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Aboriginal Health Consumers Experiences of an Aboriginal Health Curriculum Framework

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Introduction

In settler colonised countries, medical education is situated in colonist informed health systems (Sharma, 2018). This form of colonisation was characterised by overt racism and the gaining of territory through the domination and elimination of the Indigenous (Indigenous meaning here Indigenous people globally) population (Wolfe, 2006). The remaining populations were subjected to a process of elimination via aggressive assimilation into colonist society. Strenuous efforts were made to micro-manage their lives in an attempt to remove identity, language, culture and connections to family and Country (Tuck & Yang, 2012). To justify this action, Indigenous peoples were exoticised and misrepresented as uncivilised by colonists, in contrast to the colonisers, who were portrayed as heroes bringing civilisation to them (Said, 1985). However, despite the continued resistance of Indigenous people to settler colonialism (Smith, 1999), its ideological and racist informed practices and processes continue to impact social goods such as education and health care up to this day (Berman & Paradies, 2010; Brady, 1997; Dudgeon & Walker, 2015).

The perpetuation of settler colonialism is contributing to the significant health inequities experienced by Indigenous peoples compared to non-Indigenous people (Anderson et al., 2016) with well documented intergenerational impacts upon the original peoples (Anderson et al., 2016; Australian Human Rights Commission, 1997). In an attempt to assist address this issue within health care, medical accreditation bodies in settler colonised countries such as Canada, New Zealand, Australia and the United States, have mandated that curriculum provide content relating to Indigenous peoples, including attention to equity in terms of access and quality of care (Australian Medical Council, 2012; Lewis & Prunuske, 2017; The Indigenous Physicians Association of Canada and the Royal College of Physicians and Surgeons of Canada, 2009). These decisions have seen the construction of Indigenous health curriculum frameworks to guide curricular content and their use actively progressed by governments, accrediting bodies, Indigenous and non-Indigenous academics and health professionals (Commonwealth Department of Health, 2014; R Jones, 2011; Rhys Jones et al., 2018; Lewis & Prunuske, 2017; The Indigenous Physicians Association of Canada and the Royal College of Physicians and Surgeons of Canada, 2009). In Australia, the Aboriginal and Torres Strait Islander Health Curriculum Framework (herein the Framework) was developed to support higher education providers to implement Aboriginal and Torres Strait Islander (herein Aboriginal) health curricula across health professions' training programs including

medicine (Commonwealth Department of Health, 2014). The Framework aims to prepare health professions' students gain relevant capabilities that enable them to work appropriately with Aboriginal patients. Multiple resources, including associated learning domains, are provided to support implementation of Aboriginal health curricula. The development of such a Framework is however limited in its value to educators and arguably health professions' students, because the voice of Aboriginal health consumers, who will have a different worldview of healthcare than experts, is missing. (Sharma, 2018). In Australia, there remains a gap between the rhetoric and the reality; where Aboriginal health consumers worldview of health care and their nuanced lived experience of the perpetuation of the settler colonist ideology remains missing in action.

Health consumers' voices are important as they are best placed to understand their own experiences with the healthcare system (Agency for Healthcare Research and Quality, 2017). In order to provide responsive care, medical practitioners (herein practitioner) would benefit from understanding these experiences and perspectives. In particular, Aboriginal health consumers are more than just recipients of healthcare but have their own ways of knowing, being and doing (Martin & Mirraboopa, 2003) in regard to this. Aboriginal health consumers have diverse individual experiences of healthcare and collective understandings of what health means as the following definition articulates:

“Aboriginal health” means not just the physical well-being of an individual but refers to the social, emotional and cultural well-being of the whole Community in which each individual is able to achieve their full potential as a human being thereby bringing about the total well-being of their Community. It is a whole of life view and includes the cyclical concept of life-death-life (NACCHO, 2021).

However, practitioners are trained in a predominant biomedical approach which is more focused on the individual (Baum, Bégin, Houweling, & Taylor, 2009), in isolation from the social world of feelings, spirituality, family and intentions. In addition, the focus is on diagnosis and treatment, and for Aboriginal people this presents a risk of the practitioner perpetuating dominant settler-colonial paradigms (Wong, Gishen, & Lokugamage, 2021). In this scenario, the practitioner's focus on the individual and the health problem means they miss the bigger picture. This can contribute to a deficit discourse about Aboriginal people by describing people as

problems, rather than, placing these problems within the societal context that causes them (Fogarty, Lovell, Langenberg, & Heron, 2018).

The challenge to practitioners and medical educators who train them is to re-shape a curriculum so that Aboriginal health consumers' worldviews can be incorporated in a meaningful way. Whilst there are instances of Indigenous health consumers being consulted and informing a medical curriculum, their contribution was not explicitly outlined (Lewis & Prunuske, 2017). The apparent absence of Aboriginal health consumers' worldviews in Australian curriculum framework conceptualisation indicates a power imbalance and reveals cultural safety diminishment. Cultural safety includes incorporating the viewpoints and experiences of Aboriginal people (Ramsden, 2002) and their absence in the Framework counters this.

This study aimed to investigate Aboriginal health consumer experiences of medical care, in relation to an Aboriginal Health Curriculum Framework (Commonwealth Department of Health, 2014).

Methods

Study design

This study investigates the lived experience of Aboriginal Australians presenting to practitioners in South-East Australia. It was informed by an Indigenous Research Paradigm which privileges Indigenous worldviews (Wilson, 2001) and engages with Aboriginal resistance to racist oppression (Rigney, 1999). Moreover, the paradigm acknowledges the impact of the colonisation processes and the privileging of Aboriginal voices to understand our shared assumptions about social reality.

The inquiry question was: What are Aboriginal health consumers' experiences with medical practitioners in relation to the five learning domains of the Aboriginal and Torres Strait Islander Health Curriculum Framework? The learning domains are Respect, Communication, Safety and Quality, Reflection and Advocacy. These domains comprise key descriptors such as cultural knowledge, history, strengths-based approaches, racism, equity and human rights. The study was undertaken in the same geographical location with assumption that this is where the majority of graduating students will choose to work. Monash University Human Research Ethics Committee approved this study on April 30 2018, approval number 10569.

Sampling

Convenience sampling was used to recruit participants for the study to enhance accessibility to them (Marshall, 1996). Criteria for participation was being Aboriginal, over 18 years of age and having experience consulting a practitioner. Recruitment was via flyers posted on South-East Australian Aboriginal organisational newsletters and message boards and emailed to Aboriginal organisations with request to circulate. Participants self-selected and were invited to contact the researcher (author one, Aboriginal) via phone or email. A conversation then occurred for the purpose of establishing eligibility criteria and organising a suitable time and place to meet. A family member or friend who had participated in the study referred two participants. Seventeen Aboriginal participants contributed to the study, comprising 12 women and five men with an age range from 20-70. Seven participants lived rurally and 10 lived in urban areas.

Data collection

Yarning methods were employed by author one to collect data and Yarns took place between late 2018 and mid-2019. For thousands of years Aboriginal people have practiced Yarning. It has a purpose in research (Bessarab & Ng'andu, 2010) supporting the cultural practice of sharing stories (Walker, Fredericks, Mills, & Anderson, 2013) and as such, the researcher needs to have an explicit approach to using Yarning. In the context of this research, a structured approach to the Yarn comprised a Social yarn and Research topic yarn (Bessarab & Ng'andu, 2010). The Social yarn, where trust and relationship is developed (Bessarab & Ng'andu, 2010), consisted of author one sharing her cultural and professional roles with each participant and then inviting each person to share their story via the question 'can you tell me a bit about yourself'. Open-ended questions then ensued for the Research topic yarn (Bessarab & Ng'andu, 2010). Participants were asked to reflect on experiences with medical interactions that were important to them in relation to the Framework learning domains and key descriptors. For example, each participant was asked: 'what does the learning domain mean to you and your family and how would a doctor demonstrate good and poor use of the learning domain key descriptors?' The Yarns were 60 to 90 minutes in length, audiotaped and transcribed verbatim for analysis.

Data analysis

Framework analysis (Gale, Health, Cameron, Rashid, & Redwood, 2013) incorporating a five step approach was used to make sense of the data (Pope, Ziebland, & Mays, 2000). Firstly, author one became familiar with the texts by reading and re-reading them. Then, author one identified a thematic framework that consisted of the five learning domains, verified by authors two and three. Thirdly, author one and three coded two transcripts independently and compared coding for consistency coming to consensus on anomalies. Fourthly, author one coded remaining transcripts, assigning the codes to the thematic framework (each learning domain); this was reviewed with authors two and three (see Table 1). Lastly, authors one and three mapped the data searching for patterns and concepts (see Figure 1 and Figure 2). Data saturation occurred when participants were describing similar experiences and perspectives and nothing further could be achieved by persisting with questions (Braun & Clarke, 2019; Marshall, 1996). Data coding occurred in NVIVO 12 and pseudonyms provided to participants.

Results

Coding of data identified a pattern whereby Aboriginal participants described practitioners demonstrating the learning domain or not demonstrating the learning domain.

Table 1: Aboriginal health consumers experiences of medical practitioner demonstrating or not demonstrating ATSIHCF learning domains

Learning domain descriptor	Not demonstrating learning domain	Demonstrating learning domain
Respect - recognise Aboriginal peoples' ways of knowing, being and doing in the context of history, culture and diversity, and affirm and protect these factors through ongoing learning in health care practice.	Not wanting to know about Aboriginal peoples, stereotyping, grouping all Aboriginal people together, only being interested in health issue, lack of awareness of Australian history, treating everyone the	Understanding local Aboriginal context and culture, knowing own cultural heritage, understanding holistic health, value and recognition of Aboriginal people, treating whole family, kinship, acknowledging traditional

	same, being judgmental and having no humility.	owners, relationship and trust building, diversity of Aboriginal people and open to learning.
Reflection - examine and reflect on how one's own culture and dominant cultural paradigms, influence perceptions of and interactions with Aboriginal and Torres Strait Islander peoples.	Unresponsive to individual needs; doesn't acknowledge culture, holds negative stereotypes, unaware of racism, makes assumptions and is unaware of colonisation and its impacts.	Understands cultural protocols and expression, makes a connection, acknowledges diversity of cultures, aware of healthcare culture, responsive to individual needs, aware racism exists, aware racism exists in healthcare, understands effects of racism and can enact anti-racism.
Communication - engage in culturally appropriate, safe and sensitive communication that facilitates trust and the building of respectful relationships with Aboriginal and Torres Strait Islander peoples.	Arrogance, never experienced good communication, not explaining enough, attention on computer or notes, appearing not to care, not listening to needs.	Asks follow up questions, shows awareness and understanding, body language awareness, uses diversity of communication methods, listens, builds relationship, talks at patient level and is trustworthy.
Advocacy - recognise the whole health system is responsible for improving Aboriginal health. Advocate for equitable outcomes and social justice for Aboriginal peoples and actively contribute to social change.	Not providing access to health services and healthcare, stereotyping and not respecting my rights.	Providing access to healthcare and services, responsive to health needs, knowing who we are, respecting our rights, patient centered, and providing equitable outcomes.
Safety & Quality - apply evidence and strengths-based best	Only wants to know medical information, doesn't involve me in	Provides reminders, shares qualifications and medical experience, provides written

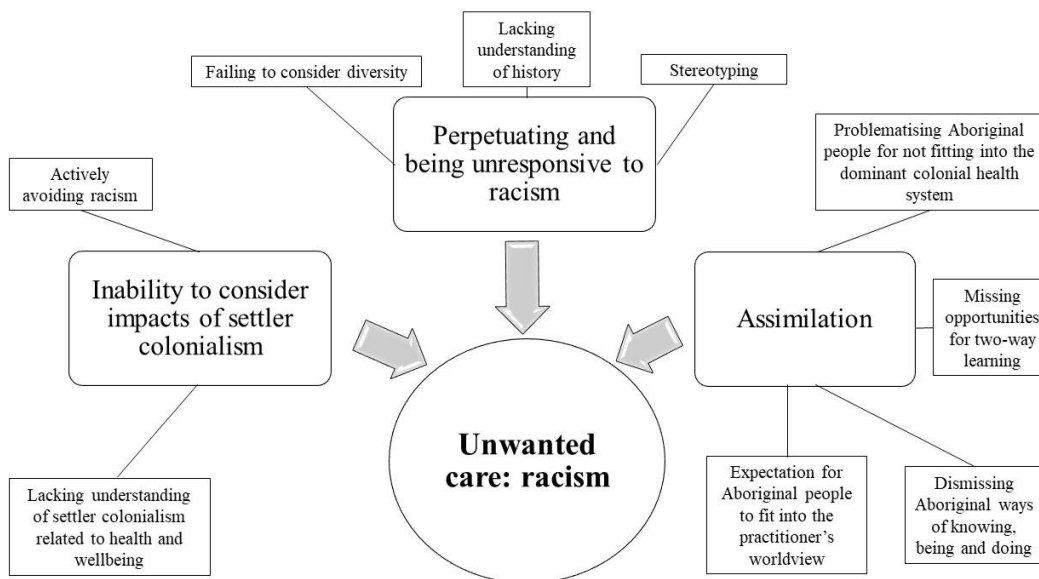
<p>practice approaches in Aboriginal and Torres Strait Islander health care.</p>	<p>care, has no connection with me, doesn't know what I need, is judgmental, doesn't provide access to healthcare or services and the practitioner is central.</p>	<p>information, reviews last appointment, uses referral services including Aboriginal services, knows about racism, is willing to learn, provides a culturally safe space, provides timely care, understands strengths of Aboriginal community, prevents illness, includes me and family in care and is accountable.</p>
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Further mapping identified the practitioner enacting practices that culminated in both unwanted racism and ongoing settler colonialism or desired anti-racism approaches (see Figure 1 and Figure 2).

Unwanted care: racism

Participants outlined three main areas of concern involving unwanted practitioner care related to racism (see Figure 1).

Figure 1. Unwanted care: racism



Assimilation

Participants described a power imbalance whereby the practitioner worldview was dominant, effectively excluding Aboriginal ways of knowing, being and doing. The power imbalance included expectations that Aboriginal people assimilate into a practitioner's world view.

Caroline (27, Urban): "I think without that awareness or without them wanting to probe further into people's Aboriginality or culture they're never going to change the experience they give to Aboriginal people, because, they might think they're asking all the right questions but they're just following the guidelines."

Betty (62, Urban): "...sometimes the doctor can be very intimidating and, a lot of the time, doctors won't - to me, when I've been in some sessions, they don't actually treat you any different than anybody else - which is okay, but you've got to be mindful of what their [patient] situation is. You've got to be careful how you [practitioner] talk."

Zane (45, Rural) "They talk to you and then they're sort of looking at the computer, or they're looking at some papers and things like that. Then you get that feeling, is he just filling out his notes and everything and I'm done here, or does he really want to know how I'm feeling."

Brian (49, Urban): "I don't think I've ever, in my experience, I don't think I've ever had a doctor sit down and ask me about my culture, ask me about me."

Participants outlined attempts to challenge practitioner notions of assimilation by asserting their Aboriginal ways of knowing, being and doing. However, sometimes these assertions were actively dismissed by practitioners for example:

Sarah (39, Urban): "The doctor said, 'well no, the science is the same between people'...but there's a different learning to be had."

Laura (25, Rural): "Just understanding that we don't just follow them [practitioner] telling us to take medicine this way that we do things a different way as well."

Maria (70, Urban): “I did have some work on Aboriginal people on how we feel when we see a doctor. I photocopied it and left it at (the) medical (centre) for everybody to read.

Participants thought that practitioners who were assimilatory missed a valuable opportunity to learn from Aboriginal health consumers:

Alex (20, Urban): “It’s not like that whole aspect of learning from encounters with Aboriginal people. It’s more like you’re just a number to them [practitioner].”

People commented that when they didn’t fit the settler colonial healthcare system, the system was not problematised, but rather, they were:

Max (45, Urban): “Your health issues are your own fault because you don't eat well.”

Brian (49, Urban): “We're not the problem, they're the problem, and they're part of the solution.”

Jo (49, Rural): “Maybe we're just too much work for them.”

Perpetuating racism and being unresponsive to racism

Another way participants explained unwanted care was as experiences with practitioners who perpetuated racism. For instance, some participants described stereotyping:

Ben (26, Urban): “They work with an Aboriginal person and don't know they're saying little things out of line and don't know they're saying these little stereotypical things to them [the patient], because they just don't know.”

Max (45, Urban): “You're a black fellow so you must a heavy drinker, you smoke. If you're an Aboriginal man, you must have been to jail and there's a good chance that you commit family violence at home. And some doctors, I think, do have that viewpoint, because they just stereotype all (the) mob.”

Furthermore, participants described practitioners failing to understand diversity of Aboriginal peoples:

Melanie (23, Rural): “I feel like Australians class us as we’re Aboriginals, and then when you break it down it’s like, No, I’m from here. I’m from this clan. That’s how we’re connected, is because our clan groups. So maybe more understanding that we are Aboriginal people but we’re from so many different tribes.”

Daisy (46, Rural): “I think they all think we’re the same”

Practitioners were described as perpetuating racism when they problematised Aboriginal people for their ill health rather than the underlying historical and social contexts:

Tracey (45, Rural): “I’ve been dismissed at hospitals or not served at hospitals before...they [hospital staff] come from a really privileged place and they – and it can come across as being quite judgemental. Why don’t you care about your own health? And it’s not sort of about that.”

These experiences of racism in the healthcare system led to health consumers being cautious and primed for another racist encounter:

Brian (49, Urban): “...but why is there a hesitance [by the health consumer]? What’s happened in the past? I mean look at their [settler colonist] own healthcare systems of the past, what’s happening today that’s different?”

Inability to consider impacts of settler colonialism

Unwanted care additionally involved practitioners who were unable to consider the impacts of settler colonialism in healthcare provision. For instance, participants related experiences of practitioners actively avoiding discussion about this:

Zane (45, Rural): “It’s real and it’s happened in the past, the history happened, and I feel that a lot of doctors don’t know that. They just turn a blind eye.”

Laura (25, Rural): “The only history that they really are interested in is if your family has heart disease or cancer or things like that.”

Participants described practitioners superficially discussing their health and lacking a deeper understanding of settler colonialism in relation to health and wellbeing:

Melanie (23, Rural): “I think because the conversations don’t go deeper than the checklist, where I can’t find out if they know our struggles...it’s just, do you smoke, how’s your eating habits, do you drink enough water? Yes, not really knowing anything really.”

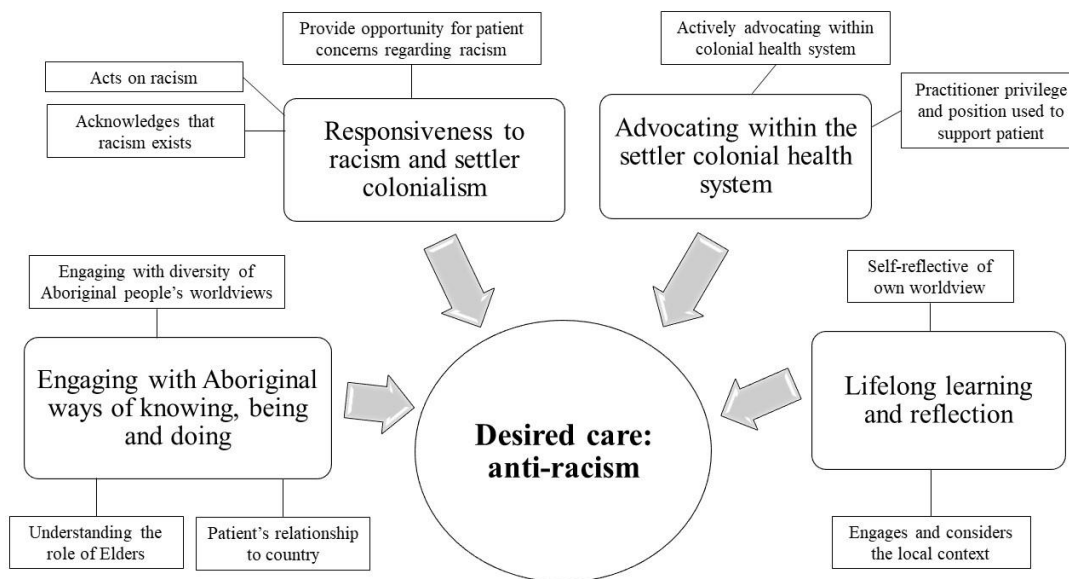
This lack of consideration left participants feeling fearful and traumatised:

Daisy (46, Rural): “I didn't trust doctors for a long time. I didn't go to a doctor for a very long time. And then when I did, I had to have someone in the room with me, a female.”

Desired care: anti-racism

Four themes were identified that outlined participant experiences of desired care. These related to anti-racist practices involving self-reflection and action to mitigate racism (Bonnett, 2000).

Figure 2. Desired care: anti-racism



Engaging with Aboriginal ways of knowing, being and doing

Practitioners were valued when they knew practical information, such as the patient’s relationship to country, including knowing why this was important to the patient’s health and wellbeing.

Alicia (23, Rural): "...understand where I'm coming from. It's obviously not from the Northern Territory or somewhere completely different, it's actually home grown where they are, on the land that they are on. That makes a big difference to me."

Alex (20, Urban): "When I think of respect in a cultural way, I think of things like acknowledgment of country somewhere on the front of the clinic or something like that."

Jo (49, Rural): "They need to know who I am. Am I on country or am I away from home? I think that has a big part in the caring, and how you're feeling and stuff."

In addition, participants appreciated practitioners who, in the context of the consultation, engaged with the patient's worldview so it could be included in their healthcare. Importantly, this was not engaging with one Aboriginal worldview but a diversity of representations:

Laura (25, Rural): "...them [practitioner] acknowledging that I am Aboriginal, and they understand that we have cultural values through medicine and the health way."

Alicia (23, Rural): "I think about it being like, our identities in regards to just being Aboriginal, what we believe in, our practices, our daily in and out, you know; how we communicate and how we interact with family members; how our family is our strength; being home on country is our strength. The small things like that. Those small things will add up to basically, what it is to be an Aboriginal person."

Brian (49, Urban): "...understanding a bit about myself, a bit about my family, a bit about who we are as a people. Also respecting the fact that we're Aboriginal people and respecting our culture and our beliefs and our value systems and just I guess the way we want to be treated."

Participants outlined that understanding the role of Elders either as patients or as part of patient's lives was essential:

Melanie (23, Rural): "I feel like we just grew up knowing to respect each other, really. Listening and communicating and respecting our Elders."

Maria (70, Urban): “Listen to some educated Aboriginal people as well as the Elders. Listen to the bad and the good. Because that’s the baggage we’ve had to carry.”

Responsiveness to racism and settler colonialism

Participants identified the importance of practitioners acknowledging that racism exists and is a feature of ongoing settler colonialism:

Betty (62, Urban): “They've [practitioners] got to understand that racism impacts Aboriginal people on a daily basis, inside and outside their home... Even when these fellas get to the doctor, they're being racially abused on the way there.”

Ben (26, Urban): “You've got to understand so much more of the past to understand the present.”

When racism was acknowledged, this allowed for extension to praxis whereby the practitioner could be responsive. Participants particularly valued practitioners skilled in providing space and understanding for the patient to raise potential concerns about racism and its impacts:

Caroline (27, Urban): “...just think asking the question, you know, are you Aboriginal, is there anything you’d like to discuss, or I’ve [the practitioner] seen this. Just having an open mind about it and having a real interest in the client.”

Alicia (23, Rural): “Yeah, the communication that he has with us is quite open, so it's like talking to someone who I've known for years...Then I feel comfortable enough to tell him what's wrong and then we can have that chat, where I'm getting advice from him on that level.”

Advocating within the settler colonial health system

Participants welcomed practitioners who used their privilege and position to advocate for them:

Sarah (39, Urban): “So someone who knows how to navigate it and is an expert of it changing it...it's like, I'm on the inside; I'll show you the secret doorways. That's what advocacy is.”

This form of advocacy was more than a referral to services. It involved the practitioner actively advocating for them within the settler colonial health system:

Alex (20, Urban): “It’s not just a promotion; it’s more like getting involved as well. So, when I think of advocacy I think of genuine understanding and genuine motivation to help whoever else is involved.”

Life-long learning and self-reflection

Practitioners who were continually learning and engaging with the local context, including history were regarded:

Tracey (45, Rural): “He [practitioner] connected with the Aboriginal community first...and was so grateful for that experience and I think that that really set him on a really awesome path, and how he could really relate to the people he was working with.”

Janet (23, Urban): “Aboriginal history, Torres Strait Islander history - it depends on where you're coming from; they really need to understand that people and that place where they are, that would mean a lot to those people there.”

Additionally, practitioners who were not from the dominant settler colonial culture were seen as more self-reflective of their worldview and open to learning and appreciating diverse worldviews:

Louise (65, Urban): “The doctors that are in the hospitals now, have a culture of their own and I think they understand it.

Tracey (45, Rural): “Generally GPs that actually have come from a cultural background of their own... [are] just sort of more aware that there are other cultures and... respectful and they learn about the mob that they're working with.”

Discussion

This study sought to describe Aboriginal health consumers experiences with medical practitioners in relation to learning domains of an Aboriginal health curriculum framework. Two main areas were identified, the first being racism which included themes: assimilation; perpetuating and being unresponsive to racism and; inability to

consider impacts of settler colonialism in consultations. Participants' experience of racism in healthcare were concerning as racism is known to have a negative impact on health and wellbeing (Kelaheer, Ferdinand, & Paradies, 2014; Priest, Paradies, Stewart, & Luke, 2011). Therefore, whilst participants were seeking healthcare to improve their health and wellbeing, in these circumstances medical practitioners were actively undermining it. In contrast, participants described medical practitioner anti-racism as positive and helpful, congruent with ongoing recommendations for this approach in healthcare (Berman & Paradies, 2010; Durey & Thompson, 2012; Paradies, 2016).

Descriptions of racism and anti-racism prevailed across the five learning domains of the Framework, highlighting the tensions Aboriginal health consumers face when attempting to interface with healthcare and the importance of addressing this overarching priority in Aboriginal health equity curriculum. The Framework learning domains describe what to teach (Commonwealth Department of Health, 2014), however, participants in this study articulated how these could be demonstrated by providing a preferred vision of enactment previously not described. For example, Aboriginal participants clearly illustrated how practitioners who operated from a biomedical model of healthcare were seen to problematise the patient with this contributing to deficit discourse about Aboriginal people.

Deficit discourse is a powerful narrative that can negatively impact relationships and health outcomes (Fogarty et al., 2018). It affects health as it is more than how the practitioner sees the patient or the words they use to communicate. It is embedded in the 'systems of thoughts composed of ideas, attitudes, courses of actions, beliefs and practices that shape reality by systematically constructing the subjects and the worlds of which they speak' (Kerins, 2012, p. 26). Participants in this study described numerous ways deficit discourse is portrayed in clinical settings, including exhibiting power imbalance by excluding Aboriginal ways of knowing, being a doing and expecting Aboriginal people to assimilate into the practitioner's world view. Conversely, practitioners who take a strengths-based approach to Aboriginal health, focus on anti-racism elements described by participants, such as engaging with diversity of Aboriginal worldviews, considering the patient's relationship to country and understanding the central role of Elders. Incorporating a strengths-based approach acknowledges the patient's environment, including the various contexts that make up their lives (Saint-Jacques, Turcotte, & Pouliot, 2009). Practitioners who function in

this way are valued, particularly when they see the Aboriginal community as a rich resource and use their own privilege and position to advocate for health equity.

Participants appreciated practitioners who actively advocated for them ensuring access to healthcare, arranging resources, guiding the patient through the system and addressing health inequities through involvement in health policy and system change (Hubinette, Dobson, Scott, & Sherbino, 2017). Participants described advocacy as practitioners doing more than referral. It included an expectation that the practitioner would use their knowledge and resources to guide them through the health system. These were essentially anti-racism acts as practitioners were seen by participants as acting as a mediator to mitigate power imbalances between the patient and the colonial health system. When practitioners did not apply advocacy in this way, participants viewed this as provision of diminished access to healthcare impacting their rights. Consequently, advocating for health equity requires practitioners to be skilled in combining expertise in disease with knowledge of factors in the patient's life that contribute to health outcomes. Practitioner life-long learning and self-reflection may help in this regard.

Participants described life-long learning and self-reflection as practitioners who continually learn and engage with the local context, including the history and experiences of local people. They reflect on how this knowledge can be used to support the patient's health journey. These practitioners are aware of concepts such as power and privilege and this knowledge is a step toward cultural safety in healthcare. Cultural safety requires practitioners to reflect on their own attitudes and biases, where they consider and act to prevent negative impact on the clinical interaction (Curtis et al., 2019). Development of self-reflection skills assists practitioners to identify and disrupt settler colonial dominance in health care settings (Diffey & Mignone, 2017) and should be a feature of Aboriginal health curriculum frameworks.

Importantly, the aim of this study was to include the voice of Aboriginal health consumers in Aboriginal health curriculum. While this is significant, we must question what does it really change? Medical education has its roots in the mind body dualism proposed by Descartes's science and the positivist paradigmatic assumptions about what counts as knowledge. Medical education is also situated in 'institutionalised forms of coloniality' (Wong et al., 2021). This bias toward Western ways of knowing, being and doing perpetuates a power imbalance in the way

curriculum is conceived. Even if Aboriginal voices are included in curricula, it appears to do little to change the continued presence of colonial epistemology that underpins the current biomedical approaches to health care (Wong et al., 2021). For meaningful change to occur there needs to be a reconceptualisation of health professions' curriculum, a decolonisation, that rejects the exclusivity associated with Western medicine (and knowledge) and incorporates inclusivity that better reflects all people. Decolonisation for Aboriginal people, is not to be confused with social justice and human rights (Tuck & Yang, 2012) and it is not achieved by including Aboriginal perspectives in curriculum. Decolonisation is the actions that recognise Aboriginal knowledge as valuable; that we existed productively prior to colonisation; it is aligned and answerable to Aboriginal sovereignty (Tuck & Yang, 2012). Until this happens, the inclusion of the voices of Aboriginal health consumers in shaping the health professions' curriculum will be a token gesture.

That being said, this study did not ask Aboriginal health consumers what or how medical students should be taught. Rather, as most Aboriginal people have sought medical care, these participants were asked about their experiences as expert consumers of health services as to how good healthcare should be modelled and provided. This is an important distinction as Aboriginal health consumers are experts in their own lives however, they are not always experts in education or curriculum design and delivery and they should not be expected to be able to provide answers to the curriculum conundrum.

Limitations

Interpretation of findings should consider that the study was set in South-East Australia with a limited number of participants, including more females than males. However, data saturation occurred whereby participants were describing similar experiences and perspectives. Participants in the study may see other things as important to their health care, but as they did not appear in the Framework, they were not asked of them. Another limitation is that people who elected to take part in the Yarn may feel more confident than those who did not. Importantly, the study emphasises that understanding the influence of Aboriginal health curricula for Aboriginal consumers is still in the early stages.

Conclusion

Practitioners are promoting ill health through racist practices with Aboriginal health consumers. Aboriginal people's experiences of racism expressed through the continued settler colonial processes seen in the Australian health system are critical to meaningful curricula. Descriptions of racism and anti-racism themes prevailed across the five learning domains of the Framework, highlighting this as an overarching priority in Aboriginal health equity curriculum. The voices of Aboriginal health consumers are important to include in curricula, however, there is a risk for tokenism if the academy continues its coloniality by privileging the biomedical model of illness and health over other models of health.

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