beneficial collaborations (Strasser et al., 2015; Preston, Larkins, Taylor & Judd, 2016). Without partnership, a socially accountable agenda might aim to achieve social responsibility or social responsiveness through outreach of service, but will fall well short of accountability to community stakeholders. Even where partnership is an explicit principle, as is the case with community-engaged medical education, engagement may not necessarily result in partnership (see: Ross et al., 2014).

Medical schools are now recognising that they have a moral obligation to address health inequities at the cultural interface. However, it would appear that most medical schools are saddled with values orientations and assumptions such as individualism and hierarchical

relations based on differences in power, privilege, and cultural validity, that make it difficult within a medical school context to even imagine forming partnerships, sharing power, or acknowledging other, non-medical indigenous sources of authority or expertise about the healthcare priorities and needs of indigenous peoples. By and large, physicians are expected to meet indigenous health needs unilaterally while continuing to practise medicine within a predominantly biomedical orientation, and yet simultaneously assumed to be able, with 'proper training', to become culturally safe and culturally responsive to indigenous communities. The following sections offer a critique of the culture of medicine and medical education through a summary of the taxonomy of curricula, institutional resistance to power-sharing, and medical professionalism.

The taxonomy of curricula

As suggested above, the overt and covert assumptions of a mainstream, white, western frame of reference pose quite a challenge to developing durable, effective partnerships with indigenous peoples. Hafferty and Frank's (1994) institutional analysis and descriptions of the formal, informal and hidden curricula of medical education provide insight into the complex process of medical education, including aspects and elements of cultural hegemony and institutional self-interest that have to date been under-recognised. To realise the potential of medical education to address health inequities, including indigenous health inequities, these hidden factors and implicit processes that influence and shape the total context and environment of medical education will need to be recognised and addressed. Hafferty and Frank's (1994) taxonomy of curricula can help to raise consciousness about and offer a critique of medical education's efforts to address indigenous health inequities. The taxonomy of curricula describes three interrelated spheres of influence – the formal, informal and hidden curriculum – in the multi-dimensional learning environment of medical education. What can be said to be taught (the formal curriculum) is often at variance with or even in direct conflict with what is learned (the informal and hidden curricula). The hidden curriculum is "a set of influences that functions at the level of organisational structure and culture" (Hafferty, 1998, p.404). The primary function of the hidden curriculum is to reproduce the culture of medicine (Hafferty & Franks, 1994). Many medical educators have suggested that what students perceive as the appropriate or 'right' values, qualities and behaviours in the practice of medicine are not produced primarily through experiences in the classroom, but more so through exposure to what is demonstrated and enacted in clinical contexts (Cooke et al., 2006;

Karnieli-Miller et al., 2010). In this way, medicine has been cited as being "unique among the professions in the degree to which it situates formal training within the context of its work" (Hafferty, 2008). In other words, the work place is the primary learning place.

This may present a problem for new paradigms in social medicine and social accountability as medical students listen and learn observationally from their elders and then replicate their example. Efforts to re-orient existing and future practitioners in the medical workplaces where medical education predominantly occurs may require new role models and role modeling. As Baum et al. (2009) note:

> Health sector workforces around the world have been trained in systems that emphasize clinical treatment with a strong disease focus. Although some health initiatives integrate the theories of social science and the practices of social accountability in training situations, these initiatives remain marginal and are often accorded only lip service (Baum et al., 2009, p. 1971).

This represents a significant challenge to the development and implementation of partnership medicine practises. Preceptors in medical education have the opportunity to model those behaviours they wish to see in future physicians such as patient advocacy, and the identification of and response to factors that influence health outside of the clinical setting (Dharamasi et al., 2011). However, according to a study carried out by Wilson et al. (2004), medical student awareness of the unfair treatment of minorities was greatest in first year and decreased over time, which suggests that "perceptions of unfair treatment may decline during the process of acculturation to the medical profession" (p.715). This suggests that students may be being socialised to accept inequity as part of the medical status quo.

Institutional resistance to power sharing: valuing difference in partnership

Not surprisingly, power sharing with indigenous populations in universities within Aotearoa New Zealand and Australia reflects the level of power sharing with indigenous peoples within wider society as a whole. Input from indigenous individuals is now sought more regularly, but indigenous paradigms and worldviews are rarely included (Phillips, 2015, Smith, 2012). The status quo, by definition, seeks to maintain power, privilege, and control over resources. Because partnership medicine requires sharing power and control, a certain amount of

resistance is inevitable. One of the important ways that this resistance manifests is through the lip service that is paid to embracing diversity without actual engagement with difference.

Valuing diversity using a partnership frame within medical education appears to be fraught with difficulty. This is well illustrated by many of the ways in which culture has been and is still debated, discussed and delivered in medical education settings (see: Wear, 2003; Taylor, 2003; Kumagai & Lypson, 2009). What these discussions and debates reveal are the embedded assumptions that medicine is a service attempting to respond to need. While this paradigm is accurate in many respects, it tends to introduce a positioning of indigenous peoples as being in a state of deficit and requiring, that is, being in need of, the benevolence of the medical establishment (Phillips, 2015). For example, Kutalek (2012) suggests that "diversity competence is mirrored when different explanatory models of disease are understood and reflected upon and when this understanding is translated into practice" (Kutalek, 2012, p. 7). Quoting Zola (1981), Kutalek (2012) outlines that the doctor-patient relationship "gets more complicated when the patient is old, suffers from a chronic condition, certain cultural issues are not understood or language barriers exist", therefore "a continual awareness of what it is like to be weak, dependent, scared, uncertain…" is needed (Kutalek, 2012, p. 7). While cultivating empathy is undoubtedly an important part of physician training, offering empathy without a balancing recognition of that persons/peoples' strength and right to self-determination is politically disingenuous. Difference cannot accurately be framed as mere examples of weakness, dependency, or uncertainty. This example of 'disablement equals deservability' highlights the way in which service medicine and a paternalistic approach continue to create barriers to valuing diversity (see: Phillips, 2015).

Medical professionalism

The aspirational ideal of professionalism may be understood to combine enlightened self-interest with an altruistic concern for others and the public good (Borgstrom, Cohn & Barclay, 2010; Sanson-Fisher, Williams & Outram, 2008; Boelen & Woollard, 2012). The professionalisation of medicine can be understood as a synthesis of science and service in which scientific medicine as a knowledge base is applied in practice as a public service. Professionalism offers medicine a positive moral basis as the application of the social contract between physician and patient. These ideals are founded in the concept of a social contract between medicine and society. The social contract should not be confused with formalised

legal contracts, but shares with the law the idea of "legitimate expectations" (Rawls, 1999). The application of utilitarianism, i.e. the greatest good for the greatest number, suggest to McCurdy et al. (1997), that medicine and medical education's social contract be extended to improving the nation's health and taking responsibility for the equitable distribution of healthcare. Medical schools and associated teaching institutions could contribute to this agenda via the transmission of professional values "by educating the next generation of physicians and biomedical scientists in a manner that instils appropriate professional attitudes, values and skills" (McCurdy et al., 1997, p.1063). Medical schools could also be expected to undertake basic research in order to "meet the responsibilities of creating new knowledge, reaching from subatomic levels to the health of populations" (McCurdy et al., 1997, p.1065).

Cruess and Cruess (2004; 2006; 2008) have repeatedly suggested that framing the social contract as the moral basis of professionalism helps to establish the moral boundaries of professional concern by making the medical profession's obligations more transparent. Professionalism becomes the vehicle for medicine's social contract. It offers a rational basis for the existence of both the expectations and obligations of the various parties involved in medicine. These collective expectations "constitute a functional definition of medical professionalism and a summary of medicine's professional obligations" (Cruess & Cruess, 2008, p. 592). As society and health care evolves, so too does the social contract. Standards of professionalism can be expected to change in response to societal needs and contemporary societal expectations.

Professionalism is often considered key to the development of accountable healthcare and the assumption is that "entry into a profession is a voluntary act, and most people who perform it are disposed to learn its ways and take its ideology seriously. They need only be told how" (Kultgen, 1998, p. 366). However, professionalism is often defined as synonymous with high standards and responsible care, but this responsible care is usually narrowly interpreted to pertain to the help-seeking individual. In fact, professionalism is not altruism, but a combination of altruism and vested self-interest (Hilton, 2004; Hilton & Slotnick, 2005). Insofar as professionalism is altruistically motivated to serve and protect, its values and standards may help it to develop its practitioners' social accountability (Boelen & Woollard, 2011). Insofar as professionalism is motivated by self-interest, however, it tends not to develop itself in the direction of social accountability, but rather towards becoming increasing

accountable to the sources of its own power and privilege such as the professional guild of the medical fraternity (Wynia et al., 1999; Hodges et al., 2011; Coulehan, 2005). While professionalism has significant positive potential to contribute to the public good (Freidson, 1994; 2001), it has a negative side as well. The negative aspect of professionalism is that it organises a tight system of power and privilege aligned to the vested interests of the medical fraternity (Wear, 2003).

While professionalism aims to develop clinical accountability via the provision and maintenance of high standards of responsible clinical care, clinical accountability is not social accountability. This may help to account for the Wilson et al (2004) study findings quoted above, that medical students, even as they are becoming more proficient in terms of technical expertise, are being socialised to become less aware of inequity, conforming to a status quo expectation of social inequity. As Braveman et al. (2011) note, "scientists like all others, should be guided by ethical and human rights values. The first decade of the 21st century has ended with little (if any) evidence of progress towards eliminating health disparities by race or socioeconomic status" (p. S154). Clinical accountability is internally referenced and dependent upon an expertise held more or less exclusively by members of the profession itself (Salter, 2001). It is this expert judgment that enables an accurate assessment of what is or isn't good clinical care. In other words, professionalism develops high standards internal to its own systems and regimes, but relatively little external accountability to the communities whose needs it serves.

Finally, a culture of non-reflective professionalism in medical education means that medical training rarely focuses attention on the culture of medicine itself. Students are rarely given time or encouragement to critically analyse and reflect on the profession and institutions of care. Little consideration is given to deconstructing assumptions about quality of care, or inquiring into how treatment choices are made or research practices shaped. Questions that arguably need to be asked do not get asked, e.g. how, despite their stated commitment to an ethos of service, equality and equity, are medical training cultures still so often able to replicate attitudes of elitism, and practices of institutional racism, aversive racism, and cultural imperialism in clinical settings? (Coulehan & Williams, 2001; Whaley 1998; King 1996). There is not enough discussion of how professional elitism and power imbalances tend to produce or at least support institutional racism (King, 1996). Good et al. (2005) suggest that:

When we are challenged to examine the culture of medicine and of our healthcare institutions, we are also challenged to bring a critical perspective that has largely been ignored by most research to date or that has circumscribed cultural inquiry to the differences between patients' and physicians' "beliefs." Disparities in medical treatment are not simply matters of differences in "beliefs." Clearly, political and economic factors that shape our medical commons and our larger society are implicated in the production of these disparities (p. 417).

It would appear that both the informal and hidden curriculum of medical education, and the ethic of professionalism, can in some instances actually impede efforts to progress social medicine within medical education settings. This reveals some of the challenges to partnership medicine practices. Attention to the social determinants of health and illness, equitable practice, and community engagement all require engaging with the institutional arrangements that determine how money and power is distributed in medicine and medical education. Institutional self-interest reveals itself most clearly at the level of the hidden curriculum, where the re-configuration of group-to-group relationships between medical schools and their community partners would be required to ensure health equity. The institution as an integrated system needs encouragement to value and make investments in partnership practices before the aims and ideals of social accountability can be realised. If partnership medicine is to be given a real chance to address indigenous health inequities, this will require serious efforts to move beyond 'reform without change' (Bloom, 1989). Changes to the hidden curriculum requires transforming the institution and reconfiguring how resources are distributed or invested.

Summary

Initiatives in medical education oriented to social justice, social accountability, community-engagement, and culturally safe practice have all attempted to impact health inequities, including indigenous health inequities. Socially accountable medical education has the potential to contribute to a strengths-based approach to indigenous health. However, all of these initiatives have been subject to critique by indigenous medical educators for various reasons, including the assumption that indigenous peoples are like any other group of medical patients in need (Phillips, 2015). Where this assumption holds sway, opportunities to integrate

indigenous values and viewpoints into medical schools are quite limited. Moreover, despite good intentions to be culturally sensitive and responsive to the needs of indigenous patients or heed the advice of indigenous practitioners, such approaches regard medical care as primarily a relationship between individual doctor and patient. In this context, non-indigenous medical practitioners may seek advice or 'consult' with indigenous individuals or groups holding cultural expertise, but are unlikely to create or take up opportunities for partnership.

However, medical schools can choose to recognise indigenous communities' historical and ongoing current experience of persistent, systemic disadvantage, and can seek to collaboratively co-determine health outcomes and strategies. Engaged in partnership relationships, medical schools can make themselves explicitly accountable to these communities (Murray et al., 2012). While the idea of cultivating group-to-group partnerships between indigenous communities and groups of medical practitioners is relatively new, the recognition of indigenous rights to health can help to reduce power disparities in what is otherwise a highly asymmetrical and power-unbalanced relationship between medical experts and indigenous peoples. Commitment to indigenous rights opens the door to a partnership of equality in diversity, where an assumption of equal dignity and equal rights for indigenous people and peoples must also recognise the impacts of a history of colonisation and consequent ongoing disparities in power, privilege, resources and cultural validity. If partnership in medicine is conceptualised as an asymmetrical but equitable relationship between indigenous peoples with health rights and people with the expertise to recognise, respect, and respond to those health rights, it becomes clear that support for indigenous rights to health has been radically under-conceptualised and under-utilised as a possible means to improve indigenous health and wellbeing. Assumptions of reciprocity and equitable partnership enable both groups to regard the other group as holding different but equally valid worldviews and sharing power and resources as well as health expertise. Within medical schools themselves, it follows that a better understanding is needed of what commitments to supporting indigenous rights to health might mean at the level of practical action steps in medical schools. These action steps may have the potential to create the conditions for a strong partnership where those with power and influence in medical school settings agree to be guided by those with indigenous health expertise.

Chapter Three: Medical education in Aotearoa New Zealand and Australia; efforts to address indigenous health inequities and contribute to indigenous health and wellbeing

Introduction

This chapter will review the contributions that medical schools in Aotearoa New Zealand and Australia have made to the indigenous health agenda. It will then describe how these contributions help to position the present research. The potential contribution of medical schools to address indigenous health inequities in both Aotearoa New Zealand and Australia have been outlined in numerous documents (see: Phillips, 2004; Minniecon & Kong, 2005; Medical Deans Australia and New Zealand, 2007; 2012, Australian Medical Council, 2010). The AMC has proposed specific requirements for medical curricula in relation to indigenous health and advocated for medical school partnerships with indigenous communities (Australian Medical Council, 2010; 2012). Nevertheless, indigenous rights to health have yet to be placed at the forefront of the medical and medical educational agenda. Perhaps this is not surprising. In colonial and neo-colonial contexts, aspirations and solutions proposed and conducted by indigenous peoples themselves rarely find much traction with governments or the wider social contexts within which governments exist. Indigenous aims and aspirations for self-governed pathways to strengthen indigenous health and wellbeing regularly clash with the dominant paradigm of profit-oriented economic growth and rapid modernisation (Hodgson, 2002). Most forms of indigenous resistance to this dominant paradigm are accompanied by aspirations for a more diverse, pluralistic and egalitarian society. Not coincidentally however, this is exactly the context in which a socially accountable medicine would be most likely to flourish, and autonomous developments in health, education and social welfare would be most actively supported (Durie, 2004; 2008).

Indigenous pressure to reconfigure the unequal power distribution between coloniser and colonised in both Aotearoa New Zealand and Australia has been increasing over the past 40 years (Paradies, Harris & Anderson, 2008; Havemann, 1999). To cite just one example of this dynamic tension, it is useful to reflect on the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP, 2008). In 2007, only four nations voted against UNDRIP; these were the members of CANZUS (Canada, Australia, New Zealand and the United States), each of whom could be characterised as settler colonial societies with significant indigenous

populations. In 2012, CANZUS reversed its position and voted for the UNDRIP. It is reported that what made this new stance possible were negotiations to soften the language of indigenous self-determination in the draft declaration (Davis, 2012). UNDRIP language reflects the current CANZUS position that allows for the promotion of indigenous cultures and languages, while still avoiding engagement with the more challenging political issues of indigenous rights to sovereignty and self-determination (Bellier & Preaud, 2011). This same stance can be found in colonial societies that embrace indigenous cultural symbols while ignoring the aspirations of indigenous peoples themselves (Sibley, Liu & Khan, 2008; Corntassel & Holder, 2008). Institutions such as universities are no exception to this rule. Far from being exempt from broader societal dynamics, educational institutions tend to replicate them (Parker, 2011).

Medical school commitments to indigenous health in Aotearoa New Zealand and Australia

In Aotearoa New Zealand and Australia, medical schools are required to meet the accreditation standards of the AMC. The purpose of accreditation is "to recognise medical programs that produce graduates competent to practise safely and effectively under supervision as interns in Australia and New Zealand, and with an appropriate foundation for lifelong learning and for further training in any branch of medicine" (Australian Medical Council, 2015, p.4). Having formally endorsed and embedded the Indigenous Health Curriculum Framework into their accreditation guidelines, the AMC put forward a proposal that medical schools undertake the teaching and learning of indigenous health (Paul, Allen & Edgill, 2011). Through their inclusion in the accreditation guidelines from 2007 forward, medical schools are required to report on progress towards the implementation of these guidelines. In 2002, the then Committee of Deans of Australian Medical Schools (CDAMS) – now known as Medical Deans Australia and New Zealand (MDANZ) - partnered with the Commonwealth Department of Health and Ageing to establish and implement the CDAMS Indigenous Health Curriculum Development Project. Hosted by the Onemda VicHealth Koori Health Unit at The University of Melbourne, the Project successfully carried out four key objectives, including: (1) an audit of existing indigenous health content in medical schools; (2)

the development of a national curriculum framework[2]; (3) the development of a network of medical educators to sustain implementation, and; (4) the inclusion of the curriculum framework in the Australian Medical Council's (AMC) Guidelines for Accreditation (Phillips, 2004).

The CDAMS Indigenous Health Curriculum Project, alongside another initiative, which focused on the support and retention of indigenous medical students (Minniecon & Kong, 2005), represented a significant shift in medical education in Aotearoa New Zealand and Australia. For the first time, there was general agreement by the Deans of Medical Schools to an agreed curriculum framework; the first of its kind in any area of health care, as well as explicit requirements for medical schools in relation to indigenous health (Medical Deans Australia and New Zealand and Australian Indigenous Doctors Association, 2012; Australian Medical Council, 2007). The CDAMS Indigenous Health Curriculum Framework (hereafter referred to as the Indigenous Curriculum Framework) outlined curriculum development processes and resources, capacity and workforce development issues. The curriculum development processes included: suggested subject areas, key student attributes and outcomes, pedagogical principles and approaches, delivery and assessment and suggested process for curriculum development.

In 2005, the key objective of developing a network of medical educators was realised in the development of the Leaders in Indigenous Medical Education (LIME) network. The LIME network encourages and supports medical school collaboration within and between Australia and Aotearoa New Zealand, to "enhance the quality and effectiveness of Indigenous health curricula in medical education and to enable best practice in the recruitment and retention of Indigenous medical students." (Haynes et al., 2013, p.65). The LIME network established a reference group with indigenous health leadership from each medical school across Aotearoa New Zealand and Australia, as well as secretariat, responsible for facilitating the core business of LIME, and a biennial LIME connection conference in which medical schools can share

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[2] Although the 2004 CDAMS Indigenous Health Curriculum framework document outlined guidelines for Aboriginal and Torres Strait Islander expectations, the framework was ratified by Māori academics as appropriate for use across both countries (Pitama, 2012).

progress related to the Indigenous Curriculum Framework (Phillips, 2004; Haynes et al., 2013).

According to the Medical Deans Australia and New Zealand and Australian Indigenous Doctors Association (2012), effective implementation of the Indigenous Curriculum Framework could be greatly supported by a 'whole of faculty' approach. However, this approach would need to be a joint effort by Deans, indigenous health staff and domain or discipline heads (Medical Deans Australia and New Zealand and Australian Indigenous Doctors Association, 2012). The latest AMC standards (2012) include the expectation that medical schools to contribute to the development of the indigenous health workforce and have "effective partnerships with relevant local communities, organisations and individuals in the Indigenous health sector to promote the education and training of medical graduates. These partnerships recognise the unique challenges faced by this sector" (Australian Medical Council, 2012, p.6). Likewise, MDANZ articulates in their mission statement[3] an objective to: "Promote improvements in Indigenous health through education and workforce development."

It is clear from the statements above that medical schools are regarded by other medical professional bodies as having an obligation to address indigenous health inequities, and that they can play an important role in doing so, primarily through: (1) developing policies and pathways to increase the number of indigenous health practitioners, and; (2) training a workforce that has the knowledge and skills to effectively deliver healthcare services to indigenous communities. As noted by the AMC (Australian Medial Council, 2012), producing such a workforce entails partnership with indigenous communities, organisations and individuals. Likewise, success for indigenous health workforce development includes increasing community and family engagement, as well as the framing of initiatives within indigenous worldviews and a tangible demonstration of institutional commitment to equity (Curtis, Wikaire, Stokes & Reid, 2012). These individual and specific commitments are grounded in and anchored by a commitment to recognise and respect indigenous rights to health. They represent important steps in articulating what the application of that commitment might mean in practice. Naturally, upholding indigenous rights to health in practice is likely to be significantly more difficult than simply granting these rights formal recognition. As Hafferty and Franks (1994) have argued, the hidden curriculum of medical education includes

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[3] http://www.medicaldeans.org.au/about/mission/

a status quo of institutional self-interest and tendencies to preserve a long-established system of medical privilege and power (see Chapter Two). Despite this, medical schools in Aotearoa New Zealand and Australia have begun to action commitments to address indigenous rights to health. Recognition is slowly dawning that this means engaging more robustly with indigenous peoples' aspirations to health self-determination and ensuring that they have a seat at the table wherever decisions are made with regard to issues that bear on indigenous health. As Phillips (2015) notes: "medical schools and faculties seemingly have a hard time comprehending and implementing this principle (of self-determination) in action, despite a clearly stated goal and accreditation standard articulating this as essential" (Phillips, 2015, p.264). As such, a number of key questions need to asked about how medical school commitments to indigenous rights can best be fulfilled. This thesis aims to address the practical implementation of this important political and ethical agenda for medical schools in Aotearoa New Zealand and Australia.

Advancing the indigenous health agenda in medical education in Aotearoa New Zealand and Australia

In Aotearoa New Zealand & Australia (and elsewhere, notably Canada) recognition of the urgent need to address indigenous health disparities has led to the development of indigenous health curricula and other indigenous initiatives in medical education. Indigenous health has now established itself as an emerging part of medical education and may be regarded as its own specialty area (Pitama, 2012). As a specialty area, indigenous health is distinct from social accountability and other approaches with a strong social mission in medical education (see: Boelen & Heck, 1995; Boelen & Woollard, 2009; 2011). As outlined in Chapter One, the indigenous health agenda in medical education is medical schools' commitment to address indigenous rights to health by developing indigenous contributions and providing institutional support for those contributions to have impact. This includes all medical school activities that can contribute to indigenous health and wellbeing, from the indigenous health curriculum and indigenous student recruitment and retention, to resourcing and workforce infrastructure, to institutional governance and leadership.

In contrast to the social accountability literature's emphasis on health needs as the basic referent for the allocation of health care resources (see: Boelen & Woollard, 2009; 2011),

indigenous health initiatives developed by indigenous peoples themselves tend to adopt what can be described as a rights-based framework of understanding, in which indigenous leadership and self-determination are essential (Phillips, 2004; Pitama, 2012). As such, indigenous peoples themselves are positioned at the centre of attempts to reduce health inequities, employing strengths-based approaches with clear understandings of sovereignty (Phillips, 2015). This is crucial because even where institutional backing for an indigenous agenda does exist, indigenous leadership is still necessary to ensure that indigenous agency is strengthened rather than undermined. As Hunter (2006) notes: "The undermining of Indigenous agency in terms of 'getting involved' may thus reflect a range of historical, developmental, contextual and circumstantial factors. However, whatever the causal mix, it has been powerfully influenced by non-Indigenous policies, processes and protagonists – by the role of governments in Aboriginal and Torres Strait Islander lives that "despite banners such as self-determination and self-management have often further compromised real agency and control of destiny" (Hunter, 2006, p. 29). This same problem can be found not only at government level, but within medical education itself. As previously discussed, approaches that focus on racial/ethnic disparities from a mainstream perspective, such as the provision of cultural competency training to mainstream practitioners, may be well-intended efforts to intervene on behalf of indigenous peoples that have the unintended effect of disempowering them (see: Paul, Hill & Ewen, 2012; Ewen, 2012).

Medical schools as sites of struggle

Many medical schools across Aotearoa New Zealand and Australia already demonstrate some level of commitment to indigenous-led initiatives that seek to increase the number of indigenous health practitioners and produce a culturally safe workforce. Examples of these initiatives include indigenous workforce development schemes (see Curtis, Reid & Jones, 2014), as well as academic indigenous-specific health domains within the medical curricula (see: Ewen et al., 2016; Medical Deans Australia and New Zealand and Australian Indigenous Doctors Association, 2012). For the success of such initiatives, institutional change is often required to ensure that indigenous leadership is maintained and that there are shared understandings as well as a coordinated, long-term approach to the support of these initiatives (Curtis, Reid & Jones, 2014). As outlined above, colonial norms may still compromise indigenous agency at government, university and medical school levels, hence the need for

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substantive institutional change. As Phillips (2015) points out, an essential part of addressing indigenous rights to health by medical schools includes "decolonisation practices of ensuring Indigenous leadership, and shared decision-making and resourcing in partnering with other academics and stakeholders" (Phillips, 2015, p. 128).

Both the Indigenous Curriculum Framework and the development of the LIME Network mark important advances made towards addressing indigenous health disparities in medical education contexts across Aotearoa New Zealand and Australia. The CDAMS Indigenous Health Curriculum Project has sought to make the health curriculum more responsive to the realities of indigenous health inequities. These efforts have typically centred on framing curricula responses around the Indigenous Curriculum Framework (Phillips, 2005; Ewen, 2011). As acknowledged in the Indigenous Curriculum Framework itself, the implementation of indigenous health into the medical curriculum is primarily an organisational reform task, inclusive of curriculum development as well as resources, capacity and workforce development (Phillips, 2004, Mackean et al., 2007). The development of the Critical Reflection Tool (CRT) marks another advance where assisted reflection on institutional structures and norms helps to ensure support for the inclusion of indigenous health content in the formal curriculum as well as indigenous student recruitment and retention strategies (Ewen, Mazel & Knoche, 2012).

Wherever there has been recognition of indigenous rights to health in medical education settings, there has been evidence of indigenous leadership and support for that leadership, as for example in the CDAMS Indigenous Health Project. However, support for this leadership often wanes at the very point at which implementation of such initiatives is imminent. This can be seen in the case of the CDAMS Indigenous Health Project, where support from Deans for indigenous-leadership in the project appears to have been offered, yet there was little follow-through in terms of the implementation of specific indigenous-led initiatives within medical schools (Phillips, 2015). In 2011, the Indigenous Curriculum Framework was evaluated by MDANZ and the Australian Indigenous Doctors Association (AIDA). The major findings from this review found that while the indigenous health curriculum content in medical schools had increased since 2003, there had been no increase in resources or mechanisms to assess curriculum quality and graduate learning outcomes. Furthermore, in the

Australian context, although indigenous medical enrolments had increased, the rate of indigenous medical graduates had not increased (Medical Deans Australia and New Zealand and Australian Indigenous Doctors Association, 2012). These findings suggest that indigenous leadership requires more institutional support to become sustainable, effective and capable of autonomous decision-making within medical education settings.

The case for an indigenous rights to health framework in medical education

Indigenous rights to health include basic human rights to health equity, i.e. equality in diversity, and health equality underpinned by principles of justice and fairness. This chapter has suggested that an indigenous rights to health framework in medical education may be able to offer an important missing link between medical school commitments to address health inequities in general (see Chapter Two), and commitments to address indigenous health inequities in Aotearoa New Zealand and Australia. As indicated in Chapter One, indigenous rights are additional to and distinct from human rights in general. The collective rights of indigenous peoples consist of the right to autonomy and independence, sovereignty, and self-determination in relation to a history of colonisation. Decolonisation requires not only the acknowledgement of historical injustices, but the recognition of ongoing and oppressive social practices in the present. This thesis proposes that the social agenda of decolonisation can and should be actively pursued through partnership with indigenous peoples and affirmative action designed to promote indigenous interests. At a fundamental level, reducing indigenous health inequities requires indigenous expertise. Indigenous peoples need to be consulted with, recognised and respected in determining their own healthcare needs and priorities. It can be argued that understanding and addressing indigenous health inequities requires an analysis of power as well. Health equity and affirmative action in healthcare can be understood as the remediation of systemic and systematic disadvantages historically imposed by colonisation and maintained in the present via the status quo assumption of a level playing field. This would explain the need for indigenous health independence, that is, all the many creative aspirations and solutions proposed and conducted by indigenous peoples themselves to address indigenous health inequities and strengthen indigenous health and wellbeing. Equally, however, it appears that indigenous health interdependence or partnership requires an equitable allocation and sharing of mainstream, non-indigenous resources and expertise. An example of this would be ensuring that there are adequate numbers of indigenous doctors and

places made available in medical schools for indigenous medical students, with the aim of producing adequate numbers of indigenous doctors.

As discussed in the previous chapter, 'person-centred' care implies understanding people as social and cultural beings; not simply as health care consumers who have "social, cultural and consumer expectations" (Boelen, 2009, p. 2; Abdalla, 2012). For many indigenous people, daily experiences of being 'othered,' and living in relationship to a collective history of colonisation and systemic discrimination, impacts health needs and the experience of health care in a variety of ways. To cite one example, proposals for the development of cultural competency, along with other culturally related teaching in medicine such as cultural awareness and cultural reflexivity, promotes the positive aspiration of equipping future practitioners with the necessary skills to effectively treat indigenous patients. However, cultural competence programmes typically neglect the need to recognise, challenge or address inherent power imbalances that are due to the persistence of colonisation at both the individual and institutional level (Paul, Hill & Ewen, 2012). Equally importantly, such approaches tend to be narrowly focused on assessing student learning, rather than widening the scope of inquiry to assess staff competence, institutional compliance, and the longer-term effects of such learning on the culture of medicine itself. It is the combination of attending to the learning needs of staff as well as students and active collaboration at institutional levels as well as workforce development that could reasonably be expected to impact and improve indigenous health outcomes (Paul, Hill & Ewen, 2012). Metzl & Hansen (2013) suggest redefining cultural competency in structural terms. This would require a shift from "an exclusive focus on the individual encounter to include the organization of institutions and policies, as well as of neighborhoods and cities, if clinicians are to impact stigma-related health inequalities" (Metzl & Hansen, p. 127).

It can be argued that indigenous peoples themselves need to contextualise and re-frame definitions of adequate care as it pertains to them, as well as co-author the standards by which Boelen & Woollard's (2009) definitions of quality, equity, relevance and effectiveness are measured. Recognition of the enduring legacies of colonisation reveal the inadequacies of an equality paradigm that assumes a level playing field. An equity-based medicine and medical training would require recognition of the role of colonisation in creating indigenous health

disparities in the first place and continuing to maintain them today. Boelen & Woollard's (2009, p. 889) definition of equity as trying to "ensure that every citizen has full access to health care services and does not face any form of discrimination" puts a strong focus on equality of opportunity, but leaves out the even more important focus on equality of outcome.

From an indigenous frame of reference, then, institutional decolonisation needs to be part of the picture, and white-settler relations with indigenous peoples must be considered in their historical context. In the context of indigenous rights, the parameters of group to group relations between indigenous peoples worldwide and the largely white and western world of medicine become much more visible and clear. Partnership cannot be based on western perceptions of indigenous need alone; these will continue to operate in a deficit model that undermines the sovereignty and dignity of one of the partners. Indigenous rights and the indigenous responsibilities attendant upon these rights, offers another, more promising path to authentic partnership. Here partnership is a contract between two parties with equal dignity and equal rights that also explicitly acknowledges an asymmetry based on evident disparities in power, privilege, resources and cultural validity. This asymmetry is the result of colonial history and colonising dynamics between white-settler and indigenous peoples in the past that continues into the present. It is therefore incumbent that the medical establishment, in this context, medical schools, as the party with greater power and privilege, recognise an obligation to uphold indigenous rights and seek to promote a partnership in which equality in diversity becomes possible. Meanwhile, indigenous rights to health equity and equality bring with them the responsibility for indigenous peoples to adopt an approach to self-care and self-determination that will play to indigenous strengths as well as indigenous needs and assist indigenous peoples to uplift themselves. For the immediate future, health independence for indigenous people requires health interdependence; skilled assistance from medical partners, and the provision of resources, training and expertise will allow indigenous partners to develop the capacity to take full responsibility for their own health and healthcare.

Partnership, as outlined above, appears to be the essential missing ingredient linking medical expertise to more effective person-centred care, not only at the one-to-one level between individual doctor and individual patient, but between the medical community and indigenous (and other marginalised) communities who already possess their own authority and point of

view regarding how best to enhance indigenous health and wellbeing. Here we can recognise the importance of aligning health care rights and health care needs. It is not a matter of abandoning the recognition of healthcare needs by replacing needs with rights, but rather of understanding how rights create a context in which needs can more effectively be addressed and met. The question of whose definition of rights might apply in any given situation, and even more fundamentally, who gets to define those rights and needs, is key to realising medical education that can address the needs of indigenous peoples. It would appear that individual and collective rights to health and healthcare continue to be defined primarily in terms of equality (absence of negative discrimination) rather than in terms of equity (affirmative action). However, affirmative action (restorative justice or 'vertical equity') is an important component of equity (Macinko & Starfield, 2002). In short, the recognition of indigenous rights to health and a robust discussion of how these rights are defined and upheld are notably missing from much of the previous literature exploring how to address contribute to indigenous health and wellbeing through medical education. As described in the previous chapter, it seems that many medical schools are still burdened with values, orientations and assumptions that hamper forming partnerships that share power or acknowledge non-medical indigenous sources of authority or expertise about the health care priorities and needs of indigenous peoples.

Many indigenous models of health challenge the monocultural assumption that health is the same thing for all peoples, asserting that cultural factors are fundamental to the attainment and maintenance of good health, not only for indigenous peoples, but for all people (Durie, 2001; 2004; Smylie & Anderson, 2006). Indeed, the most well-known definition of health from the WHO supports this holistic understanding: "Health is a state of complete physical, mental, and social wellbeing and not merely the absence of disease or infirmity" (World Health Organisation, 1947). Yet, health in a western medical context continues to be limited by a disease-focused and reductionist framework, and as a result, western medical education continues to frame health in terms of illness, or the absence of health, rather than in terms of wellbeing (Cooke et al., 2006; Crowley-Matoka, et al., 2009; Russell, 2013). As indigenous populations tend to have comparatively higher rates of disease, indigenous health status is often presented within this deficit frame (Phillips, 2004; Bourke et al., 2010). Various attempts have been made to address indigenous health disparities within a western medical paradigm

(see: Stephens et al., 2005; Phillips, 2015). These attempts have tended to rely on deficit models of health without invoking the wider context of indigenous rights to health. Currently, the health status of indigenous peoples shows them to be one of the most under-resourced groups on the planet in terms of access to healthcare. As such, indigenous people are often dependent upon the largesse of well-resourced doctors with need-meeting expertise. However, to position indigenous peoples as beneficiaries, and mainstream health services as their benefactors, is both factually incorrect and politically disingenuous. As underserved populations, indigenous peoples should not be unilaterally subjected to non-indigenous assumptions about indigenous health needs and how best to meet them. Indigenous peoples characteristically consider health to be something that extends far beyond human beings to include the health of the planet and all the forms of life that the planet sustains. Although considerations of ecological health have now visibly become part of the contemporary health landscape, western conceptions of health still have some distance to go to catch up with indigenous holism. Even the relatively holistic WHO definition quoted earlier could be considered less than sufficiently inclusive by indigenous standards. To meet health criteria that are implicitly and often explicitly proposed within a traditional indigenous worldview understanding of the world, we would need to consider, at the very least, individual health, social health, and the health of the natural world. This conception of health would need to be understood in psychological, mental, emotional and spiritual terms as well as physical and material terms. An indigenous health rights framework offers a perspective in which indigenous worldviews are explicitly recognised as central to indigenous understandings of health and healthcare needs.

Linking a rights framework to the research questions of this study

This thesis suggests that medical education can positively contribute to indigenous health and wellbeing by recognising and supporting indigenous rights to health and healthcare. A rights framework can assist medical educators to recognise and value diversity, appreciate indigenous values and worldviews, and work collaboratively and effectively with indigenous communities towards the realisation of indigenous health and wellbeing. Indigenous rights to health are located at the intersection of indigenous rights and universal human rights to health. Like any other human need, healthcare needs may be met without accompanying rights being recognised. However, attempts to theorise indigenous health and healthcare needs without

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identifying the impacts of colonisation is problematic, and once the impacts of colonisation have been identified, the obligation to find ways to redress the systematic violation of indigenous rights and mitigate their ill effects is clear (Durie, 2004; Kenrick & Lewis, 2004; Morgan, 2011). Without explicit recognition of indigenous rights to health and healthcare, the medical establishment may choose at any time to re-define their commitments to indigenous people or withdraw them altogether. It can therefore be argued that it is rights that secure the conditions under which needs are most likely to be regularly, routinely, and adequately met (see Waldron, 1996; 1998). Although different groups will vary widely on measures of health determinants according to their social status, access to political power and economic resources, whenever people are understood to have a right as well as a need for equitable health and healthcare, they are given a voice and potentially, a seat at the table. They are positioned and potentially empowered to negotiate for what they need on the basis of those rights. A rights-based approach endorses the aspirations of indigenous peoples to enlighten and empower themselves and to determine their own health priorities and address their own healthcare needs (Durie, 2004; 2008). An indigenous rights approach to medical education calls for sharing power and appeals directly to medical schools to take up an active role as a partner in the pursuit of health equity for indigenous peoples. This research asks what are medical schools' commitments to the indigenous health agenda, how are these commitments currently being realised, and how can these commitments best be realised in future? As this chapter has outlined, medical schools have made significant commitments to develop an indigenous health curriculum in medical schools in the service of contributing to indigenous health and wellbeing. However, the relationship between an indigenous rights approach and the indigenous health agenda remains to be explored. Accordingly, this research proposes to ask study participants about the role of medical schools in contributing to indigenous health and wellbeing and how commitments to indigenous rights to health can serve that agenda.

Summary

This chapter has provided an overview of the commitments medical schools in Aotearoa New Zealand and Australia have made to the indigenous health agenda. Much has been achieved over the past 15 years. Cause for optimism includes advances in the teaching and learning of indigenous health in medicine as well as in the recruitment and retention of indigenous medical students across Aotearoa New Zealand and Australia (Mazel & Anderson, 2011).

However, the progression of the indigenous health agenda in medical education requires more development, particularly in the practical details of how to build on progress already made and address individual and institutional resistance more effectively.

As outlined in Chapter One, this research will explore how medical schools in Aotearoa New Zealand and Australia currently address indigenous rights to health through medical education and how this could be more effectively demonstrated through the development of specific action steps. As has been suggested in this chapter, an indigenous rights to health approach to medical education has yet to be fully explored. However, an indigenous rights to health framework may be an effective means to address indigenous health inequities and contribute to the development of equitable health partnerships between medical schools and indigenous communities. This approach is aligned to a wider social agenda to decolonise the settler colonial societies of Aotearoa New Zealand and Australia, and is supported by the Kaupapa Māori methodological approach discussed in the following chapter.

Chapter Four: Kaupapa Māori Methodology

Introduction

This research is situated in a Kaupapa Māori methodological frame. It explores the commitments of medical schools in Aotearoa New Zealand and Australia to the indigenous health agenda, and sought to determine how these commitments could be more effectively demonstrated. Ultimately, this research lays the groundwork for the development of practical steps that could support indigenous rights to health, in the service of improving indigenous health outcomes through medical education in Aotearoa New Zealand and Australia.

Kaupapa Māori methodology (KMM) provides a framework with which to determine methods that will best support an indigenous agenda. A qualitative approach was the logical choice for this research topic and research question. Qualitative research is a term that covers a range of techniques and philosophies, but ultimately allows for the exploration of people's experiences embedded in their own local context. Qualitative research is well suited for revealing complexity and enabling underlying issues to be unpacked and understood (Fossey et al., 2002). Moreover, "critical, interpretive qualitative research creates the power for positive, ethical, communitarian change and the new practitioners entering this field deeply desire to use the power of the university to make such change" (Denzin, Lincoln, & Giardina, 2006, p. 779).

Although Kaupapa Māori approaches do not prescribe or privilege any particular research methods, qualitative methods are often used with indigenous methodologies as they offer the ability to explore narrative from multiple perspectives, consistent with other indigenous philosophies which are grounded in oral traditions and relationship-based (Foley, 2003; Kovach, 2005). This research sought to explore from multiple perspectives how medical education commitments to reducing indigenous health disparities and supporting indigenous rights to health can be understood and how this agenda can be advanced within the complex and dynamic contexts of medical education in different sites across Aotearoa New Zealand and Australia. Such an inquiry requires uncovering the multi-layered meanings embedded in institutional and organisational processes and structures.

This chapter will begin by positioning the researcher, followed by an explanation of some of the terms associated with Kaupapa Māori approaches to research. Next, the appropriateness of

a Kaupapa Māori approach to indigenous contexts other than Māori will be argued. Finally, the relevance of KMM to this research will be described and the conceptual framework that has shaped the study outlined.

Positioning the researcher

Many indigenous scholars and researchers cite 'locating oneself' as one of the fundamental principles of indigenous research methodologies (Absolon & Willett, 2005; Martin & Mirraboopa, 2003; Smith, 2012). Martin (2003) acknowledges and locates herself "firstly as an Aboriginal person and then as a researcher" (Martin & Mirraboopa, 2003, p.204). Likewise, I identify as a Māori researcher and not simply as a researcher of Māori descent. This distinction is made in terms of identification; a researcher is a social role. In positioning myself as a Māori researcher, I identify as Māori first, and researcher second. I am not proposing that this distinction is a strict binary, but rather, a way in which to show primary identification for myself with respect to my work.

I am descended from a long line of strong Māori women. My whakapapa is principally through my maternal grandmother and this lineage lives in me. I hold myself responsible to my people and am answerable to this felt sense of responsibility. This consciousness is both a privilege and an obligation; to my whānau, to the wider Māori community, and to indigenous peoples worldwide. In all my research endeavours, my intention is to uplift indigenous peoples and serve indigenous health and wellbeing by actively engaging in Māori principles of relationship and responsibility. In undertaking this research, I explicitly position myself as a Māori researcher who recognises the choice of KMM as having cultural and political implications. As explained further in this chapter, KMM is not neutral.

Intrinsic to my role as a Māori researcher is an ethical responsibility to recognise myself as belonging to a broader collective in which I hold both insider and outsider status. Regarding the land in which this research takes place, I can broadly be considered both as an indigenous 'insider' and as an 'outsider.' Although 'insider/outsiderness' is multi-dimensional, in an Aotearoa New Zealand context, I can broadly be seen as an 'insider' as I explicitly identify as a Māori researcher and member of the wider Māori community. Being an 'insider' in this sense is considered a strength and in some cases, a necessity within Kaupapa Māori research (Smith, 2012). However, I am equally clearly an 'outsider' in the context of Australia. Smith (2012) explains that "insider research needs to be as ethical and respectful, as reflexive and

critical, as outsider research. It also needs to be humble. It needs to be humble because the researcher belongs to the community as a member with a different set of roles and relationships, status and position" (Smith, 2012, p. 140). What this quote emphasises is that humility is essential regardless of insider/outsider status. This equally applies to the insider/outsider perspective identified by other indigenous researchers between belonging to indigenous communities (insider), while trained and working within western academic institutions (outsider) (see: Weber-Pillwax, 2004). The binary of insider/outsider is not what it significant here, but rather a consciousness and a willingness to be responsive and mindful of boundaries. In other words, cultural humility and the capacity for self-reflection are paramount. As emphasised in Chapter One, the values and worldview of Te Ao Māori are comparable with other indigenous worldviews, however, indigeneity is not uniformic and intimate understanding of cultures other than one's own cannot be taken for granted.

Across both country contexts, guidance, support and partnership is vital, but partnership with an indigenous Aboriginal insider is deemed to be essential to conducting research in an indigenous Australian setting. My supervisory team includes both a Māori and an Aboriginal supervisor. In an Australian context, I was guided and mentored by my Aboriginal supervisor in every stage of the research process. In some ways, the implications of outsider status in the Australia context evokes the same considerations of those carrying out research that aims to achieve positive social change for marginalised peoples, such as participatory action research, or constructivist grounded theory. Inherent in such research approaches is an orientation towards change, ethical considerations of culture in research processes, and a critical stance towards the 'researcher/researched' distinction (Charmaz, 2011; Fossey et al., 2002; Cochran et al., 2008). As such, this research shares many of the assumptions that characterise research approaches orientated by and to equity and social justice. However, the assumptions made using KMM are also informed by distinctively indigenous ways of knowing, being, and doing. Indigenous epistemologies, ontologies and axiologies may be compared to but must also be sharply distinguished from western approaches to social justice. KMM holds the complexity of indigenous worldviews and knowledges at the very centre of all its research inquiries. In other words, KMM explicitly orientates me as a Māori researcher to draw on the knowledges, beliefs, customs, experiences and realities of Māori to inform the framework for my research. By undertaking this research in an Australian context as well, I am drawing upon the interconnectedness of indigenous peoples across Aotearoa New Zealand and Australia and

indeed, indigenous peoples elsewhere. This unanimity of purpose does not imply uniformity of approach, and is explored further in the following sections. Ultimately, the use of KMM aims to promote empowering and self-determining research outcomes for indigenous peoples, through the privileging of indigenous voices, from a particular position as a Māori researcher. This intention can be identified in other indigenist research by indigenous Australian academics and practitioners such as Rigney (1999), Martin & Mirraboopa (2003), and Nakata (2002) as well as other indigenous research, theories, methodologies and practices (see: Wilson, 2001; 2008; Kovach, 2005; and Smith, 2012).

Kaupapa Māori: Research, Theory and Methodology

This research is undertaken from a particular position, within a particular frame, which distinguishes between Kaupapa Māori, Kaupapa Māori Theory (KMT), Kaupapa Māori Methodology (KMM) and Kaupapa Māori research (KMR). Kaupapa Māori research recognises and validates the distinctiveness and uniqueness of a Te Ao Māori worldview (Mahuika, 2008). Kaupapa Māori research is a critical, constructivist, decolonising, and emancipatory research practice that challenges dominant, colonial understandings of research knowledge and practices, including claims to objectivity and neutrality (Mahuika, 2008; Eketone, 2008). The practical, emancipatory intent of KMR is pursued through empowerment strategies to engender social, political and economic change (Henry & Pene, 2001; Cram et al., 2004). This research is KMR, utilising a KMM framework, as outlined in the following sections.

As this research uses KMM to investigate how medical schools can contribute specifically to indigenous peoples' rights to health and healthcare, it identifies the university as a site for decolonisation which has a responsibility "not just to pay lip-service to alternative ways of knowing and being, but to embrace and celebrate them" (Henry & Pene, 2001, p. 240). Although there is significant literature that explores aspects of the interface between medical education and indigenous health, much of this literature has been grounded in a western scientific paradigm or has focused exclusively on medical curriculum development. The use of KMM allowed this research to take for granted that indigenous peoples have the right to a place in the academy and that the academy has a responsibility and obligation to uphold this right. Such a position is a challenge to the dominant stance and discourse regarding how

medical schools address indigenous health disparities, including but not limited to how such disparities are framed in medical school curricula.

Kaupapa Māori Theory as a basis for indigenous inquiry

Historically, research has been instrumental in the marginalisation of indigenous peoples worldwide, inextricably linked to the history of colonisation and its ongoing effects (Smith, 2005). These effects include impacts from inbuilt and implicit assumptions of European cultural superiority, pseudo-objectivity and pseudo-neutrality, marginalisation of indigenous knowledge and traditions, and insufficient indigenous research and researchers (Smith, 2012; Pihama, 2010). As a transformative practice, KMR challenges the use of research as a colonising tool by upholding indigenous knowledge, voices, experiences and analyses as valid and distinct. Likewise, as a theory, KMT challenges dominant western notions of theory and provides "counter-hegemonic practice and understandings" (Smith, 1997, p. 455). In its capacity to draw on a distinctively indigenous theoretical base (explored further in the following sections), as well as locate research within a broader struggle against colonisation, it can be argued that KMM has the potential to serve as an emancipatory research methodology for indigenous contexts beyond Aotearoa New Zealand. The KMM frame used in this research aimed to do this by eliciting a diversity of indigenous voices and demonstrating a high level of reflexivity; a position from which indigenous perspectives across Aotearoa New Zealand and Australia can offer an incisive critique of colonial status quo assumptions, as well as a range of constructive suggestions.

Indigenous research methodologies have been generally described as vigorous and active fields of knowledge production that are pluralistic and diverse, yet share a common philosophical basis (Moreton-Robinson & Walter, 2009). This common philosophical base has as yet been only partially articulated, but should be capable of linking and unifying the many ways in which indigenous peoples make visible the meaning and logic of their experiences and apply it to the research process (Martin & Mirraboopa, 2003; Smith, 2005). An examination of medical education oriented to the rights of indigenous people should accurately reflect the diversity and pluralism of views held within indigenous communities. However, where unity and coherence within this community does exist, such an examination should also be able to acknowledge that unity and coherence. The intent of KMT to position research as an instrument that can contribute to an indigenous, as opposed to colonial, agenda affirms its

ability to be "a local theoretical positioning which is the modality through which the emancipatory goal….in a specific, historical, political and social context, is practised" (Smith, 2012 p.186).

Many indigenous aspirations for the future are grounded in a positive orientation to traditions, principles and practices that refer to the past (Pihama, 2010; Foley, 2003). Indigenous worldviews have their own ontology (ways of being), epistemology (ways of knowing) and axiology (ways of doing) (Martin & Mirraboopa, 2003). For example, indigenous cultural traditions tend to hold that relationality is the inherent foundation of the universe, and that the social world, natural world, and cosmic world are interdependent and inextricably linked. All human being, knowing and doing is part of this larger holistic pattern of continuous, dynamic evolution (Durie, 1998). Indigenous worldviews likewise describe through their creation stories the genealogy which has unfolded to produce humankind (Durie, 1998; Foley, 2003).

Indigenous worldviews tend to hold that human subjectivity precedes any 'objective' knowledge or truth and that the living present-day generation is the pivot between those who have preceded and gone before, and those yet to come who will follow. Cultural traditions and strong links to ancestors and unborn descendants are therefore intrinsic to indigenous positions and perspectives (Mikaere, 2011; Martin & Mirraboopa, 2003). While these understandings have parallels with other cultural perspectives, they find unique expression within particular indigenous cultural traditions. The locating of indigenous methodologies as derived from indigenous worldviews do not require that there be an essentialised "fixed and stable indigenous identity" (Kincheloe & Steinberg, 2008, p. 143). In employing KMM, this research claims a methodology that is (1) critical, (2) constructivist, and (3) reflects indigenous worldviews. This approach holds an indigenous perspective that is positively oriented to maintaining continuity with holistic and integrative indigenous traditions.

A Kaupapa Māori Methodological framework

As described above, Kaupapa Māori methodology provided the theoretical 'lens' for this study. This frame consists of three key 'claims' that underpin and ground indigenous methodologies across a diverse range of settings. Critical theory claims that indigenous self-determination requires a critique of dominant western paradigms of knowledge and value (Smith, 2012). Social constructivism claims that indigenous knowledges are socially situated,

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partial, and grounded in the subjectivities of everyday life. An indigenous position claims an indigenous worldview as its basis, while indigenous reflexivity claims that traditional indigenous philosophies and worldviews are integrative in character: social, natural and cosmic realities are held in a single holistic frame, although the exact nature and understandings of this frame are diverse and unique to each indigenous culture (Durie, 1998; Foley, 2003; Smith, 2012). The table below (Table 2) depicts my understanding of the major features of and relationships between the underpinning theoretical 'claims' of KMM that are discussed in the following sections.

Explanatory Theoretical 'Claim'	Key Elements	Approach	Goals
Critical Theory	Power analysis Resistance Empowerment Emancipation	Kaupapa Māori Methodology	Change/action towards a just society
Social Constructivism	Subjectivity Reality Context Reflexivity		Explores how experience is linked to social structure, culture and practices.and puts emphasis on researcher reflexivity
Indigenous Worldviews	Indigenous knowledges, values, and processes		Indigenous advancements as indigenous peoples, on indigenous terms

Table 2: Kaupapa Māori methodology: the integration of critical theory, social constructivism, and indigenous worldviews

All three components of KMM synthesise conceptual and practical levels of analysis. Both constructivist and critical theory literature reference the promotion of social justice through research praxis. Praxis, in this sense refers to the inseparability of action and analysis (Smith, Hoskins & Jones, 2012). However, an indigenous position defines praxis from a worldview

that understands the material world and the spiritual world as interconnected. Concepts such as whakapapa intersect "both the temporal world and the transcendent world" (Marsden, 2003, pp. 23). From this position, KMM is a methodology that may evolve and change as needed in political and social settings, but never stops being innately indigenous.

Critical theory

Critical theory, which evolved from Marxist/Socialist theory, is a paradigm in which social justice is sought through a focus on understanding and changing systematic power differences (Crotty, 1998; Wiri, 2001; Eketone, 2008). Critical inquiry emphasises challenging oppressive, dominant structures, existing power relations, and hegemonic assumptions. Critical theory is primarily concerned with issues of power and oppression, proposing that social legitimacy is largely conferred by economic privilege and political power (Crotty, 1998). This social legitimation of power and privilege should not be confused with intellectual and moral legitimacy. In other words, simply because things are customarily done in a certain way does not make the norms and assumptions thereby constructed true, or right. The intent of a critical theoretical framework is to be able to identify and understand the operations of power and privilege and its effects. When power and privilege are deployed, this deployment is regularly accompanied by a set of rationalisations and justifications that portray the operations of power and privilege and its effects as logical, necessary and inevitable (Mahuika, 2008, Pihama, 2010). Critical theory deconstructs the claim to logical necessity or inevitability and puts in its place a free and open inquiry into what might be socially possible or socially desirable and most particularly, socially just (Crotty, 1998).

Kaupapa Māori approaches challenge dominant, western models of knowledge construction insofar as these models represent and result from a colonising agenda in the academy. This analysis of existing power structures and social inequities strongly aligns with critical theory (Eketone, 2008; Pihama, 2010; Smith, Hoskins & Jones, 2012). Within Aotearoa New Zealand, the tradition of critical theory has been extended and applied locally through the development of KMT as a theory as well as KMM as a decolonising methodology (Smith, 2012; Smith, Hoskins & Jones, 2012). Indigenous peoples worldwide continue to bear a disproportionate share of the burden of inequities that result from colonising assumptions. As such, the normative stance for this research supports the rights of indigenous peoples to challenge dominant discourses that continue to justify or make excuses for colonising agendas.

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Accordingly, this research interrogates the assumptions of dominant discourses in medical education settings regarding indigenous health disparities and how to address these disparities.

Decolonising methodologies seek to raise the awareness of indigenous peoples about the roots of our current historical and social positions, and to reclaim the meaning and value of our own unique perspectives (Smith, 2003). Emancipatory methodologies attempt to progress this project of consciousness-raising further, towards definable goals, action steps and positive outcomes. As Morice (2003), makes clear: "Kaupapa Māori theory and practice is not a neutral discourse, it is inextricably linked to the Māori struggle for self-determination" (Morice, 2003, p. 16). The upholding of tino rangatiratanga is located at the centre of KMT and is essential to its emancipatory intent (Smith, 2012). A 'by Māori, with Māori, for Māori' approach would be considered emancipatory to the degree to which it contributes to tino rangatiratanga. Tino rangatiratanga or self-determination is recognised as a fundamental principle of KMT and relates to sovereignty, autonomy, control and independence (Walker, Eketone & Gibbs, 2006).

Critical theory stresses the union of structural analysis and transformative practice. Part of the Māori struggle for self-determination is reflected in the vigorous debate within Māori academic circles about which western paradigms are most closely aligned to KMT and which influences should be considered most important (Eketone, 2008). However, regardless of which western theoretical basis is given priority, KMT is fundamentally an assertion of the right to draw on our own base and provide our own understandings and explanations of phenomena as indigenous peoples (Pihama, 2010). Kaupapa Māori approaches require praxis, that is, a space from which to foreground both analysis and action (Smith, Hoskins & Jones, 2012). However, identifying Kaupapa Māori approaches as being only about critiquing persistent colonial dominance undermines their power and potential to provide self-generated strategies for positive change that arise from the cultural basis unique to Māori. While critique remains central to emancipation for indigenous peoples in Aotearoa New Zealand and Australia at this point in time, the strength of working from a Kaupapa Māori theoretical base extends far beyond critical intent to embrace these transformative action strategies.

Social Constructivism

While KMT can be aligned to critical theory, it can also be aligned to constructivist approaches inasmuch as KMT emphasises the acquisition and validation of local knowledge. Social constructivism proposes that truth and morality are not pre-existing givens, but are continuously evolving social products of human needs and human interests (Mills, Bonner & Francis, 2006). In other words, meaning is constructed, rather than discovered. Crotty (1998) explains that this is not limited to our thoughts alone, but rather, "all reality, as meaningful reality, is socially constructed" (Crotty, 1998, p. 54). As such, what we 'know', our ideas of what is true and right, are all context-dependent rather than context independent. In making these determinations, we are reliant on our culture, our personal history, our language and practices, and our current social circumstances. What is 'true' and what is 'right' may look very different depending upon our age and stage of life, gender, cultural affiliations, and social aspirations and circumstances (Crotty, 1998; Denzin, Lincoln & Giardina, 2006; Mills, Bronner & Francis, 2006). Constructivist research is therefore attuned to the positionality of the researcher and the researched alike. For the purpose of this research, social constructivism is understood principally as the recognition of subjectivity in the process of making meaning.

From a constructivist perspective, KMM is an approach that is grounded in an indigenous worldview and utilises concepts that do not require non-Māori approaches in order to position itself (Eketone, 2008). Here the emphasis shifts from a critical perspective, in which the primary focus is the systematic oppression and suppression of indigenous knowledges in the context of a colonising agenda, to the *content* of those indigenous knowledges themselves. What KMM draws from social constructivism concerns the validity and legitimacy of indigenous knowledges and processes, irrespective of their marginalisation in western contexts (Eketone, 2008). In identifying the philosophical basis of KMT, Eketone (2008) asserts the utility of 'Native theory,' which is defined as "the right of indigenous people to make sense of their time and place in this world" (Russell, 2000, p. 10). In Native theory, the emphasis is on the emancipatory desire to progress, "as Māori in Māori contexts" (Eketone, 2008, p. 7), through the advancement of Māori communities through Māori development using Māori concepts. Eketone (2008) identifies the Māori development agenda as aligned to a constructivist approach.

There still exists a lingering assumption that research is only rigorous when conducted within western frameworks, and must be seen to operate by the values and principles of univocal meaning, logic, rationality, objectivity, and neutrality or non-partisanship. For this reason, a certain degree of tension between indigenous methodologies and other research methodologies is inevitable (Kovach, 2005; Denzin, Lincoln & Giardina, 2006). Indigenous frameworks of knowledge will tend to be regarded with some suspicion by the mainstream community of academics and researchers (Pihama, 2010). However, indigenous values, beliefs and knowledge can exist independently without having to be brought into relationship with non-indigenous majority opinions or traditions. It is not sufficient to "construct Kaupapa Māori just culturally" (Smith, Hoskins & Jones, 2012, p. 14), that is, to emphasise the validity and legitimacy of Māori language, culture and knowledge. Without a focus on the political and critical aspects of Kaupapa Māori, its transformative potential would be diminished. The emancipatory intent of KMT, KMM and KMR, is aligned to the values and principles of critical theory (Pihama, 2010; Smith, Hoskins & Jones, 2012), while the unique and distinguishing cultural specificity of Kaupapa Māori approaches is aligned to the values and principle of social constructivism. Constructivist approaches to emancipatory research have been increasingly advocated for by a number of researchers, most notably Charmaz (2011). The constructivist version of grounded theory in particular has been acknowledged as having potential for advancing social justice-orientated inquiry as it "assumes that people construct both the studied phenomenon and the research process through their actions. This approach recognises the constraints that historical, social, and situational conditions exert on these actions and acknowledges the researcher's active role in shaping the data and analysis" (Charmaz, 2011 in Denzin & Lincoln). Such an approach allows a reflexive, value stance which acknowledges multiple realities and rejects rigid research techniques (Charmaz, 2011).

Indigenous worldviews

Native Theory as described by Eketone (2008) is derived from an indigenous philosophical basis that has strong affinities with traditions of social constructivism. This research proposes that while these two are closely aligned, they should not be taken as synonymous, nor should KMT be subsumed under the label of any western tradition. Likewise, while the development of KMT has been an expression of the resistance to imperialism and persistent colonial agendas characteristic of critical theory, KMT has equally been powered by the aspiration to

reclaim and uphold indigenous knowledge, language and culture. As Smith (2012) makes clear:

> There is more to Kaupapa than our history under colonialism or our desires for self-determination. We have a different epistemological tradition, one that frames the way we see the world, the way we organise ourselves in it, the questions we ask and the solutions that we seek. It is larger than the individuals in it and the specific 'moment' in which we are currently living (Smith, 2012, p. 190).

Indigenous methodologies have a common philosophical base from which research principles can be derived that reflects indigenous epistemologies, axiologies and ontologies (Moreton-Robinson & Walter, 2009). A Te Ao Māori worldview, which KMT is grounded on, is consistent with most other indigenous philosophies (Durie, 1998; Mahuika, 2008). This is outlined in Chapter One, in the description of indigenous understandings of universal interconnectedness; an understanding that takes the position that the human or social world is embedded in the natural world, which is embedded in the cosmic world. This understanding of the universe speaks to a set of shared values that are ancient. Indeed, as Pihama (2010) explains:

> While the theoretical assertion of Kaupapa Māori theory is relatively new, Kaupapa Māori as a foundation is not. Kaupapa Māori is extremely old – ancient, in fact. It predates any and all of us in living years and is embedded in our cultural being (Pihama, 2010, p.6).

It is this state of embeddedness in being that exists outside or beyond the boundaries of the purely socially constructed, that distinguishes what Eketone (2008) calls Native Theory from social constructivism. The recognition of whakapapa may be socially constructed, but whakapapa itself is not. This difference turns on the distinction between ontology and epistemology: what counts as knowledge is determined by the socially constructed conditions of knowledge, but these conditions themselves are determined by what grounds them, underlies them and makes them possible.

The commitment of KMM to contributing to an indigenous research agenda involves the recognition of indigenous voices as the channel of valid knowledge and a shift in perspective from analysing the limitations of colonised groups to analysing the limitations of colonising attitudes, practices and policies. In the context of this research, this includes acknowledging efforts to decolonise our thinking about medicine and medical education in Aotearoa New Zealand and Australia. Clearly, these efforts are not limited to indigenous peoples alone. However, decolonisation of health and healthcare necessitates the privileging of indigenous perspectives. As Smith (2012) articulates:

> Kaupapa Māori theory, as a big 'game changer' idea with respect to Māori development, is bigger than any of us as individuals. I want Māori to have a legitimate part to play in New Zealand life today and in the future. I want those Māori scholars….to be respected for their ideas and contribution. Notwithstanding there are many people struggling in a range of sites to create a space for Māori—and this includes some Pākehā and other indigenous peoples. So this is not an exclusive place for Māori, but there are some expectations and rules that apply (Smith, Hoskins & Jones, 2012, p. 19).

As KMR is the practical application of the principles of sovereignty and self-determination in KMT to the field of research, KMR must be led or co-led by indigenous peoples, as well as explicitly oriented to indigenous needs and interests (Smith, 2012; Walker, Eketone & Gibbs, 2006). Kaupapa Māori research seeks to value and validate the diverse experiences of being indigenous while at the same time maintaining high standards of empiricism, truthfulness and ethical integrity (Smith, 2012). Decolonising research challenges imperialistic and colonial assumptions and seeks closer connections between the academy of researchers – including indigenous and non-indigenous researchers and local indigenous communities (Pihama, 2010; Botha, 2010).

Summary

For the purpose of this research, KMM frames a process of inquiry that is committed to the advancement of indigenous peoples in Aotearoa New Zealand and Australia. Kaupapa Māori methodology gives primacy to the unifying features of indigeneity and collective indigenous aspirations. Indigeneity is acknowledged as being multi-dimensional and the nuances of local context cannot be taken for granted. As Kovach (2005) notes:

> Indigenous ways of knowing encompass the spirit of collectivity, reciprocity, and respect. It is born of the land and locality of the tribe. Indigenous knowledge ought to be purposeful and practical. It is born of the necessity to feed, clothe, and transmit values. As such, the method of knowing must be practical and purposeful (Kovach, 2005, p.28).

To this end, this research utilises the analytic power of thematic analysis within a particular cultural frame to advance the understandings of how medical schools can contribute to indigenous rights to health in Aotearoa New Zealand and Australia. These specific tools used are explored further in the following chapter.

Chapter Five: Research Methods

"...*how* we go about acquiring knowledge in indigenous communities is just as critical for the elimination of health disparities—if not more so—as the actual knowledge that is gained about a particular health problem" (Cochran et al., 2008, p. 24).

This chapter will present the methods employed during this research. This thesis is an inquiry into how medical schools in Aotearoa New Zealand and Australia can reduce indigenous health inequities and support indigenous rights to health. The overarching research question was: How can medical schools in Aotearoa New Zealand and Australia best fulfil their commitments to addressing indigenous rights to health in the service of reducing indigenous health inequities and contributing to indigenous health and wellbeing? This question has three sub-questions:

1. What are Aotearoa New Zealand and Australian medical school commitments to the indigenous health agenda?
2. How are these commitments currently enacted?
3. How can these commitments best be realised in future?

As emphasised in the Cochran et al. (2008) quote above, research methodology and methods are of vital importance to this research agenda. This chapter begins with an overview of the research methods, outlining the methodological approaches of both phases of the study, including governance and ethical approval. Following this, the two phases of the research are described in detail.

Overview of Methods

Data collection was undertaken in two phases, between November 2014 and October 2015. Each phase had a specific aim, design and sample. Both phases were necessary in order to meet the research aim of developing practical steps that will strengthen indigenous rights to health and may improve indigenous health outcomes through medical education. As outlined in the previous chapter, the research topic lent itself to a qualitative approach. In Phase One, key informant interviews were conducted to gain insight into stakeholder perceptions of medical school commitment(s) to addressing indigenous health inequities and contributing to indigenous health and wellbeing; how these commitments could be strengthened or enhanced,

and how an indigenous rights approach could potentially contribute to this agenda. These perspectives were then summarised and synthesised for the purpose of offering practical assistance to medical schools to fulfil their commitments to address indigenous peoples' rights. In Phase Two, a case study was carried out at The University of Auckland Faculty of Medical and Health Sciences, in which key informants discussed the relevance and potential applications of Phase One findings.

In both phases, sampling was purposeful with the intention of collecting a diversity of insights into the research topic, from a varied sample of key informants. Data were collected through individual, group, or focus group interviews, which were audio recorded with informed participant consent. All the interviews were transcribed verbatim by either the primary researcher or a professional transcriber. During each interview notes were taken on key ideas emerging from the interview and after each interview a research memo of the interview was drafted by the primary researcher. These notes were referred to once the interviews were transcribed to assist with accuracy, as well as during data analysis for consistency of meaning. Data collection and analysis was carried out simultaneously in both phases, consistent with inductive techniques used to test ideas and assess emerging theoretical concepts (Charmaz, 2011). Transcripts of the Phase One audio recordings were then analysed using NVivo 10 qualitative analysis software (QSR International Pty Ltd, Version 10, 2014) to assist with data organising and coding in Phase One. Phase Two transcripts were analysed manually.

Governance

As a Kaupapa Māori research study utilising a Kaupapa Māori methodological framework, governance of the study was a fundamental consideration. This research was carried out within the tri-nation Educating for Equity, or E4E project and was a joint PhD between The University of Auckland and The University of Melbourne (see Chapter One). As a joint PhD, the supervision team was comprised of two supervisors at each university. Because this research was carried out across two countries, each with unique indigenous contexts, having an indigenous supervisor from each country was deemed to be essential. These supervisors offered on-going guidance and input to ensure that the research process was appropriate. Members of the E4E project informally offered advice and suggestions, as did other indigenous academics and researchers at the various conferences and hui, or meetings, I

attended throughout the duration of this project. Two Kaumātua[4] whom I see regularly and with whom I am personally connected also helped to guide some of the queries I had regarding tikanga or cultural protocol. Both have considerable experience working across indigenous contexts. All of this helped inform my research approach to enable me to have confidence in my indigenous identity and engagement, while still maintaining cultural humility.

Many indigenous researchers have described indigenous research as research that is undertaken by indigenous peoples, with indigenous peoples, for indigenous peoples (Rigney, 1999; Smith, 1995). Such a description identifies the potential importance of indigenous researchers as instruments for transforming institutions, communities and society through the power of research, for the benefit of their peoples. As Smith (2005) notes, "most indigenous researchers would claim that their research validates an ethical and culturally defined approach that enables indigenous communities to theorize their own lives and that connects their past histories with their future lives" (Smith, 2005, p. 90). However, indigenous researchers necessarily have differing interpretations of what this means for their research practice. Indigenous researchers engage in lively debate regarding principles and practices, values, processes, and actions, as these relate to indigenous identity, ethics, political landscapes, historical contexts and cultural terms of reference (Walker, Eketone & Gibbs, 2006; Kovach, 2005; Rigney, 1999). Indigenous researchers may differently prioritise the knowledge and understanding of particular cultural practices or languages, or the degree to which one is mentored by elders, or simultaneous engagement with the broader political struggle of indigenous peoples (Walker, Eketone & Gibbs, 2006; Rigney, 1999; Battiste, Bell & Findlay, 2002). As emphasised in the previous chapter, indigenous peoples are not homogenous, rather "indigenous knowledges are unique to given cultures, localities and societies" (Wilson, 2003, p. 171). Nevertheless, research that utilises indigenous theory, methodology and method tends to regularly emphasise certain key components: a collective orientation, relationality, respect for indigenous rights, and indigenous control of the research (Bishop, 1998; Kovach, 2005; Hudson & Russell, 2007).

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[4] Kaumātua are koroua - male elder(s) and kuia – female elder(s) who are acknowledged as guardians of tikanga and consensus makers for the collective (Moewaka Barnes, 2000).

This research was nested within an existing international network of relationships within and between indigenous and non-indigenous investigators, all of whom are committed to addressing indigenous health disparities. The E4E project seeks to build international capacity to develop new and positive approaches to indigenous health and wellbeing through the education of health care professionals who work with indigenous peoples. This research explored the potential of medical schools across Aotearoa New Zealand and Australia to commit to the E4E agenda by honouring indigenous rights to health. As explained further in Chapter One, indigenous studies as a field of scholarship requires a certain degree of 'strategic essentialism' (Hoskins, 2012; Paradies, 2006) in order to define the boundaries of its subject area. However, association among and collaboration between indigenous researchers at an international level does not require a uniform, one-size-fits-all definition of what it is to be indigenous. Rather, a plurality of definitions of indigeneity can reflect and support unanimity or unity of purpose, within the international indigenous research community (Smith, 2012). The E4E project reflects this unanimity of purpose, offering a supportive context in which this research could be positively employed to contribute to indigenous health across different indigenous groups and settings.

As a member of the Māori and Indigenous (MAI) network, I was able to receive ongoing support from a network of fellow indigenous post-graduate students throughout Aotearoa New Zealand, as well as access to other indigenous researchers and activists who offered suggestions and support throughout the project, particularly in the early stages.

Defining key informants

Thirty-two semi-structured interviews (28 individual; two joint, and; two focus group interviews) were undertaken across two research phases. In Phase One, 20 interviews were carried out with key informants from 14 medical schools (across 12 universities), and six community settings. In Phase Two, a case study at The University of Auckland Faculty of Medical and Health Sciences was carried out that involved eight key informant interviews, two joint interviews and two focus groups. Interviews with key informants were chosen as the primary data source for a number of reasons. Although it could be argued that medical schools in Aotearoa New Zealand and Australia have already made commitments to indigenous rights to health in principle (see Chapter One), this research aimed to explore how these rights are understood in practice, how their practical application is currently enacted, and if and how it

could be done better. As such, diverse perspectives from a range of medical school contexts were sought. Consistent with Kaupapa Māori methodology, such an exploration required methods that could consider the complexities, contradictions, and tensions that may arise in unpacking the understandings and experiences of participants in advancing and/or reflecting on the indigenous health agenda within medical education in Aotearoa New Zealand and Australia. Using interview methods offered the opportunity to consider the nuances of particular medical school contexts and gather varied understandings of how an indigenous rights to health approach may advance the indigenous health agenda. Limitations of this research are noted and reflected upon in Chapter Nine.

Given the focus of the research topic and the methodology, it seemed logical to begin by seeking key informants among those who are familiar with medical school contexts and identify as indigenous. However, indigenous scholars located in the academy are not the only key informants and certainly not the only key stakeholders in this research. Key informants, as defined in this thesis, are individuals who can articulate expert knowledge about their community, offering an understanding of cultural norms and responsibilities (Fetterman, 2008; McKenna et al., 2011). In the context of this research, this could include knowledge of the indigenous community, the community of medical educators, or the community of a particular key stakeholder group within either of these communities. Indigenous academics may belong to all three of these communities. They may be 'cultural brokers', straddling two cultures, and thereby positioned to offer unique perspectives. As Hoskins (2012) notes: "Māori academics are unlikely to ever be far from sites of Māori political engagement… Many Māori people hold multiple roles simultaneously and change work positions across these sectors with regularity. Academics are thus usually also practitioners and activists" (Hoskins, 2012, p.88). However, indigenous leaders or experts outside the academy are also key stakeholders in a discussion regarding how indigenous rights to health can be realised or progressed through medical education. While they share common aspirations and membership in the broader indigenous community, the participation of those stakeholders who are external to the academy could potentially offer a very different perspective on this topic than those who work within the academy. Likewise, non-indigenous members of key stakeholder groups may also have much to contribute to this discussion. As such, all participants, including academics, community stakeholders, and students are considered to be key informants.

Ethical considerations

In Kaupapa Māori research, ethical protocols tend to emphasise and prioritise indigenous values and values-based engagement. Te Tiriti o Waitangi principles of partnership, participation and protection provide a "framework for identifying Māori ethical issues in terms of; rights, roles and responsibilities of researchers and Māori communities; the contribution that research makes towards providing useful and relevant outcomes; and addressing inequalities" (Hudson et al., 2010). Such priorities may be complementary to the aims and values of formal ethics approval processes, but they are almost never identical with them. As Smith (2005) notes, research ethics is often more about institutional and professional regulations and codes of conduct than it is about the needs, aspirations, or worldviews of "marginalized and vulnerable communities" (Smith, 2005, p. 96). The codes of behaviour and moral norms that guide research via institutional ethical boards, such as university ethical boards, may support rule-based rather than value-based engagement – which ultimately works to preserve researcher autonomy rather than to enact responsibility for others and relationality (Hudson, 2004). As such, I had to navigate between ethical frameworks, acknowledging and seeking to honor multiple accountabilities as a Māori researcher undertaking indigenous research with indigenous peoples in Aotearoa New Zealand and Australia. What this meant in practice was consultation with other indigenous academics who have learned how to earn the trust of their indigenous informants as well as satisfy the requirements of their ethics approval committees, as well as seeking guidance around the complexity of carrying out indigenous research across indigenous contexts (see Governance section above).

Ethics approval was sought from the University of Auckland Human Participant Ethics Committee (UAHPEC). Under the joint PhD agreement, UAHPEC was named the primary ethics committee for the duration of the project, as the University of Auckland was the primary institution. Approval was granted on 18 June, 2014, for a period of three years, reference number 2014/011704. The project was subsequently registered with the partner institution, The University of Melbourne Health Sciences Human Ethics Subcommittee, reference number 1544030.

Phase One

Aim

The aim of Phase One was to explore how medical schools in Aotearoa New Zealand and Australia address indigenous rights to health through medical education and how this could be more effectively demonstrated. As mentioned earlier, this aim was met through the eliciting key informant perspectives on how medical schools can fulfil their commitments to address indigenous peoples' rights to health. This included examining key informant perceptions of how medical schools currently demonstrate commitment to the indigenous health agenda and how this could be done more effectively. Semi-structured in-depth interviews were chosen as the method for Phase One for a variety of reasons; these are explained in the data collection section (p. 89). A further aim was to then synthesise this data in a way that might practically assist medical schools to fulfil their commitments to indigenous peoples' rights to health in Aotearoa New Zealand and Australia.

Sampling & recruitment

In Phase One, potential participants were defined as those who currently have a vested interest or involvement in addressing indigenous health through medical education in Aotearoa New Zealand and Australia. This included academics, health practitioners, and other professionals in the medical or health care sector, community members, community activists, and cultural liaisons. The intention was to include stakeholders from a wide diversity of settings and life experiences, with a particular focus on obtaining a range of indigenous stakeholder perspectives. Many Phase One participants identified themselves as occupying more than one of the roles identified above. All participants are considered to be key informants or expert sources of information.

Recruitment began with invitations to members of the Leaders in Indigenous Medical Education (LIME) Reference Group, followed by invitations to broader key informants, who were identified by LIME members. The LIME Network is a programme of Medical Deans Australia and New Zealand, committed to ensuring best practice in the recruitment and graduation of indigenous medical students as well as the quality and success of the teaching and learning of indigenous health in medical education (see: http://www.limenetwork.net.au/). The LIME Reference Group was identified as the primary key stakeholder group in the area of

addressing indigenous health through medical education in Aotearoa New Zealand and Australia. Members are nominated by the Dean of every medical school in Aotearoa New Zealand and Australia. All members demonstrate commitment to indigenous health through their membership, research interests and teaching, and most members are indigenous themselves. Initial sampling using the LIME Reference Group allowed a range of key informants representing medical schools across both countries to be invited to take part and offered the opportunity to explore contrasts and commonalities across and between institutions and countries, while still observing realistic time frames for data collection.

All 22 LIME Reference Group members – representing all medical schools across 20 universities in Aotearoa New Zealand and Australia – were invited by email to contribute to the research, with the participant information sheet and consent form attached. If no response was received to the email invitation, members were emailed a second time. A non-response to the second email was considered a rejection. There were two potential participants who chose not to participate, explaining their reasons, which were noted. There were also two potential participants who did wish to take part but had difficulty finding the time to schedule an interview. After several attempts to organise interviews, these potential participants had to regretfully decline participation, due to other pressing commitments, although they were vocal in their support of the study. Interviews with 14 LIME Reference Group members were carried out.

Following these LIME key informant interviews, a snowballing technique was employed to include broader key stakeholder perspectives. LIME Reference Group members who were interviewed were asked to identify other key informants whom they believed could offer unique insight into the topic, consistent with the snowballing sampling technique (Noy, 2008). Snowball sampling was chosen to include key informants who potentially had different and varied expertise on this topic than the LIME reference group members. As explained above, potential participants for Phase One included non-indigenous members of key stakeholder groups as well as indigenous key stakeholders external to the academy. These indigenous experts or leaders, although identified mostly by indigenous academics, tended to be defined and recognised as such by indigenous communities themselves, rather than academies or other professional institutions. Input from these broader key stakeholders, in particular the indigenous key stakeholders, was an effective means of gathering a diverse range of key

stakeholder insights into the topic. By using the LIME members' social networks, snowball sampling facilitated access to participants who had knowledge, experience and expertise related to the topic. These key informants included individuals who have contributed to or influenced the LIME participants' work or institution in some important way(s), as well as those more known to have a vested interest in indigenous rights to health, particularly in health professional education contexts.

Snowball sampling has been shown to be particularly effective in research that seeks input from participants where they are relatively few in number and when a certain degree of trust is required to initiate contact (Atkinson & Flint, 2001). In the Aotearoa New Zealand context, I can locate myself in a tribal or genealogical frame that is recognised by other Māori and contributes to building a relationship and trust between us. In an Australian context however, it seemed advantageous to be 'vouched for' by someone known to the potential participant. It is worth noting that several indigenous participants who were 'snowballed' in the Australian context wanted to know whether or not I was indigenous before agreeing to participate. This may speak to the importance for many indigenous peoples that research with indigenous peoples contributes to an indigenous, as opposed to colonial agenda(s), holding the complexity of indigenous worldviews and knowledges at the centre of the research inquiry (see Chapter Four).

By using LIME Reference Group member networks, I was able to access potential participants that I might otherwise not have been able to locate within the timeframe of Phase One. While it is feasible that my own network, as well as my indigenous supervisors' networks, could have facilitated access to a number of potential key informants in Aotearoa New Zealand and Australia, using the snowballing technique was the obvious choice for offering access to a broad and diverse range of possible experts on this topic. A number of LIME participants, however, could not identify potential key informants, for a variety of reasons, which were noted. Some of these reasons related to the way that some LIME Reference Group members viewed themselves in relation to the topic. For example, a couple of members identified themselves as having an interest and commitment to the topic, but not belonging to an established group of people who held expertise on the topic, apart from the Reference Group itself. A number of LIME participants could identify potential key informants to 'snowball' but believed that it would not be possible for me to interview these potential participants, due

to the logistic and time constraints. These explanations were noted. Finally, a few LIME participants identified potential key informants who they believed would be interested in taking part but when following up with these participants, reported that due to unforeseen circumstances such as illness or family commitments, these potential participants would not be able to take part in the research. All key informants apart from one that were 'snowballed' by LIME participants identified as indigenous. Although I did not ask these key informants 'snowballed' by LIME participants to suggest other potential participants, if one of these key informants explicitly suggested another potential participant, I did follow up with an invitation. The 'snowball' process was as follows:

1. LIME participants suggested potential participants
2. LIME participants then noted whether they thought it was appropriate for me to contact these potential participants directly
3. If the LIME participant believed direct contact was fine, these potential participants were then invited to contribute to the research by me via email, with the participant information sheet and consent form attached
4. If the LIME participant wished to discuss the project with them first, I waited until the key informant responded positively before emailing an invitation.

All participants apart from one that was 'snowballed' were invited directly by me. In total, 20 semi-structured interviews were undertaken during Phase One. Each interview took between 40 minutes to 1.5 hours. The participant sample is presented in Table 3 on the following page.

	Indigenous	Non-Indigenous	Total
LIME Reference Group members	11	3	14
Broader key stakeholders	5	1	6
Total	16	4	20

Table 3: Phase One participant sample

Data collection

Semi-structured, in-depth individual key informant interviews were carried out in Phase One. The purpose of this method was to encourage informants to speak personally and at length about their experiences and perceptions. Using interview methods offered the opportunity to consider the nuances of particular institutional and community contexts. In-depth, varied understandings were sought to reach the research aim of exploring how rights might be understood in practice, as well as how their practical application is currently enacted and could be more effectively realised in medical schools in Aotearoa New Zealand and Australia.

The interview schedule was prepared and adapted over time as the research progressed. In line with Kaupapa Māori methodology, kanohi-ki-te-kanohi (face-to-face) interviews were preferable, as it allowed for whakawhanaungatanga[5], so that trust and relationships can be established (Pipi et al., 2004). Durie (2000) notes that acknowledgement of peoples' mana[6], is enacted via face-to-face relations among Māori through practices of maanaki.[7] As such, the

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[5] The process of identifying, maintaining or forming past, present and future relationships (Bishop, 1998).

[6] "To respect the mana of others is to acknowledge others according to how they see themselves" (Durie, 2000, p.96).

[7] Greeting and welcoming, providing hospitality and care for others (Hoskins, 2012).

kanohi kitea, or 'the seen face', is a Kaupapa Māori principle that emphasises the importance of face-to-face contact and reflects Kaupapa Māori values in research (Smith, 2012). Also in line with Kaupapa Māori methodology, all interviews used a Māori protocol of initial engagement whereby I shared my tribal/genealogical connections, my commitment to this work and any connections that we might already share. This process was reciprocated with many informants likewise sharing stories of where they come from, how they came to be involved in this work, and commenting on shared connections. Face-to-face interviews were undertaken with 19 of the 20 participants in Phase One. One interview was carried out via Skype with a participant known to me prior to our interview. Interviews were completed during a six-month period from November 2014 to April 2015.

The interview schedule (see Appendix A) explored several subject areas by asking open-ended questions to gain an understanding of the way each participant understood these subject areas. The interview schedule was developed so that perceptions could be gathered on relevant subject areas without limiting participant responses. A general outline of the study was explained to each participant to offer some common orientation. Each interview opened with a broad question, followed by a series of prompts when required to assist the participant to fully explore the subject area and offer their perceptions before moving on to the next broad question/subject area. The prompts and wording of each broad question changed depending on who was being interviewed. This allowed each interview to be personalised while still maintaining the line of enquiry that Phase One intended to explore.

All interviews were recorded and transcribed verbatim with full participant consent by a professional transcriber or me. At the end of each interview I made notes detailing a summary and evaluation of the interview, including what I thought went well and what I perceived to be the key ideas emerging from the interview at that point in time. These notes were referred to throughout review and analysis of the transcripts for accuracy.

Data analysis

All Phase One interviews were audio recorded. Where possible, recordings were listened to by the primary researcher immediately after the interview. Once transcribed, interviews were carefully worked through by being listened to and read simultaneously to correct any content errors and to make notes for clarification where necessary. Data analysis began before the

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final interviews were transcribed, through listening to interview recordings and making preliminary notes on the dataset. As more transcripts became available, some of these recordings, and the transcripts and memos were repeatedly reviewed. Those interviews that offered the greatest number of insightful comments into the research topic were chosen to help prioritise the transcripts, which could then be used to generate initial codes. Each transcript was coded in its entirety using NVivo (10) software. NVivo assisted with coding interview material. The meaning making process that is shared between interviewer and interviewee, and assists with the development of a conceptual analysis of the data was foregrounded.

This research held that the research process is co-constructed between researcher and participants, and that the researcher takes an active, reflexive and explicit value stance, which shapes the data and analysis (Charmaz, 2011). By analysing Phase One data employing such an approach, patterns of meaning could be conceptually located as well as described in detail. Data analysis used a combination of inductive and deductive logic. The primary approach was inductive and comparative with the intention of keeping as close as possible to participant understandings while beginning to make comparisons within and between interviews. This is consistent with constructivist grounded theory methods, where inductive logic and comparative inquiry constitute the core approach to data analysis (Charmaz, 2011). However, the analysis was also deductive inasmuch as theoretical constructs drawn from Kaupapa Māori methodology (see previous chapter) were employed to help make sense of patterns of institutional distributions of power and the underpinning values that informed institutional policies and practices.

To begin with, five interviews that offered particularly rich data were used to identify the initial open codes, or categories. Each transcript was then coded according to these categories. As coding progressed, these codes were modified to incorporate new material, which usually resulted in a code becoming broader in scope, or the creation of a new 'child' code nestled under an existing 'parent' code. Three of the four research supervisors reviewed the coding structure that was developed after these initial codes were generated. In the second stage of coding, the relationships between the open codes were interrogated, consistent with axial coding. A process of refining and analysing how the codes related to each other resulted in the development of themes.

Phase Two

Aim

A case study was chosen for Phase Two as it allowed an in-depth exploration of how perceptions are related to practice. The case study was carried out at The University of Auckland's Faculty of Medical and Health Sciences (FMHS). Questions regarding whether and how the findings of Phase One reflected the University of Auckland's FMHS setting and what key stakeholders would prioritise facilitated further understandings of the practical application of Phase One's findings. Ultimately, the case study created an opportunity for the relevance and potential application of the findings of Phase One to be considered at a greater depth.

Case study design

A case study design was chosen for Phase Two of this research as it allowed for exploration and analysis of Phase One findings within a specific context. Qualitative case study design is acknowledged as being particularly valuable in health science research as it can be used to "develop theory, evaluate programs, and develop interventions because of its flexibility and rigor" (Baxter & Jack, 2008, p. 544). Such a design was well-suited to unpacking specific aspects of Phase One findings, as I need to pursue the 'how', 'what' and 'why' questions that naturally lend themselves to a case study approach (Yin, 2003).

A case study approach can allow researchers to explore wide-ranging levels of analysis (individuals, groups, organisations, or policies); interventions (simple or complex); relationships; communities, or; programmes within their 'true' environment, and is further validated if the researcher is familiar with that environment (Yin, 2003; Zainal, 2007). Case studies typically focus on theoretical underpinnings and a specific phenomenon of interest, with research questions determining the chosen methods (Stake, 2000). Used as a research strategy, case studies can illuminate how complexities within a particular context contribute to an understanding of a site, providing a context in which to interpret results that are meaningful for the site - and potentially other sites or settings that have similar complexities (Stake, 1995). The most common criticism of case study design is that it is not generalisable, and therefore lacks scientific rigor as a research tool (Zainal, 2007; Baxter & Jack, 2008). However, as Yin (2003) notes:

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> Case studies are generalizable to theoretical propositions and not to populations or universes. In this sense, the case study…does not represent a 'sample'…your goal will be to generalize theories (analytical generalization) and not to enumerate frequencies (statistical generalization) (Yin, 2003, p.10).

In Phase Two, University of Auckland's FMHS was used as a single site with an instrumental case study design applied. Like Phase One, the choice of study design in Phase Two had to be able to explore narrative from multiple perspectives. This case study explored Phase One findings, bound by one site. The case study was descriptive in the sense that it allows the narrative of participants to describe how the findings of Phase One related to their institutional setting, but predominantly instrumental in that the primary aim of the case study in Phase Two was to play a supportive role in facilitating further understandings of Phase One's findings. As such, representation as a typical medical school in Aotearoa New Zealand or Australia was secondary to eliciting rich insights into the relevance and application of the Phase One findings to FMHS. This is consistent with Stake's (1995) claim:

> We do not study a case primarily to understand other cases…The first criterion should be to maximise what we can learn…if we can, we need to pick cases which are easy to get to and hospitable to our inquiry…of course we need to carefully consider the uniqueness and contexts of the alternative selections, for these may aid or restrict our learnings. But many of us case-workers feel that good instrumental case study does not depend on being able to defend the typicality of Ө (the case) (Stake, 1995, p.4).

Given the in-depth analysis that a case study strategy requires, it was determined that a case study in Aotearoa New Zealand was most appropriate, primarily because I am a Māori researcher, which enables a depth of understanding regarding cultural concepts and context. The University of Auckland's FMHS was selected as the case study site as it was an accessible site and large enough to provide a wide spectrum of perspectives. As a student of FMHS, I had optimal access to key stakeholders. Ease of access and familiarity with and knowledge of the institutional context was particularly helpful in this regard. Potential limitations of the case-study method are reflected upon in Chapter Nine.

Sampling & recruitment

Multiple perspectives were sought to ensure that the full range of stakeholders was included in Phase Two interviews or focus groups. Key stakeholders in Phase Two are defined as those that have a vested interest in how the findings of Phase One relates to the FMHS context, by role and/or membership in a stakeholder group. As in Phase One, all participants are considered to be key informants or expert sources of information based on their vested interest.

Key stakeholders were invited to discuss the findings of Phase One, either in an interview or, if they belong to an identified stakeholder group, as part of a focus group or joint interview. Members of stakeholder groups who took part in either joint interviews or focus group interviews included the Tōmaiora Māori Health Research Unit, 5th and 6th year medical students, and a group of Kaumātua associated with FMHS. Stakeholder groups were identified as those groups who have a shared purpose or a collective identity, i.e. they already function as a group. Key stakeholders such as the Head of the Medical Programme, the Director of Assessment, the Associate Dean (Education) and Phase Directors were invited to take part in individual (one-on-one) interviews on the basis of their role.

All individual key stakeholders in Phase Two were invited by email to contribute to the research, with the participant information sheet and consent form attached. If no response was received to the email invitation, a second email was sent. A non-response to the second email was considered a rejection. Of the 10 potential individual key stakeholders that were invited based on role, eight responded and were interviewed. One of these key stakeholders was invited to take part at the suggestion of a previous participant. Both the Tōmaiora Māori Health Research Unit group and the Kaumātua group were invited via email to the respective group's main contact person who in both cases was already known to me. These contact people then discussed my invitation with the rest of the group and responded to me with possible interview times.

Medical student group invitations were circulated in two ways: one involved an announcement posted by the medical programme directorate coordinator on the learning management system of the University of Auckland, for all 5th and 6th year medical students; the second involved a direct email to all 5th and 6th year Māori and Pasifika Admission Scheme (MAPAS) students from the MAPAS coordinator. Māori and Pasifika students who wished to partake in a focus

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group with only other MAPAS students were given this option. The announcement was the same for both groups, asking students who were interested to email or call me for more details.

In total, eight individual interviews, two joint interviews, and two focus groups were undertaken during Phase Two. A table of the participant sample is presented below.

	Indigenous	Non-Indigenous	Total
Individual interview participants	1	7	8
Joint interview (n=2) participants	10	0	10
Focus group (n=2) participants	4	1	5
Total	15	8	23

Table 4: Phase Two participant sample

Data collection

Individual, joint, and focus group interviews were carried out with key stakeholders in Phase Two. Like Phase One, semi-structured individual and joint interviews were employed to gather key stakeholder perceptions and opinions and kanohi-ki-te-kanohi (face-to-face) interviews were preferable. An interview schedule was prepared to elicit views regarding how Phase One findings were understood by Phase Two participants and how they related to the FMHS context. The interview began with a few broad questions to orientate the participant to the research topic, followed by a description of aspects of Phase One findings and a discussion of these findings (see Appendix B). Prompts and wording of the questions were adapted depending on who was being interviewed. The discussion of the findings aimed to gather various, broad responses to Phase One findings, but also to identify examples of the findings in action based on each key stakeholder's role.

Joint interviews were held with two stakeholder groups; one with two participants and another with eight participants. These joint interviews followed the same semi-structured, in-depth interview schedule as did the individual interviews. The aim was to gather a broad understanding of the FMHS context in relation to the research topic as well as reflect on Phase One's findings through stakeholder understandings and expertise.

The joint interviews followed a semi-structured format, while the two focus groups began with a summary statement followed by participant discussion. While the joint interviews noted similarities in expressed understandings or perspectives amongst participants, this was not the explicit focus. By contrast, focus group interviews concentrated on and gave priority to participants' shared construction of meaning. In this research, conducting focus groups also enabled the medical student stakeholder groups to have more control over the interview process, as the interaction between the participants supersedes the interaction between the researcher and participants.

Focus group interviews in this research had the advantage of being able to explore how Phase One findings could illuminate stakeholder group collective identity – in this research, as medical students – and shared sense of purpose. The emphasis in the focus group interviews was on the interaction between members of the group, rather than interactions between the interviewer and participants (Bryman, 2015). Both focus group sessions began with a short introduction of the research, followed by a series of statements which the participants read and discussed in order. This interaction allowed a process through which members of the group could fully explore and clarify their views in relation to the key areas of Phase One's findings and how it affected them based on their membership of the group. Through this process, members could make sense of the research topic and construct collective meaning around it, enabling not only an understanding of shared knowledge and values, but also *why* members felt the way that they did.

The student invitation announcements resulted in one focus group with three MAPAS students and one focus group with two students, one of whom identified as a MAPAS student. While relatively small numbers for focus groups, thus limiting the number of participant accounts, this is not necessarily considered a drawback. All participants engaged in a lively discussion, acknowledging the complexity of the subject matter and expressing emotional investment in

the research topic. The combination of emotional investment and willingness to engage with complexity is considered optimal for smaller groups comprised of participants that have a lot to say about a particular research topic (Bryman, 2015). The discussions that occurred in both student focus groups were robust and considered to be of a high quality. Of the five students that took part, four identified as indigenous.

All Phase Two interviews were carried out face-to-face over a two-month period from the beginning of August to the end of September, 2015.

Data analysis

As in Phase One, data collection and analysis occurred concurrently. General principles of constructivist grounded theory were taken for granted, including the acknowledgement that the research process is co-constructed and that the researcher holds an active, reflexive and explicit value stance which shapes the data as well as analysis (Charmaz, 2011). However, Phase Two's purpose was ultimately to 'unpack' and refine aspects of Phase One's findings as a means to further understand how the application of Phase One's findings might work in practice. As such, while Phase One was intentionally inductive in its analytic approach, Phase Two was more deductive in its approach. Making sense of Phase Two data was driven by questions that related to specific areas of Phase One. Interview content was therefore initially coded descriptively by topic, including the specific areas of Phase One that were considered to be of particular interest. Next, these descriptive codes or categories were analysed in relationship to one another. Questions regarding the relationships between the major themes then led to the development of a model, in which the themes could be conceptually located. The model and the key themes are described in the following chapter.

Summary

This research consisted of two distinct phases, both of which attempted to understand how medical schools in Aotearoa New Zealand could better fulfil their commitments to addressing indigenous rights to health. In Phase One, key informant, semi-structured interviews were carried out to investigate expert perceptions of medical school commitment(s) to the indigenous health agenda and explore how an indigenous rights approach could potentially contribute to strengthening these commitments. In Phase Two, a single instrumental case study

explored multiple key stakeholder perspectives through semi-structured interviews as well as focus groups. By exploring how perceptions are related to practice at the University of Auckland's FMHS and discussing examples in action, the Phase Two Case study extended and further refined insights initially discovered in key areas of the Phase One findings. An inductive approach to analysis was used in Phase One. Phase Two used a deductive approach with descriptive coding. Findings are presented in the Chapter Six.

Chapter Six: Drivers of and obstacles to the indigenous health agenda

Introduction

This thesis has proposed that, within the context of medical education, advancing the indigenous health agenda can be accomplished by making commitments to honouring indigenous rights to health in the service of reducing indigenous health inequities and promoting indigenous health and wellbeing. This research was undertaken to explore how medical schools in Aotearoa New Zealand and Australia could contribute to advancing this indigenous health agenda. Informants were asked to discuss their views and ideas about how their medical schools might understand and apply commitments to indigenous rights. Chapter Six presents the findings of this research. It explores the key components of **drivers** of and **obstacles** to the indigenous health agenda.

This chapter and the following chapter present ideas thematically rather than chronologically. Thematic representation is consistent with an inductive approach. Informant ideas and views are illustrated and enriched by accompanying quotes. Participants are identified by their country, as indigenous or non-indigenous, and by their participant number. For example, Aus/I-12 is an Indigenous Australian designated as key informant twelve, or NZ/non-I-25 is a non-indigenous New Zealander designated as key informant 25. Key informants numbered from 29-38 participated in joint interviews. Key informants numbered 39-43 participated in student focus groups. As there was a distinctly indigenous 'voice,' amongst the plurality of indigenous perspectives, identifying participants as indigenous or non-indigenous was important. Indigenous informants tended to position themselves as holding an 'insider' perspective based on their familiarity with the issues discussed. For them these issues tended to be deeply personal, based on their sense of collective identity and often directly related to their personal life experience. Non-indigenous advocates positioned themselves as being located 'outside' the indigenous struggle to some degree. To varying degrees, non-indigenous informants identified themselves as being in solidarity with that struggle. For example, those who self-identified as activists described themselves as strongly committed to the indigenous health agenda. Nevertheless, they maintained some degree of separation between their indigenous advocacy work and their personal life. For indigenous informants, by contrast, this separation was generally either less real or less relevant. Differences in country were more subtle but also important. Indigenous Australian peoples are a smaller minority and are generally more marginalised than their counterparts in Aotearoa New Zealand. Not

surprisingly then, Indigenous Australians, as compared with Māori, tended to articulate more modest aspirations and their claims. Differences in aspirations and claims that reflect differing social realities do not as a result imply a double standard of indigenous health accountability. They do raise, however, the question of how to determine expectations and apply standards across medical schools in a contextually sensitive way that recognises and respects these differences. These issues are explored and explained more fully throughout this chapter and the discussion chapter that follows.

Interview content was initially coded descriptively by topic, including specific areas of Phase One that were considered to be of particular interest. These descriptive open codes or categories were then analysed in relationship to one another to generate axial codes. Axial codes identified the three key themes presented in this chapter and the following chapter: (1) drivers for change, (2) obstacles to change, and (3) strategic pathways that can effect change. Where drivers are stronger than obstacles, strategic pathways are more likely to be employed and to be successful; a strong indigenous presence within medical education can then be developed. The sub-themes of each of these three key thematic areas are described in detail. A visual model is presented on the following page, showing how these key themes fit together. The thematic analysis of Phase One data formed the basis of this model. Phase Two findings were then used to refine and add detail, based on examples found in action. Each of the themes and sub-themes are then presented in turn.

Building indigenous presence in medical education: drivers, obstacles and strategic pathways

The model shown on the following page (Figure 2) describes how an opposition or dynamic tension between drivers for the development of an indigenous health agenda and obstacles to the development of that agenda can be synthesised through the development of strategic pathways that overcome status quo opposition or resistance to the indigenous health agenda. These strategic pathways can be identified as a combination of valuing and representing indigenous knowledge and information, process and practice on the one hand, and investing time, money and energy in indigenous people and projects on the other hand, including increasing indigenous personnel and developing a resource base available for advancing indigenous priorities. The emphasis in this model (Figure 2) is primarily on indigenous-led initiatives and institutional support for those initiatives. Improved indigenous health outcomes

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are the responsibility of all health professionals and all institutions within the health sector, including medical schools, are responsible for developing effective strategies additional to or different from the strategies proposed in this thesis.
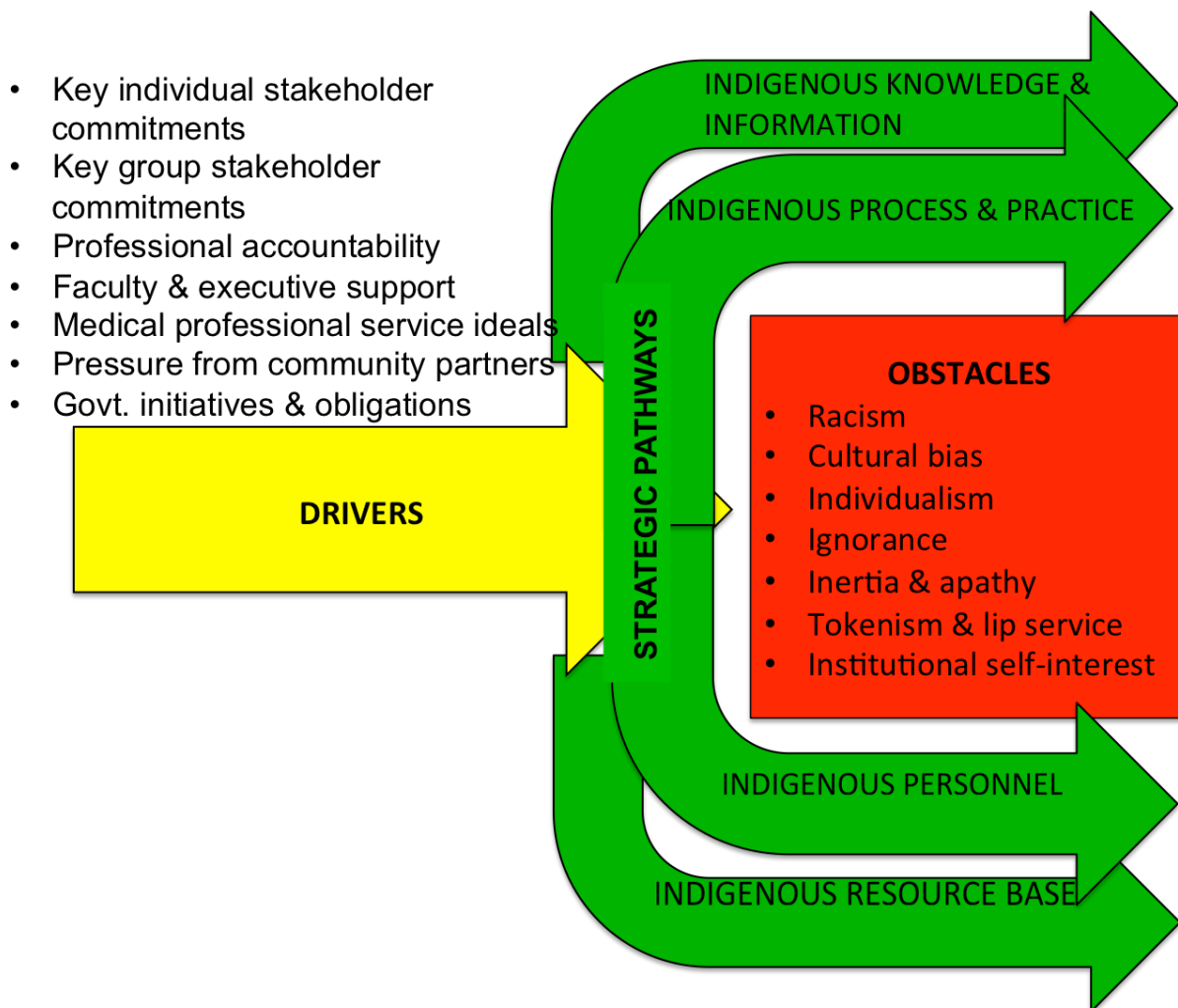
Figure 2: Developing Indigenous Presence in Medical Schools

Drivers for the indigenous health agenda

This section describes the first major theme from key informant interviews: drivers of the indigenous health agenda. This theme is a collection of ideas from participants' perspectives regarding what potentially progresses the indigenous health agenda within medical education. The sub-themes of drivers of the indigenous health agenda comprise the various forces or pressures that participants believed could focus attention on indigenous inequities and encourage the support of indigenous rights to health within medical schools. The majority of participants discussed nearly every one of the drivers identified, with the exception of

government-level initiatives and obligations discussed by a smaller number of participants. Drivers are described from smaller-scale, 'bottom up' to larger-scale, 'top-down' pressure or initiatives.

Although participants often echoed views and perspectives similar to existing literature in the areas of indigenous health and medical education, much of the discussion of drivers was based directly on participants' own experiences. Participants also went beyond their current experiences to describe aspirations for positive change and perceptions that positive change would require some additional forms of pressure on medical schools. Most of the drivers identified reflect relatively recent developments within medical education.

All participants agreed that the progression of the indigenous health agenda in any medical education setting was dependent on multiple drivers and their combined effect. The relationship between drivers was widely recognised as highly interconnected. Where there was positive synergy between drivers, progress was evident. Conversely, deficiency in one area often signaled deficiencies in other areas as well, which in turn indicated barriers to positive change. Each of the sub-themes of drivers for change are considered in the following sections.

Key individual stakeholder commitments

The commitment of key individual stakeholders was consistently cited as the single most important driver for the indigenous health agenda within medical schools in Aotearoa New Zealand and Australia. Without the sustained efforts of key individual stakeholders, informants expressed the opinion that other drivers for change would be insufficient to overcome obstacles to progressing the indigenous health agenda within medical education. This driver was usually referenced to the informant's own personal and professional experiences as a key stakeholder themselves. Most participants offered examples of their aspirations and commitments, and the degree to which they held themselves personally responsible for positive change was impressive. Due to their personal commitment, participants were highly alert to opportunities to contribute to change, despite what they generally perceived as their institutions lack of 'readiness.' All participants agreed that individual efforts were invaluable to advancing the indigenous health agenda.

Many informants, mostly indigenous, but several non-indigenous participants as well, spoke of placing their responsibility to indigenous communities above their loyalty to their employing institution:*"it's a cultural thing, so we* (indigenous peoples) *have cultural obligations* (to indigenous communities*)" (Aus/I-15).* Commitments were made above and beyond professional roles at institutions and represented something personally meaningful that led them to take initiative and make efforts beyond the requirements of their work role. Non-indigenous informants who expressed this level of responsibility and loyalty to indigenous communities referenced the relationships they held with indigenous communities as preceding their professional role within their medical school: *"a lot of it* (partnerships with indigenous communities) *is still, you know driven by personal relationships…you know, you're known; you've been there for a while and you haven't pissed people off too much (Aus/Non-I-5).* These informants identified themselves as activists in the indigenous space. They were motivated to seek and find opportunities to contribute to change, however, their activism was often portrayed as being in tension with the institutional context. For some indigenous participants, this tension was heightened by experiences of cultural hostility from colleagues or the institution itself.

The high levels of personal involvement that participants demonstrated were explicitly related to their core values, personal identity, and beliefs. These core values led the majority of participants to feel strongly about indigenous health inequities as something potentially very destructive to society. A significant number of participants framed indigenous health inequities as an outrage and an affront to basic principles of equality and justice. They described the reality of indigenous health inequities with passion and conviction, conveying a sense of the urgency with which they believed medical education needed to act to change this status quo:

> *We* (indigenous peoples) *are saying goodbye* (referencing high rates of preventable indigenous deaths) *to people at a very young age …and we have a medical school who are supposed to be churning out responsible doctors to help people, our most vulnerable groups, and we're not doing it…it's wrong, it's criminal (Aus/I-2)*

Here the collective indigenous experience is felt and expressed very personally by an indigenous academic. This experience of being so personally connected to and invested in

one's area of professional expertise was quite typical of indigenous participants, but was also noted as something fairly unique within the medical school environment. As one indigenous academic in Aotearoa New Zealand put it:

> *So indigenous health is a little bit different…by biological definition, you're connected to a community that immediately makes you have social accountability, which doesn't exist in other components of the med school. Unless they are a pregnant O and G consultant. Or an oncologist with cancer. That's the only time that they merge their clinical practice with their own lived reality. Whereas for indigenous colleagues, that's never separated (NZ/I-14)*

While many participants noted the tensions that arose from belonging to indigenous communities as well as western institutions, they also stated that their indigenous communities offered them guidance and a 'grounding' in their professional role, particularly in the context of building relationships between the university and indigenous communities. Being a responsible gatekeeper and taking a protective stance towards the collective was highly motivating "*'cause our* (indigenous people within the university) *relationship is also our integrity, our community, our families, you know, our reputations…so we're very protective*" *(Aus/I-10)*. The recurrent emphasis on protection also expressed informants' concerns for the maintenance of cultural safety within university practices. Both indigenous and non-indigenous informants identified the need for cultural safety within their institution without which indigenous peoples would remain at risk. Establishing cultural safety was understood as a process that required decolonisation and multiple challenges to existing power structures: "*You gotta find your ground, right…and I guess along the way there'll be challenges in terms of, y'know cultural safety, because of the system*" *(Aus/I-15)*.

Some of these discussions also revealed points of tension between indigenous and non-indigenous activism in the context of a rights approach to indigenous health. Differences as well as commonalities between indigenous and the non-indigenous voices were identified. As one indigenous academic explained:

> *I think it* (institutional support) *has to be at all levels…The trouble is if you have a really proactive* (non-indigenous) *person who's really into indigenous rights and just gets it, they're often marginalised by their other colleagues…And then, actually, the*

> *more they try and advocate for indigenous rights, the more it makes it worse for*
> *indigenous rights. So it can be counter-intuitive (NZ/I-14).*

A non-indigenous ally may mean well, and yet, in the opinion of their indigenous partner, they may not able to effectively help to create institutional change. This is 'counter-intuitive' inasmuch as the support of non-indigenous allies should be helpful, but there are often repercussions for this support, and occasionally they do more harm than good when they provoke 'backlash.' This point encapsulates the nature and difficulties of activism in the institution, which may affect non-indigenous and indigenous stakeholders quite differently and even drive a wedge between them. Difficulties are also experienced from the non-indigenous side of the partnership. Non-indigenous allies may lose confidence and wonder where to position themselves. In the words of this non-indigenous academic:

> *What right do I as a non-Aboriginal person have to be talking about indigenous*
> *people's rights? So it's awkward to talk about, clearly, as a non-Aboriginal person,*
> *but it's fundamental, because the basic human rights of indigenous people aren't*
> *recognised by significant proportions of broader society (Aus/Non-I-5).*

Non-indigenous allies may struggle to determine how to engage in strong and effective advocacy while maintaining cultural humility. Effective advocacy means being willing to speak out in alliance with and beside – but not in place of – indigenous peoples. Having the confidence needed for effective advocacy without loss of appropriate humility is a fine line that can be fluid and highly contextual. Non-indigenous allies may be congratulated in one context and reprimanded in another for saying exactly the same thing. All non-indigenous participants who identified as allies spoke of the ally role as a contested space, a role and position that is often fraught with tension. Recognition of this difficulty often prompted a conversation about the need to grow the number of indigenous key stakeholders within the university. Increasing indigenous personnel within the institution was cited as being critical to progressing the indigenous health agenda in part because of the complexity and difficulty of teaching non-indigenous peoples how to be effective allies to the indigenous struggle. As one non-indigenous academic pointed out:

> *...if we could teach all of our students to be, to have the understanding of indigenous rights and to improve health around that context it would almost be moot how many indigenous doctors 'cause it would, the person's own background might be less relevant (NZ/Non-I-24)*

Teaching indigenous health within a rights frame might eventually mean that the indigenous identity of practitioners becomes less necessary at a clinical level. However, at the institutional level, there was a general recognition that more indigenous faculty were needed to enable this teaching to be developed and implemented to begin with. More indigenous personnel within the institution was thus frequently cited as an efficient way to create a more unified position moving forward (see Chapter Seven).

Key group stakeholder commitments

A second driver were the commitments of group stakeholders. Many participants viewed the LIME Reference Group as the frontrunner of change in medical education, due to the collective intentions and actions of the group. As well as referring to the individual efforts of group members, many study participants referred to the collective efforts of the LIME Reference Group. For example, participants who were new to the indigenous health agenda and had limited experience in this area, such as new members of the LIME Reference Group, or community members who were relatively new to their role in relationship to a medical school, were able to find direction and draw strength from the collective. There was a general understanding that LIME reference group members were working in solidarity across widely varying contexts and situations, systems with their own systemic characteristics or properties:

> *...we're all working towards that in our own way and it's different depending on the system in which we're currently sitting in. The degree of commitment in my system might be different to the degree of commitment in your system... It looks different for all of us because we're all at different stages of either readiness or our systems are at a different stage of readiness, or what they're* (the university) *prepared to negotiate is varying at the moment (Aus/I-7)*

Many of the group members testified to how the LIME Reference Group enabled individual efforts within widely varying institutional contexts to sustain momentum, particularly in the

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absence of other forms of collegial and institutional support. The importance of support was acknowledged by both indigenous and non-indigenous informants. As one non-indigenous academic noted:

> *We've gotta keep the network going, we've gotta keep it, you know, LIME, alive to enable what is a very vulnerable workforce able to maintain, to survive in what is a very contested space sometime (Aus/Non-I-5)*

The effort and energy with which LIME Reference Group members sought to move the indigenous health agenda forward was impressive. As well as maintaining their LIME membership, many of these key informants belonged to other stakeholder groups within their institution and held key roles within those groups or more broadly within their employing institutions. Key informants who were not LIME Reference Group members also typically belonged to other stakeholder groups within their organisation or across organisations and were similarly committed to progressing the indigenous health agenda and similarly reliant upon group solidarity and support.

Professional accountability

A third key driver for medical school initiatives were the professional structures to which the medical profession holds itself accountable in Aotearoa New Zealand and Australia, most notably, the Australian Medical Council (AMC). Most participants agreed that accountability to the profession through accreditation of medical schools and guidelines from professional bodies and/or organisations was a key driver for implementing indigenous initiatives. In some cases, the demand to be professionally accountable was instrumental in creating new key stakeholder roles within the university:

> *There's no doubt that accreditation as a process for example, through the AMC, definitely drives some of the agenda…I wouldn't have a job if it weren't for the fact that the AMC standards actually specify that this* (indigenous health) *is something that needs to be taught (Aus/I-12)*

Many participants described the accreditation process as being essential for ensuring some kind of indigenous health agenda within the medical school. Recommendations from medical

councils and other professional bodies were seen as potentially very helpful for bringing attention to indigenous health issues in the wider medical curriculum. For example, the CDAMS Indigenous Health Curriculum Framework integrated indigenous initiatives and resources into the accreditation process. The demand to meet these requirements "*meant that there was finally a stick, if you like, that medical schools had to respond to" (Aus/Non-I-5)*. Professional initiatives offered a set of tools and leverage that could be used by key stakeholders to gain momentum within their particular institution.

Overall, guidelines and standards from medical councils and especially the process of accreditation by which these standards might be enforced was identified as an important driver across all institutional contexts, particularly those that were resistant to the indigenous health agenda. Professional accountability was seen as particularly important and necessary where support at the university level was missing, and this was evident in descriptions of AMC accreditation as a 'stick' that could potentially be used to overcome resistance. However, this needed to be paired with some commitment at the university and faculty level as well, in order to make these professional initiatives operational. As this indigenous academic noted:

> *So to avoid the kind of the hollowness that we were talking about earlier and the idea of lip service or doing what seems to be right but in fact…has no teeth or can't be followed through on…We need, if you like, bodies both at the university level and at a discipline level that make people accountable for implementing something real (Aus/I-1)*

To actually realise institutional commitments and see them through to fruition, a coordinated effort was needed to follow these through, and where real accountability for implementation was lacking, results tended to be lip service and 'hollowness.'

So while many informants acknowledged the importance of accreditation as one main driver of professional accountability, and all participants agreed accreditation could not be ignored, the effectiveness of accreditation was debated. Most participants expressed the view that the potential of accreditation to progress the indigenous health agenda was not being fully realised. Some participants viewed accreditation requirements as too restrictive and over-prescriptive, others worried these definitions or guidelines had been allowed to become out-dated or over-simplistic, and so were bound to fail. Some participants described the

accreditation process as a *"series of hurdles or a checkbox list that they have to tick off"* *(Aus/I-12)*. This criticism was held in tension with recognition of the potential importance of accreditation as an external pressure that could sometimes assist key stakeholder efforts.

Faculty and executive support for indigenous health initiatives

Informants consistently suggested that the progress of the indigenous health agenda was highly dependent upon the institutional support provided by faculty and executive leadership. Embedding indigenous health initiatives in the institution could only happen where faculty and executive support was strong. External professional initiatives or requirements alone were insufficient to produce lasting change. Genuine commitment to indigenous health initiatives required willing hearts and minds and the creation of a supportive medical school environment. Faculty and executive support was defined variously as: recognition of indigenous expertise, provision of resources, and structural support by the faculty and the executive body. Medical schools responded to the call for commitments to indigenous health, *"in different ways depending on the enthusiasm, and the passion, or the resources" (Aus/Non-I-5)*. Executive faculty played a key role in advancing or impeding of the indigenous health agenda:

> *Did they* (the medical school) *have people already working within their schools who had some knowledge, and expertise and passion? Did the Dean, was the Dean one of those who could hear and act, or resist, or just be passive, you know? And resisting the call for change is obviously much worse than, you know, not resisting it (Aus/Non-I-5).*

Nearly every participant that worked in a medical school setting regarded executive support as an essential requirement for a medical school environment that could progress indigenous health initiatives beyond the minimum requirements of the AMC standards. Participants recognised that whatever was valued at the executive level tended to inform both indigenous content and process (see Strategic Pathways 1 and 2 in the following chapter). As one indigenous academic explained:

> *Those values inform what he* (the Head of Department) *thinks medical students should learn about…part of that is the decision about content. What is core knowledge and required. And then there's the peripheral sort of parts that might or might not be core*

> *knowledge depending on what you think medicine is about. And then there is process in how your medical school runs and what informs its process (Aus/I-12).*

The view that structural or executive support was necessary to support individual and group stakeholder commitments by those committed to indigenous health was often expressed in the context of a discussion of the university as a contested space. The expectation of a 'backlash' seemed to be part of taking up a critical and proactive position with respect to indigenous health. As a result of being susceptible to backlash from other colleagues, or due to other expected obstacles, participants often mentioned the need to be pragmatic and take advantage of whatever resources were available within their particular institutional context. As one indigenous academic put it:

> *I guess I try to be pragmatic about things and realise that not everyone's, you know, people have got different drivers…some of them are accreditation, some are the funding that they have, and some is the philosophy within the school (NZ/I-13).*

This point identifies the importance of recognising other stakeholder's motivations, and strategically working to capitalise on these to move the indigenous health agenda forward. Many participants noted that the success of indigenous initiatives depended on a supportive medical school environment. According to the majority of participants, where faculty and executive support for stakeholder efforts was strong in a particular area, there was more likely to be effective action in this area. Structural support at medical school and University level empowered individual key stakeholder efforts.

While executive support was key to making efforts to embed indigenous initiatives within the medical school sustainable, participants were also careful to point out that executive support for the indigenous health agenda should not be equated with executive power or control over it. Several key stakeholders articulated their role in the institution as three-fold: (1) to remind the institution of the importance of the indigenous health agenda (2) to hold the specialised knowledge that can make this agenda effective: and (3) to defend indigenous autonomy and sovereignty. As this indigenous academic explains:

> *I'm saying within the academy, you need a squeaky wheel that reminds them about the importance of social accountability but that can also actually navigate them to social accountability and indigenous health. So even if they* (the institution) *have the best intentions, if there's not that critical voice inside the institution who understands social accountability to indigenous communities in a non-patronising way, the institution will have really good intent but not have good navigation skills on how to land on that shore (NZ/I-14).*

Participants expressed the belief that successfully embedding the indigenous curriculum in medical education depended in part upon key stakeholders or other indigenous health experts being able to maintain control of the indigenous health curriculum. In turn, the effectiveness of indigenous input was contingent on executive faculty's willingness to solicit and support that input:

> *Some of them* (components of the indigenous health curriculum) *are given lip service, some of them are taught more whole-heartedly. And that's dependent on the theme and who's looking after it and whether the core team looking after the indigenous health component is incorporated into the decision-making around 'how do I teach that?'(NZ/I-13)*

While executive support was repeatedly cited as a critical ingredient necessary for positive change, several informants also pointed out that good intentions at the faculty and executive levels could not take the place of indigenous expertise and authority in decision-making. Many study participants felt they were let down by executive authority within their institution, and several key stakeholders complained of feeling disenfranchised and/or excluded from executive level decision-making processes. Those participants who reported feeling unsupported by their Dean generally reported that he or she did not appear to consider indigenous health a core part of the curriculum. By contrast, those who felt supported by faculty at large, and particularly by executive faculty, felt that they could advance the indigenous health agenda beyond AMC standards and demonstrate real progress. Here, participants described a faculty-wide approach as a collaborative partnership effort between indigenous health staff, the Dean, and other faculty responsible for the curriculum. However, even where participants felt supported by their Dean and other executive staff, they still

needed to remind executive authorities of the terms of their partnership, in order to ensure that indigenous health was not overlooked or marginalised, as well as to ensure that indigenous health staff were not considered solely responsible for 'all things indigenous' within the curriculum or other school initiatives.

Medical profession service ideals

Many participants discussed how an ethics of care orientated to service could contribute to the indigenous health agenda. Service ideals was an encompassing term for all of the ways in which participants identified medicine's role in addressing social issues, such as public health, human rights, and social accountability. Some participants spoke about the disinterested pursuit of science versus an engaged service ideal, and how differently medicine is understood in these two different paradigms. As this indigenous clinician indicated:

> *So if you think that medicine is essentially about a disembodied scientist who does, you know, sort of, at arm's length decision-making about health, then your idea of what core knowledge is, is really different to if you had what I, as a clinician, see as a more realistic picture. Which is that you engage with both your patients directly and your community that you serve. Let alone your role and standing and credibility within the community and therefore your possible responsibility as an advocate within your community (Aus/I-12)*

Many participants believed that if service ideals in medicine were not valued or considered to be integral to medicine within a medical school context, addressing advancing an indigenous health agenda within that medical school would be difficult. Some talked about public health approaches to medicine as a way in which to introduce service ideals and a broad focus on health and society. As this non-indigenous academic explained, a public health focus could be a 'gateway', through which indigenous health could be taught:

> *If my role was explicitly to teach Aboriginal health then I would perhaps come at it through a different framework and maybe more from an indigenous rights framework. But given that I come to teaching it from a public health, population health standpoint then that's the place I'm trying to bring it in to the medical school curriculum (Aus/Non-I-11).*

A number of participants considered service ideals to be allied to the indigenous health agenda rather than 'direct' drivers of it. Indigenous health equity was not necessarily synonymous with broad service ideals and could still be marginalised within this broader service framework:

> *Indigenous health isn't just about public health, you know? And if you do that* (have indigenous health sit within the School of Public Health)*, then you sweep it under the carpet again. And it gets lost (Aus/I-12).*

Service ideals could, however, be used to support an indigenous health agenda. If the medical school publicly valued service ideals, even if indigenous health was not explicitly considered as the enactment of these ideals, an environment conducive to supporting indigenous health initiatives was created. For some medical schools that held service mandates, these mandates offered another way in which indigenous health initiatives could be 'fought for' or 'justified' within the school:

> *That* (medical school mandate for social accountability) *then sets a tone, even though you still get resistance from individuals and people, you know, at least that's the official line that they have to find a way around if they're going to critique it. Then they say… this is marginal to the real work of a doctor, but they still have to face up to the school's extant mandate (Aus/Non-I-11).*

Where medicine service ideals were valued, indigenous health initiatives were more likely to be valued as well. Many non-indigenous participants first came to teach indigenous health content as part of their work in public health and human rights approaches to medicine. However, as service ideals were not synonymous with indigenous health, some participants also believed that there was potential for indigenous health to be marginalised within a broader service rhetoric.

Pressure from community partners

Service ideals in medicine were considered by most participants to support indigenous health in principle, Where participants perceived their medical school as valuing service ideals, they

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were inclined to perceive their school as valuing relationships with indigenous community partners, such as rūnanga[8] or Aboriginal Community Controlled Health Services. In other words, a key way of enacting service ideals was through community partnerships with indigenous community groups. Some participants also identified indigenous community relationships as important to their medical school even if the school did not explicitly value service ideals. However, many informants expressed suspicion about the motives for developing community relations, and some described their concerns that partnerships were not being formalised in agreements that could enable accountability. As this indigenous health expert reported:

> *So yeah, I think it* (the University-community relationship) *very rarely comes from the community. It really comes from our institution. And I think our institution wants to do the right thing, but often that right thing isn't motivated by disparities. It's motivated by kind of more political correctness about, and people not wanting to get into trouble (NZ/I-14)*

Participants expressed the view that where community partnership agreements were dependent on indigenous relationships, they should be informed by or set-up based on these relationships as well as by their institutional mandate. Yet many participants mentioned that community relationships were not adequately resourced in the development phase or supported to reach a level of formal partnership that could ensure accountability. Similar to the notion that executive support for indigenous health initiatives does not mean executive control over those initiatives; formalised agreements at the institutional level do not replace relationship-based understandings. Some participants expressed the view that the goal was to create empowered community partners. This required formalised agreements that were institutionally embedded, yet still determined or controlled by their indigenous partners, as this indigenous academic explains:

> *We promise as an institution that we can do say research, and we're gonna work in their communities but actually the* (indigenous community's) *expectations are that*

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[8] Rūnanga are the administrative or governing body of Māori hapū or iwi in Aotearoa New Zealand.

> *they will benefit from that, in terms of, via better health, better education, better business models…We've got this high-level document that just says you know, we're gonna do something together, but we're now working on a next step, which is actually that* (the indigenous community) *is refusing to sign the MOU* (Memorandum of Understanding) *until they have an action plan….I think will be our very first one really trying to push social accountability in terms of, from an institutional level (NZ/I-14)*

Many participants described community relationships and agreements as still in their infancy. Participants suggested that where community partners could hold medical schools accountable to their agreement, indigenous health initiatives were more likely to be successful and sustainable. In the same way that the Curriculum Framework was often not adequately institutionalised or embedded within many medical schools, many participants reported that community relationships did not receive adequate institutional support. Participants reported a lack of faculty and executive understanding regarding the time, energy and resources required to maintain community relationships. Formalising partnerships between medical schools and indigenous community groups and organisations was considered a highly desirable outcome as it facilitated sustained resourcing and accountability. However, participants noted that these agreements or partnerships were primarily relationship-based, and so needed to remain dynamic and evolving, and personal, informal and open-ended as well as institutionally supported.

Government-level initiatives and obligations

Government obligations, initiatives and funding were noted by a small number of participants as having potential as leverage for indigenous health advocates at the university level. Several participants in both Aotearoa and Australia specifically mentioned government obligations under Te Tiriti o Waitangi:

> *… in principle, that's the stick that you guys* (Māori) *can roll up and go you know what, here's this friggin' document…That's where I think the leverage, the signing for Waitingi has, is different in terms of that leverage (Aus/I-7)*

Several participants likewise mentioned national-level initiatives and the impact these had on prioritising indigenous health within their institution. In the Australian context, initiatives such

as Closing the Gap[9] were discussed by a number of participants. One indigenous academic suggested that prioritising Aboriginal health at the medical school level was significantly influenced by these strategies:

> *... also driven very much by, you know, Closing the Gap, this is part of the Government's drive…Yeah, so they are forming part of that national initiative, you know, and starting it back in medical school…So yeah, so our funding comes from a different source and, like everything else, it's the Government of the day that decides what it will be…you know, Closing the Gap is the flavour, so you know, I've no doubt they'll provide funding that will enable us (the Indigenous health unit) to exist, but what they would more likely do is give the university this bucket of money and say, "within that bucket of money, if you think Aboriginal health is important, you have to prioritise it out of this bucket of money (Aus/I-9)*

This quote both illustrates how government initiatives such as Closing the Gap can directly impact indigenous health resourcing at university level, and how in practice those initiatives are likely to depend on executive authorities at the university making decisions and taking action with the resources available to them. It also highlights the difference between 'hard' and 'soft' money and how insecure funding is at times. As a 'flavour', as this informant calls the Closing the Gap strategies, initiatives may be developed or gain traction because they appeal to the current administration at government level. If those initiatives fall out of favour, funding dries up, and if the outcomes of such initiatives are devolved to institutional level without accompanying accountability, tokenism or lip service can result. Some participants expressed cynicism about the sincerity of government intentions:

> *You look at this whole rubbish about Closing the Gap, you know, people are, we're still, even though it's been on the agenda for so many years, we're still not much better off (Aus/I-17).*

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[9] Closing the Gap are national strategies that aim to address indigenous disadvantage by improving indigenous Australian outcomes in the areas of life expectancy, health, education, and employment.

Indeed, all of the participants who mentioned government-level initiatives and obligations as drivers for change also noted how these could be undermined and never get beyond lip service if there was no will to implement change at the institutional level. According to participants, broad statements of aspirations at the government-level only translated into actual practice when government support for indigenous health initiatives was strengthened locally at the medical school and faculty level.

Summary of Drivers for change

Almost every participant emphasised the importance of key individual and group stakeholder leadership to maintain motivation and effort. Key stakeholders had the commitment, motivation and expertise, particularly at the group level through LIME and in other community-based organisations, to progress the indigenous health agenda within medical school contexts. What was equally needed, however, was adequate institutional support to fully apply stakeholder expertise and implement existing strategies. Participant commitment to finding opportunities to contribute to change occurred in tension with the institutional context of many participants, which held other, non-indigenous priorities for their work. Many participants spoke of the importance of group-level efforts to support stakeholder activism and ensure individuals did not 'burn out' or lose heart in the face of inevitable resistance. A person-centred approach dependent upon the heroic efforts of a few key individuals would continue to put the indigenous agenda at risk. Participants also consistently identified the need to ensure that indigenous leadership initiatives were institutionally embedded.

When discussing how best to support drivers and create positive change, most participants focused on the medical school and university level, because it was at this level that most initiatives were seen as realistically possible. The majority of key informants were medical educators. As such, the teaching and learning of indigenous health was the primary context for discussions of drivers. The consensus of participants was that in order for indigenous health education to be effective, the environment of the medical school needed to support that teaching by including the indigenous health curriculum as part of medical education's core teaching and learning. This meant linking the indigenous agenda to valued parts of the curriculum such as public health awareness or the service mission of medicine. Where those aspects of medical education were themselves undervalued, this became more difficult. What

this meant in practice was the need to find creative ways to invite reflexive awareness of the multiple tensions that arose when attempting to realise indigenous health initiatives, and then explicitly linking these to the curriculum, to teaching and learning strategies, and to institutional goals and strategies.

Obstacles to the indigenous health agenda

Obstacles to the indigenous health agenda describe sources of resistance to change, or pressures to maintain the status quo. Drivers refer to pressure, and the sources of influence that exert pressure, but where counter pressure is equally strong, obstacles tend to block action. Every driver for change can be theorised to have obstacles specific to it, forces or influences that impede or block that driver, exerting counter pressure. As well as identifying drivers for change, all participants identified a variety of obstacles that impede the indigenous health agenda within medical education. However not all obstacles were identified by all participants. Rather, participants were more likely to note obstacles that they could identify from their own experience. Whereas drivers were aligned to aspirations and a wish for change, obstacles represented the counter-veiling tendency to reject change and seek to maintain or preserve the status quo:

> *…what's stopping us from getting ahead…it's because A) people are ignorant to what we were doing, or B) they don't want us to get ahead, they wanna make sure that they keep that power imbalance (Aus/I-17).*

This quote illustrates some important distinctions between two different types of obstacles. The first (ignorance) does not actively reject change, but nevertheless passively maintains the status quo. The second (desire to preserve power advantage) more actively rejects attempts to reduce inequities. Opposition to the indigenous health agenda may reflect a passive attachment to the status quo. Alternatively, it may reflect a more active rejection of demands for equity that would require those with power and privilege to share that power and privilege. Moreover, this rejection may be overt or covert. The greatest challenges to the indigenous health agenda are not obvious negative attitudes held by individuals, but rather the more subtle and powerful systemic bias of groups and institutions. Accordingly, obstacles to change are presented on a gradient from obvious and overt to subtle and covert.

Racism and racist attitudes; conscious and unconscious

Many participants referred to the presence of racism as hegemonic and very much a part of the status quo within the medical school, the university, and more generally in the medical profession itself. As such, institutional or structural racism might be covert rather than overt, manifesting through a variety of forms of bias or culturally self-centered attitudes. These attitudes were considered obvious, but only once someone had developed a consciousness about this and knew where to look for it. Many participants advocated for the embedding of indigenous health within the university as a means to combat institutional racism. Several participants stressed that this meant valuing indigenous health at all levels within the university:

> *I think it's important to make a commitment to Aborigines and Aboriginal health an important part of the important people's jobs, but it's also important to have it as part of everybody's business… Yeah, everybody from the receptionist to the admin assistant to whoever decided to put all those white people on the walls downstairs…(Aus/Non-I-11).*

What this participant asserts is the need for indigenous health to be valued across the entire university. In this person's opinion, this is not currently being done. If it were, there would be more consciousness of what the university values, whom it displays, and in whom it takes pride and identifies with.

Most participants asserted that if you knew where to look, institutional racism could be clearly identified. A number of participants emphasised the importance of teaching people, particularly students, how to identify racism. Many participants felt that a large number of people within their respective institutions were not aware of how to identify racism or understood their responsibility to help eliminate it. As the participant cited above continued:

> *That's one of the things to teach about, and for students to learn about, how to counter racism, you know, to understand what racism is, and to understand their power and responsibilities in countering the racism that they come across (Aus/Non-I-11).*

Participants also acknowledged that reproducing the culture of western medicine could be evidence of cultural bias without necessarily indicating racist intent. At both the individual and interpersonal level, cultural bias was fairly ubiquitous. Cultural bias is more obvious, more pervasive, and generally more acceptable than racism. While many participants, particularly indigenous informants, readily and routinely found evidence of racism at their schools, identifying racism publically was a particularly tricky situation to try to manage. Because it is socially undesirable to be perceived as racist, attempts to confront this reality put both parties at personal risk. Racist behaviour might be obvious, but it was often difficult and sometimes nearly impossible to hold individuals accountable for their conduct. Participants suggested that the lack of acknowledgement and accountability for racism had multiple origins. Some participants believed it was due to medical schools refusing to have their self-image tarnished, while others framed it as a function of power dynamics between individuals within their school:

> *And it's one thing to have an accountable, socially accountable school mandate, it's another to make sure it filters through all the clinicians and all the potential gatekeepers in the bureaucracy of the school and the teaching. And that's what we don't really know. I mean, people aren't going to show their hand. They're going to talk the talk but, you know, it's a big ask to say this person at best is a gatekeeper, at worst is racist. It's a big, when that person is an important big wig in the faculty, that's a big call (Aus/I-1)*

In cases where participants identified service ideals as key drivers of indigenous health, particularly where the medical schools had made explicit commitments to service ideals, most participants also mentioned the difficulty of being able to fully embody these ideals because of racism, at both the individual and institutional level:

> *I think the institution, to really to be able to become more socially accountable, I think before they go out and keep talking to people, they need to become less racist themselves…they need anti-racism strategies so that they're safe enough for our* (indigenous) *community (NZ/I-14)*

A number of participants spoke about cultural humility in the context of the cultural bias of the medical profession, and how a lack of cultural humility can result in racism and the reproduction of entrenched racist norms and values:

> *When a white professional can only look through that professional gaze, they're blind to the continuing machine of whiteness rolling on … So the whiteness of that institution is so confident in its capacity that it cannot have that capacity questioned. (Aus/Non-I-20)*

One racist norm was the expectation that all indigenous peoples within the academy automatically held knowledge and expertise relating to 'things indigenous.' As this non-indigenous academic pointed out:

> *And so that's one of the places where the institutional stuff falls down is because indigenous people are treated as if they're interchangeable. And so there's that kind of racism that operates there (Aus/Non-I-11).*

Many indigenous participants expressed the desire to be afforded the right to speak on behalf of their collective as well as being seen in their uniqueness. That indigenous peoples are so often considered interchangeable in terms of indigenous knowledge and expertise led to some interesting discussions with participants regarding how indigenous peoples are often seen as 'all the same.' This was considered at best, a form of ignorance and at worst a form of racism by both indigenous and non-indigenous participants.

Cultural bias against the indigenous health agenda

Most participants were well aware of the cultural bias of medicine and its resulting impact on indigenous health and medical education. Many participants asserted the need to address cultural bias in medical education, and also more broadly in the way in which western medicine is practised in general:

> *Yeah, I mean I think there are all kinds of things about the culture of western medicine, and the culture of western medical schools, that institutionalised power and dominance and western ways of thinking that are problematic for the health of all of the people*

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> *that are marginalised by their way of being. And yeah, so I mean decolonising the academy is a really important thing (Aus/Non-I-11).*

Decolonising the academy was mentioned by several participants who described how cultural bias at the university was related to racism and entrenched at the institutional level, as well as how this was related to the health professions:

> *One of the things I don't think that we do very well is for students to come out of any of our programmes with any understanding of the cultural and historical context in which those professions have evolved and the theories and the models that underpin them. Like the biomedical model of health and you know, how that is a, you know, where are the origins of all of these things? Why is medicine like this and nursing like that? And what are the colonising and decolonising influences in that? (NZ-Non-I-22)*

Participants noticed multiple ways in which western norms and values were privileged within universities and medical schools. Some participants spoke about the need to have more flexibility within medical schools, so that indigenous students are not disadvantaged. Some participants also highlighted how indigenous students may feel pressured to conform to these western norms and values. All participants who spoke about this kind of cultural bias emphasised that this needs to be addressed not just at the university level, but at the professional level as well:

> *That's saying, you know, we need to find ways of making sure that you can practise medicine without denying your cultural heritage. So what does that mean? Well it means we maybe have to change the way medicine is practised (NZ/Non-I-23).*

Several participants gave specific examples of cultural bias in medical settings, highlighting that what is emphasised in theory is not always practised. Student participants consistently expressed the belief that reinforcing cultural bias diminished the potential to engage patients as partners in health care settings:

> *That whole old school thought that doctors are, like, know everything, you know and you talk down to patients, and they do what they're told, you know, I think that that's just not helpful. It's not how the world works anymore (NZ/I-42)*

For many who identified cultural bias in medicine and medical education, the idea of an 'old boys network' or 'old school thought' was a short-hand description of how the medical profession resists giving up its power. Most participants identified power-sharing as necessary in order to address indigenous health inequities and improve indigenous health:

> *If we want radical improvements in Māori health, which is our end game, then we, it has to be threatening to the way in which we practise medicine. But because medicine is such a sovereign power-holding profession, that's very difficult, so, you've got a unique problem (NZ/I-28)*

Several participants who spoke about the maintenance of power in this context also recognised that cultural bias was linked to racism and commented on the difficulty of addressing this at a structural level, not just within universities, but in the medical profession in general:

> *That's how white men reproduce power structures, right? And so white medicos will continue to reproduce that power structure...So to address that at a structural level, you would want a medical school that has some way got some reach into the institutions that it's putting graduates into (Aus/Non-I 20)*

Individualism as an embedded assumption

Participants noted that the daily reality of being part of a western institution like a university generated considerable tension between individual and collective ways of thinking about the world. When discussing western norms and values in medicine, several participants spoke of how individualism was embedded within the university as well as in other western institutions:

> *It's* (indigenous health equity) *never been a priority because we've not been able to recognise humanity. So we've absolved ourselves of doing anything wrong because people were obviously just making poor lifestyle choices (Aus/Non-I-20)*

The attitude described in the above quote highlights one of the ways in which the indigenous health agenda challenges assumptions within medical schools, just as it equally challenges assumptions in the wider society of which medical schools are a part. Many participants identified the emphasis on individualism as being at odds with the emphasis on collectivity in indigenous cultures. A number of participants acknowledged that the academy followed their own rules and had their own hierarchy in accordance with western norms and values, except regarding indigenous matters. In these cases, many believed the university relied on indigenous staff to guide and/or lead. Insofar as this helped to ensure indigenous sovereignty, participants mostly approved of this deferential attitude. In practice, however, this was also recognised as potentially problematic:

> *There are different cultural paradigms and they don't fit…But the problem with trying to make them fit is sometimes you compromise on the things you shouldn't and, and when you do make them fit without compromise there is resistance (Aus/I-17)*

A few participants spoke of more progressive responses from their institution, for example, instances where uncompromising stances by indigenous peoples within the academy were viewed as an opportunity to learn about and fulfil bicultural partnership responsibilities. However, most participants viewed this response as coming from enlightened individuals within the academy acting on their own rather than a commitment to biculturalism embedded at the institutional level.

For some participants, it was obvious that an unbalanced dependence on indigenous staff to guide university process pertaining to 'all things indigenous' increased the workload for indigenous staff, and in most cases without adequate acknowledgement or recompense. Indeed, for several participants, this conversation led to a discussion about the reliance of this entire agenda on themselves within the university, and the uncertainty about what would happen if they were to leave:

> *So when I go, it's a real problem. It's very, I mean, I think that's a really major issue for all of the medical schools. It is very single person, personality dependent (Aus/I-12).*

Participants acknowledged the difficulty of determining how individual authority operates within a collective in practice. As noted above, many indigenous participants wanted to reserve the right to speak on behalf of the indigenous collective, but did not want this taken to mean that any and all indigenous people can offer guidance, leadership, or even just an 'indigenous perspective' on any given process or topic. Rather, according to participants, many indigenous peoples would situate themselves on a continuum of holding knowledge relating to indigenous culture, language, customs, and understandings, and would defer to those who held more authority – in most cases, their elders – whenever it was possible to do so. When faced with having to offer indigenous expertise in the absence of others who would be more appropriate, most indigenous and even some non-indigenous participants defended the need for expert consultancy. All the participants who spoke about this situation described having to repeatedly explain the need for as well as justifying the cost of outside indigenous expertise within their institutional context. This often led to a discussion of how a western individualistic paradigm fails to grasp participants' own understandings of their right to speak on behalf of the indigenous collective.

Authority regarding indigenous knowledge was fluidly determined by whoever had the wisdom, age, expertise, or mana in a particular situation. An indigenous person typically does not situate themselves on this continuum without reference to the collective, and their position will change depending on the context of whoever else is available and is most appropriate for offering knowledge and guidance for that particular situation. Several participants made this point regarding leadership within the indigenous collective:

> *I think there can be a role of champions within a collective structure, absolutely. In fact I think it's probably more a western way of thinking that we divide the two. And not understanding how that operates (NZ/I-29)*

Several participants noted that formal organisational structures within the medical school had difficulty incorporating this kind of fluid, contextual authority, and spoke of the difficulty of changing embedded western assumptions of fixed, unchanging roles.

Ignorance of indigenous realities

Where there was a genuine interest and will to drive the indigenous health agenda forward, but an accompanying lack of understanding regarding how best to go about doing this, ignorance rather than inertia was perceived as the obstacle. Many participants spoke of individuals within the institution who had good intent but lacked the knowledge and understanding to successfully execute their good intent. Several participants gave specific examples of how they had witnessed ignorance at the individual and structural level within institutional contexts – including but not limited to the medical school:

> *the prejudice of overtly prejudiced and racist people is of course terrible, but it's so out there that in some ways it has less impact than the prejudice of good people that so often don't see that what they're doing is oppressive…It's about the respect of the protocols of how their local Aboriginal organisations work…And they (medical schools) do it in some kinds of ways, you know, like this university's just appointed elders in residence, but they haven't done it through the proper process… And I don't think that the medical school or any of the other organisations I have ever worked for recognise what is really needed to have a reciprocal relationship in terms of sharing of resources…And it's the complete, it's the lack of recognition of what the level of need is within the Aboriginal community (Aus/Non-I-11)*

Here a respectful attitude is linked to developing the necessary knowledge and understanding of indigenous protocols that can build and maintain relationships with indigenous community partners. Participants repeatedly identified a lack of mainstream understanding and investment regarding what is needed in order to maintain reciprocal relationships with indigenous community partners. As this participant mentions, this is not unique to medical schools.

Several participants made comments that referred to deficiencies in medical teachers, or teaching that had become outdated, no longer relevant, or worse, reinforcing of racist stereotypes. As one non-indigenous stakeholder described it:

> *Because a cultural awareness training session these days has really ended up becoming almost a romantically racist way of viewing Aboriginality. So it has to be*

> *something that is around cultural safety that has the principles around diffusion of*
> *power imbalances at its core (Aus/Non-I-20)*

Participants who mentioned ignorance at the professional level also spoke about how indigenous community partners or faculty members are expected to contribute expertise when requested, but are often undermined or underappreciated at the same time. This lack of critical awareness results in inadequate acknowledgement and valuing of the crucial role that indigenous partners play:

> *We're* (indigenous staff members).*being expected to unpick the stuff that's already*
> *been done. You know, "oh we've got this thing, we'll put it out for draft comment",*
> *well hang on a minute, why didn't you talk to us before we got to that level? (Aus/I-17)*

Likewise, many participants spoke about indigenous community partners in the context of indigenous student support, noting that community partners, particularly elders, are uniquely positioned to offer valuable knowledge:

> *The white world considers there is only one world. The black world knows there's two*
> *and has to straddle them. So to learn how to do that is not in any course offered at*
> *university. So those elders there can give that education from an experiential*
> *standpoint that isn't going to come from anywhere else (Aus/Non-I-20)*

Ignorance was discussed by many participants as being inherent in the cultural bias of medical education and medicine. A lack of awareness or appreciation of indigenous knowledge resulted in missed opportunities for strengthening indigenous presence and indigenous impact within the institution.

Inertia and apathy: under-responding to the indigenous health agenda

Many participants mentioned widespread apathy as a significant obstacle to the indigenous health agenda. Acting on drivers for change requires individual initiative and significant investments of time and energy. Inactivity or inertia was also described by participants in relation to the difficulty of generating momentum for change within large organisations. Many participants mentioned the maintenance of the status quo as a structural issue within institutional context of the university and the medical school. Some participants described a general apathy within their institution that impedes action, while others mentioned more

detailed and specific instances of inertia. Many participants mentioned the gap between theory and practice in how universities and medical schools operate and the resulting lack of alignment to drivers for change. For some, these gaps reflected the limitations and hard realities of being part of a western institution. One indigenous academic cited an experience of the institutional status quo being upheld or reinforced by executive authority:

> *There's been times where the executive Dean of the Faculty has kind of come down and, you know taken control of things…And, you know, and that's really got, you know got me pissed off, but, but you sort of, yeah you just have to be realistic in that. And I guess the thing is, is that universities are, non-indigenous institutions where you're not gonna have total autonomy to direct how things are done (Aus/I-4)*

Many participants commented on the effort required to generate enough momentum to implement change, particularly change at a structural or institutional level. Some comments were directed towards the medical school in the context of University-wide practices or those of wider society, while others referred more specifically to the medical school context itself. As this non-indigenous participant asserted, structural change requires commitment to a strong challenge to the status quo:

> *So to interrupt that kind of entrenched prejudice, it takes a medical school that takes a very hard line about indigenous health. That doesn't just give it some half-sucked section of the curriculum that's about some, you know, cultural awareness, but that is about white culpability in indigenous health outcomes. And that takes a committed medical school to do that, you know (Aus/Non-I-20)*

Many participants referenced medical school priorities. Intense competition for time, space and resources often resulted in indigenous health being marginalised, or treated as an after-thought, rather than embedded within the core curriculum:

> *It* (indigenous health curriculum) *just gets shoved and fitted in where it can. Rather than it actually being something that's core and that you have to actually work through as a relevant component (Aus/I-8).*

A participant who spoke about inertia also described how even drivers could be used as obstacles, if there was a lack of institutional will to make use of their potential: *the accrediting body is a bit of a soft option because they could use their power for good, but they just maintain the status quo (Aus/I-17)*. Inertia within the institution and in broader society was viewed by most participants as a reflection of how indigenous health is undervalued, resulting in a lack of will to support the indigenous health agenda.

Tokenism and lip service; insincere support for the indigenous health agenda

As most participants discussed an absence of genuine commitment to indigenous health as an obstacle, and offered examples of tokenism or lip service as evidence of this, it has been included here. However, participants mostly considered lip service as an indicator of other more substantial obstacles, rather than being an obstacle in itself. Most examples of lip service that participants offered occurred within medical schools themselves. For example, while accreditation was described as a driver for change, the accreditation process was also perceived by many to be just another hoop that medical schools jumped through at accreditation time, signaling a lack of true commitment:

> *Whatever the rhetoric is, is not necessarily what's delivered…whatever we say to the accreditation party is not necessarily what happens on the ground…The rhetoric tends to be, "we need to be seen to be doing; AMC will be very interested in"…So not a reflective exercise, which is what I think accreditation should be (Aus/I-12).*

What this quote references is the fact that indigenous health is often a symbolic priority, rather than a genuine priority within the medical school. If there is an obligation to make indigenous health a priority (through AMC accreditation in this example), then it will be given strategic prioritization for accreditation purposes rather than being made an ongoing priority within the medical school. Several participants also described examples of lip service in community consultation processes. One of these examples pertained to the medical school tendency to objectify and label communities, while another referenced the difficulty of engaging meaningfully with communities while at the same time trying to meet institutional targets:

> *"Yeah good we've met with lots of people" - Did you meet with the people who have the greatest health needs or did you meet with the 'community'? I dunno. How do you do it? So you can get away with not doing it by doing it (Aus-Non-I-5).*

Participants identified resource allocation as a good practical measure of whether the lip service being paid to indigenous health at medical school or faculty level would result in action:

> *So if you were to ask yourself what's non-negotiable for medical schools to deliver on, what would be on that list? If we're (indigenous health) not on that list, then I would say we're lip service still. It's okay while everything's going good, but as soon as there's budget squeezes, you're gone (NZ/I-13).*

Institutional self-interest

Not unlike cultural bias, most participants saw institutional self-interest as something taken for granted within the university. As such, it could be somewhat invisible or difficult to identify unless you knew where to look for it. Institutional self-interest only became apparent as an obstacle in relationship to a particular driver or means to enable that driver. For most participants, institutional self-interest was referenced in the context of discussing other obstacles such as individualism, cultural bias, and lip service.

Participants viewed the medical school as pivotal in the relationship between the university and the medical profession. Participants repeatedly mentioned institutional self-interest as a major contributing factor to the general lack of willingness to implement structural change. This applied not only to medical schools themselves, but also to the wider university and medical profession. However, a number of participants did note that as a pivot, the medical school had a strategic position and role that could potentially allow it to exercise positive leadership. A medical school with a strong service ethic might lead both the university and the profession in indigenous health strategies. However, the greatest challenge would be to make this mandate operational. As this indigenous academic noted:

> *I think the university chucks around social accountability left, right and centre but when it comes to work they don't know how it relates at a local level. They do all the airy-fairy stuff up top, but they don't know how it relates to local level (Aus/I-6)*

Lack of action at the local level was seen as not only due to the difficulty of making aspirations operational, but also because it was to the university's benefit to appear to be committed to social agendas like indigenous health but not to actually demonstrate this commitment in action. Participants gave specific examples of how universities or medical faculties invest in the indigenous health agenda only to the point that this benefits the institution. If the medical school has to challenge another medical institution as part of their commitment to indigenous health, for example, this is unlikely to happen because the cost of this challenge outweighs the benefit to the institution:

> *I would expect that Dean to be doing something about the failure of that hospital…But it's not happening, you know…Well, when those indigenous people are dying in that hospital with graduates from that university…I can't really see how you can avoid that responsibility…there's been some really powerful innovations with regards to the education of med students; to see that go backwards and to see that fail and to see no strong objection from the med school, to me is nothing less than culpability in those deaths (Aus/Non-I-20)*

Participants discussed how institutions such as universities might be vocal in their support of indigenous health in principle, yet lack the will to enact the power sharing that is required to action this support. Tokenism and lip service were identified as signs of institutional self-interest. If an institution can appear to support indigenous health, without having to take the necessary steps to actually support whoever is driving this agenda, the institution will tend to take advantage of that perception. This leads to efforts that are merely symbolic, or tokenistic, rather than more substantial changes at the medical school and wider university level.

Summary of Obstacles to change

Participants identified a variety of obstacles to the indigenous health agenda, including racism, cultural bias, individualism, ignorance, inertia and apathy, and institutional self-interest. Lip service and tokenism were also identified as indicative of one or more of the other obstacles.

Generally, participants weighted the first six obstacles evenly; no single obstacle trumped other obstacles. Any one obstacle was frequently described as compounded by the others. For example, ignorance contributed to inertia, and individualism, ignorance and cultural bias combined to undermine support for indigenous collective authority. Participants viewed drivers to change as nearly always powerfully limited and conditioned by these obstacles. The overall sense of the significant resistance to creative initiative was quite pronounced when participants were discussing obstacles. Yet this seemed to lift when the focus shifted to strategic pathways by which obstacles might be overcome.

Summary

This chapter reported the findings in the areas of drivers for the indigenous health agenda and obstacles to that agenda. The following chapter reports on the findings of the strategic pathways to enable obstacles to be overcome and drivers to become effective.

Chapter Seven: Strategic pathways to building a strong indigenous presence within medical education

Introduction

This chapter continues from the previous chapter, with the presentation of **strategic pathways** for the indigenous health agenda. Strategic pathways includes four areas which together form indigenous presence in medical education. Chapter Eight follows with a discussion of findings, exploring issues relevant to the pragmatic means by which indigenous presence can be supported to make a real difference in influencing the culture of medical schools towards a favorable outcome in which the indigenous health agenda could promote indigenous health and wellbeing.

Strategic pathways: indigenous knowledge and information, process and practice, personnel, and resource base

All participants recognised the need for a strong indigenous presence in medical education and medical schools. All participants offered specific strategies to overcome obstacles and empower the indigenous health agenda within medical schools. These strategies formed four clusters or strategic pathways: (1) indigenous knowledge and information, (2) indigenous process and practice, (3) indigenous personnel and (4) indigenous resource base. Actively pursued, these strategies were capable of creating a strong indigenous presence in medical education. Participants gave different emphasis to the importance of different strategic areas, but all participants mentioned aspects of all four areas. While participants from Phase One primarily contributed to the identification of these four strategic areas through their many examples of how to progress the indigenous health agenda in medical education, participants also offered their perspective on what was most important in progressing this agenda. Phase Two participants offered specific examples of how these strategies could be monitored and evaluated and which of these strategic areas needed to be prioritised in order to maximize progress and impact.

Indigenous Knowledge and Information (Strategic Pathway One):

Indigenous knowledge refers to familiarity with the indigenous world and some degree of expertise in relation to it. Indigenous information or content refers to the sum total of indigenous words and images found in the context of medical education. This includes the

formal indigenous health curriculum, indigenous references within mainstream curricula, indigenous art and ceremony, indigenous faces on the walls of the university, and teaching and learning indigenous health relevant activities. Without indigenous knowledge and information, indigenous presence in medical education would lack visibility and impact.

<u>The indigenous health curriculum</u>

The formal indigenous health curriculum was the most obvious and most commonly discussed component of indigenous content within medical schools. Most participants emphasised its central importance. Of all the types of indigenous content discussed, the curriculum came closest to being defined as the core indigenous content, and as such, had the least chance of being considered tokenism. Many participants reflected on how much the indigenous health curriculum within their respective institutions had been developed in recent years and continues to be developed in new and creative ways. In some cases, participants described how aspects of indigenous health curriculum had become successfully embedded within the medical curriculum at their institution:

> *We're constantly looking at our (indigenous) curriculum and how we do that, updating it, revising it, it's constantly being tweaked every year… And then across the 4 years of the curriculum, indigenous health is embedded across the 4 years (Aus/I-9)*

Participants described aspirations for the medical curriculum that included increasing the number of teaching hours, ensuring continuity across the medical curricula, and developing greater clarity about the purpose these curricula serve. Quantifying the number of teaching hours allocated to indigenous health and supporting curricula was among the most commonly cited way of identifying medical education's commitment to the indigenous health agenda. Many participants commented on the need to increase teaching hours allocated to indigenous health curriculum and supporting curricula: *it's really hard…you've got 2 hours to give history of what, forty thousand years? (Aus/I-9)..* Particularly as the indigenous curriculum occupied only a tiny portion of the total curriculum, participants were keenly aware of the insecure place of the indigenous health curriculum within the broader medical school curricula. The value of teaching indigenous health was regularly challenged in mainstream contexts and needed to be defended on a regular basis. In part, this was felt to be due to the intense competition for limited teaching space and time. Many participants acknowledged the density of the medical curricula and the difficulty of 'finding a balance.' The most frequently

identified barrier to increasing indigenous teaching hours was that increasing the indigenous health focus would likely require decreasing something else equally important in the medical curricula. Participants worried that teaching indigenous health would be perceived as shortchanging parts of the curricula that students might value and enjoy more, such as clinical time. However, a number of participants suggested that integrating an indigenous health focus in other parts of the medical curriculum such as clinical teaching was entirely feasible and increasingly relevant and central to the goals of the overall curriculum:

> *Yeah, but I think that, you know, it's really possible. I mean it's possible to teach, what better way to teach respiratory health and illness than to teach it through Aboriginal health? (Aus/Non-I-11)*

Participants expressed a range of opinions about how to handle student resentment at having to study indigenous health. A certain amount of student resistance to the indigenous curriculum could be explained with reference to obstacles such as ignorance, cultural bias or racism. While participants were fully in support of exposure to the indigenous health curriculum being required rather than optional, most informants hoped to find ways to make this a positive experience for students and one that was based on attraction rather than demand. However, several participants were in favour of assessing and imposing consequences for cultural resistance on the grounds that this might lead in future to unsafe clinical practice. Participants also noted that the establishment of indigenous health as a core area of the medical curriculum would probably require measurement and accountability in order to have 'teeth' at both institutional and professional levels of training. If knowledge and skills in indigenous health were to be considered a basic part of medical professional standards, then indigenous health and supporting curricula should be formally taught and formally assessed. Those students who failed their assessments could potentially be prevented from progressing until they were reassessed and passed:

> *This is 2015 and we need to draw the line in the sand and say "you are a professional individual, you're doing your medical training to do good and to make people's quality of life better. And part of your registration to practise is around your code of professional conduct, which requires you to take into account the person that's before*

> *you. Who may not look like you. How are you going to do that and what does your*
> *code of conduct say?" (Aus/I-18)*

Participants also frequently mentioned the need for effective teaching in the indigenous curriculum and the advantages of having access to outside indigenous expertise. Several participants suggested that access to cultural resources was enhanced by partnerships with existing indigenous community members, groups or organisations. Without these community partnerships, the indigenous health curriculum might remain entirely reliant on existing indigenous health curriculum staff:

> *I feel that for a lot of the process stuff it's only coming from us (indigenous staff) at*
> *this stage. Again, it's not been built into basic theory or basic understanding of*
> *practice for medicine at say stage one or stage two level. It's something people*
> *generally only encounter in Māori health, which I think is odd given the relevance it*
> *has, you know, for any sort of prejudice or discrimination (NZ/I-29)*

Clinical teaching

Both indigenous and non-indigenous students mentioned that indigenous health often seemed an afterthought considered by most clinical teachers to be a relatively unimportant part of their learning or assessed outcomes. These participants also mentioned the degree to which many medical schools rely on competency-based learning. They viewed this as a barrier to developing reflexivity and thinking skills: [it's] *good for surgeons, surgical procedures and technical procedures. But it's not good for thinking. And it's not good for measuring your ability to synthesise (NZ/Non-I-27)*

Informants also suggested that external, competency-based assessments within the apprenticeship model might be problematic due to the large numbers of clinical mentors holding monocultural views:

> *They* (clinical teachers) *don't even know how to really assess that* (Hauora Māori
> domain)*, which I think, like, it's good that it's there as part of our assessment, but if*
> *they don't even know how to assess it, then it's like, what's the point? Especially when*
> *that person, that same person ticking you off, is racist (NZ/I-42)*

Informants mentioned a lack of feasibility and resources for training or ensuring that large numbers of clinical teachers could adequately assess aspects of indigenous health teaching and learning. As one academic noted:

> *Who's, who's vetting these clinical teachers in terms of the appropriateness?...There is an assumption that if you're a consultant or a general practitioner who is vocationally trained in General Practice, that all of this stuff* (cultural awareness) *is there. Well it's not, it simply isn't. And yet the Medical School is caught, you need, given the apprenticeship system that we have, you need hundreds and hundreds of teachers. (NZ/Non-I-25)*

Cultural teaching

A number of participants suggested explicitly addressing the cultural bias of medicine and examining how this impacts indigenous people and their health and wellbeing. Participants observed that many medical students and even faculty members have never had the opportunity to engage with the indigenous history of their country. For many, this is a revelation. However, many students who have had some exposure to indigenous history remain still close-minded. These students frequently declare themselves "sick and tired" of learning about the Stolen Generation in the Australian context or Te Tiriti in the New Zealand context. In those instances where critical theory and critical analysis is part of the curriculum, opportunities exist to identify and mitigate resistance:

> *you can have Australian graduates who are sick and tired of Aboriginal health training, they've done it at Uni and when they get into the profession they've gotta have it again because their professional colleges have a curriculum on that... y'know "we're sick of doing it" and so on. So the minute somebody says that, they haven't learned a thing. It becomes just a task that they have to undertake to get the endpoint...it's gotta be...systemic approaches that students are used to, y'know, getting feedback, doing assignments, getting feedback on that, assessment, critiquing...(Aus/I-15)*

Several participants also suggested the importance of teaching both the history of medicine and the culture of medicine, and suggested that the absence of an analysis of the culture and history of western medicine and its impacts on indigenous health were attributable to the cultural bias of medicine. Another important topic area in the indigenous curriculum related to cultural awareness was critical awareness and critical analysis. Most informants who identified themselves as activists in the indigenous struggle for health equity discussed the importance of being critically engaged. Those engaged in critical analysis, particularly indigenous personnel, tended to be more invested in claiming and holding fast to the aims and values of indigenous rights in the struggle to advance the indigenous health agenda. Activists, particularly non-indigenous activists, understood their role as allies to include engaging in advocacy within the wider medical system and lobbying their less aware colleagues.

Critical analysis was discussed as being essential to identifying obstacles to progress and devising specific strategies to overcome these obstacles. For example, critical awareness was necessary to identifying institutional racism and the many and varied ways in which such racism operated at the institutional level and may or may not be being addressed within the university. As this non-indigenous activist notes, recognition and understanding of institutional racism occurs within a broader political context:

> *I think that we* (the university) *are only doing a little towards creating that kind of change* (understanding and dismantling institutional racism) *and that we could do a lot more about it within the medical school, but we're doing it in the face of an increasingly conservative political environment (Aus/Non-I-11)*

Participant critical awareness and engagement with critical analysis contributed to understanding how the broader political environment shaped particular obstacles or contributed to strategies. Critical analysis is key to understanding the relevance and importance of indigenous rights to socially accountable health and health care. Likewise, support for equity schemes relies a critical analysis. One non-indigenous academic participant demonstrated the ease with which an equity ideal that values equality in difference can be confused with an equality ideal, in which sameness is presupposed:

> *There is a tremendous tension in New Zealand, OK, between the bi-cultural mandate*
> *and the multi-cultural context that we live in… Māori in New Zealand have the right to*
> *be in partnership and, and we, and the principles of the Treaty should be enshrined*
> *and honoured. But I don't believe that other people's rights and voice and the right of*
> *other people to have their voice heard should be trampled by that….I think that there is*
> *a real problem in New Zealand… there are two separate ways of looking at our society*
> *and that we, that in health we have to meet our obligations for partnership with, meet*
> *our Treaty obligations for partnership with Māori. And that as a result of that, there*
> *are initiatives available to Māori, which are not available to other people. And that*
> *creates an unequal society (NZ/Non-I-21)*

The declaration that equity-based initiatives for Māori create an unequal society seems curiously lacking in awareness that the social status quo is already unequal, due to the history and ongoing impacts of colonisation. This quote illustrates the point that without critical awareness, health equity initiatives are quickly and easily undercut and undermined. By contrast, where faculty held critical awareness and were actively engaged in critical thinking, support for equity was strengthened.

Curriculum alignment and institutional support

Participants emphasised the importance of alignment across the medical curriculum and linked formal assessment of the indigenous health curriculum to improving institutional accountability and professional responsibility. Conversations regarding curricula alignment cited the need for clarity of purpose across the curriculum and how more indigenous content in supporting curricula could contribute to the indigenous health agenda within the medical school. Increasing continuity across the indigenous health curriculum and supporting curricula in clinical teaching was widely perceived as positive. Several participants such as the person quoted above gave examples of how lack of alignment across these curricula could reduce or even undermine the positive impact of the indigenous health curriculum. The majority of participants who spoke of assessment identified a close relationship between assessment and accountability: "*that's* (measurability through assessment) *one strand of it, because that does give that underlying accountability*" (Aus/I-1). Conversely, a lack of assessment was seen as reflecting institutional inertia or undervaluing that portion of the curriculum. Participants felt that both quantitative and qualitative measures of indigenous curriculum content were potential ways to test if medical schools were 'walking their talk' as well as a means of

assisting them to action their commitment to the indigenous health agenda. Quantitative variables were a good place to start as these were relatively easy to measure: *I think the numbers game is always easier to see (NZ/Non-I-27)*. Possible measures included the number of staff teaching indigenous material, the number of indigenous health related curricula teaching hours, the number of hours spent with indigenous patients or indigenous community partners, and so on. Many participants stressed that formal assessment of students' knowledge and understanding of the indigenous health curriculum would be one way to ensure that it was taken seriously.

Informants regarded assessment as a challenging area to develop, due in part to a lack of clear direction or guidance from the AMC and the ambivalence shown by medical schools towards making indigenous health core to the curriculum:

> *It's the assessment side of things that needs to be worked on, and sort of realistic assessment, not just that tick the box...It's kind of probably, it's like a social kind of assessment around capabilities, and I think it's a journey kind of thing…At the moment, it's* (assessment) *at the institutional level, so accreditation, you know, the AMC has very basic requirements around appointing indigenous staff and having presence in their curriculum…But there's nothing in there* (AMC standards) *around assessment and there's nothing there that really gives any teeth to what you teach, because yeah if they don't want to engage they don't have to (Aus/Non-I-3).*

Despite these difficulties, most participants described significant achievements in their medical school's development and implementation of the indigenous health curriculum, In doing so, they acknowledged key drivers such as stakeholder group commitments, professional accountability, and faculty and executive support. However, at the same time, many participants suggested that inclusion of indigenous content did not mean that medical schools were taking full advantage of opportunities to strengthen indigenous presence and support it to have impact. Participants described specific instances where obstacles had reduced or undermined the ability to enhance and advance indigenous content. While many participants regarded symbolic indigenous representation within the university as a step in the right direction, this was seen as having little real impact unless it was accompanied by more robust efforts to progress the indigenous health agenda. Many instances were cited of lip

service being paid to indigenous content within the academy in the absence of genuine commitments to embed that content within the curriculum. In these cases, indigenous content stood alone, with minimum requirements being met in a largely unsupportive environment. Notably, within predominantly unsupportive environments, indigenous personnel were expected to take sole responsibility for indigenous content:

> *So the creation of a brown face is interesting, but the hiding behind the brown face and expecting the brown face to do everything becomes a problem (NZ/I-13).*

While indigenous content had symbolic importance in representing the 'face' of the indigenous health agenda within medical schools, many participants voiced their conviction that the potential of indigenous content could only be realised when it was accompanied by indigenous process. Participants had many ideas about how to embed indigenous process as well as content in the indigenous health curriculum, which could help to integrate this curriculum more fully into the culture of their medical school.

Indigenous Process and Practice (Strategic Pathway Two):

Indigenous process refers to a wide variety of indigenous ways of being and doing linking the indigenous world to the context and mission of medical education. These may take traditional form, as in ritual and ceremony, or they may reflect contemporary indigenous understandings and self-understandings. Indigenous process reflects core indigenous norms and values, for example, respect and care for land, language, kinship, reciprocity, relationality, hospitality, group identity, collective decision making, a politics of difference and self-determination, and a holistic and eco-spiritual worldview. Embedded within a context of indigenous process and praxis, indigenous presence has the potential to positively contribute to the political and cultural landscape of medical education by educating, enhancing and extending cultural and critical awareness and the reflexivity and self-awareness of medical students and faculty alike. At a practical level, indigenous process helps to develop medical education's commitment to culturally safe and sensitive practice, social justice, and equality in diversity.

While informants generally began their commentary focused on indigenous content, most went on to discuss indigenous process as well. Many informants noted that the inclusion of indigenous curriculum content in medical education did not necessarily result in the inclusion

of indigenous process. The process aspects of the indigenous health agenda in medical education, broadly understood, included areas such as indigenous ceremony and celebration, immersive cultural experiences, decolonisation, cultural humility, and cultural safety training, development of service ideals of equitable practice and partnership, reflective practice, and other forms of consciousness-raising.

For many participants, indigenous process was an effective means to create an optimal environment in which to progress the indigenous health agenda. Such an environment was described as having both a mainstream aspect and a specifically indigenous aspect. An optimal, pro-indigenous mainstream environment was viewed as something to aspire to that could be created by a critical mass of engaged faculty who were aware of how to identify racism and willing to address it at multiple levels, including engaging other faculty and/or students who might be resistant to the indigenous health curriculum. Participants discussed at length how and why students might be resistant to the indigenous health curriculum. These discussions identified the fact that many medical students could not see the relevance of this curriculum to their clinical training, and therefore attached less value to it. Participants emphasised the need for indigenous content and process to align itself to other parts of the medical curriculum. Reflective practice, personal self-awareness, professional skill development, and communication competences were all considered relevant to indigenous health and healthcare. Alignment among these was regarded as having potential to contribute positively to the indigenous health agenda.

Indigenous ceremony and celebration

Participants observed that indigenous staff are routinely asked to take responsibility for indigenous ceremonies and celebrations. Several participants suggested while these special occasions meant good public relations for the faculty or the university, indigenous ceremony was often treated as a 'badge' or token gesture of 'cultural appreciation.' What was needed more was a consistent and normal daily integration of indigenous content and process. Indigenous participants were quick to point out that being asked to be 'on call' for ceremonial occasions placed an additional burden on indigenous staff, who are still expected to continue performing all their normal duties.

Cultural immersion

Participants described culturally immersive experiences as an important part of the indigenous health curriculum with transformative potential for students. There was general consensus among participants that cultural immersion was likely to be the most effective way of overcoming resistance to the indigenous health curriculum. Participants reported that many of their students described feeling 'changed' by culturally immersive experiences. For this reason, the process of an immersive cultural experience was deemed more effective than formal teaching of indigenous knowledge and information or assessment of that teaching. Student participants in particular acknowledged the transformative potential of cultural immersion experiences as part of the indigenous health curriculum. Even though several participants noted that some students were unlikely to be changed by such experiences, and expressed misgivings about the potential for doing unintended harm in these experiences and the risk of alienating or 'losing' students as a result of their not feeling safe, others participants' described how such experiences can transform a majority of students and contribute to the development of both personal and professional clinical and communication skills. Students that were affected by indigenous immersion experiences were more likely to be able to relate to other cultures with cultural humility.

A number of participants described how immersive experiences had to struggle for legitimacy and compete with more orthodox medical activities. Advocacy for consciousness-raising activities was problematic within some institutional contexts and could in some cases put staff responsible for the indigenous health curriculum in a difficult position within the academy. Many participants also mentioned how many of their students had never had the chance to engage with the indigenous history of their country. Many of these same participants noted the resistance to learning such history from those students who felt they had already 'done' indigenous history, or as a result of being socialized to adopt attitudes based on ignorant and racist assumptions commonly found in the wider society. What these discussions made clear was the need to provide students with opportunities to 'unlearn' these attitudes. A number of participants spoke specifically about how to provide immersive experiences as part of cultural safety training:

> *We had the freedom in one particular year to bring in a number of community people to run some cultural immersion workshops…That's what should be happening every*

year. Funnily enough, the funding couldn't be found to do that again and we only did it once. But it was an example, it was, to me it was an example of best practice in indigenous health education. Because it wasn't just that this was a bunch of white fellas being able to view the other. This was a bunch of med students taking part in something that ostensibly they might not necessarily be able to see the science behind it or the relevance to their profession, but once they had done it they had a greater understanding...It raises their whole conscientisation around what respect actually means and what it could mean as a health professional to understand the richness of people's lives, you know, beyond an understanding of what a white life is, you know (Aus/Non-I-20)

Culturally immersive experiences were sometimes regarded as 'going beyond the curriculum,' particularly when there was a lack of support or resources available for these activities. Participants spoke of learning by trial and error how to operationalise good intentions and obtain adequate resourcing and support. Yet most participants regarded culturally immersive experiences as a core and crucial component of the indigenous health curriculum and indicated their wish to strengthen it. Student participants were particularly vocal in expressing their support for hiring indigenous clinical teachers:

I know for me working alongside, because I've had the opportunity to work alongside a few indigenous practitioners and it's inspiring aye, to see how they work, especially with indigenous people...if everyone had an opportunity to work with someone who...alongside indigenous professionals to see how they're interacting and maybe pick up some skills that way. 'Cos it's awesome when you see it and then it just makes you want to be able to do that. (NZ/I-42)

Cultural humility versus cultural competence

A number of participants strongly contrasted cultural humility with cultural competency. 'Tick-box' exercises pay lip service to becoming culturally aware, but lack a meaningful engagement with what it means to be a culturally safe practitioner. Participants identified the 'tick-box' attitude and approach to culturally competency amongst medical professionals as follows:

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And the outputs of that teaching (cultural competency training)*, I'm not sure how effective it is. I know they put some effort into it and, you know they teach how to sort of be culturally competent…But I'm not sure how well that teaching flows into practice, I know there's a huge sort of emphasis on that happening, but I'm not sure how effective….just about how much non-Māori really take on board that teaching…But my impression from other non-Māori colleagues is that it's sort of something they do to tick the box, but not something that they actually try to implement* (in clinical practice) *(NZ/I-32).*

Cultural competency 'training' was frequently cited as an example of the use of indigenous content that failed to incorporate indigenous process and as a result had limited impact on practice. One indigenous academic summed up years of teaching cultural safety as follows:

In med school we get a lot of unlearning in that we (indigenous health staff) *teach cultural safety, yet it's always labeled in the medical student assessment reports as cultural competency…given the length of the course, 5 to 6 years where we have very few opportunities to touch the students, we have intense learning opportunities…and they come out loving it, and feeling you know, good about wanting to improve Māori health outcomes. But there's an unlearning that happens, particularly once they hit clinical situation and you see that, that they start off the beginning of the year after finishing the last talking about racism, talking about the Treaty. By June they're talking "it was really helpful to learn Māori health because now I'm more culturally competent and… I'm not putting kai next to where I'm examining their head." And that disappoints me, you know, I feel despair when I see that… thinking we had you and we lost you (NZ/I-29).*

A number of indigenous informants were particularly clear about the relationship between diversity awareness, reflexivity, and safe and equitable practice, as for example:

There is a, there is still mixed messages on what is cultural competence…"cultural competence is knowing a bit of te reo and tikanga"… through to "it's knowing about Māori," to "it's knowing about myself and the way in which I cope with people who are different from me." So we've got a long way to go to actually, "it's not about

> *others, it's about me", and that's why I'm interested in now all the curriculum's going*
> *through med school have all this reflex practice, reflection, knowing about yourself,*
> *work life balance and mindfulness… And so perhaps we have to take, you know,*
> *perhaps in another generation things will happen. (NZ/I-28)*

<u>Cultural safety and equitable practice</u>

When referring to indigenous process, participants repeatedly spoke of the limitations of competency based learning to assess students' capacity for self-reflection, cultural awareness, and the underlying attitudes and values that shape commitments to cultural humility and safe, equitable practice. The assessment of equitable practice was seen as particularly challenging, and raised the practical issue of who was best capable of assessing this area of the curriculum. A number of participants mentioned that if their medical school were to start seriously assessing student readiness to engage in equitable practice, they might need to change the way they teach. Participants differed in their ideas about how to approach the issue of safe and equitable practice. Often a discussion of the need for assessment of equitable practice at the professional as well as institutional level led to questions about who was best equipped to carry out such assessments.

Several participants suggested that assessments did not have to be carried out during clinical placements or practice sessions, but could be assessed through the university. These participants acknowledged that this would require more indigenous personnel and more resources to undertake robust assessment, but believed this to be more feasible than training and monitoring large numbers of clinical teachers. A minority of participants believed that although clinical teachers might be unable to adequately assess in the area of indigenous health or aspects of supporting curricula, this was not necessarily a bad thing, as it allowed students to recognise poor practice and become motivated to want to practise differently: *even students work out when someone's a bad doctor and it's quite good for them to learn, I don't wanna be a bad doctor like this (NZ/I-28)*. However, the majority of participants who identified a lack of appropriate assessment by clinical teachers also believed that this would likely shift over time, as more and more doctors understood what it meant to assess student readiness to engage in equitable practice. As one indigenous medical student noted:

> *There are a lot of consultants who actually don't know how to assess that Hauora*
> *Māori domain. Once there are a lot more Māori doctors in that area they will be able*
> *to assess that properly and so they'll be able to actually write proper feedback in that*
> *domain and assess the students on that, sort of, aspect appropriately (NZ/I-42)*

Alongside this generational change, many participants believed that aligning the indigenous health curriculum with an assessment of students' abilities to absorb and make use of this curriculum could support and help advance the indigenous health agenda. Several participants suggested that integrating indigenous process could be a highly effective long-term strategy, eventually growing a new culture of understanding in mainstream medical education. In their view, embedding indigenous process would lead to active growth of indigenous personnel and a larger share of the budget allocated to the indigenous health agenda. As one non-indigenous participant put it:

> *I think if we focus on the indigenous process as being our number one, then that's*
> *where all of this will flow on...Because in order to do that and do that well you need*
> *money, time, energy and an organisational structure that backs it. You need a faculty*
> *that's behind it and you'll need the content to back it up (NZ/Non-I-27).*

Indigenous process was generally regarded as the most difficult strategic area to assess. Several participants suggested that this might be due to a cultural bias in medical schools and the wider profession regarding what was measurable and how to assess it. For example, participants identified aspects of indigenous process such as reflective practice as challenging, although far from impossible, to measure:

> *My thinking around why the personal and professional skills domain has, has had*
> *some storms to fight, is that this is the first time that students actually have had to*
> *reflect on practice. Now they may present their arguments in a bunch of different*
> *ways, "it's too subjective, it's too this, it's too that." I think in fact it's, it is a*
> *resistance to reflection on practice ...So is that measureable? Yes it is…it's a matter*
> *of accepting that the type of assessment that occurs in there is fundamentally different.*
> *And that what you're talking about is much more in the way of, the difference between*
> *qualitative research and quantitative… it's not gonna make sense if you, if you, if you*

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> *try to tackle the issue using reductionist, positivistic psycho-metrics. If you're starting*
> *to look at a much more qualitative assessment and you start to look at all the, you*
> *know, the terminology around reliability in qualitative research then you're starting to*
> *talk about something that actually is viable (NZ/Non-I-25)*

Not only were many aspects of indigenous process and supporting curricula difficult to measure, but also the traditional privileging of quantitative assessment diminished the worth of curriculum that incorporated process and attempted to measure student readiness to engage in equitable practice. Nevertheless, qualitative assessment measures were an important means by which to gauge changes in 'hearts and minds': [what] *we'll only be able to assess through specific studies, qualitative studies, is peoples' attitudes (NZ-Non-1-27)*. Several participants considered the presence or absence of such assessment measures to be an indicator of whether or not the indigenous health agenda was taken seriously beyond mere lip service:

> *If it's not assessed, students won't read to it. And that's the same for anything in any*
> *degree at university…So we need to assess decolonising processes. If we don't, then*
> *we just make aspirational statements about it that have no teeth (Aus/Non-I-20).*

Community partnership development

Most participants expressed the desire to make stronger links with indigenous communities. Community partnerships were widely regarded as essential to the progression of the indigenous health agenda with potential to positively impact other areas of medical education. Many participants, both indigenous and non-indigenous, valued opportunities to connect and build relationships with indigenous community groups and organisations. The majority of participants believed that indigenous relationships, particularly reciprocal partnerships with indigenous community groups, were a good indicator of commitment and progress in the area of indigenous health. Several participants noted medical schools' privileged position in relation to indigenous community groups and organisations:

> *And in some ways the privilege of medical schools means that medical students are*
> *going…to be able to learn more about indigenous health and indigenous people and*
> *culture, and history, and health, than what lots of other people do … indigenous health*
> *services are much more willing to put into here than they are into the nursing school*

> *or physiotherapy or the history programme, or plant plants or whatever. You know, it's the privilege of medicine. Indigenous people and organisations really want to have doctors, good doctors and doctors who come and work for them. And so they put themselves out there to try and get a good outcome (Aus/Non-I-11)*

A number of participants linked privilege with responsibility. Every participant who mentioned that indigenous individuals and organisations are willing to put energy into relationships with medical schools also expressed that universities have much to offer such community members and organisations. Universities were described as capable of providing training in those areas in which partner organisations might require assistance or additional training:

> *What can we as a school...provide in reciprocity to, you know it's not just a, you know, farming opportunity of clinical experience...We can offer a whole range of stuff...on an individual level I can assist with research, or we can assist with educational opportunities. We can do a whole range of things. (Aus/Non-I-5)*

Although a number of participants spoke of the difficulty of organising and making operational a reciprocal relationship with community groups, they also identified the potential opportunities and benefits for both parties. The university had much to offer community groups, but equally, much to gain. Resource allocation towards this agenda was always welcome, but as several participants noted, community engagement and partnership do not necessarily require large sums of money, particularly where local community groups already exist:

> *There's no reason why that* (engagement with a local indigenous community organisation) *couldn't be happening...it's 5 minutes away from the University. Yeah, and that needs to be driven and supported by the medical school...it's going to be funded, there's going to be a trip every year for med students...every med student will get the chance to go on a trip like that... it's very easy to do it...because the transport issue isn't a problem...So it would have, there'd be multiple facets to it, you know. Then, not only is your community engagement real, but it's actually supportive of community organisations doing what they're there for (Aus/Non-I-20).*

While many participants mentioned the importance of recompense and adequate financial support for community partners, participants were equally clear that reciprocal relationships are not simply transactional. Where relationships with community groups are dependent on funding models, they often fail to become sustainable and long-term. In other words, community engagement fails to grow into community partnership. In this sense, succession planning of these relationships was essential to ensuring the future of reciprocal partnerships at the community level.

Some participants emphasised how the indigenous health curriculum creates opportunities for community investment and engagement with indigenous community groups. Other participants described indigenous ceremonies within the medical school and faculty or having indigenous art and indigenous faces on the wall as a tangible marker of the university valuing indigeneity, potentially contributing to community engagement:

> *And looking at the school's history…Survival Day could be an opportunity for the university to have a look at that history but have a time of celebration as well, you know. And that would go a long way in healing for those people that are still involved in repatriation and reburying bones and are in so much pain around that. For the university to acknowledge their role, their central role in that (Aus/I-8).*

A number of participants also referred to relationships at the inter-professional level. For example, as primary health care settings become more central to medical education, relationships between medical schools and primary health organisations (PHOs) could evolve to capitalise on the opportunities for contributing to the indigenous health agenda:

> *Does the Medical School specifically interact with PHOs to say, hey look, here is an educational experience that we want these students to have, how can you now help us to do that? The really good PHOs would cotton on that long-term this is a huge investment…I think into the future, a much better relationship between the Medical Schools and as PHOs continue to evolve and mature, that might in fact actually be a very profitable relationship…. in particular if the Government starts to tweak the way that the PHO, the back to back contracts between the DHBs (District Health Boards) and the PHOs work…that becomes a very powerful lever for saying, yes we do need to*

> *be involved in education and if we are interested in reducing disparities this is a way*
> *of doing it (NZ/Non-I-25)*

Participants who spoke about such inter-professional relationships were emphasising the need for a more integrated system in accordance with new developments in medical education. Strengthened relationships with other professional organisations offered the university an opportunity to lead changes in medical culture at the professional level. Several participants spoke about the impact that medical colleges and councils have on the current medical curricula across both Aotearoa New Zealand and Australia. These participants all identified how colleges and councils can learn from medical schools in this area and eventually be held to the same standards that the AMC holds medical schools to with regard to indigenous health. This conversation echoed many informants' perceptions of the medical school as a pivot between the university and the medical profession with an opportunity to exercise positive leadership. Medical schools could demonstrate leadership by developing partnerships and collaborations with professional bodies, and most particularly with community groups and organisations, and this was considered an important area in which to assess progress. When participants spoke about indigenous process within the medical school, they often linked this to the need for reciprocal relationships with indigenous communities, and described how these relationships can contribute to the indigenous curriculum and enhance and extend the efforts of medical school indigenous staff.

Indigenous Personnel (Strategic Pathway Three)

Indigenous personnel refers to all indigenous faculty, academic and administrative staff, indigenous students and clinical teachers, indigenous community partners, and indigenous stakeholder group members. All participants across both phases emphasised the critical importance of having indigenous staff visibly present and actively involved within medical schools. Participants interpreted the presence of these key stakeholders within the university as an indicator that the indigenous health agenda was valued within the university. There was virtually universal agreement about the need for more indigenous personnel, within the medical school itself, within the university, and inclusive of indigenous community partners. Many participants also acknowledged that key stakeholders and indigenous health staff need not and should not be limited solely to indigenous peoples. For some, this assertion was

backed by a belief that indigenous health was everyone's responsibility, including faculty, staff, students, executive, and clinical educators:

> *I've always had the view that indigenous health is a faculty problem, it's not a problem of (indigenous academic staff) solely, they're the experts but they don't have to fix it (NZ/Non-I-26)*

On the other hand, most participants identified the presence of indigenous personnel within the medical school as essential to moving the indigenous health agenda forward. Expertise in indigenous health was generally perceived as the domain of indigenous faculty. This assertion echoed many participants' narratives about the importance of indigenous key stakeholders:

> *I think the changes that have happened… have happened because you have indigenous staff who have got to know the culture of our organisation, and then have worked out what points you need to manipulate to be able to advocate for* (indigenous) *rights (NZ/I-14)*

When discussing the importance of indigenous personnel within the academy, most participants emphasised the high level of investment and accountability that indigenous peoples have to indigenous communities. Indigenous staff were generally perceived as having the strongest relationships and most influence with indigenous communities, while indigenous students were perceived to be the students most likely to go on to work in the area of indigenous health. Growing the number of indigenous clinical teachers or consultants was therefore seen as an effective means to ensure that indigenous health could be effectively taught and assessed. That greater numbers of indigenous personnel within medical schools are needed to progress the indigenous health agenda was considered obvious by most participants. However, many participants also mentioned the importance of having non-indigenous experts in indigenous health, and not assuming that all indigenous personnel have one-size-fits-all indigenous expertise. This links back to the idea that indigenous peoples in the medical school context are not interchangeable in terms of their particular skill set:

> *So yeah, maintaining some focus on having indigenous health expertise is different than maintaining focus on indigenous people just for being indigenous. So our*

> *expectation is that the faculty now understands that not anyone who happens to be*
> *indigenous can teach indigenous health (NZ/I-13).*

Building relationships

Many participants asserted the importance of partnerships between medical schools and indigenous community groups and organisations. These were considered to be key indicators of commitment to the indigenous health agenda within medical education settings. While a number of participants noted that inter-professional partnerships, e.g. between the medical school and other colleges of medicine or medical councils were important, community partnerships could usually be distinguished based on the quality of personal relationships. All partnerships within and beyond the medical school were described as needing to be based on reciprocity and mutual respect, sharing of knowledge and resources, and the development of targeted strategies to reduce obstacles to indigenous health equity. However, many informants considered personal relationships to be the cornerstone of partnership development. As one indigenous academic noted, *"[if] you've got a respectful, mana enhancing, two-way relationship then you'll get a really good relationship happening (NZ/I-28).* Personal relationships were seen as offering the strongest means by which to make sustainable community partnerships with long-term impact:

> *Relationships, if they're real, well, they continue and they're substantive and they're*
> *not just for a service or for an appropriation or for some form of, you know, approval.*
> *Often white fellas will only have a relationship with indigenous communities because*
> *they want some form of approval from some institution that says they're performing*
> *community engagement. And it's, so it's a very mercenary relationship (Aus/Non-I-20)*

As this participant noted, relationships that developed beyond a transactional level to genuine reciprocity were highly valued by indigenous people. Sometimes these were not valued in the same way by non-indigenous people. However, non-indigenous participants who maintained close personal relationships with indigenous community members and organisations also made clear their views that while the insider status of indigenous people obviously made such relationships more likely, non-indigenous people were fully capable of developing these relationships as well:

> *it would be better if the university were employing Aboriginal people who did have trust and recognition and relationship and knowledge and skill and all of those things, but there are also non-Aboriginal people who have those relationships* (built on trust and time, etc.)*... a lot of it is relationship dependent, whether or not you're indigenous or not. (Aus/Non-I-11)*

Time and energy were cited as necessary requirements for cultivating and maintaining community relationships. These relationships were more likely to flourish in the institutional context when given support and resources within the faculty, regardless of whether the role of developing these relationships was held by a non-indigenous or indigenous staff member within the university. As this non-indigenous academic noted:

> *The relationship* (with the local Aboriginal cooperative service) *has really improved…So I wasn't involved in the indigenous health component until two years ago and it was going downhill rapidly so they got me to bring it back up to where it should be… And then along with me having employed tactically a couple of other people and our plan is to get a director of indigenous health within our team…So the head of school basically gives us the support and I guess the time to develop these relationships (Aus/Non-I-3).*

Many informants identified the relationship between the institutional commitment to indigenous health and consistent support for community relationships. When valued at the institutional level, these could be supported to develop, demonstrating real commitment to indigenous health: "*if the commitment was there the relationships could be built quite easily*" *(Aus/I-7)*. What was most challenging was the widely differing understandings of what constituted partnership. Indeed, this is what participants noted as the major difference between indigenous and non-indigenous approaches to relationships. Real partnership requires flexibility and adaptability based on an appreciation of the nuances of context. Both non-indigenous and indigenous informants acknowledged that indigenous peoples were more likely to understand and accommodate these nuances. However, personal relationships based on a history of mutual trust and shared understanding allowed non-indigenous partners to develop this kind of flexibility as well.

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Community cultural expertise

Several participants referred to the limits of their indigenous knowledge and experience. While they felt comfortable teaching indigenous content within the context of the mainstream curriculum, contributing to the indigenous health agenda beyond what is taught as part of the curriculum and offering guidance to medical schools about this can be a complex and somewhat daunting task. Indigenous community expertise was recognised as potentially supportive of both indigenous and non-indigenous participants. However, institutional support for indigenous community expertise was recognised as something that often met resistance on the grounds of limited resources such as cost and time availability. Indigenous expertise from outside the academy also challenged a culture of insularity and self-sufficiency held by some medical schools. Even when institutional support for cultural consultation did exist, indigenous expertise was often in short supply, or unavailable, either because there was an insufficient number of indigenous health staff within the school, or because the faculty lacked strong partnerships with indigenous community members and/or organisations outside the school.

Indigenous Resource Base (Strategic Pathway Four):

All participants remarked on the need for resources to activate, support, and continue to progress the indigenous health agenda. For most participants, the development of an indigenous resource base referred to the reliable and consistent allocation of money, time, and energy towards the indigenous health curriculum:

> *It would be nice to have that; our own unit, to have our own money. And look, in the perfect world, more time in the curriculum (Aus/I-9)*

Many participants spoke about how staff at the faculty and executive level within their institutional context increasingly perceived indigenous health as a staple part of the medical curriculum. A number of participants commented on the degree to which indigenous health had been institutionalised, as this non-indigenous academic noted:

> *I mean if I think back five, and certainly 10 years, there were a lot of people who would've been saying, "...why do we have to put this sort of stuff into our programme, aren't we providing doctors for all of New Zealand here?" Don't hear that so much*

> *now… what's happened is rather than being an add-on or something that, in some people's eyes, was an unnecessary add-on that we have to do in order to satisfy some Treaty obligations, this has now become more of an integral part of the programme throughout every year (NZ/Non-I-23)*

However, some participants were quite adamant that the resourcing of indigenous health is still highly contested and relatively insecure, either because the funding for this curriculum comes from a separate source, such as the rural clinical school, or because even with direct funding it remains a 'negotiable' budget item:

> *It's* (indigenous health) *been institutionalised in the thinking. Having said that, it's constantly under threat so it's not truly institutionalised. In other words, as soon as the budget pressures come on, we get squeezed… When you start reducing that budget line, you start reducing what my teams can do. And then when you reduce what the teams can do, you start reducing your outputs. So that is the pressure being put on us because it's not a non-negotiable product (NZ/I-13)*

This highlighted an important difference between establishing indigenous health as a core component of medical education in the first place and maintaining it as such year after year. Because resources are such an essential requirement to bring aspirational intentions to life, a number of participants identified resource allocation as the most important strategic area to increase and advance, a primary causal agent that would then generate flow-on effects. An indigenous resource base might be used to support and develop autonomous indigenous units or departments. These departments and units could then take responsibility for indigenous admissions schemes, develop the indigenous curriculum, provide clinical teaching in areas related to indigenous health, lead community engagement, develop partnerships, MOUs, Memoranda of Agreements (MOA)s, etc. certify fitness to practice equitably, the list goes on.

Indigenous workforce development

A number of participants identified development of an indigenous workforce as an important long-range strategy to increase the quantity and quality of indigenous personnel within medical school contexts. Participants consistently mentioned indigenous workforce development strategies as a possible progress indicator within institutional contexts. Some participants who spoke about workforce development strategies were referring to growing the

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future health workforce through affirmative action admissions schemes that reserved places for promising indigenous students, while others spoke about developing pathways for indigenous graduates to enter clinical specialties or academia. A smaller number also spoke about attracting indigenous staff to medical schools through the creation of a favorable climate for indigenous practice, including increased indigenous content and process and advancement and promotion of indigenous personnel. Participants expressed the view that indigenous workforce development required an increased number of indigenous staff members in leadership positions, as well as increased numbers of staff allocated to teaching indigenous health, to mentoring students and conducting immersive cultural experiences, and to ensuring that completion rates for indigenous students improved. All of these developments would need to be underpinned by a strong indigenous resource base with a fixed annual budget allocated to indigenous health. Despite difficulties obtaining data on some of these quantitative measures, a majority of participants agreed that any of these could potentially indicate institutional commitment and valuing of indigenous health. For example, workforce data was noted as a means of assessing whether the number of indigenous doctors was increasing, and how initiatives in medical schools were flowing on into the clinical specialties:

> *…the proportion of* (indigenous) *students in the class is negative to the population… and we know nothing about how they convert to senior doctors in the workforce yet… so we need workforce data to just look at conversion rates. And one of the jobs I'm doing is trying to look at pipelines* (for Māori) *from medical school into house surgeon jobs (NZ/Non-I-26)*

Most participants who spoke of these long-range development strategies also cited the importance of indigenous leadership and indigenous collective ownership and control over programmes and the resources necessary to fund them.

Aligning the institutional system of recognition and reward

For a number of participants who worked in medical schools, the medical school official claim that faculty were expected to balance their time and energy between research, teaching, and service was open to challenge. Participants had strong opinions regarding the responsibility of medical schools to align their institutional system of recognition and reward to better reflect stated aims and values supporting the indigenous health agenda. Participants observed that recognition and reward within medical school contexts was disproportionately geared to research rather than teaching, and least of all to service. This was in marked contrast to how

many indigenous participants saw the purpose of the university. As this indigenous academic put it: *if the research dies in the university we still go on being a university. We stop teaching; we're not a university anymore (Aus/I-12).* Several participants offered reasons they believed their institution valued research more than either teaching or service. One obvious reason was that institutional reputation tends to be more dependent upon research excellence than on faculty excellence in teaching or graduate's record of service. Participants were concerned about the lack of compatibility between what was valued in the institutional context and what was needed to support the indigenous health agenda:

> *It's also hard because of things like the PBRF. There is an expectation, so while we're* (indigenous staff) *doing more service, you know, the university only funds us so much money, PBRF money, based on our research outputs. And I think the same is for teaching, you don't get funding for service so much. And so kind of understanding that there is that higher tension above that, even still - Yeah, so we're not able to compete in a way for PBRF funds for our department…Because they* (other departments) *don't do any of the service that we do, and so they've got more time left to chase that funding (NZ/I-29 & 30)*

Specific examples were given of ways in which research was favoured over service and how this impacted negatively on the indigenous health agenda: "*so while we're* [indigenous staff] *doing more service, you know, the university only funds us so much money, PBRF money, based on our research outputs*" *(NZ/I-30).*

Service activities, such as building community partnerships, were widely perceived as not being accorded adequate value within medical schools. Additionally, the lack of assessed service activities made it more difficult to produce data that might be used to support promotion for those working in indigenous health within the medical faculty. Some participants believed that a service equivalent to PBRF would need to be developed to recognise and reward these activities. A number of participants suggested rebalancing the institutional system of recognition and reward by implementing service demand indicators that might be able to track the service work outputs of indigenous health staff. One emergent idea was that service outputs might be used to identify and reward outstanding examples of service by indigenous practitioners. Participants also suggested that rewarding service was closely

related to the idea of rewarding partnership medicine, which might include collaborative research and/or teaching, but is most often found in the context of community service, and specifically in collaboration with existing community groups and not just individuals. The opportunity to reward partnership medicine was perceived to be an alignment at both the institutional level and at the professional level with potential for AMC accreditation. For some participants, this reflected an evolutionary shift, whereby systems of recognition and reward might come to more accurately reflect how it is possible to 'grow' the kinds of practitioners that medical schools and the medical profession claims to value:

> *it's just how the standards were written in the first-place and, you know it's the same old story, you know, who was at the table when the thing was designed… And it's that tack on kind of attitude, you know, whereas, you know you'd almost say go back to square one and just think, you know if you want to grow these kind of practitioners in a partnership kind of way then definitely the standards by which you judge should have been developed in an organic partnership sort of way (NZ/Non-I-26)*

However, these same participants also noted that raising service expectations and standards without actually adding additional resources could potentially add to the workload of indigenous staff already fully committed to the indigenous health agenda.

Indigenous organisational autonomy

Many participants noted that as numbers of indigenous personnel at any given institution increase, the more attractive that institution becomes to new, prospective indigenous members. With large enough numbers, the indigenous group can then advocate for increased autonomy and self-determination. Autonomous indigenous units or departments was consistently cited as an example of progress at the institutional level: *how could it be done better? I'm still waiting for them to officially be able to call us a unit (Aus/I-9).* With such autonomous indigenous units/departments, collective governance structures could be enacted, enabling autonomous control over resources. Many participants identified this impact factor as mostly a function of numbers, that is, the higher the number of indigenous health staff members, particularly indigenous staff members, the better. However, organisational autonomy also required the development of indigenous leadership within systems. Most informants who spoke about the formation of autonomous indigenous units and departments described the need for advocacy and leadership from within and institutional support from without. The LIME reference group

was repeatedly acknowledged as enabling sharing of knowledge about how indigenous organisational development could best be facilitated:

> *So it takes a lot of effort when we have, and it takes a lot of manpower when we've got very little available. That is where LIME is very, very important. That is where the LIME reference group, the secretariat, are playing a helpful monitoring surveillance role. Without it, and prior to it being there, it probably wasn't happening and you were left to the deans really and what happened then?… Yeah, no, LIME has been pivotal, I think, in this. They've just, yeah, it's been able to pull people together, it's been allowing them to share experiences and created a, sort of a critical mass across multiple institutions (NZ/I-13)*

Although many participants described indigenous organisational autonomy as a goal, others who spoke about their institutions' indigenous organisational autonomy discussed how this autonomy could still feel fragile and contestable even after it has been created and put in place. Several participants also noted the importance of continuing to grow indigenous personnel even where indigenous organisational autonomy had been established. As this non-indigenous academic noted:

> *What I think we're missing at the present moment is… we don't have at the periphery is people who have got, who are, who are indigenous, who may have an indigenous health focus… I don't think we've done that bit where we've grown Māori clinical academics in other areas beyond public health… So I think what we've got is a really, really good centre but what we need is the periphery now… Coz one person can't do it all… one department probably can't do it all, even if it was a huge department (NZ/Non-I-22)*

The power of the autonomous collective was theorised by a number of participants to be able to surround and support individual expertise outside of the indigenous unit/department, enabling both the center/hub and the periphery to be populated with indigenous personnel. Where autonomous indigenous units or departments existed, informants believed that medical schools were in a better position to realise specific initiatives and grow indigenous presence.

Phase Two participants in the case study conducted in the FMHS context at The University of Auckland spoke at length about Te Kupenga Hauora Māori (TKHM) and the Māori and Pacific Admissions Scheme (MAPAS). These discussions underscored the importance of Māori departmental ownership and control. As one non-indigenous academic noted:

> *So we write it in a particular way, we say you know, this many MAPAS places which includes the Undergraduate Target Admission Scheme (UTAS) and the University doesn't like that, they want to say, well you know, just, we just want you to put this as the UTAS quota. And my argument is that what that's actually about is who owns the process and who controls who gets it… we say this is MAPAS and this is under the control of a MAPAS team. So if they say these people go in, these people go in. It's not up to me to say, well no they don't, because they don't meet this that and the other thing. It's about who controls that, that admission process. So that's an, you know, I find it an interesting tension every year… You know, every year I have to explain, why we do it the way we do it (NZ/Non-I-22)*

These conversations echoed participants' comments regarding how indigenous health was institutionalised, and the importance of developing and maintaining it under the control and direction of indigenous staff. The existence of MAPAS was well established within the institution, nevertheless, control over its processes and final decision-making had to be defended on a regular basis. Participants who discussed indigenous workforce development strategies in general, and MAPAS in particular, all agreed on the need for ownership and control by indigenous personnel at the unit or departmental level, supported by the faculty and wider University. An obvious difficulty with advancing these strategies elsewhere was that many medical schools had neither an autonomous indigenous health unit or department, nor indigenous academics in leadership positions. Where indigenous staff were subsumed under another unit or department within the faculty of medicine, they were unlikely to have the capacity or be given the resources necessary to control such strategies. To keep the indigenous health agenda moving forward, long-range departmental/unit strategic plans were needed to develop semi-autonomous indigenous health units or departments with established indigenous leadership roles.

In discussing how to assess progress in the indigenous health agenda, participants made a variety of suggestion as to how progress might be measured and put on a continuum that helps to make meaning of them and invite comparison to each other and related to a bigger picture. Ideally, some measures would have applicability to all med schools. In conclusion, a number of study participants identified improved indigenous health outcomes as the ultimate measure of whether or not the indigenous health agenda was being progressed in medical education:

> *I think you'd look at, in the end this* (indigenous health outcomes) *becomes absolutely critical. That you have outcomes data on, on health. There's nothing like that to, as long as your data is good, to, to let you know how you're doing. So you can have a whole bunch of surrogate outcomes that can come before this* (indigenous health outcomes) *(NZ/Non-I-25)*

As this participant subsequently made clear, the 'surrogate outcomes' in this statement were assessments of indigenous content, process, personnel and availability of resources in medical schools.

Summary

This chapter has reported findings on how commitments to the indigenous health agenda in medical education in Aotearoa New Zealand and Australia might be translated into practical action through four strategic pathways of indigenous knowledge and information, process and practice, personnel, and resources by which indigenous presence in medical schools can be developed.

Along the first strategic pathway, indigenous knowledge and information, key areas of development include indigenous curriculum content, indigenous health relevant clinical teaching, cultural understanding and cultural safety, social accountability, equity, and reflexivity, and the theory and practice of community medicine. Along the second strategic pathway; indigenous process and practice, key areas of development include process aspects of the indigenous curriculum, indigenous clinical placements, immersive cultural experience, practical training in cultural safety, training in equitable and reflexive practice, and community engagement. Along the third strategic pathway, indigenous personnel, key areas of

development include recruitment and retention of staff for an indigenous curriculum, indigenous clinical placements, community cultural expertise, and indigenous community partnership development. Along the fourth strategic pathway, institutional resources and executive support, key areas of development include the development of a sustainable indigenous resource base to support an indigenous led curriculum, indigenous clinical placements, safe, equitable and reflexive practice, indigenous community engagement and partnership development, and indigenous leadership and organisational autonomy.

Participants in the present study identified many specific ways in which medical schools could put commitments into action and progress the indigenous health agenda. Medical schools in Aotearoa New Zealand and Australia have a mandate and moral obligation to provide medical education that is committed to supporting indigenous rights to health in order to reduce indigenous health inequities. Whether the challenge of this mandate and moral obligation will be taken up by medical schools remains to be seen, but will be determined in part by a number of factors both within and external to the university that will be considered in the following chapter.

Chapter Eight: Realising commitments to indigenous rights to health; helping medical education 'walk its talk.'

Introduction

The first three chapters of this thesis outlined the theoretical proposition that a rights approach was largely absent from efforts to reduce indigenous health inequities and contribute to indigenous health and wellbeing through medical education, and was therefore a worthy topic of exploration. A two-phase research process involving individual key stakeholder interviews and a case study at the University of Auckland was carried out to explore the contribution of an indigenous rights approach to progressing the indigenous health agenda within medical education in Aotearoa New Zealand and Australia. The study asked key informants how they understood medical school commitments to address indigenous health inequities in Aotearoa New Zealand and Australia, and the place of indigenous rights to health in that agenda. Furthermore, the study explored the potential of medical school commitments to indigenous rights to advance the indigenous health agenda by asking about specific action steps by which medical schools might fulfil these commitments.

This chapter begins with a discussion of the main research findings of drivers, obstacles and strategic pathways. These summarise informant ideas and understandings of indigenous presence and how to ensure this presence has impact in medical schools in Aotearoa New Zealand and Australia. Following this, three domains of medical school activity, comprising the clinical, cultural, and community aspects of medical education are introduced and to these a fourth domain of indigenous leadership and management is added. A 4 X 4 table (Table 5) shows the intersection of these four domains with the four strategic pathways. This table is used to conceptualise and clarify the territory of the indigenous health agenda. Once the territory of the indigenous health agenda can be held clearly in mind with the help of this table, it becomes possible to contrast and compare different approaches and different stages of the development of the indigenous health agenda. Building on the model shown in the previous chapter, an updated model of developing indigenous presence incorporating the domains of medical school is presented. Following this, several key dynamic tensions in the development of the indigenous health agenda are explored and discussed. Finally, the relationship between an indigenous rights to health framework and the indigenous health agenda is considered, and possibilities for bicultural partnership are explored.

Defining the Indigenous Health Agenda in Medical Education

The indigenous health agenda in medical education in Aotearoa New Zealand and Australia reflects a broad consensus of what the informants in this research believe is needed to (1) address indigenous rights to health (2) develop a strong indigenous presence in medical schools and transform institutions to enable that presence to have impact, and (3) actively seek to contribute to indigenous health and wellbeing. Addressing indigenous rights to health is defined as a powerful motivation or active intention to reduce indigenous inequities and contribute to indigenous health and wellbeing. Developing a strong indigenous presence within medical schools and institutionally supporting that presence to have impact is defined as the practical means to that same end. Indigenous presence can now be defined as the inclusion of indigenous content, process, personnel, and resources across all aspects and domains of medical education. Indigenous presence is strengthened through the strategic combination and integration of pathways across domains. With the addition of institutional support from faculty and executive bodies, indigenous presence develops indigenous impact, the net effect of which is to amplify the effects of drivers for change and reduce the effects of obstacles to change. A strong indigenous presence in medical schools has the capability to actively lobby for the indigenous health agenda within a wide variety of medical school contexts, including university executive and faculty, professional organisations and settings, and government policy and planning. Indigenous presence is theorised to have impact and the indigenous health agenda advanced to the degree to which indigenous presence is supported institutionally by medical school and university faculty and executive leadership in each domain and across domains: indigenous teaching and learning, indigenous cultural practice and critical awareness, indigenous community relations and partnership development, and indigenous leadership and management.

Discussion of Drivers

The results of research into drivers of the indigenous health agenda in this study suggested significant differences between individual, group, institutional, professional, and government levels of initiative. Individual and group support for the indigenous health agenda was mostly driven from the bottom 'up,' while institutional, professional and government efforts to develop and shape the indigenous health agenda were mostly driven from the top 'down.' While acknowledging the authority and potential power and influence of institutional and

government initiatives, drivers such as government level initiatives and funding were identified as important, but not terribly effective, unless reinforced from macro to micro, at university level, medical school faculty level, and small group and individual level. Effective implementation of policy and programme required initiative from indigenous health faculty and staff themselves, assisted by individuals or groups in a position to exert local influence. This might include Deans, medical schools faculties, or members of professional organisations. Similarly, university or faculty-level initiatives required implementation by individual stakeholders, supported by their collective stakeholder groups. It is not surprising, then, that key individual and group stakeholder commitments were perceived as the most essential driver of all. The history of advancement in indigenous health in medical education always has – and still does - rely on the dedication of key individuals and key stakeholder groups (see: Haynes et al., 2013; Ewen, Mazel & Knoche, 2012). While faculty and executive support is required for specific initiatives to be realised, these key stakeholders are the main source and vehicle for organisational change (Smith, 2005b).

Medical schools are accountable to professional bodies, most notably through accreditation, and these are an obvious source of pressure for medical school reform in the area of indigenous health (Mackean et al., 2007; Ewen et al., 2016). Accreditation standards need to accommodate the reality of variable progress in different institutions, but at the same time be strong enough to meet each institution at its forward edge and demand evidence of real progress. The standard of scrutiny provided by the AMC accreditation standards with regard to indigenous health has been found to be below that of the rigorous scrutiny applied to many other medical specialities (Phillips, 2015). Informants that held this perception felt this accurately reflected the degree to which clinical aspects of medical education are valued and perceived to be more important than cultural aspects. Practical difficulties also exist in writing standards that can be applied to widely differing institutional contexts, and interpreting and applying these effectively. Participants noted that the AMC standards pertaining to indigenous health had become more prescriptive over time, but also become more of a 'tick-box exercise' since the Curriculum Framework had first been integrated into the AMC standards in 2007. According to some participants, high-level AMC standards were vague and couched in such general terms that they could be met without actual implementation of 'best practice' as outlined in the Curriculum Framework. In study participants' perceptions, within many medical schools, the Curriculum Framework was not being adequately institutionalised so as

to contribute to meaningful, lasting change. These findings are consistent with other research exploring the Curriculum Framework and its implementation (see: Mazel & Anderson, 2011; Pitama, 2012; Medical Deans Australia and New Zealand & the Australian Indigenous Doctors' Association, 2012).

Issues regarding the leadership and management of each of the strategic pathways were revealed in discussions of drivers. The question of who is responsible for the implementation of the Curriculum Framework highlights tension between indigenous health academic leadership and executive 'ownership' or control over the project and its implementation and the relative absence of a 'whole of faculty' approach (Jones et al., 2010). In other words, study participants believed that the indigenous health curriculum needs to be expert-led by indigenous health faculty and staff, yet these personnel cannot be realistically expected to simply get on with the job by themselves and carry the entire responsibility for its implementation without support. Again, this demonstrated how indigenous health initiatives were dependent on institutional support, consistent with previous literature (see: Jones et al., 2010; Medical Deans Australia & New Zealand and Australian Indigenous Doctors Association, 2012).

Strategic pathway four, indigenous resource availability, was seen as particularly crucial to the success of 'top down' strategies. Executive support at dean and faculty levels can be tangibly expressed through recruitment, retention, and promotion of indigenous faculty and staff as well as the provision of adequate resources to design and implement indigenous specific education and training. Support within domain four, indigenous leadership, management and organisational autonomy, was also deemed important in this regard. Emphasis on these strategic pathways and domains suggests the potential effectiveness of a 'wrap-around' strategy for implementing government and AMC guidelines, however, this strategy would require and remain dependent upon partnership and power-sharing between indigenous leaders and faculty members with executive authority within the medical school and university.

The service ideals of the medical profession itself drives a number of initiatives that include an emphasis on public health, on human rights frameworks, and on social accountability; all of these initiatives can have a marked positive impact on the indigenous health curriculum within medical schools (Phillips, 2004; Meili, Fuller & Lydiate, 2011). Community partnerships

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between medical schools and communities have previously been identified as important vehicles for change, particularly those with explicit agreements such as MOUs and MOAs with their indigenous community partners (Minniecon & Kong, 2005; Arabena & Moodie, 2011; Hays, 2002). Despite the cynicism frequently expressed by informants towards government initiatives, it is clear that political rhetoric emphasising improved indigenous health equity can offer symbolic support, and resources directed to indigenous health equity at a national level have the potential to contribute to the indigenous health agenda at medical school level.

Identifying drivers was a first step. The next step was to seek to determine how these drivers can best be supported and nurtured so that they remain strong and continue to drive the indigenous health agenda forward within medical schools. Study participants frequently emphasised that drivers of the indigenous health agenda are interdependently linked and need each other for success; conversely, undermining or weakening one driver often impacts other drivers as well.

Discussion of Obstacles

Briefly, the results of research into obstacles to the indigenous health agenda suggested significant differences between overt and covert obstacles, between passive resistance to change grounded in implicit attachment to the status quo and more active and conscious forms of opposition to change, and between obstacles at an individual, group or institutional level. Racism was frequently identified as the one of the strongest and most overt forms of active opposition to the indigenous health agenda. According to informants, racism underpinned the assumption that indigenous people are interchangeable; that any indigenous person had the same authority or knowledge to offer indigenous expertise. Racial stereotypes may also be partially responsible for the assumption that negative indigenous health statistics are a product of indigenous culture itself (Curtis, Reid & Jones, 2013). Racism was relatively easy for study informants to discern, but difficult to challenge from a minority position. Informants described feeling intimidated as the prospect of challenging high status individuals about their racist remarks or challenging the institution itself about its overtly discriminatory practices. To speak directly of racism from a minority position is often seen as provocative and invites majority reactions ranging from hurt and offended withdrawal to active rejection, and social exclusion (Smith, 2012).

While racism was identified as overt, less active or virulent forms of cultural bias were often implicit rather than explicit and more unconscious than consciously intended. Forms of bias that were culturally sanctioned and nearly entirely unconscious, such as individualism or ignorance, supported resistance to the indigenous health agenda in the form of inertia, apathy, or disinterest. Lip service and tokenism, by contrast, offered the appearance of support without accompanying commitments. Institutional self-interest was one of the most hidden obstacles, often covered by the rhetoric of endless 'reform without change' (Bloom, 1989). This was also considered one of the most powerful obstacles, precisely because it was more embedded and harder to shift than the aggregate effects of individual self-interest. At one end of the obstacle continuum that the indigenous health agenda must challenge, study findings suggest that in some medical school settings, indigenous staff and their allies felt a duty to speak out but often did not, hoping to avoid a backlash in which they were likely to be marginalised or become a scapegoat. At the other end of the continuum, institutional self-interest is continuously present, an important part of what Hafferty and Franks (1994) refer to as the hidden curriculum, an anchor that frequently weighs in heavily to support the status quo. Often institutional self-interest does not actively oppose progress so much as just nullify or stalemate progress. Despite lip service declarations to make change and token gestures of support, change seems not to occur. Covert obstacles present different challenges than overt obstacles. Many participants recognised the need for sophisticated strategies in order to address multiple obstacles and their interactions, particularly those that elude clear description. As previously noted, drivers and obstacles exist in dynamic tension, and the speed at which the indigenous health agenda can be progressed depends to a significant degree on their balance relative to each other.

Discussion of Strategic Pathways: Developing Indigenous Presence in Medical Education

All medical schools across Aotearoa New Zealand and Australia have declared their commitment to addressing indigenous health inequities and have made a start towards advancing the indigenous health agenda. However, many medical schools have yet to pursue this agenda strategically or systematically. Study participants attempted to identify drivers in context and discussed how various obstacles influenced, impeded and diminished the potential of drivers to effect change. Drivers for change are often thwarted by powerful obstacles and in some instances, actually attract those obstacles. The results of this study have suggested that

the dynamic tension between drivers for an indigenous health agenda and obstacles to that agenda can be synthesised or resolved through the development of strategic pathways that overcome status quo opposition or resistance to the indigenous health agenda, enabling the development of a strong indigenous presence in medical schools.

Indigenous knowledge and information

Indigenous knowledge and information was widely regarded as essential but insufficient by itself to progress the indigenous health agenda. The presence of indigenous content in the formal curriculum was seen as an obvious indicator that the school had some investment in indigenous needs and interests. Indigenous knowledge and information delivered in lectures and upfront teaching was a core part of the indigenous health curriculum. Including indigenous knowledge and information in clinical teaching and student-centred learning contexts extended its range and effectiveness. In order to best equip students to be able to practice in a pro-indigenous mindset that could reduce indigenous health inequities, participants strongly supported the need for indigenous leadership within a rights framework and the need to increase the number of indigenous health professionals with indigenous expertise.

Medical students and practitioners were more likely to engage their indigenous patients successfully and provide them with culturally safe treatment and care when clinical understandings of the indigenous patient are complemented by cultural understandings of indigenous people and their values and worldviews. Where clinical and cultural knowledge are complemented by foundational knowledge of community treatment and care, student practitioners can be educated to extend the parameters and impact of medical treatment and care far beyond the individual patient. Teaching and learning strategies can then be explored for engaging indigenous families and groups in preventative practices, risk management, and an orientation towards enhanced health and wellbeing as defined by indigenous peoples themselves.

Indigenous process and practice

Study participants regarded indigenous process and practice as a necessary complement to indigenous knowledge and information. Clinical practice situations oriented to the indigenous

patient can be complemented by cultural immersion experiences and familiarity and comfort with indigenous contexts. With an appreciation of the indigenous world and comfort with it, medical students and practitioners can learn to engage with indigenous people on their own terms, successfully engaging their indigenous patients and providing them with culturally safe treatment and care. Community engagement and partnership development in the context of culturally humble and safe practice can extend the range and impact of medical treatment and care, successfully engaging indigenous families and groups in preventative practices, risk management, and the enhancement of their own health and wellbeing. Teaching a critical history of Aotearoa New Zealand and Australia was named as key to enlightening medical students about the context of the society in which they will practice. This is consistent with Phillips (2015), who notes that teaching the 'real history' of Australia, as a key action that would positively contribute to Indigenous Australian humanisation in the eyes of broader society.

Indigenous personnel

Study participants viewed the presence of indigenous personnel as essential to the indigenous health agenda. These were primarily of two kinds: medical school personnel with cultural and community health expertise, and indigenous community leaders with cultural expertise and an understanding of medical education and the medical school context. Partnership between these two indigenous groups, complemented and supported by their non-indigenous allies, was seen as strengthening all aspects of the indigenous health agenda. Participants recognised and validated the contribution of non-indigenous allies; in particular, critical awareness was considered valuable contribution coming from non-indigenous allies.

Indigenous resource base

The development of an exclusive indigenous resource base was viewed as essential to the success of the indigenous health agenda. This required a sustainable institutional budget with protection from political and economic pressures. It also required executive and wider faculty support. Development of indigenous leadership and management can also be expected to lead to greater degrees of organisational autonomy over time, perhaps by the formation of indigenous units which can be grown over time into indigenous departments.

Domains of Medical School Activity

Study findings suggest that indigenous health and wellbeing requires the integration of clinical health, cultural health, and community health. Accordingly, the aim of the indigenous health agenda in the context of medical education is to promote indigenous health and wellbeing in all of these domains, or areas of medical school activity. Within the clinical domain, clinical capability can be developed through the indigenous health curriculum and clinical teaching and learning oriented to providing high quality care for indigenous people and peoples. Within the cultural domain, cultural understanding and critical awareness can help to develop culturally safe, equitable and reflexive practice. Within the community domain, community health can be understood in a systemic, holistic and integrative frame and community health partnerships developed through active community engagement and ongoing involvement. As medical schools develop their educational mission across these three domains, and support these initiatives with indigenous leadership development and an indigenous health budget protected within the school, this might reasonably be expected to result in medical education that can contribute to indigenous health and wellbeing. Implementing the indigenous health agenda requires that medical personnel benefit from engagement with indigenous experts and leaders from the indigenous community, as well as from the university and medical school itself. An immersive training as described above might be expected to equip medical school graduates to demonstrate capable clinical, cultural and community practice with indigenous people and peoples, and thereby reduce indigenous health inequities and contribute to indigenous health and wellbeing.

The data collected in this thesis identified that what is most needed in medical education to contribute to indigenous health and wellbeing is a strong indigenous presence within medical schools with support from faculty and executive. Some of the practical requirements to build a strong indigenous presence in medical education along four strategic pathways by which indigenous presence in medical education might be developed have been identified: indigenous knowledge and information, indigenous process and practice, indigenous personnel, and indigenous resources and control over those resources. Indigenous presence can be developed and strengthened via these four pathways across four domains of medical school activity: clinical, cultural, and community practice and indigenous leadership and organisational autonomy.

Efforts to build indigenous presence can be conceptualised as located in four distinct domains or arenas of medical school activity: (1) clinical medicine, including the indigenous curriculum and specialised indigenous health oriented clinical teaching; (2) cultural practice, including safe, equitable, and reflexive practice as well as cultural awareness and cultural safety; (3) community relations, including the use of indigenous community expertise, community engagement and the development of community-based health partnerships and joint ventures; (4) indigenous leadership and organisational autonomy, including the autonomous and self-directed efforts of indigenous units and departments as well as the individual leadership of indigenous personnel. This suggests a simple but comprehensive picture of how medical schools can contribute to the indigenous health agenda, by ensuring that indigenous knowledge and information, process and practice, personnel, and resource base are aligned and integrated across clinical, cultural, community, and organisational domains.

Domains of Med School Activity Indigenous Presence	Clinical Teaching and Learning	Indigenous Cultural Understanding & Critical Awareness	Indigenous Community Relations	Indigenous Leadership and Organisational Autonomy
Indigenous knowledge and information	*Indigenous health formal curriculum	*Indigenous knowledge and understanding, cultural safety, reflexivity, critical theory	Indigenous community health theory and practice	Indigenous leadership & management of indigenous health curriculum
Indigenous Process and Practice	*Indigenous-specific clinical training and practice	*·Immersive cultural experiences, training in safe, reflexive & equitable practice	Indigenous community engagement and partnership development	Indigenous leadership & management of indigenous process
Indigenous Personnel	Indigenous lecturers, clinical teachers and trainers	Indigenous lecturers, cultural experts and mentors	Indigenous community experts, mentors, trainers	Indigenous leadership of medical students and staff
Indigenous Resource Base	Indigenous curriculum and clinical teaching budget w/ executive support	Indigenous cultural process and practice budget w/ executive support	Indigenous community partnership budget w/ executive support MOUs, MOAs	Indigenous organisational autonomy, management of indigenous resource base

Table 5: A table of the practical means of the indigenous health agenda

Table 5 can be systematically explored by following the four vertical columns representing domains of medical school activity and linking and integrating strategic pathways relevant to that domain.

· *Different parts of indigenous health curriculum..

Clinical teaching and learning

Column one identifies the need for indigenous knowledge, information, process and practice within the general medical curriculum and its application by indigenous clinical teachers in clinical teaching and learning settings. The top row of this column locates the formal indigenous health curriculum, providing medical students with knowledge and information on indigenous health status, causal factors relevant to that health status, and population health and public health approaches to the reduction of indigenous health inequities. Below this in the second row are clinical practice settings that are oriented to the treatment and care of indigenous patients. These are settings in which indigenous knowledge and information can support and enhance clinical teaching and learning activities and indigenous patients can receive a higher standard of care as a result. The application of clinical skills can become more accurately oriented to the condition, situation, and needs of indigenous patients by developing greater familiarity with current indigenous health issues, reducing negative discrimination, and prioritising indigenous health needs. Both of these first two boxes, marked with an asterisk, can be considered core components of the indigenous health curriculum. The third row identifies the need for indigenous lecturers and clinical teachers with medical expertise. These personnel function as role models. They possess the expertise to flexibly apply indigenous content and process in clinical settings. The fourth row targets resources and executive decisions necessary to support an indigenous health curriculum and provide clinical teaching relevant to indigenous health, identifying specific pathways of support by which medical schools and their university executive and faculty can become more effective. Clinical teaching and learning about the care and treatment of indigenous patients is the domain or set of medical school activities most closely aligned to traditional medical education and clinical specialisation. As such, it is the most obvious place to initiate an indigenous component of the general curriculum. However, opportunities to integrate indigenous oriented medical education may exist elsewhere and find a home more easily, as for example if a cultural safety, diversity awareness or community practice component of the curriculum is opportune and lends itself to development.

Indigenous Cultural Understanding and Critical Awareness

Column two identifies the need for cultural understanding and critical awareness as a vital part of medical education. In the top row of this column might be found the formal teaching of indigenous cultural knowledge and history, or a critical and decolonising understanding of medical culture and medical history. Cultural education in an indigenous context includes the use of indigenous language, ritual, image, and symbol. The second row identifies the need for indigenous immersive cultural experiences and training in culturally safe, reflexive, and equitable practice. Both of these boxes, also marked with an asterisk, can be regarded as core components of the indigenous health curriculum. The third row identifies the need for need for lecturers, trainers and mentors with indigenous cultural expertise, both within and outside of the university. The fourth row targets all the resources necessary to support an indigenous cultural curriculum and identifies pathways by which support from medical school and university executive and faculty can become more effective. Within a strictly biomedical approach, the cultural component of medical education is likely to face an uphill battle to be accorded respect and value. However, once a bio-psychosocial approach to medicine is found acceptable, a significant impact of culture on illness and wellness becomes obvious. In this context, care and treatment can be expected to include a cultural component, and teaching about culture becomes a normative part of the medical curriculum.

Indigenous Community Relations

Column three describes a domain or set of medical school activities that concern community medicine and indigenous community relations. The top row identifies the need for education in indigenous community theory and practice and population health relevant to indigenous peoples. Here might be found some formal teaching about the idea of medical education as a group and institutional phenomena, or that group to group relations exist between medical schools and the communities in which they are located, or that these relations might be passive or active, or fail or succeed to provide benefits to those communities. The second row identifies the need for indigenous community engagement and partnership development as the practical application of that theory building. The third row identifies the need for medical school personnel with community development expertise and the ability to liaise with indigenous community leaders and members, as well as those indigenous community members who could become available to provide additional resources to the medical school. The fourth

row targets all the resources necessary to support an indigenous community partnership development agenda and identifies pathways by which support from medical school and university executive and faculty can become more effective. Developmentally, the domain of indigenous community relations might be thought of as reaching farther afield and perhaps arriving later after cultural understanding, and indigenous-oriented clinical teaching and learning have already been established. This is for the very good reason that these external relations generally represent a more substantial culture change requiring an institution to move outside or beyond its self-referenced orbit. However, as already mentioned, each medical school may vary in this regard depending upon its particular circumstances and history.

Indigenous Leadership and Organisational Autonomy

Column four identifies the need for indigenous leadership and management of the clinical, cultural, and community domains of the indigenous health agenda. Again, this is unlikely to become a major priority in a medical school until the indigenous health curriculum has been well established and expanded to include cultural and community health initiatives. The top row describes the indigenous knowledge and information aspects of medical education requiring indigenous specific leadership and/or management of clinical teaching and learning. The second row identifies the need for indigenous leadership and management of all of the indigenous process and practice elements of medical education; of staff as well as students. The third row identifies the need for indigenous leadership and management of students and staff across clinical, cultural and community domains of medical education, including the external relations that need to be tended to and nurtured to make these initiatives successful. The fourth row targets all the resources necessary to support indigenous leadership and organisational autonomy, and identifies pathways by which support from medical school and university executive and faculty can effectively help to grow indigenous units and departments.

The complex unity of indigenous health agenda

There are a number of different ways of viewing the indigenous health agenda as a complex unity through the lens of the intersection between pathways and domains as presented in Table 5. For example, the indigenous health agenda can be pictured as three concentric circles: the indigenous health curriculum, the indigenous personnel who teach it, and the institutional

support structures that enable those personnel to do a good job. The upper left quadrant of the table shows the indigenous health curriculum as a combination of clinical and cultural domains (columns one and two) along the knowledge and information and process and practice strategic pathways (rows one and two). This quadrant is supported from 'underneath' by indigenous personnel at the medical school who have principal responsibility for teaching the indigenous health curriculum in strategic pathway/ row three. The indigenous health curriculum is partnered by the indigenous community health domain shown adjacent to it in column three, where indigenous community resources are located that exist outside of the medical school but function in relation to it and amplify its effects. Both these sets of personnel are in turn supported and 'wrapped around' by institutional support in strategic pathway/row four and indigenous leadership and organisational development in domain/column four.

Moving through time, the development of the indigenous health agenda can be understood as a bi-directional movement from curriculum to personnel to executive and faculty support, or moving in the other direction, from support for recruitment and retention of indigenous staff, to the indigenous health programming that those staff, given time and resources, are able to develop. Every aspect of this agenda contributes and 'counts,' from a brown face on the wall, to the incorporation of indigenous ceremony and celebration as a normative medical school cultural practice, to the development of standards of culturally safe practice, to a new indigenous community placement, to the involvement of indigenous community leaders with that placement, to a new indigenous staff hire, to the signing of a MOU or MOA, to a dean who takes an active interest in indigenous health issues, to the formation of an autonomous indigenous health unit, and so forth.

Indigenous Presence: Combining Drivers, Obstacles, and Pathways

Most participants acknowledged the synergy required for indigenous presence. Each of the strategic areas was recognised as interdependent. While each participant tended to select and identify one specific area or another as their personal priority, most participants clearly understood indigenous presence as a whole that was more than the sum of its parts. Without indigenous knowledge and information, the dissemination of the knowledge required to understand and appreciate indigenous process and practice was lacking. Without indigenous process, the unique qualities and characteristics of indigenous culture available through direct

immersive experience was lost. Without indigenous personnel, expertise and leadership were lacking and without an adequate resource base, each of the three other pathways would become increasingly stretched and impoverished.
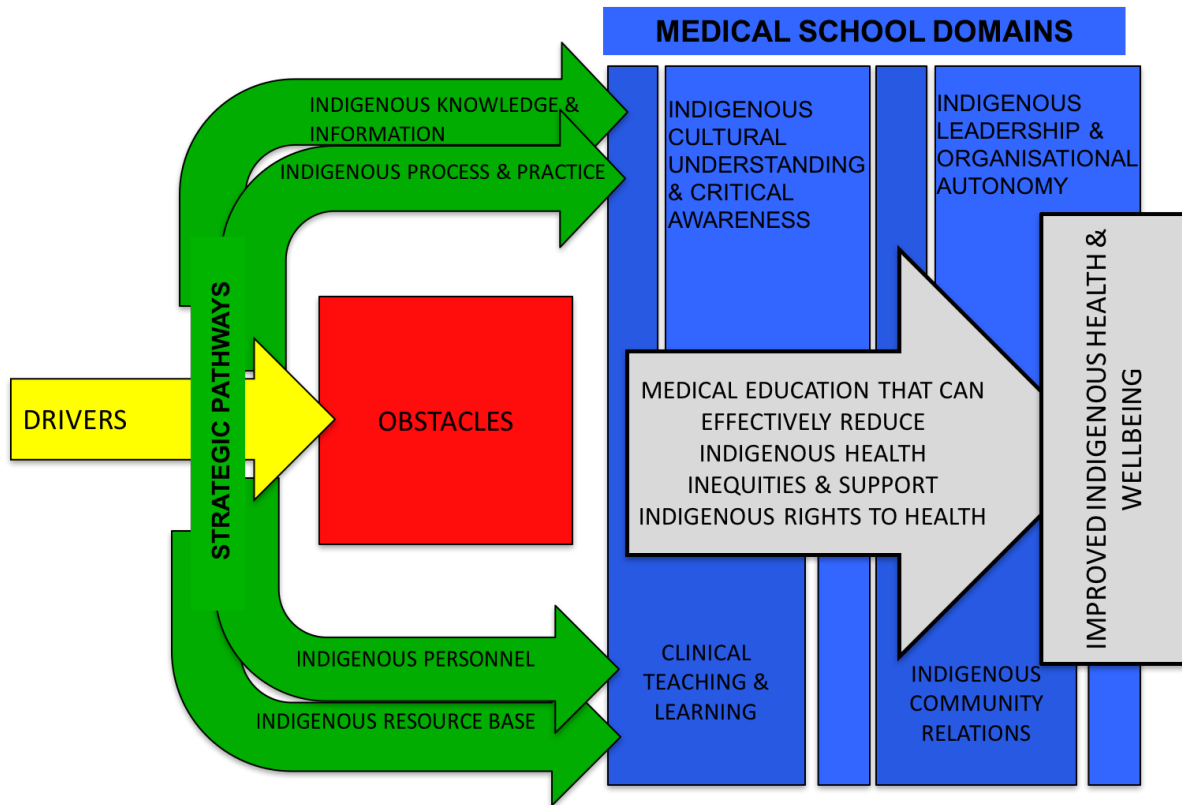

Figure 3: Indigenous presence to indigenous impact in medical education

Holding the synergy of drivers, obstacles and strategic pathways clearly in mind offers a conceptual frame in which a range of indigenous health initiatives can be understood in relation to one another and mapped according to the specific structural arrangements that would be needed to enable and empower their success. Figure 3 builds on the model of indigenous presence presented in Chapter Six, incorporating the medical school domains of activity presented in the table in the previous chapter. Each of the components of the model is simple enough, but they become much more complex when understood as a system, a whole in which each of the parts is working for and against each other. Providing a systematic overview offers the potential to assess and compare strategic pathways within or across institutions. Examples of successful initiatives undertaken by different medical schools can be located on the model. As such, the model has begun to lay the groundwork for evaluating 'goodness of fit' or alignment or non-alignment with the indigenous health agenda (see future

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directions in Chapter Nine). Different medical schools have significantly different strengths and weaknesses across different areas of the model. They may also have different needs. Structural commitment to indigenous health in a particular medical school can be measured and reflected on through the use of the Critical Reflection Tool (CRT) (see: Ewen, Mazel & Knoche, 2012). Potentially, a tool such as this, which considers wider institutional influences on the indigenous health curriculum, could be extended and used across the domains of medical school activity.

Embedding or institutionalising certain aspects of indigenous presence requires support from institutions that are accustomed to conserving power and maintaining control. Yet the indigenous health agenda requires indigenous autonomy and indigenous control; anything else would run the risk of becoming culturally unsafe. Successful medical school indigenous health initiatives depend upon multiple factors. One crucial factor is leadership from key stakeholder and stakeholder group efforts (Mazel & Ewen, 2015). The LIME Reference Group is a primary example of such leadership. Furthermore, simply earmarking or allocating more resources to indigenous health initiatives may not suffice to bring about sufficient changes to effectively reduce indigenous health inequities and contribute to indigenous health and wellbeing. The allocation system itself may need to evolve, raising questions about how medical schools are funded, and to whom they are accountable for their spending decisions. The core values that inform local care of local people may exist in tension with, or may even be on a collision course with, a market economy that currently informs decision-making and to a significant extent determines the nature of medical research, teaching, and service (see: Hodgson, 2002).

Support for Indigenous Presence Within Domains of Medical School Activity

Medical education will evolve as it always has, in response to the needs and interests of those whom its expertise serves. Insofar as medical education responds with increasing accuracy to indigenous needs and interests, its clinical as well as cultural and community focus will be expected to evolve and change. Having acknowledged the importance of clinical expertise and clinical capability in any and every clinical situation, recognition and respect for the cultural and community factors that influence clinical success or failure can be considered. Cultural and community elements are integral parts of how most indigenous people identify themselves (Smith, 2012). When medical education trains medical students to recognise and respond

sensitively and accurately to indigenous people, and learn how to work effectively with their culture and their community, nearly everyone benefits, not least medical practitioners themselves. Nor should this be thought of as merely a peculiarity of indigenous individuals or communities. It would not be surprising if almost everyone responded positively to some degree to being recognised as a person who belongs to a family and is connected to a group and a community (Bleakly, 2012). Likewise, the development of indigenous leadership and management in medical schools, presence on relevant committees and steering groups, is good for indigenous patients and practitioners alike. As the vast majority of study participants were indigenous health educators, the teaching and learning of indigenous health was spoken about in much greater depth than strategies for growing the indigenous health workforce or preferential admission of indigenous students. However, study participants' emphasis on indigenous leadership and participation at the senior leadership level was consistent with the findings from the Medical Deans review, which suggested that executive appointments of indigenous health staff were instrumental to the implementation of the Curriculum Framework and the enablement of institutional change (Medical Deans Australia and New Zealand and Australian Indigenous Doctors Association, 2012). Phillips (2015) suggests that where indigenous staff are offered token gestures of 'consultation' rather than strategic approaches based on partnership, one can only assume that indigenous health is not considered core to the medical curriculum by executive faculty. Real partnership implies not merely 'consultation' or 'inclusion' but rather, sharing power and authority and delegating organisational decision-making responsibility (Medical Deans Australia and New Zealand and Australian Indigenous Doctors Association, 2012). These same principles apply to the deployment of resources; for example, indigenous health may be described as a university or medical school priority, but where strategic investment is lacking, actions speak louder than words.

Discussion of Indigenous Impact: Support for Integration and Alignment of the Indigenous Health Agenda

What is needed to advance the indigenous health agenda within medical schools in Aotearoa New Zealand and Australia are not only new strategies but more favorable conditions in which to advance existing strategies. It appeared that the belief in the importance of indigenous rights to health, or alignment to or empathy with or sympathy for the importance of indigenous rights to health, supplies much of the motivation for the indigenous health agenda. This motivation may arise from extrinsic sources such as government regulations or initiatives, medical

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authorities (e.g. AMC), or university or medical school institutional norms and expectations. However, the most powerfully motivated group advancing the indigenous health agenda were key individual and collective stakeholders whose passionate conviction in the importance of indigenous rights to health was intrinsic to themselves, and included personal identifications, community loyalties and justice and service ideals. Conversely, many obstacles to the indigenous health agenda appeared to be based on an antipathy to indigenous rights to health, or a belief that these rights were not important, or were less important than other medical schools agendas. Further research on this point is needed, but this may help to explain why previous research suggests that the indigenous health agenda is not fully supported in medical schools in either Aotearoa New Zealand or Australia (Jones et al., 2013; Curtis, Reid & Jones, 2013; Ewen, Paul & Wilkin, 2014). This evidence suggests that significant institutional change, i.e. transformative changes, may be needed in order to ensure a coordinated approach to the teaching and learning of the indigenous health curriculum. Informants likewise identified the challenge of ensuring that indigenous leadership initiatives are institutionally embedded. This requires maintaining enough indigenous faculty to grow leadership capacity, creating positions where leaders can actually lead; and supporting leaders to seek appointments to relevant boards and committees where they can network and have influence. Having indigenous staff in senior leadership positions is consistent with 'best practice' as stipulated in the Medical Deans Review (Medical Deans Australia and New Zealand and Australian Indigenous Doctors Association, 2012). This is particularly important given current indigenous workforce shortages, which can result in inaction due to there being no 'appropriate' person to do the job (Phillips, 2015).

Vertical integration of pathways can be complemented by horizontal integration of domains. A stronger cultural component to the curriculum can include a focus on historical understanding, critical thinking, and safe, reflexive, equitable practice. A stronger community component to the curriculum can include a focus on population health, community engagement and the development of community partnerships, with medical expertise supporting primary prevention, risk management, and an orientation towards enhanced health and wellbeing as defined by indigenous peoples themselves. All of these require institutional support, meaning executive support and 'whole of faculty' support. Here we encounter a number of interesting challenges, dynamic and systemic tensions between tolerance for cultural diversity and political and economic monoculture, between individuality and collectivity, between

institutional and community norms, and between indigenous leaders and their non-indigenous allies.

Exploring Key Dynamics and Tensions in the Development of the Indigenous Health Agenda

This section explores some key dynamics and tensions that arise in the development of the indigenous health agenda. To some degree, these tensions may be necessary aspects that are inherent in the challenge posed to the status quo of medical education by the indigenous health agenda. However, these tensions may also be a matter of perspective, in other words, a consequence of the Kaupapa Māori and indigenous rights-based approach taken in this research. This section will discuss these tensions and seek to disentangle what is inherent from what belongs to the specifically pro-indigenous and rights-based framework of the research.

Tensions between symbolic and cultural diversity versus political and economic monoculture

Findings in this study suggested an important distinction between issues concerned with curriculum and culture, and issues concerned with institutional politics and economic arrangements that directly influence distributions of power and money. Many study participants noted the striking difference between non-indigenous acceptance of indigenous cultural symbolism and antipathy to indigenous politics. Where non-indigenous people feel included in indigenous ceremony and celebration, attitudes are positive and evidence of indigeneity is often warmly embraced. Where non-indigenous people feel excluded, however, as in the case of indigenous demands for sovereignty or power sharing, attitudes tend to be more antagonistic, with little tolerance for power-sharing or political equity. It appears that indigeneity can only be embraced and celebrated if the politics of being indigenous are absent. This tension is closely tied to the difference in understandings of 'inclusion.' Tolerance or even recognition of cultural diversity can allow multiculturalism to flourish at a symbolic level without significantly altering the dominant monoculture. For example, basic structural arrangements of power, privilege and cultural validity are not altered by celebrations of multi-ethnic cultural diversity.

That the indigenous health agenda seeks to alter to some degree, the assumptions and structures of settler-colonial society by including indigenous peoples as partners in health and

active stakeholders in their own future seems inherent and non-contingent. However, the degree to which health partnerships and active health stakeholder involvement requires changing the traditional ways in which health is delivered may be debated and may vary. The distinction between change at symbolic and cultural levels versus changes to status quo political and economic structures and systems is a familiar feature of critical analysis. This analysis of power and powerlessness is based on the distinction between saying and doing, between superstructure - ideological position, beliefs, and discourse - and infrastructure or ownership of the means of production (Crotty, 1998). Kaupapa Māori theory requires an analysis of both the saying and the doing of power and powerlessness (Smith, Hoskins & Jones, 2012). It is in this context that the emancipatory intent of indigenous demands for power sharing can be best understood.

If the aspirations of partnership are to be realised, partnership must be based on actual and real equality. Formal and symbolic rituals and observances may signal shared aspirations to equality, but they do not bring it about. Kaupapa Māori theory also challenges the tendency of modern western cultures to make a sharp distinction between the private life of individuals and the public life of social groups and institutions or 'society' as we name it. However, mainstream efforts to disentangle and dis-embed cultural practices from their socio-political context have always been highly problematic for minorities in general and indigenous peoples in particular. The missing intermediary term is community, the collective space where individual cultural practices arise from and return to their particular socio-cultural and socio-political context. The individual members of any culture have the right to choose forms of self-expression congruent with that culture, but more than this, they have the right to challenge the narrow definitions of political liberty that society offers when it makes the assumption that the majority has the democratic right to choose for all minorities as well as for the majority. It is not surprising that the politics of the indigenous health agenda, if rights-based, resemble the politics of other bicultural initiatives that seek significant social change to fulfil conditions of social equity and justice.

Tensions between hierarchical decision-making versus collective identity and consensus decision-making

Indigenous peoples tend to operate according to collectively referenced norms, thus the development of the indigenous health agenda within medical schools assumes the need for

indigenous collective decision-making and consensus, yet indigenous medical school staff often find themselves in the position of being either on their own or part of a minority presence with a minority voice. In many institutions, low numbers of indigenous staff lack the collective authority to design and implement change themselves. Despite an increase in numbers of indigenous staff within medical schools in recent years, overall staff numbers remain low (Medical Deans Australia and New Zealand and Australian Indigenous Doctors Association, 2012). Indigenous advocacy requires critical mass. Functioning as a lone individual without the collective authority of the group is stressful. A single indigenous person alone may feel they are being treated as a mascot while at the same time being expected to manage or at least consult to everything indigenous. For example, seeking a 'Māori perspective', however well intended, may still fail to recognise the complexities inherent in that request. The best person to offer this perspective within a particular Māori community may not be identifiable based on their academic position, but rather based on their age or status (Durie, 2004). At the same time, most indigenous informants wished to be afforded the right to speak on behalf of their collective if they chose to do so. In many institutions, this can result in 'burnout' as key individuals wear themselves out trying to do too much (Phillips, 2015). While medical service ideals may be marginalised within a wider medical curriculum dominated by bio-medical approaches, so in many instances, indigenous health may be marginalised as an emerging curriculum under the broad umbrella of medical service ideals. Key stakeholders championing the indigenous health agenda may be at risk of social exclusion for upholding positions considered too radical within their institution.

Institutional norms, rules and hierarchy may drive resistance to indigenous process, indigenous staff, and even the indigenous health agenda itself. Collective forms of authority appear to often struggle to find recognition or support in an institutional environment that assumes the necessity of individual and individualistic perspectives and hierarchical forms of engagement with authority (Morgan & Allen, 1998). Institutions may seek to genuinely engage with indigenous processes and try to integrate collective and consensus decision-making into their institutional culture. However, when these processes require something beyond what is expected or can be 'justified' in ways that the institution can understand, the default response is to revert to western cultural norms. The embedded assumption that authority and leadership are based on institutional roles and titles is evident, even where boards or committees exercise collective power and authority and regard themselves as

'inclusive' or 'representative' of groups and organisations. Structural change is a challenge for any institution, but as the history of the union movement makes clear, collective power presents a particularly potent threat to institutional power (Rao, Morrill & Zald, 2000). Universities and medical schools may tend to remain ambivalent in their support for indigenous collective authority so long as the maintenance of hierarchy serves their institutional self-interest. This ethos of medical schools also runs counter to the 'whole of faculty' approach frequently recommended by study participants and suggested in previous research (see: Jones, 2010). The idea of collective responsibility is also anathema to anyone who believes that we can only be morally responsible for our own individually chosen actions (Morgan & Allen, 1998).

A rights-based approach makes explicit the indigenous point of difference in claiming collective decision-making. It invites the institution to consider changing its decision-making norms. Making full use of collective authority would benefit the progression of the indigenous health agenda. However, willingness to work with existing institutional norms and to take advantage of patronage where it exists may succeed where a more direct challenge to institutional power and authority would not. Case studies of different ways of working and their outcomes would be useful in this arena (see future directions in Chapter Nine).

Tensions between institutionally-referenced norms and community-referenced norms

Relationships with indigenous community individuals, groups and organisations were repeatedly cited as a means of strengthening indigenous health initiatives. These relationships can facilitate student exposure to a wider range of learning opportunities (Crampton et al., 2003; Mazel & Anderson, 2011). Less obviously, they can expose the teaching faculty to a wider range of learning opportunities (Phillips, 2004). Least visibly, and perhaps most importantly, community relationships re-position the institution as contingent rather than absolute. In other words, reciprocal partnerships with communities enable the university to acknowledge belonging to the community in which it's located. As Phillips (2015) notes:

> people of the land should be involved in decision-making over activities that occur on their lands. Many medical school academics do not observe the landscape in which they are situated in this way. They may be happy to ask local Elders to do a welcome to country at a conference, or perhaps ask them to raise a flag at a NAIDOC week

event, but they are often not willing to respect that Elder as an owner and sovereign decision-maker over activities occurring on their lands (p. 181).

This recognition of local indigenous sovereignty through community engagement and partnerships re-contextualises the university, allowing faculty and students to understand themselves as existing in a social context that is wider than the educational institution and to some degree outside of or beyond its institutional context. However, just as the Curriculum Framework may not be institutionalised or embedded within many medical schools, many participants reported that community relationships lacked institutional support. Study participants reported that faculty and executive regularly under-estimate the time, energy and resources required to maintain community relationships. Formalising partnerships between medical schools and indigenous community groups and organisations was considered a very desirable outcome inasmuch as it brought with it sustainable resourcing and better accountability. However, many participants noted that these community agreements and partnerships were highly dependent on personal relationships, and as such needed to remain informal, open-ended, dynamic and evolving.

A Kaupapa Māori approach positions academic theorising and research as accountable to the indigenous community in which it is situated. Even without this basic assumption, however, non-indigenous advocates of a social accountable medicine and medical education make the point that medical schools must become more than internally accountable to their own norms of professional and ethical practice, but externally accountable to their patients and patient communities. Partnership between medical providers and stakeholder communities implies both formal, binding agreements that secure resources and the informal and personal relationships that nourish and sustain the wise investment of these resources.

Tensions between indigenous and non-indigenous advocacy

A key tension in developing the indigenous health agenda is the relationship between indigenous and non-indigenous medical faculty and staff. Informants varied according to the degree to which they defined themselves as activists, or engaged in active bi-cultural partnerships with other indigenous or non-indigenous allies. Indigenous medical school staff routinely found themselves thrust into positions of leadership and/or advocacy regarding all things indigenous. In matters of cultural authority, rights and responsibilities are inseparably

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linked. Claiming cultural authority or finding oneself thrust into a role of cultural authority carries with it a weight of responsibility. This weight that is much more easily carried when it is distributed on the shoulders of the collective rather than concentrated on a single individual. Yet effective advocacy requires taking the weight. If an indigenous staff member chooses to decline the invitation to lead, it will usually be by referring the issue to some other indigenous staff member either more appropriate to the task or with some cultural authority greater than their own. Otherwise, if an indigenous person is unable to refer an indigenous issue on to some specific other person, they often find themselves in the default position of having to step up and speak for the indigenous collective, notwithstanding any self-doubts they might experience about being the best person or even the right person for the job.

Indigenous informants observed that their non-indigenous allies tended to oscillate between over-confidence and under-confidence. A high degree of personal confidence is considered normal for professionals within the dominant culture, and allies are often eager to be of service in a cause they passionately support. For this reason, non-indigenous allies may be quick to speak up. They may accidentally infringe on the sovereignty of their indigenous partners. Indigenous partners have plenty of experience being infringed on and as a consequence may feel quite sensitive to intrusion, even by allies that clearly mean well but are nevertheless over-reaching their authority in their enthusiasm to be of help. Alternatively, even when they possess appropriate knowledge and skills, indigenous allies may be quite appropriately concerned about 'crossing the line.' This may result in extreme trepidation about speaking out on indigenous issues. Effective advocacy by non-indigenous allies does entail being willing to speak out – not in place of – but in alliance with and beside indigenous peoples. However, the line between effective advocacy and humility is fluid and highly contextual. In some cases, allies may be reprimanded and in other cases congratulated for saying exactly the same thing. Working in partnership on both sides of the indigenous and non-indigenous alliance requires tact and timing. Non-indigenous allies add presence and strength to an underpowered or under-represented indigenous minority and can be crucial allies and advocates for the indigenous struggle. However, there are many complexities to integrating this voice and recruiting non-indigenous partners to become staunch advocates without producing high levels of conflict. Activism in the academy, for example, may exert a polarising effect. In some cases, allies can cause offense or create alienation and provoke a 'backlash' that results in a

backward step, and when this occurs, typically tends to impact indigenous more than the non-indigenous partners (Came, 2012).

Many participants spoke about the unique situation of advocating for a particular form of medical education and healthcare, that being aware of indigenous needs for and right to better healthcare, often from the standpoint of being indigenous themselves, and therefore being intimately familiar with and personally identified with the 'condition' they were advocating receive better treatment. This raised the question of indigenous advocacy - from those who knew the issues best by virtue of living them daily - versus non-indigenous advocacy – from those who could stand in solidarity and remind their non-indigenous colleagues of the moral obligation to support indigenous peoples who continue to suffer the legacy of colonial oppression. Came (2012) frames her activist scholarship as making use of 'co-intentional praxis', whereby oppressed peoples and those belonging to coloniser populations can work towards the same goals and outcomes utilising different strengths. This co-intentional approach recognises that "the descendants of the colonisers have different decolonisation tasks from the descendants of the colonised" (Nairn, 2002, quoted in Came, 2012, p.20).

Partnership activism involves contextually determining the most effective way to work collaboratively to effect change. With this comes considerable tension. Indigenous leaders and non-indigenous allies need each other, and need to work together. They also need to define their differences, particularly with regard to privilege, power and cultural validity within the dominant culture and the impact and meaning of minority and majority status within the status quo. A parallel situation involves non-indigenous medical practitioners working in indigenous communities with indigenous patients. Partnership medicine and partnership activism could be seen as seeking integration or alternatively, as being allowed to remain separate. These partnerships are asymmetrical partnerships based on differences that demand recognition and respect. Equity requires not just reducing disparities but a new relationship in which the disparity is treated not as an anomaly but as a history. Restorative justice recognises a history of relationship. For indigenous peoples, the historical relationship is colonisation, which can only be overcome by a new relationship of partnership. Equity recognises the embeddedness of present day power disparities and gives them a history. Numerous indigenous academics have made the point that wittingly or unwittingly, academic institutions are still caught up in the maintenance of colonial discourses (Smith, 2012; Battiste, Bell & Findlay, 2002; Nakata,

2007). As such, those who challenge the status quo will tend to be marginalised by a 'backlash' that includes ignorance, individualism, cultural bias, and racism. Tensions are inherent in activist scholarship, or research and action that focuses on exposing injustices and working collaboratively to effect social change (Came, 2012). The recognition of this tension raises some interesting questions regarding how best to manage activism in the context of the academy generally, as well as the nuances of being engaged in activism within the academy as a non-indigenous ally to indigenous struggles for justice.

Indigenous rights to health and (bicultural) partnership: Contributions to the Indigenous Health Agenda

This research suggested that there is widespread recognition of indigenous health inequities among medical educators and significant interest in how medical education could contribute to the reduction of these inequities. However, there seemed to be much less clarity regarding the potential contribution of an indigenous health rights approach to indigenous health and wellbeing through medical education. Where indigenous rights to health were raised as a consideration, there was a marked absence of consensus about what this meant. Study informants struggled to articulate the specifics of health rights. The intimate relationship between rights and responsibilities was intuitively grasped, but hard to articulate. A critical component of indigenous rights are their accompanying indigenous responsibilities. The difficulty in making these connections explicit appears to contribute to the misconception that indigenous rights are entitlements without accompanying responsibilities.

So how and why is an indigenous rights to health framework an important part of the indigenous health agenda? This research suggests that the indigenous health agenda does not necessarily require an indigenous rights to health framework. While many key informants held a basic assumption of human rights to health, significantly fewer claimed the assumption of indigenous rights. It is possible to imagine that a staunch advocate of the indigenous health agenda could argue for that agenda purely on the basis of prioritising indigenous health needs without accompanying rights. However, those informants who explicitly identified themselves as holding a human rights to health framework actively sought to integrate this into their work as medical educators. Their rights framework gave them energy and conviction and focused their efforts in the service of the indigenous health agenda. While a belief in the moral obligation of medical education to reduce health inequities could be interpreted as an

expression of the ancient Hippocratic philosophy of responsible care and responsiveness to medical need, for these informants it was something more. The rights approach endemic to study participants assisted them to identify and identify with the uniqueness and unique value of indigenous people. It strengthened their conviction that justice and equity are core values closely aligned to the core values of medical care and medical education, Study participants believed that a diverse range of people and peoples, including minorities and the marginalised, have the same rights to exist and enjoy health and wellbeing as everyone else. If minorities and the marginalised have this basic right and deserve this basic recognition, then this also enshrines their rights to equitable healthcare and treatment. These rights represent a very particular and important aspect of universal human rights, rights that always require application not just 'in general' but specifically to specific persons, specific groups, and specific peoples.

For those informants who held an indigenous rights to health framework, this task of advocacy was generally even more impassioned and personal. Many of the informants who self-identified as activists held an indigenous rights framework, and for them, indigenous health rights were inseparable from the larger story of indigenous rights to equity and justice and the task of decolonisation as a moral and social obligation. Activists either were minority, as was the case with indigenous informants who saw themselves as activists, or if non-indigenous, they identified and empathised with a minority consciousness and worldview. In many respects, what the four key tensions referred to earlier in this chapter are fundamentally about is the dynamic nature of engagements between majority and minority social groups and forms of consciousness specific to each group. As signalled in Chapter One, Te Tiriti o Waitangi can be considered a guide for partnership at all levels of the asymmetrical partnership of majority and minority parties.

Te Tiriti o Waitangi and the indigenous health agenda

Basic human rights are by their very nature inalienable; they can be trampled on, but they cannot be ceded to others nor removed by them. Many authors have suggested that the inalienable health rights of indigenous people do not depend on whether they made a treaty with their coloniser (Behrendt, 2003; Alfred & Corntassel, 2005; Langton & Palmer, 2004). A treaty may, however, prove useful when the terms of the treaty agreement have been violated (Ring & Elston, 1999). As a treaty is a relationship between nations comprised of a sovereign

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people and their land, a subjugated people cannot make a treaty; this power is exclusively the prerogative of a free people with an authoritative body that has some equivalence to a central government. In response to failures to honour treaties due to the claim that tribal authorities were disparate and disunited and therefore did not constitute a valid authority with whom to continue to negotiate. McGinty (1992) notes: "Arguably, capacity to enter into relations with other states is evidenced by the Treaty's existence" (McGinty, 1992, p.701). In other words, if tribal authorities did not constitute a valid authority, the treaty could not have been valid or even entered into in the first place. However, even without a formally recognised treaty/treaties, as is the case in Australia, indigenous rights are still inalienable (Behrendt, 2003). In the view of some, without a treaty, genuine reconciliation becomes even more essential (Ring & Elston, 1999).

As the foundational document of Aotearoa New Zealand, Te Tiriti o Waitangi underpins the claim to Māori sovereignty and more generally, to indigenous rights (Durie, 2004). However, the way the governments of Aotearoa New Zealand have often chosen to apply Te Tiriti principles is through needs-based distributive policies that narrowly focus on Article 3 rights to equal treatment (Humpage & Fleras, 2001). This ideological emphasis on equality, understood as the absence of negative discrimination, filters down and may be seen to influence policies across universities, as well as government-led initiatives for improved indigenous health. Such policies are broadly aspirational in nature. While this research identified such policies as having the potential to provide leverage with which to advance the indigenous health agenda at the institutional level, skepticism about the authenticity of international, governmental, or professional body claims to prioritise indigenous health was also expressed. What Closing the Gap, WHO principles, and AMC accreditation standards all have in common is high-level aspirations and the use of generalised and abstract guidelines. These have a tendency to lose application and accountability as they filter down to the level of service delivery. Where government initiatives generated actual health dollars funding indigenous health initiatives, these do have impact at medical school level and as a result are taken seriously. Again, participants emphasised the importance of indigenous input into decision-making and noted that it was almost always executive authority and not indigenous leadership who were tasked to manage the deployment of these funds.

By contrast, the intent of Te Tiriti o Waitangi is very clear. To honour their Te Tiriti obligations, organisations and institutions in Aotearoa New Zealand are required to recognise indigenous needs, rights and interests, consult with indigenous collective authority regarding those needs, rights and interests, and in partnership with those authorities, evaluate the impacts of training and practice standards on **t**he safety and wellbeing of indigenous patients; the availability and quality of training opportunities for indigenous health practitioners who wish to become medical practitioners; the availability and quality of training opportunities for non-indigenous medical practitioners who aspire to work with indigenous patients in culturally appropriate ways; the development of bicultural and indigenous medicine, and; the integration of Te Tiriti Articles, principles and practices in the practice of medicine across all its specialties offered within Aotearoa New Zealand.

The alignment between Te Tiriti and principles of social accountability in medicine appear to offer a framework for developing the relationship between the medical community and indigenous communities seeking better health. It is possible that the articles of Te Tiriti and their practical consequences as listed above can be of service in helping to expand and clarify the relationship between indigenous rights to health and broad principles of health and healthcare such as the four WHO principles described earlier. Again, while Te Tiriti is not an absolutely necessary influence for the advancement of the indigenous health agenda, it does provide a good guide to implementing a rights-based approach to partnership in the service of a just and equitable society, particularly in settler colonial societies like Aotearoa New Zealand and Australia.

Summary

These summarised informant ideas and understandings of indigenous presence and what they believed was needed to transform their institutions to enable that presence to have impact. Drivers of the indigenous health agenda included both extrinsic and intrinsic motivations to develop the indigenous health agenda. Obstacles to the indigenous health agenda included a variety of forms of negative bias or indifference. Strategic pathways develop the indigenous health agenda via indigenous knowledge and information, indigenous process and practice, indigenous personnel, and indigenous resource base. Indigenous presence results from the integration of these four. Following this, clinical, cultural, and community aspects of medical education were identified as three domains of medical school activity, to which a fourth

domain was added of indigenous leadership, management, and organisational autonomy. A 4 X 4 table (Table 5) showed the intersection of these four domains with the four strategic pathways for developing the indigenous health agenda. These domains and pathways were able to conceptualise and clarify the territory of the indigenous health agenda. Table 5 suggested possibilities for contrasting and comparing different approaches to and different stages of the development of the indigenous health agenda. Building on the model presented in Chapter Six, an updated model of developing indigenous presence incorporating the domains of medical school was presented. Following this, several key dynamic tensions were considered, seeking to discern to what degree an indigenous rights framework was necessary to advance the indigenous health agenda. The relationship between an indigenous rights to health framework and the indigenous health agenda was further explored, identifying possibilities for bicultural partnership and the relevance of Te Tiriti o Waitangi.

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Chapter Nine: Conclusions and future directions

Introduction

This chapter summarises answers to the research questions and considers limitations, researcher reflections, and future directions. The overarching research question was: how can medical schools in Aotearoa New Zealand best fulfil their commitments to addressing indigenous rights to health. To answer this research question, three sub-questions (restated below) were developed to enable exploration of the indigenous health agenda as the practical means for the realisation of those commitments. The study synthesised key informant perspectives regarding the commitments of medical schools to address indigenous rights to health into specific action steps by which those commitments could best be fulfilled. The action steps were then considered in a case study at the University of Auckland Faculty of Medical and Health Sciences.

This thesis has to some degree laboured under the weight of its own conceptual framework. This is unfortunate but necessary insofar as its task has been to consistently keep the whole of the indigenous health agenda in view while exploring and trying to understand each of its parts. Following the presentation and discussion of study findings, it is now possible to define the indigenous health agenda more succinctly as consisting of three parts: ends, means and motives. The ends, or overarching final purpose of the indigenous health agenda is the long-term goal of reducing indigenous health inequities and contributing to indigenous health and wellbeing. The practical means to those ends were initially defined as indigenous contributions and institutional support to enable those contributions to have have impact in medical schools. Indigenous contributions became indigenous presence, the sum of the four strategic pathways. Table 5 (p. 175) reinforced the possibility that indigenous contributions and institutional support could be located across all domains of the institution, woven together, and developed. The idea of transforming the institution to enable indigenous presence to have impact was further developed along two lines, one of which emphasised the importance of the indigenous resource base and executive support for that resource base (strategic pathway four); the other of which explored the potential impact of indigenous leadership, management, and organisational autonomy (domain four). Finally, the primary motivation to drive the indigenous health agenda forward was initially defined as the recognition of indigenous rights to health and the responsibility of medical schools to address those rights. This research has determined that an indigenous rights to health framework is not absolutely necessary to

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support the practical means to realise the indigenous health agenda. However, without explicit recognition of indigenous rights to health and the responsibility of medical schools to address those rights, the transformative potential of the indigenous health agenda, and the full potential of indigenous leadership and autonomy is unlikely to be realised.

What are Aotearoa New Zealand and Australian medical school commitments to the indigenous health agenda?

This research found that all medical schools in Aotearoa New Zealand and Australia have made commitments to the indigenous health agenda. The overarching purpose of reducing indigenous health inequities and contributing to indigenous health and wellbeing has broad support within medical education in both countries. The specific nature of the commitments made by medical schools to indigenous rights to health, by contrast, are much more modest. Indigenous rights to health exist in the overlap between human rights to health and indigenous rights. Support for indigenous rights to health depends on support for both human health rights and indigenous rights. For indigenous key informants, indigenous rights to health appear to be a normative assumption. Indigenous rights to health are both linked to and distinct from indigenous rights in general. Non-indigenous key informants were less likely to claim an indigenous rights to health framework, but equally capable of distinguishing health equity from health equality. Health equity means equality in difference, not equality in sameness, and it was indigenous informants who were most aware of what this difference meant.

Understanding indigenous health equity means understanding specifically indigenous models of health and wellbeing, which in turn requires understanding something of indigenous values and worldview. Indigenous models of health and wellbeing are by their very nature holistic and integrative (Mark & Lyons, 2010). In these models, physical health is never far removed from mental, emotional, relational, and spiritual health. Many indigenous peoples want to continue to identify as indigenous and live according to the indigenous values that they have adapted to the circumstances of contemporary life (Smith, 2012; Kovach, 2010). Issues related to indigenous rights, including indigenous rights to health are contentious and potentially divisive. Objections to the political and social agenda of indigenous rights activism may be due to a concern that rights translate to entitlements without responsibility. Support for indigenous rights may be withheld based on the belief that special entitlements for indigenous peoples are not fair as they disadvantage either other minorities, or the dominant majority of

non-indigenous people. These objections appear to be based on two misunderstandings, both of which introduce the requirement for sameness under the guise of fairness. First, equity actually does include the requirement to remediate disadvantage. Positive discrimination is sometimes necessary to offset negative discrimination on the pathway to equality, and there are always individuals disadvantaged by positive discrimination as there are by negative discrimination. Second, every indigenous right carries with it certain responsibilities, many of which are responsibilities specific to indigenous peoples and therefore attached to rights that do not apply to everyone equally. A good example would be indigenous control over local natural resources, for which indigenous peoples feel responsible and view themselves as guardians and caretakers in any case as their identity is derived from the land (Durie, 2008). Indigenous land rights are not entitlements. Their claim does not depend upon ownership, nor upon a legal benefactor, such as the government or support from a majority population. While legal remedies may be required to address impediments to indigenous land rights claims, the claim itself is not defined by law, nor does it depend upon legal jurisdiction. Similarly, human health rights are not entitlements. They do not depend upon a medical benefactor, although they do require medical remedies to address impediments to their claim. As even a cursory examination of needs-based health assessment would demonstrate, priority healthcare for indigenous peoples makes sense. The health 'entitlement' of priority healthcare for indigenous peoples can be considered on its own merits, independent of generalised attitudes towards the politics of indigenous rights. In other words, indigenous health rights are health specific and can be distinguished from indigenous rights in general, with which they may also, but need not necessarily, be concerned.

In summary, the existence of indigenous rights to health do not depend on whether they are being honoured or not; they can be dishonoured but will still endure. In the context of medical education in Aotearoa New Zealand and Australia, this means that a pro-indigenous health agenda is always a possibility, whether or not the medical school in question has the resources and expertise available to realise that agenda. The initial question that can be posed in any given medical school is whether that aspiration is present, and what degree of priority it holds in relation to competing agendas.

How are these commitments currently enacted in medical schools in Aotearoa New Zealand and Australia?

The pressures that drive the indigenous health agenda have been summarised in the findings and discussion of drivers. These describe a range of aspirations, goals, programme initiatives and budgets from a variety of sources that prioritise indigenous health inequities and target their remediation. Nevertheless, most of the work needed to realise this agenda is still being done on a 'health champion' basis by individual indigenous stakeholders, supported by their indigenous collectives and networks and their non-indigenous allies. The results of this labour have been described in the findings on strategic pathways, which as previously noted, seek to capitalise on drivers, contend with obstacles, and develop practical strategies for contributing to indigenous health and wellbeing by building a strong indigenous presence in medical education and continuously negotiating for the institutional transformations needed to give that presence impact. The findings of this study suggest that resources plus expertise generate the capability needed to realise commitments to the indigenous health agenda if, and only if, those commitments have been made a priority. Realistically, the indigenous health agenda has to compete with other medical school agendas and priorities. What this research suggests is that commitments to an indigenous rights to health framework gave the indigenous health agenda a priority at least equal with other competing agendas.

How can these commitments best be realised in future in medical schools in Aotearoa New Zealand and Australia?

Once the connection is made between indigenous health rights and indigenous rights in general, it becomes easier to recognise that indigenous communities have excellent reasons to seek health independence as well as health interdependence (see Chapter Three, p. 58). Health interdependence requires asymmetrical partnerships oriented towards health equity. Health independence requires health autonomy, health sovereignty, and health self-determination. This means indigenous people claiming the right to define, protect, and decide how they wish to achieve their own good health. It means indigenous training programmes whose purpose is to equip indigenous doctors, indigenous nurses, and indigenous allied health practitioners. It means indigenous led and managed healthcare delivery systems that respond to indigenous priorities and are culturally appropriate to the norms and values of the indigenous contexts in which these systems operate. It means a seat at the table where decisions regarding indigenous

health are made. Fundamentally, rights are about responsibilities rather than entitlements. To the degree that power is shared and indigenous peoples become more self-determining, this empowerment can lead to greater responsibility and more capacity to assume responsibility.

How the indigenous health agenda might best be advanced, and medical school commitments to indigenous rights best fulfilled, is summarised in the table (Table 5, p.175) and accompanying discussion of the possible integration of strategic pathways across domains of medical school activity. The explicit recognition of indigenous rights to health and the responsibility of medical schools to address those rights is empowering, rather than absolutely necessary to this agenda; the clearest and strongest voices advocating for the indigenous health agenda were indigenous and non-indigenous informants who recognised indigenous rights to health. The contention in Chapter One that an indigenous rights to health framework provides the motive force which drives the indigenous health agenda has been supported by the research findings. Support for indigenous rights to health requires support for human health rights or support for indigenous rights, and preferably both. For indigenous informants who contributed to this study, both were a normative assumption. Accordingly, an indigenous rights to health approach is the most effective motivation in advancing the indigenous health agenda, and an appropriate and fruitful path by which to seek to transform institutions, to enable indigenous presence to have impact in medical education. Correlatively, the indigenous health agenda is the best practical means of fulfilling medical school commitments to address indigenous rights to health.

Study limitations

The major limitations of this study relate to methodological constraints. These constraints include the exclusive use of interview-based data, as well as the use of case study method. Attempting to understand the practical application of an indigenous rights to health approach to medical education required unpacking some rather complicated concepts. The purpose of interviews with key informants was to explore perceptions and experiences in relationship to the research topic. Such perspectives may have been difficult to obtain using a standardised approach. However, the use of purposive sampling and snowballing technique did potentially exclude others who may have been either overlooked or even deliberately left out as key informants acted as 'gatekeepers' for snowballing other participants. Although both interviews and case studies are frequently employed as qualitative methods, their use potentially leads to

findings that are very context-specific and therefore, potentially of limited relevance to other contexts (Bryman, 2015). The use of a case study meant that this research is highly contextualised to the case study site. As such, some of the strengths and weaknesses in the findings are placed within the specific context of the Faculty of Medical and Health Sciences at the University of Auckland. In this respect, it is hoped that those who read this thesis may be able to draw from the findings what is transferrable and applicable in their own institutional setting.

As a Kaupapa Māori researcher, it was most appropriate for the case study to be carried out in an Aotearoa New Zealand setting. However, as a result of being a researcher 'insider' in this context, although common in Kaupapa Māori research, may be seen as contributing to potential biases. It is hoped that the high response rates in this research reflects the acceptability of the researcher. Given the breadth of the study, it might have been strengthened with a case study from an Australian context, although this can be considered an area for future research, as opposed to a limitation as it may be more appropriate for an Indigenous Australian researcher(s) to carry out an Australian case study or studies focused on this research topic.

Researcher reflections

Initially, this research was focused on the development of medical student cultural self-understanding and awareness, in the service of exploring how the teaching and learning of health equity in medical school could influence more equitable health care delivery for indigenous peoples in Aotearoa New Zealand and Australia. This led to an interest in the potential of socially accountable medical education and from there, to ideas about partnership from an indigenous perspective. At this point, my naïve researcher idealism met the reality of a research project that threatened to – on more than one occasion – become unmanageable. Fortunately, I had great role models in my informants, particularly LIME members, whose contributions made such an expansive project, manageable. From these informants, I learned that both idealism and pragmatism are needed in the process of research and the ends towards which it is directed. Without idealism, pragmatism risks becoming cynical; without pragmatism, idealism remains ineffectual. Likewise, in the area of indigenous health, both idealism and pragmatism are needed to maintain momentum and avoid burnout. I come to the conclusion of this project with the sense that I have learned a great deal, some of which has

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been learnt from making mistakes. At this age and stage of my life, I look forward to projects going forward that are somewhat more modest than the present study, but resemble it in being aligned to my values and able to satisfy my aspiration to contribute to the empowerment of indigenous peoples.

Future research

This research has suggested that medical schools in Aotearoa New Zealand and Australia are able to enhance indigenous presence across medical school domains of activity, and that an indigenous rights to health approach can provide a powerful motivating force to drive the indigenous agenda forward. The recognition of indigenous peoples as a legal and social identity/category and indigenous rights at a global level through the UNDRIP, represents an extraordinary achievement. However, indigenous contexts are very diverse and may vary widely within and between countries. Medical school contexts also vary within and across countries. Therefore, how to further define and refine an indigenous rights to health framework in medical education is an important task for future research.

Using the 4 X 4 table (Table 5, p. 175), there is potential to identify where any given medical school may be aligned to the indigenous health agenda, as well as where there is opportunity to progress. Using the model, there is potential to explore the broader context in which the indigenous health agenda exists in any given medical school. In other words, the table asks what the medical school is doing and could do with regards to the indigenous health agenda, while the model offers context in terms of drivers of and obstacles to action in the advancement of the indigenous health agenda. Both of these tools have potential for tracking progress of the indigenous health agenda alongside other evaluative measures. Both tools likewise can contribute to transparency and accountability in the tracking of this progress at medical schools in Aotearoa New Zealand and Australia.

Research that investigates the relationship between medical education and patient health outcomes is scarce. Although the research findings from this study has potential for exploring how medical schools in Aotearoa New Zealand and Australia may align with the indigenous health agenda, the application and evaluation of outcomes across a range of contexts is still required. Nevertheless, with further research, there is potential to develop both the table and

the model into tools to organise data, or the descriptive picture of any given medical school, and ask for data that is needed, or explore the context of that descriptive picture.

In Conclusion

Progressing the indigenous health agenda can be considered a small but important part of the wider struggle for indigenous autonomy that continues around the world; a global struggle of indigenous peoples for recognition of their rights. Often in the face of overwhelming odds, indigenous people will continue to claim sovereignty and self-determination and demand recognition and respect for their right to do so. As Farmer (2005) notes, "violence against individuals is usually embedded in entrenched structural violence" (2005, p. 219). Many indigenous health inequities are embedded in the entrenched structural violence of colonisation and its multiple legacies, including poverty, discriminatory social practices, and internalised negative self-representations within indigenous people themselves (Rassmussen, 2001; Anderson et al., 2009). Medical education has little power to change many of these basic social facts. However, medical education does have a moral obligation to reflect basic human aspirations for a generous and harmonious social order in which people with skills care for those in need. This may be understood as an evolutionary process that is developmentally driven and therefore unstoppable. Many of the tensions within contemporary medical education can be appreciated as attempts to integrate competing agendas within the culture of medicine itself. As a scientific discipline, modern medicine will likely continue to rely on evidence-based practice. However, the parameters and nature of what constitutes evidence may alter, as for example, when a focus on illness shifts to a focus on wellness, or when the objective body of the biomedical paradigm is reframed as the whole person of biopsychosocial medicine. Universal standards of 'best practice' have to contend with the rights of the individual practitioner to practice autonomously, as well as the rights of groups of practitioners to adapt and align treatment and care to the specific groups and communities with whom they work. Demands for social responsibility, social responsiveness, and social accountability, all of which position medicine as a fundamentally altruistic enterprise, have to contend with the self-interest that limits the supply of doctors in order to ensure their status in the community.

It can be acknowledged that the changes to medical education proposed by the indigenous health agenda are not trivial and they are not straightforward. They reflect an organic living

process rather than a mechanistic progression, subject to 'birthing pains' and requiring work and time to develop. Faced with demands for change, multiple obstacles may arise to slow progress. Institutions may push back and individuals may become defensive. Those who identify themselves with the status quo may feel oppressed as well in various ways, and lodge a competing claim for status as a disadvantaged minority. Yet it is clear that the culture of medical education and medical schools can be developed to value indigenous knowledge, beliefs, and practices. The core business of medical education can include indigenous people and indigenous projects deemed worthy of significant investments of time, money and energy. Curriculums can be aligned. Personal relationships can be developed. MOUs and MOAs can be signed. Faces on the wall can reflect diversity and challenge monoculture. New departments of medical education can be created. By making strategic pathways more explicit and learning to distinguish between them, and by clearly naming and describing the domains in which those pathways operate, advances in the indigenous health agenda can be more closely monitored and more critically evaluated. Quantitative and qualitative progress indicators can be developed to not only signal increases in indigenous presence in particular domains such as the curriculum, or culturally immersive experiences, or human resources, or budgets, but to evaluate the quality of these activities via their effects and outcomes. Consideration can be given to the characteristics of institutional environments in which strategic pathways to a strong indigenous presence in medical education can be effectively supported. It appears both possible and timely to develop ways of measuring the effects or outcomes of institutional contexts that facilitate progress in the indigenous health agenda, and then try to determine how much of this progress can reduce indigenous health inequities and contribute to indigenous health and wellbeing.

It makes sense for indigenous people to progress the indigenous health agenda because they are the people most likely to know what the outcome should look like. However, non-indigenous allies are absolutely needed to assist in the realisation of this outcome. The same principles of partnership that apply to indigenous health experts and their non-indigenous allies can be applied to any population that suffers systematic disadvantage and who therefore need to be understood on their own terms, in terms of their unique history. The same requirement to engage in partnership and lend resources and support health interdependence until health independence is possible, always applies. Linked to indigenous rights, but also distinct from them – and one of the most important things that drives the indigenous health

agenda, particularly for non-indigenous allies – is the recognition that what is good for indigenous peoples is good for everyone. Support for indigenous peoples to be treated humanely and respect for their uniqueness and humanness is implicitly if not explicitly an expression of support for all human beings to be treated likewise. Humane treatment and care are aligned to the Hippocratic Oath. The principles of beneficence and non-maleficence that ethically underpin medical treatment and care can and should be considered an integral part of practicing and teaching medicine. Ultimately that is what this thesis is seeking to do, to raise the level of medical education's specificity and skill to answer an ethical call, recognising and responding effectively to the health rights and needs of indigenous people, and through the development of that specificity and skill, to become able to recognise and respond to the rights and needs of human beings from every culture and every way of life. Medical education could be and might become a place where resources and expertise are shared widely, where active engagement in health partnerships with diverse communities serves to empower those communities, where people and peoples can design and develop their own healthcare in the service of making the dream of their own health and wellbeing a reality.

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Appendix A

Interview Schedule: Phase One

How can medical schools in Aotearoa New Zealand best fulfill their commitments to addressing indigenous peoples' rights to health?

1. What role do medical schools have in addressing health inequities?
   i. Indigenous peoples specifically?
2. What does social accountability mean to you?
   i. Role in medical education?
   ii. Relevance to addressing health inequities?
   iii. Relationship to indigenous rights?
3. Do universities have a role in addressing indigenous rights to health?
4. How might medical schools demonstrate commitments to addressing indigenous rights to health?
5. Are there factors that limit demonstration of this commitments?
   i. In your institution?
   ii. At a broader level?
6. Does partnership between medical schools and communities play a role in addressing these rights?
   i. How?
7. How can medical schools develop partnerships with indigenous communities?

Appendix B

Interview Schedule: Phase Two with initial strategic areas (strategic pathways)

How can medical schools in Aotearoa New Zealand best fulfill their commitments to addressing indigenous peoples' rights to health?

1. Can you just tell me a bit about your role and how it relates to what you perceive as indigenous rights in medical education?

2. Questions regarding Phase One strategy areas: Interested in your thoughts of these four areas:

Indigenous Content	Indigenous Process
- indigenous health curriculum - indigenous art and ceremony - indigenous faces on the walls of the university	- indigenous ways of being and doing - ritual and ceremony - indigenous understandings and that emphasise core indigenous norms and values
Indigenous Personnel	**Institutional support for indigenous initiatives**
- indigenous faculty, including professional, academic staff and clinical teachers - indigenous students - indigenous community partners - indigenous stakeholder group members	- money - time - energy - organisational structure

- With regard to Auckland medical school
- With regard to your role
- What do you see as obstacles to these areas?
- How could those obstacles be addressed?
- Which of these areas would you prioritise based on your experience and role?
- What do you see as indicators that these areas are being progressed/advanced?