Journal of the Australian Indigenous HealthInfoNet

Volume 4 | Issue 2 Article 4

2023

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Recommended Citation

Atkinson, P., Baird, M., & Adams, K. (2023). Intersectionality Based Policy Analysis of How Racism is Framed in Medical Education Policies Guiding Aboriginal Health Curriculum. *Journal of the Australian Indigenous HealthInfoNet, 4*(2).
http://dx.doi.org/10.14221/aihjournal.v4n2.4

Intersectionality Based Policy Analysis of How Racism is Framed in Medical Education Policies Guiding Aboriginal Health Curriculum

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Abstract

Introduction: Racism has a profound impact on health inequities for Aboriginal and Torres Strait Islander people. Australian medical schools are required to include Aboriginal and Torres Strait Islander health curriculum in their medical courses and policies have been developed to support this work.

Methods: The research question was: how is racism framed in medical education policies guiding Aboriginal and Torres Strait Islander health curriculum for entry-level medical courses? Applying an Indigenous Research Paradigm and Intersectionality Based Policy Analysis, three key policies were analysed: Australian Medical Council (AMC) Standards for Assessment and Accreditation of Primary Medical programs; Aboriginal and Torres Strait Islander Health Curriculum Framework (ATSIHCF); Committee of Deans of Australasian Medical Schools Indigenous Health Curriculum Framework (CDAMS).

Results: The AMC standards did not refer to racism, while CDAMS and ATSICF supported the notion that teaching students about racism would lead to reduced racism or increased anti-racism in healthcare practice. However, both policies' learning objectives lacked inclusion of critical reflection required to inform responsive action to racism. As the CDAMS and ATSIHCF were not mandated, there is little accountability for medical schools to implement either of the curriculum policies.

Conclusion: Realising the goal of medical practitioners who understand racism and practice anti-racism requires a multi-layered approach. This involves evidence-based teaching about racism and anti-racism, Aboriginal and Torres Strait Islander leadership in curriculum development, inclusion of racism and anti-racism in medical school accreditation standards, and development of student critical reflection skills. Importantly, education and health institutions need to value and model anti-racism.

Keywords

Aboriginal health, Indigenous health curriculum, racism, anti-racism, medical education

Australian medical schools are required to include Aboriginal and Torres Strait Islander health curriculum in their medical courses (Australian Medical Council, 2012). This Australian Government mandate has led to the development of curriculum frameworks and accreditation guidelines in the belief they will improve health outcomes for Aboriginal and Torres Strait Islander people (Commonwealth Department of Health, 2014; Ewen et al., 2015; McKivett et al., 2020; Paul, 2013; Phillips, 2004). However, irrespective of these initiatives there is compelling evidence that racism, relating to the colonisation of Australia, continues to have a profound impact on Aboriginal and Torres Strait Islander people's health and wellbeing (Dudgeon et al., 2014; Kelaher et al., 2014; Larson et al., 2007; Paradies, 2016; Priest et al., 2011; Sherwood, 2013).

Race is a multifaceted social construct used to divide people into groups on the basis of their physical characteristics (Bond et al., 2019 ; Dudgeon et al., 2014). Racism as the ideological expression of racial theories (Tucker, 2007), occurs between individuals and within cultural, institutional (systemic) and interpersonal contexts (Berman & Paradies, 2010; J. M. Jones, 1997). Whilst its impact can be difficult to measure, it is known to evoke significant negative emotional responses (Nayak, 2011). Racism toward Aboriginal and Torres Strait Islander people is deeply entrenched within Australia, via ongoing settler colonisation. This often involves political, health, education and justice systems where power and prejudice are expressed through discriminatory practices (Bolt, 2001; Dunn, 2001; Kelaher et al., 2014; Larson et al., 2007). The persistence of the experience of racism in healthcare is of great concern where its presence can be "literally a matter of life and death" (Weber & Fore, 2007, p. 191). For these reasons, within Australia, racism is a key determinant of health impacting the emotional, spiritual and physical wellbeing of Aboriginal and Torres Strait Islander people (Kelaher et al., 2014; Paradies et al., 2015). For instance, Aboriginal and Torres Strait Islander health consumers report experiences of racism related to ongoing settler colonisation in consultations with medical practitioners (Atkinson et al., 2021). Additionally, in healthcare interactions with Aboriginal and Torres Strait Islander health consumers, some medical practitioners struggle to respond to consumer experiences

of racism (Atkinson et al., 2021). This is consistent with other literature identifying Indigenous health inequity to be driven by unequal power relationships, expressed through privilege and institutional racism (Curtis et al., 2019; Reid et al., 2019; Robson & Harris, 2007). Additionally, it has been identified that there are problems in medical training with inadequate teaching about racism and anti-racism in the curriculum (Crampton et al., 2003; Nelson et al., 2015; Vass & Adams, 2020). In this paper we examine how racism and anti-racism are framed in policy documents that guide entry level medical curriculum in relation to Aboriginal and Torres Strait Islander health.

Methods

Theoretical Framework

This investigation is situated within the Indigenous (meaning Indigenous people globally) Research Paradigm (IRP) that privileges Indigenous worldviews, particularly the importance of emancipation from oppression and privileging Indigenous voice (Rigney, 1999). When Indigenous researchers apply policy analysis, particularly within an IRP, the privileging of an Indigenous voice and worldview is strengthened (Hogarth, 2017). Equally, when Indigenous researchers conduct research into Indigenous affairs, there is opportunity to privilege an Indigenous reality and decolonise the research process (Smith, 1999). The IRP obliges Indigenous researchers to link their research to the broader decolonising struggle for self-determination, equal representation and recognition (Rigney, 1999). Given the focus of this research, the paradigm is fitting as it acknowledges the importance of addressing oppression arising from ongoing racism and colonisation for Aboriginal and Torres Strait Islander people.

The paradigm also informed the choice of Intersectionality Based Policy Analysis (IBPA). Intersectionality aligns with an IRP in several ways. Firstly, it highlights the ways in which multiple systems of inequity operate (Bastos et al., 2018). Secondly, IBPA as a form of analysis, focuses on inquiries related to context (Cho et al., 2013) which is central to considering the ways the policy documents contextualise racism in relation to Aboriginal and Torres Strait Islander people and healthcare. Thirdly, when led by Aboriginal and Torres

Strait Islander people, IPBA respects Aboriginal and Torres Strait Islander knowledge, including the diverse and inseparable ways Aboriginal and Torres Strait Islander people know themselves (Clark, 2012). Lastly, it can assist to identify colonisation processes and reframe the policy problem from the perspective of anti-racist and Aboriginal and Torres Strait Islander epistemologies (Fridkin, 2012).

Policy Selection

A policy provides a process, political decision or program that guides approaches across sectors (Blackmore & Lauder, 2004). In this study we searched for medical education policy documents that were created to guide Aboriginal and Torres Strait Islander health curriculum for entry level medical courses. The policy documents analysed were:

1. The Australian Medical Council (AMC) Standards for Assessment and Accreditation of Primary Medical Programs
2. The Aboriginal and Torres Strait Islander Health Curriculum Framework (ATSIHCF)
3. Committee of Deans of Australasian Medical Schools Indigenous Health Curriculum Framework (CDAMS).

Intersectionality Based Policy Analysis Method

IBPA has two core components: a set of principles that guide policy analysis and a set of questions that shape the analysis (Hankivsky, 2014). These questions are further divided into two categories: descriptive and transformative, which are applied to transform the ways policies and their processes are understood (Hankivsky, 2014). Following the IBPA guidelines (Hankivsky, 2012) author one, in consultation with authors two and three, firstly responded to the descriptive questions. These questions collect information that aids understanding of the problem context. Here, background information is generated, focusing on ways the policy problem is identified, formed and addressed (Hankivsky, 2012). Whereas the descriptive questions ask about the researcher's knowledge, values and experience of the policy problem. These include what the policy problem is, how it is represented, how groups are affected and the current responses to the problem (Hankivsky, 2014).

In contrast, the transformative questions assist the researcher to identify alternative policy approaches. These questions prompt the researcher to think about actions and outcome measures (Hankivsky, 2014). They encourage the researcher to consider the inequities of the problem, interventions to improve the problem, how responses will reduce inequities and how implementation and uptake can be assured (Hankivsky, 2014). To answer the transformative questions in this study, framework analysis was used. Firstly, author one became familiar with the policies by reading and re-reading them. Secondly, author one constructed a coding framework comprising the IBPA transformative questions. Thirdly, author one and three coded one policy document independently specifically identifying references to racism. The two authors then compared coding for consistency coming to consensus on anomalies. Fourthly, author one coded remaining policy documents and this was reviewed with authors one and three. Lastly authors one and three mapped the data. Data coding for the transformative questions occurred using NVivo 12.

Analysis and Discussion

IPBA Descriptive Questions

What knowledge, values and experiences do you bring to this area of policy analysis?

Hankivsky (2012) outlines that reliable analysis requires the analyst to declare their experience, personal values, interests, and beliefs. As such, author one's standpoint is outlined below.

Researcher Standpoint: I have personal experiences of healthcare and racism across my life, including the Welfare attending our home in the 1970s to remove one of my siblings. I experienced interpersonal racism as a patient, where a child and maternal health nurse visited my home to weigh my newborn and proceeded to conduct an unscheduled risk assessment in case she 'had to report me to the authorities'. This was in 1994, more than twenty years after the Forcible Removal of Aboriginal Children policy had (arguably), concluded (Behrendt & Fraser, 2013). Here was a health practitioner threatening me with

repercussions (removing my newborn), if I didn't meet her standards. As a health worker, I also witnessed racist treatment of Aboriginal patients in hospital settings, where patients were denied necessary and life-saving treatment because they had substance abuse issues or when a young Aboriginal girl who had tried to take her own life, was ridiculed and mocked by the nurses who were in ear shot outside her room. I recognise racism when it happens and I know how it feels to experience it, the shock, anger, humiliation, hopelessness and withdrawal for preservation. As an Aboriginal health educator, I have taught health professions students (including medical students) for over ten years. My teaching priority has been to teach truth-telling about my family's and community's lived experience of being Aboriginal and to build student capability to respond to ongoing colonisation and racism. These experiences have assisted to inform this policy analysis.

What is the policy problem under consideration?

The problem considered here is how racism is framed in policy documents that were created to guide Aboriginal and Torres Strait Islander health curriculum for entry level medical courses. To understand the problem it is helpful to clarify the assumptions that underlie it (Hankivsky2012). In this analysis an assumption is that curricula should not only involve concepts about racism, but also, ways to respond to or prevent racism. For instance, a key way to mitigate racism is through anti-racism, defined as 'forms of thought and/or practice that seek to confront, eradicate and/or ameliorate racism' (Bonnett, 2000, p. 4). In order for anti-racism to be meaningful for medical practitioners and students, it needs to enhance understanding by reflecting on anti-racism concepts, and include actions and practices that address racism (Kendi, 2019). Importantly, identifying and addressing various levels of racism is a key element of anti-racist practice (Hollinsworth, 2006). In relation to healthcare, the focus of anti-racism is more on equity (everyone receiving the same outcome) rather than equality (everyone receiving the same resources) (Berman & Paradies, 2010). Therefore, this analysis sought to understand how racism and anti-racism is specifically named and referred to within medical education policies guiding Aboriginal health curriculum.

How have representations of the problem come about?

Understanding representations of how the problem came about requires identifying the types of evidence used and ways the problem has changed over time (Hankivsky, 2012). Policy is always framed within a sociopolitical milieu. Unpacking the entirety of racism and medical education in relation to Aboriginal and Torres Strait Islander people is beyond the scope of this paper. Instead, some key events are outlined. For instance, Aboriginal and Torres Strait Islander people, alongside allies, have provided lengthy activism aiming to influence, among other things, medical curriculum with some success. In 1979, the House of Representatives Standing Committee on Aboriginal Affairs recommended schools of nursing and medicine include Aboriginal and Torres Strait Islander health content in curricula at both undergraduate and graduate levels, however did not stipulate guidance to do this (House of Repesentatives Standing Committee on Aboriginal Affairs, 1979). At around this time, a non-Aboriginal rural general practitioner wrote one of the first medical education articles on Aboriginal health. He identified a cultural gulf and need for medical education to include understanding of Aboriginal culture (Kamien, 1978). However, this observation was in stark contrast to evidence which would emerge across following decades, that identified power and race as major issues.

In 1987 a Royal Commission into Aboriginal Deaths in Custody (Royal Commission) noted a wide-spread non-Aboriginal view (including of healthcare professionals) that Aboriginal and Torres Strait Islander people were inferior. Despite Aboriginal and Torres Strait Islander people resentment and resistance to this, it was used to justify paternalistic policies, demeaning attitudes and methods of power over Aboriginal people (Johnston, 1991). To counter this view, the Royal Commission made recommendations for health professional self-reflective practice: “health professionals should examine their styles of operation with a view to checking whether those styles can be improved” (Johnston, 1991, p. 91). The Royal Commission was closely followed by the landmark publication of the first National Aboriginal Health Strategy in 1989. This recommended training for health

professionals in Aboriginal health, but side-stepped issues of racism and power, instead stating that training should involve: “encouraging health professions to undertake an advocacy, awareness raising, and community educational role” (National Aboriginal Health Strategy Working Party, 1989, p. 91). Whilst the National Aboriginal Health Strategy identified healthcare skills and processes required to work with Aboriginal people, their attainment was optional and not mandated. Additionally, the Strategy was later deemed never effectively implemented (NACCHO, 2020).

Almost ten years later, a national inquiry was held into the “Separation of Aboriginal and Torres Strait Islander Children from their Families” (Human Rights and Equal Opportunity Commission, 1997). Similar to the previous Royal Commission, the inquiry found issues of racism and power in access to and delivery of health services and made stronger recommendations in regard to training health professionals than the National Aboriginal Health Strategy. It advised training should ensure knowledge and responsive capability about the history and effects of forcible removal:

> 34a. That government health services, in consultation with Indigenous health services and family tracing and reunion services, develop in-service training for all employees in the history and effects of forcible removal.
>
> 34b. That all health and related training institutions, in consultation with Indigenous health services and family tracing and reunion services, develop under-graduate training for all students in the history and effects of forcible removal” (Human Rights and Equal Opportunity Commission, 1997, p. 346).

There is little doubt that these specific recommendations to provide health professionals with training in Aboriginal and Torres Strait Islander health led to the creation of several key medical education events. The earliest of these was the publication of CDAMS in 2004 (Phillips, 2004), followed in 2006, with the inclusion of Aboriginal and Torres Strait Islander people within the Australian Medical Council’s (AMC) Assessment and Accreditation of Medical Schools Standards and Procedures framework (AMC, 2006 in Mackean et al., 2007). The AMC continued to provide focus on Aboriginal and Torres Strait

Islander health with the inclusion of Aboriginal and Torres Strait Islander health standards in the subsequent Assessment and Accreditation Standards for Primary Medical Programs 2012 (Australian Medical Council, 2012). A few years later the multi-disciplinary ATSIHCF was published in 2014 (Commonwealth Department of Health, 2014). Also influencing these events were emerging concepts of cultural competence, cultural safety and anti-racism.

The practice of cultural safety was conceptualized by Māori nurses in New Zealand. This considered the impacts of power and culture on health, including the culture of the patient, healthcare professional and the healthcare environment (Curtis et al., 2019; Ramsden, 2002). Additionally, the term cultural competence also started being applied in healthcare, with this meaning the ability of systems to provide for a diverse range of patient cultures (Betancourt et al., 2002). A further concept emerged in Malaysia called anti-racism (Bonnett, 2000), which was later adopted and popularized in other countries, such as, the United States (Kendi, 2019). In contrast to cultural competence and cultural safety, anti-racism considered power and race as social structures impacting on health (Bonnett, 2000). While much has been written about cultural safety and competence in relation to Aboriginal and Torres Strait Islander health curriculum, less is understood about racism and anti-racism. Better understanding of racism and anti-racism is particularly important, as racism relating to ongoing settler colonisation processes is known have had a profound impact on Aboriginal and Torres Strait Islander health (Paradies, 2016).

How are groups differentially affected by this representation of the problem?

An important element of policy analysis is to identify the groups impacted by the problem and consider how current representations shape understanding of these groups (Hankivsky, 2012). There are several key groups affected by the problem of racism in Aboriginal health curriculum policies. This includes, governments, health services, accreditation bodies, students, educators and health consumers. Here we consider three key groups of people commonly mentioned by the policy documents, medical students, medical educators, and Aboriginal health consumers, families and communities. Within each of these groups there is diversity, such as, socioeconomic status, histories, gender,

sexuality and ethnicity. In relation to medical students, diversity includes domestic, Aboriginal and Torres Strait Islander and international students. These students have various experiences of racism, some subjected to it themselves and others not experiencing it at all. However, many medical students are aware of racism and are committed to efforts that move beyond symbolism and address structural racism, particularly in relation to Aboriginal and Torres Strait Islander people (Australian Medical Students' Association, 2021). Medical students' experiences of curriculum also vary despite the provision of curriculum frameworks, as medical schools make autonomous decisions to include Aboriginal and Torres Strait Islander health in curricula. As a consequence, there is diversity in the content and mode of delivery of Aboriginal and Torres Strait Islander health and may or may not include Aboriginal and Torres Strait Islander leadership in teaching and learning activities, implementation and evaluation (Pitama et al., 2018).

The second key group, medical educators, (often practitioners themselves), are also diverse in their experience with racism and some reporting feeling unprepared to teach racism (Vass & Adams, 2020). Educators are also immersed in health and education sectors where systemic racism exists and may normalise this (Kishimoto, 2018). Importantly, educators who may have been victims of racism, can also encounter systemic bias and racism in employment (Lett et al., 2018), which likely impacts who teaches medical courses (Iacobucci, 2020). Educators can also be Aboriginal and/or Torres Strait Islander, including academics and community representatives. They too are diverse in terms of educational experience, traditional Country, disciplines, connections, role in community and as such, bring a particular standpoint to their teaching.

The third group, Aboriginal and Torres Strait Islander health consumers, have a breadth of diversity with more than 250 distinct language groups across the country (AIATSIS, 2021). Consumers have varied experiences of being Aboriginal and/or Torres Strait Islander, such as, living on or off Country or being from the "Stolen Generations" and will have unique expressions of Aboriginal and Torres Strait Islander knowledges. As such, they have individual healthcare needs and are more than just recipients of healthcare,

having their own ways of knowing, being and doing (Martin & Mirraboopa, 2003). In relation to healthcare experiences, Aboriginal and Torres Strait Islander people have not been passive recipients of inappropriate healthcare, but rather, have strongly advocated for many decades for better healthcare from the colonial healthcare system. For instance, when Aboriginal people were incarcerated onto missions and reserves in the 19th century, there were many petitions and protests led by Aboriginal people about health and wellbeing conditions (Attwood, 2004; Horner, 1988). In another example, in the mid to late 20th century Aboriginal communities established Aboriginal Medical Services and the Aboriginal Health Worker profession (Vickery et al., 2005).

What are the current policy responses to the problem?

To understand response that the three policy documents provide it is helpful to consider who has responded to the problem (racism) and in what way, what the policies hope to achieve and how they hope to address the problem (Hankivsky, 2012). While the AMC policy did not mention racism at all, CDAMS and the ATSIHCF had identified racism as an important teaching component. This identification occurred via the differing processes used to construct the curriculum frameworks.

The CDAMS policy arose from the Committee of Deans of Australasian Medical Schools partnering with the former Commonwealth Department of Health and Ageing (Phillips, 2004). The Committee had committed to ensuring medical students received the right information and skills to develop doctors who could improve Aboriginal and Māori health outcomes (Phillips 2004). The partnership established a project which was administered by an Aboriginal and Torres Strait Islander unit at University of Melbourne. The project audited Aboriginal and Torres Strait Islander content in medical education courses and as part of the consultation process, engaged with numerous stakeholders, including medical educators, Aboriginal and Torres Strait Islander doctors and student bodies. This informed the development of the CDAMS curriculum framework to guide inclusion of Aboriginal and Torres Strait Islander health related concepts into medical curricula. An aim was to include the curriculum framework in AMC accreditation standards for medical

schools, but this did not eventuate. Following the consultation, a network for educators concerned with Aboriginal and Torres Strait Islander health related curriculum was created.

In contrast, the ATSIHCF (Commonwealth Department of Health, 2014) was created in response to the *Growing Our Future: Final Report of the Aboriginal and Torres Strait Islander Health Worker* project (Health Workforce Australia, 2011). Similar to CDAMS the Commonwealth Australian Government was also involved and commissioned Curtin University and Health Workforce Australia to develop a multi-disciplinary ATSIHCF to guide health professions education (Commonwealth Department of Health, 2014). Unlike CDAMS, the ATSIHCF was constructed through a research process involving a literature review, online survey and stakeholder meetings (Commonwealth Department of Health, 2014).

IBPA Transformative Questions

Overview of the policies

The IBPA provides several questions to guide understanding of the policy documents, they are outlined below.

What are the inequities?

In analysing policy, it is important to consider how the policy problem (racism) is being conceived. The two policies that mentioned racism had varied conceptualisations of this concept (see Table 1).

Table 1

References to Racism in the Three Policy Documents

	AMC (Australian Medical Council, 2012)	**CDAMS** (Phillips, 2004)	**ATSIHCF** (Commonwealth Department of Health, 2014)
Is racism considered in this policy?	No	Yes	Yes
Contextual information about racism		**Guiding Principles** Aboriginal and Torres Strait Islander people require equity of access not only to mainstream services that are free of racism and other forms of discrimination, but also to services which are specific and culturally appropriate (p.7).	**Context** Discrimination based on race or racism is also a social determinant of Aboriginal and Torres Strait Islander health. Evidence suggests that racism occurs in health services, compromising care and leading to reluctance by Aboriginal and Torres Strait Islander people to attend services for treatment (p.9).
Subject area/learning domain		Subject areas of history and communications skills both mention racism.	**Cultural Capability of 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 people (p.30).
Student attributes		**Key Student Attributes and Outcomes** Subject area of history - explain the connection between history and present health outcomes, including the forms and impacts of racism (p.9). Subject area of communication - identify features of overt, subtle and structural racism or discrimination in interactions between patients and health professionals and systems, identify ways to address such occurrences, and acquire skills to advocate for their resolution (p.12).	**Reflection Graduate Cultural Capability - Key Descriptors** ***Cultural Self and Health Care*** Recognise the influence of one's own cultural identity and the culture of the Australian health care system on perceptions of Aboriginal and Torres Strait Islander people. ***Racism*** Evaluate different forms of racism and associated stereotypes that impact on Aboriginal and Torres Strait Islander health, and demonstrate practice that is free from racism. ***White Privilege*** Critique privileges and advantages afforded to white Australian society and understand the role of power relations in the inequitable distribution of privileges (p.30).

Curriculum accountability	CDAMS proposed to the Australian Medical Council (AMC) that this framework be included in their accreditation guidelines. The AMC have formally approved this proposal, meaning that all medical schools in Australia will be required to report on the implementation of these guidelines as part of their regular accreditation requirements (p.5).	The Framework contextualises the issue of Aboriginal and Torres Strait Islander health, responds to the need to improve tertiary education in this area, offers suggestions that encourage consistent learning outcomes related to Aboriginal and Torres Strait Islander health and wellbeing, and provides a benchmark for graduate cultural capability standards (p.8).
Learning outcomes	**Key Student Attributes and Outcomes** Subject area of History - explain the connection between history and present health outcomes, including the forms and impacts of racism (p.9). Subject area of communication – • Identify features of overt, subtle and structural racism or discrimination in interactions between patients and health professionals and systems, identify ways to address such occurrences, and acquire skills to advocate for their resolution (p.12). • Identify it, encourage discussion, and make sure it is dealt with in a respectful and safe environment. This can be done in ways that empower victims, educate perpetrators and contribute to a sense of shared co-operation, resolution and learning (p.21). Teaching caution: in instances of racism and discrimination, it is our experience that if such instances are 'swept under the carpet, or alternatively 'blown out of proportion, then learning environments can be seriously compromised. A recognised strategy of dealing with such instances may assist in the process of shared learning and growth.	**Reflection – learning objectives relating to racism** ***Novice level*** Identify different forms of racism and prevailing stereotypes about Aboriginal and Torres Strait Islander people in Australia and how they impact equitable health service access and health outcomes for Aboriginal and Torres Strait Islander people. ***Intermediate level*** Demonstrate internal strategies to examine and monitor personal responses to cultural and social differences. ***Entry to practice*** Generate strategies for incorporating anti-racist and affirmative action approaches in health care practice (p.35). Progress/ racial equity gains with caution; and critiquing liberalism (p.70).

Firstly, the CDAMS policy conceptualised racism in the guiding principles (see Table 1) and this was referred to as important for students to understand and address. Racism was siloed in key student attributes and outcomes under two of eight subject areas, history and communication (see Table 1), despite being relevant to all eight subject areas. The CDAMS additionally had an aim to provide healthcare free of racism, a lofty ideal for curriculum alone to achieve (see Table 1). In contrast, the ATSIHCF conceptualised racism as actions, such as, race-based discrimination that undermines and compromises access to healthcare. Similar to CDAMS, racism was siloed to one of the five cultural capabilities, however, was relevant for all five capabilities. However, unlike CDAMS the ATSIHCF provided theory to inform teaching about racism, such as Critical Race Theory and White Privilege. Importantly, the detail provided on conceptualisation of racism and anti-racism in these curricula policies was vitally important to inform the way the policies are interpreted and implemented by educators.

What are the interventions?

In addition to noting the interventions, it is also important to identify who is part of the intervention and positioned to influence implementation (Hankivsky, 2012). In terms of interventions to address racism, the CDAMS policy proposed this should involve educators, students, curriculum, and systems. This required confident educators, passionate about improving Aboriginal health outcomes, and able to form a strengths-based position, plan, deliver and evaluate the curriculum. For students, the key recommended attributes related to skills in identifying healthcare professional and systemic racism and discrimination practices to advocate for their resolution (see Table 1). The ATSIHCF outlined similar teaching topics to CDAMS, but, additionally included anti-racism as a strategy to address racism (see Table 1). The implementation of teaching topics and attributes recommended by CDAMS and the ATSIHCF would require educators skilled to provide this, however skill level has been found to be a barrier (R. Jones, 2011; Vass & Adams, 2020). This is of concern because for students to practice anti-racism they need to see anti-racism being modelled in their training institutions and by their educators and clinicians (Bourke et al., 2019). In addition, although

students can be taught to practice anti-racism, they have little power within healthcare institution hierarchies. This limits their ability to influence change and they may also fear being seen as troublesome whistle blowers if they report professional dilemmas (Monrouxe & Rees, 2012).

What feasible solutions are proposed?

A key aspect of IBPA policy analysis is to consider how solutions can be promoted and positioned (Hankivsky, 2012). Both the CDAMS and the ATSIHCF policies proposed that teaching about racism in medical education would improve healthcare delivery provided to Aboriginal and Torres Strait Islander people. For instance, CDAMS outlined learning objectives relating to identifying forms and impacts of racism and identifying features of overt, subtle and structural racism to identify ways to address these (see Table 1). It also proposed that educators engage students who have experienced racism to share their experiences as a means of enhancing the topic (see Table 1). However, in contrast an anti-racist pedagogy requires students to critically self-reflect and act whereby, “action takes the form of being aware and noticing injustice and checking stereotypes. It’s using my lens of anti-racism, figuring out what it is I’m seeing, and taking action” (Jewell, 2020, p. 96). The CDAMS also warned that teaching about racism could result in problematic student and educator interactions (see Table 1) suggesting strategies were needed for this. However, no further guidance was provided.

The ATSIHCF includes the expectation that graduates are capable of evaluating forms of racism and demonstrate practices free from racism. However, within the Graduate Cultural Capability Model, the descriptors and learning outcomes for reflection do not actually include reflection. Instead, the learning outcomes focus on identifying and generating strategies, rather than encouraging student learning through critical thinking (see Table 1). This is in contrast to what has been recommended in ATSIHCF (Commonwealth Department of Health, 2014). Importantly, critical reflection “focuses specifically on the personal experience of the practitioner” requiring consideration of the values and assumptions that underpin practice (Pockett et al., 2011, p. 11). In relation to anti-racism

teaching, students need to be taught about meta-cognition, critical reflection and supported as they develop meaningful reflexivity skills. Arguably, it is critical thinking that will enable students to begin to understand: power in relation to race (Kishimoto, 2018); how settler colonisation is a form of racism (Power et al., 2021) and; ways to challenge colonial oppression within healthcare (Diffey & Mignone, 2017).

How will the policy responses reduce inequity?

The CDAMS and the ATSICF supported the notion that teaching students about racism would lead to reduced racism or increased anti-racism in healthcare practice. However, also impacting on ability to practice anti-racism is the socio-cultural-historic context within which education is situated. In Australia students learn, train and are culturally immersed in environments, such as universities and health services, that are founded and informed by colonial values (Smith, Tuck, & Yang, 2019). It is in these places that students can encounter the construction of Aboriginal and Torres Strait Islander people as a healthcare problem while absented is the more than 200 years of colonisation and trauma which caused the problems (Sherwood, 2013). Importantly, teaching about racism and anti-racism will have a limited impact unless a multi-layered approach to change is taken. As R. Jones et al. (2018, p. 512) argue, “to contribute effectively to Indigenous health development, medical education institutions must engage in decolonisation processes and address racism and privilege at curricular and institutional levels”. Therefore, alongside teaching it is important to consider how to address the systematic racism also existing in higher education (R. Jones et al., 2018; Medical Deans of Australia and New Zealand & Australian Indigenous Doctors' Association, 2012) and clinical teaching places (Amutah et al., 2021; Quigley et al., 2021) where students are immersed. This will require a united vision and enaction of anti-racism by medical schools and clinical partners. Unless both institutions are coordinated in approaches it makes it very difficult to teach students to respond to racism in a meaningful way.

How will implementation and uptake be assured?

The IBPA policy analysis requires consideration of who is responsible for implementation, timeframes and accountability processes and collaboration across diverse groups (Hankivsky, 2012). Medical schools are responsible for the implementation of medical curriculum, however, the extent of teaching about racism or anti-racism in medical curriculum is relatively unknown. However, what is known is that some medical schools are notoriously well known for providing minimal coverage of Indigenous health content (Pitama et al., 2018). In terms of implementation and uptake of CDAMS and the ATSIHCF seems to be little accountability for medical schools to implement either of the curriculum documents. For instance, the ATSIHCF policy states it is a curriculum guide and the CDAMS policy states it is a curriculum resource. The only policy that could have had an accountability process for the inclusion of racism or anti-racism in medical school curriculum was the AMC Accreditation Standards however, the current version of the standards omitted this.

How will it be known that inequities are reduced?

The IBPA policy analyst must also consider how policy implementation and outcomes are measured, including how affected communities are engaged (Hankivsky, 2012). The ATSIHCF policy outlines that its aim is for graduates to have the cultural capability to evaluate racism. In comparison, the CDAMS policy aims for students to: "Explain the connection between history and present health outcomes, including the forms and impacts of racism" (Phillips, 2004, p. 9) and to "Identify features of overt, subtle and structural racism or discrimination in interactions between patients and health professionals and systems, identify ways to address such occurrences, and acquire skills to advocate for their resolution" (Phillips, 2004, p. 12). As such, one policy is looking at a higher level of learning (evaluate), while the other is looking at the lower level (identify and explain) (Anderson et al., 2001), which are not actions. This raises the question; how do educators assess students practice that is free from racism, indicating a need for better assessment tools?

In terms of evaluation, the CDAMS advised that Aboriginal and Torres Strait Islander

academics and community members be part of the design, delivery, and evaluation of curriculum. It further recommended Aboriginal and Torres Strait Islander people have oversight of teaching materials and assessment prior to use and that staff and community be involved in developing evaluation tools and methodologies (Phillips, 2004). Similarly, the ATSIHCF recommended that implementation specifically include Aboriginal and Torres Strait Islander people's perspective of curriculum design, monitoring, evaluation, professional development for staff and assessment of achievement of capabilities and learning outcomes (Commonwealth Department of Health, 2014). However, while medical schools are provided with internal tools to encourage critical reflection and review of practice when implementing Aboriginal and Torres Strait Islander health curriculum (Onemda VicHealth Koori Health Unit & Medical Deans Australia and New Zealand, 2007), neither of the curriculum policies have an evaluation strategy to see if healthcare had been improved and racism reduced because of the frameworks. Therefore, while understanding impacts of entry to practice programs is helpful, the greater evaluation need is likely across the educational development of a medical practitioner. Particularly as there remains work to be done to understand the effectiveness of ongoing development of medical practitioners in relation to their ability to identify and respond to racism.

Limitations

A limitation of this review is that only policy documents related to Aboriginal and Torres Strait Islander health in the medical curriculum were included. In addition, this review was limited to policies for entry to practice into the medical profession. Finally, a full exploration of the impact of racism towards Aboriginal and Torres Strait Islander people upon the trajectory of medical education is beyond the scope of this paper.

Conclusion

This analysis sought to examine how racism and anti-racism is framed in medical education policies guiding Aboriginal and Torres Strait Islander health curriculum for entry to practice medical courses. Differing approaches have been taken by each policy. The AMC policy did not refer to racism or anti-racism at all. Meanwhile, the ATSIHCF recommended

teaching about racism and anti-racism providing theory to inform this, such as critical race and whiteness theory. The CDAMS also recommended teaching the topic of racism and how to respond to this, but did not suggest theory to inform pedagogy. Both the ATSIHCF and CDAMS provided learning objectives relating to racism and anti-racism. However, these did not recommend teaching critical reflection, which is required to inform responsive action to racism. While the CDAMS and ATSIHCF policies recommended teaching about racism and anti-racism, at times this was performative rather than functional.

This research has highlighted the need to take a multi-layered approach to including teaching about racism and anti-racism in medical education. Firstly, medical school accreditation standards must include education on racism and anti-racism, including the relationship of this to ongoing settler colonisation processes. Secondly, any racism and anti-racism curriculum needs to be informed by appropriate theory and evidence-based teaching and learning approaches. Involvement of meaningful Aboriginal and Torres Strait Islander leadership in the development of curriculum and assessment of racism and anti-racism would strengthen these propositions. Thirdly, curriculum and assessment should include content that genuinely engages students so they can develop the necessary meta-cognition, critical reflection and reflexivity skills required to enact anti-racist practice. Finally, reducing racism and improving anti-racism in healthcare demands a meaningful commitment to modelling of desired strategies and behaviours within teaching places where students are immersed, such as medical education institutions and clinical teaching places (R. Jones, 2018). Future research and evaluation should focus on the holistic requirements needed (systems, services, practitioners, and patients) to reduce racism and strengthen anti-racist responses in the medical profession.

References

Australian Institute of Aboriginal and Torres Strait Islander Studies. (2021). *Living languages*. Australian Institute of Aboriginal and Torres Strait Islander Studies. https://aiatsis.gov.au/explore/living-languages

Australian Medical Students' Association. (2021). *AMSA: Efforts to address structural racism must accompany symbolic change*. Australian Medical Students' Association. https://amsa.imiscloud.com/Web/Advocacy/Media-Releases/structuralracism.aspx

Amutah, C., Greenidge, K., Mante, A., Munyikwa, M., Surya, S. L., Higginbotham, E., Jones, D. S., Lavizzo-Mourey, R., Roberts, D., Tsai, J., & Aysola, J. (2021). Misrepresenting race - the role of medical schools in propagating physician bias. *New England Journal of Medicine*, *384*(9), 872-878. https://doi.org/10.1056/NEJMms2025768

Anderson, L. W., Krathwohl, D. R., Airasian, P. W., & Bloom, B. S. (2001). *A taxonomy for learning, teaching, and assessing: A revision of Bloom's taxonomy of educational objectives* (Abridged ed.). Longman.

Atkinson, P., Baird, M., & Adams, K. (2021). Aboriginal health consumers experiences of an Aboriginal health curriculum framework. *Australian Indigenous HealthBulletin*, *2*(3). https://ro.ecu.edu.au/aihhealthbulletin/vol2/iss3/3

Attwood, B. (2004). *Thinking black william cooper and the Australian Aborigines' league*. Aboriginal Studies Press.

Australian Medical Council. (2012). *Standards for the assessment and accreditation of primary medical programs by the Australian Medical Council 2012*. Australian Medical Council Limited.

Bastos, J. L., Harnois, C. E., & Paradies, Y. C. (2018). Health care barriers, racism, and intersectionality in Australia. *Social Science & Medicine*, *199*, 209-218. https://doi.org/10.1016/j.socscimed.2017.05.010

Behrendt, L., & Fraser, M. (2013). *Indigenous Australia for dummies*. John Wiley & Sons, Inc. http://ebookcentral.proquest.com/lib/monash/detail.action?docID=871510

Berman, G., & Paradies, Y. (2010). Racism, disadvantage and multiculturalism: Towards effective anti-racist praxis. *Ethnic and Racial Studies*, *33*(2), 214-232. https://doi.org/10.1080/01419870802302272

Betancourt, J., Green, A., & Emilio Cariollo, J. (2002). *Cultural competence in health care: emerging frameworks and practical approaches*. T. C. Fund. https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_fund_report_2002_oct_cultural_competence_in_health_care__emerging_frameworks_and_practical_approaches_betancourt_culturalcompetence_576_pdf.pdf

Blackmore, J., & Lauder, H. (2004). Researching Policy. In B. Somekh & C. Lewin (Eds.), *Research methods in the social sciences* (pp. 97-104). SAGE Publications. http://ebookcentral.proquest.com/lib/monash/detail.action?docID=254604

Bolt, R. (2001). *'It's just how you've been brought up!': An Aboriginal perspective on the relationship between the law, racism and mental health in NSW* [Unpublished honours thesis]. University of Sydney.

Bond, C., Singh, D., & Kajlich, H. (2019). *Canada – Australia Indigenous health and wellness racism working group discussion paper and literature review.* https://www.lowitja.org.au/content/Image/Canada_Australia_Discussion_Paper-web_hi_res.pdf

Bonnett, A. (2000). *Anti-racism*. Taylor & Francis Group. http://ebookcentral.proquest.com/lib/monash/detail.action?docID=235073

Bourke, C. J., Marrie, H., & Marrie, A. (2019). Transforming institutional racism at an Australian hospital. *Australian Health Review*, *43*(6), 611-618. https://doi.org/10.1071/AH18062

Cho, S., Crenshaw, K., & McCall, L. (2013). Toward a field of intersectionality studies: Theory, applications, and praxis. *Signs*, *38*(4), 785-810. https://doi.org/10.1086/669608

Clark, N. (2012). Perseverance, determination and resistance: An Indigenous intersectional-based policy analysis of violence in the vives of Indigenous girls. In O. Hankivsky

(Ed.), *An intersectionality-based policy analysis framework*. Institute for Intersectionality Research and Policy, Simon Fraser University. www.sfu.ca/iirp/ibpa.html

Commonwealth Department of Health. (2014). *Aboriginal and Torres Strait Islander Health Curriculum Framework*. http://www.health.gov.au/internet/main/publishing.nsf/Content/aboriginal-torres-strait-islander-health-curriculum-framework

Crampton, P., Dowell, A., Parkin, C., & Thompson, C. (2003). Combating effects of racism through a cultural immersion medical education program. *Academic Medicine*, *78*(6), 595-598. http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=ovftf&NEWS=N&AN=00001888-200306000-00008.

Curtis, E., Jones, R., Tipene-Leach, D., Walker, C., Loring, B., Paine, S.-J., & Reid, P. (2019). Why cultural safety rather than cultural competency is required to achieve health equity: A literature review and recommended definition. *Internatioanl Journal of Equity Health*, *18*(1), 174. https://doi.org/10.1186/s12939-019-1082-3

Diffey, L., & Mignone, J. (2017). Implementing anti-racist pedagogy in health professional education: A realist review. *Health Education and Care*, *2*(1), 2-9. https://doi.org/10.15761/HEC.1000114

Dudgeon, P., Milroy, H., Walker, R., Australia. Department of the Prime, M., Cabinet, Australia. Department of Health and Ageing, Telethon Institute for Child Health Research, Kulunga Research Network, & University of Western Australia. (2014). *Working together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice* (2nd ed.). Kulunga Research Network.

Dunn, M. (2001). Lessons from the past: Education and racism in Australia. *Education in Rural Australia*, *11*(1), 65-75.

Ewen, S., Barrett, J., Paul, D. J., Askew, D., Webb, G., & Wilkin, A. (2015). When a patient's ethnicity is declare, medical students' decision-making processes are affected:

Medical student bias. *Internal Medicine Journal*. *45*(8), 805-812. https://doi.org/10.1111/imj.12800

Fridkin, A. (2012). Decolonizing Policy Processes: An intersectionality-based policy analysis of policy processes surrounding the Kelowna Accord. In O. Hankivsky (Ed.), *An intersectionality-based policy analysis framework.* (pp. 18). Institute for Intersectionality Research and Policy, Simon Fraser University. www.sfu.ca/iirp/ibpa.html

Hankivsky, O. (2012). *An intersectionality-based policy analysis framework*. Institute for Intersectionality Research and Policy, Simon Fraser University.

Hankivsky, O., Grace, D., Hunting, G., Giesbrecht, M., Fridkin, A., Rudrum, S., Ferlatte, O., & Clark, N. (2014). An intersectionality-based policy analysis framework: Critical reflections on a methodology for advancing equity. *International Journal for Equity in Health*, *13*(1), 1-16. https://doi.org/10.1186/s12939-014-0119-x

Health Workforce Australia. (2011). *Growing our future: the Aboriginal and Torres Strait Islander health worker project final report*. Health Workforce Australia.

Hogarth, M. (2017). Speaking back to the deficit discourses: A theoretical and methodological approach. *The Australian Educational Researcher*, *44*(1), 21-34. https://doi.org/10.1007/s13384-017-0228-9

Hollinsworth, D. (2006). *Race and racism in Australia* (3rd ed.). Thomson/Social Science Press.

Horner, J. (1988). Patten, John Thomas (Jack) (1905–1957) *Australian Dictionary of Biography*, *11*. https://adb.anu.edu.au/biography/patten-john-thomas-jack-7980/text13899

House of Repesentatives Standing Committee on Aboriginal Affairs. (1979). *Aboriginal Health*. Australian Government Publishing Service

Human Rights and Equal Opportunity Commission. (1997). *Bringing them home: Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families*. Human Rights and Equal Opportunity Commission.

Iacobucci, G. (2020). Specialty training: Ethnic minority doctors' reduced chance of being appointed is "unacceptable". *British Medical Journal (Online)*, *368*. https://doi.org/10.1136/bmj.m479

Jewell, T. (2020). *This book is anti-racist: 20 lessons on how to wake up, take action, and do the work*. Quarto Publishing Group, ProQuest Ebook Central. http://ebookcentral.proquest.com/lib/monash/detail.action?docID=6254292

Johnston, E. (1991). *National report: overview and recommendations*. Australian Govt. Pub. Service.

Jones, J. M. (1997). *Prejudice and racism*. McGraw-Hill Humanities, Social Sciences & World Languages.

Jones, R. (2011). Te Ara: A pathway to excellence in Indigenous health teaching and learning. *Focus on Health Professional Education*, *13*(1), 23-34.

Jones, R., Crowshoe, L., Reid, P., Calam, B., Curtis, E., Green, M., Huria, T., Jacklin, K., Kamaka, M., Lacey, C., Milroy, J., Paul, D., Pitama, S., Walker, L., Webb, G., & Ewen, S. (2018). Educating for Indigenous health equity: An international consensus statement. *Academic Medicine.*, *94*(4), 512-519. https://doi.org/10.1097/ACM.0000000000002476

Kamien, M. (1978). *The dark people of Bourke: A study of planned social change* Australian Institute of Aboriginal Studies (No. 1). Australian Institute of Aboriginal and Torres Strait Island.

Kelaher, M. A., Ferdinand, A. S., & Paradies, Y. (2014). Experiencing racism in health care: The mental health impacts for Victorian Aboriginal communities. *Medical Journal of Australia*, *201* (44-47). https://doi.org/10.5694/mja13.10503

Kendi, I. (2019). *How to be an antri-racist*. Bodley Head.

Kishimoto, K. (2018). Anti-racist pedagogy: From faculty's self-reflection to organizing within and beyond the classroom. *Race, Ethnicity and Education*, *21*(4), 540-554. https://doi.org/10.1080/13613324.2016.12.48824

Larson, A., Gillies, M., Howard, P., & Coffin, J. (2007). It's enough to make you sick: The impact of racism on the health of Aboriginal Australians. *Australian and New Zealand Journal of Public Health*, *31*(4), 322-329. https://doi.org/10.1111/j.1753-6405.2007.00079.x

Lett, L. A., Orji, W. U., & Sebro, R. (2018). Declining racial and ethnic representation in clinical academic medicine: A longitudinal study of 16 US medical specialties. *PLoS ONE*, *13*, e0207274. https://link.gale.com/apps/doc/A562458037/AONE?u=monash&sid=bookmark-AONE&xid=da195d19

Mackean, T., Mokak, R., Carmichael, A., Phillips, G. L., Prideaux, D., & Walters, T. R. (2007). Reform in Australian medical schools: A collaborative approach to realising Indigenous health potential. *Medical Journal of Australia*, *186*(10), 544-546.

Martin, K., & Mirraboopa, B. (2003). Ways of knowing, being and doing: A theoretical framework and methods for Indigenous and indigenist re-search. *Journal of Australian Studies*, *27*(76), 203-214. https://doi.org/10.1080/14443050309387838

McKivett, A., Hudson, J. N., McDermott, D., & Paul, D. (2020). Two-eyed seeing: A useful gaze in Indigenous medical education research. *Medical Education*, *54*(3), 217-224. https://doi.org/10.1111/medu.14026

Medical Deans of Australia and New Zealand, & Australian Indigenous Doctors' Association. (2012). *A review of the implementation of the Indigenous health curriculum framework and the healthy futures report within Australian Medical Schools*. Medical Deans Australia and New Zealand and the Australian Indigenous Doctors Association.

Monrouxe, L. V., & Rees, C. E. (2012). “It’s just a clash of cultures”: Emotional talk within medical students’ narratives of professionalism dilemmas. *Advances in Health Sciences Education*, *17*(5), 671-701. https://doi.org/10.1007/s10459-011-9342-z

National Aboriginal Community Controlled Health Organisation. (2020). *Aboriginal health news alert. in 30 years 1988-2018 of Aboriginal male health, strategies and summit recommendations*. National Aboriginal Community Controlled Health Organisation. https://nacchocommunique.com/2018/06/14/naccho-aboriginal-menshealthweek-and-ochreday2018-launch-download-30-years-1988-2018-of-aboriginal-male-health-strategies-and-summit-recommendations/

National Aboriginal Health Strategy Working Party. (1989). *A National Aboriginal health strategy*. National Aboriginal Health Strategy Working Party.

Nayak, A. (2011). Geography, race and emotions: Social and cultural intersections. *Social & Cultural Geography*, *12*(6), 548-562. https://doi.org/10.1080/14649365.2011.601867

Nelson, S., Prasad, S., & Hackman, H. (2015). Training providers on issues of race and racism improve health care equity. *Pediatric Blood & Cancer*, *62*(5), 915-917. https://doi.org/10.1002/pbc.25448

Onemda VicHealth Koori Health Unit, & Medical Deans Australia and New Zealand. (2007). *Indigenous health project critical reflection tool*. Onemda VicHealth Koori Health Unit.

Paradies, Y. (2016). Colonisation, racism and Indigenous health. *Journal of Population Research*, *33*(1), 83-96. https://doi.org/10.1007/s12546-016-9159-y

Paradies, Y., Ben, J., Denson, N., Elias, A., Priest, N., Pieterse, A., Gupta, A., Kelaher, M., & Gee, G. (2015). Racism as a determinant of health: A systematic review and meta-analysis. *PLoS One*, *10*(9). https://doi.org/10.1371/journal.pone.0138511

Paul, D. (2013). Creating change: Building the capacity of the medical workforce in Aboriginal health: Creating change in Aboriginal health. *ANZ Journal of Surgery*, *83*(1-2), 55-59. https://doi.org/10.1111/ans.12031

Phillips, G. (2004). *CDAMS Indigenous Health Curriculum Framework*. https://medicaldeans.org.au/md/2018/07/CDAMS-Indigenous-Health-Curriculum-Framework.pdf

Pitama, S. G., Palmer, S. C., Huria, T., Lacey, C., & Wilkinson, T. (2018). Implementation and impact of Indigenous health curricula: A systematic review. *Medical Education*, *52*(9), 898-909. https://doi.org/10.1111/medu.13613

Pockett, R., Napier, L., & Giles, R. (2011). Critical reflection for practice. In *Skills for human service practice: working with individuals, groups, and communities* (Second edition. ed.). Oxford University Press.

Power, T., Geia, L., Adams, K., Drummond, A., Saunders, V., Stuart, L., Deravin, L., Tuala, M., Roe, Y., Sherwood, J., Rowe Minniss, F., & West, R. (2021). Beyond 2020: Addressing racism through transformative Indigenous health and cultural safety education. *Journal of Clinical Nursing*, *30*(7-8), E32-E35. https://doi.org/10.1111/jocn.15623

Priest, N., Paradies, Y., Stewart, P., & Luke, J. (2011). Racism and health among urban Aboriginal young people. *BMC Public Health*, *11*, 568. https://doi.org/10.1186/1471-2458-11-568

Quigley, A., Hutton, J., Phillips, G., Dreise, D., Mason, T., Garvey, G., & Paradies, Y. (2021). Review article: Implicit bias towards Aboriginal and Torres Strait Islander patients within Australian emergency departments. *Emergency Medicine Australasia*, *33*(1), 9-18. https://doi.org/10.1111/1742-6723.13691

Ramsden, I. (2002). *Cultural Safety and Nursing Education in Aotearoa and Te Waipounamu* [Unpublished doctoral dissertation]. Victoria University of Wellington.

Reid, P., Cormack, D., & Paine, S. J. (2019). Colonial histories, racism and health - the experience of Māori and Indigenous peoples. *Public Health*, *172*, 119-124. https://doi.org/10.1016/j.puhe.2019.03.027

Rigney, L. I. (1999). Internationalization of an Indigenous anticolonial cultural critique of research methodologies: A guide to indigenist research methodology and its principles. *Wicazo Sa Review*, *14*(2), 109-121. https://doi.org/10.2307/1409555

Robson, B., & Harris, R. (2007). *Hauora: Màori standards of health IV. A study of the years 2000–2005.* Te Ròpù Rangahau Hauora a Eru Pòmare.

Sherwood, J. (2013). Colonisation - it's bad for your health: The context of Aboriginal health. *Contemporary Nurse*, *46*(1), 28-40. https://doi.org/10.5172/conu.2013.46.1.28

Smith, L. T. (1999). *Decolonizing methodologies: Research and Indigenous peoples*. Zed Books.

Smith, L. T., Tuck, E., & Yang, K. W. (2019). *Indigenous and decolonizing studies in education: Mapping the long view*. Routledge.

Tucker, W. H. (2007). The ideology of racism: Misusing science to justify racial discrimination. *UN Chronicle*, *44*(3), 18+. https://link.gale.com/apps/doc/A173423302/AONE?u=monash&sid=bookmark-AONE&xid=3e05feef

Vass, A., & Adams, K. (2020). Educator perceptions on teaching Indigenous health: Racism, privilege and self-reflexivity. *Medical Education*. *55*(2), 213-221. https://doi.org/10.1111/medu.14344

Vickery, J., Clarke, A., & Adams, K. (2005). *Nyernila Koories Kila Degaia: Listen up to Koories speak about health*. Koorie Heritage Trust and Onemda VicHealth Koori Health Unit, Melbourne.

Weber, L., & Fore, M. E. (2007). Race, ethnicity, and health: an intersectional approach. In H. Vera & J. R. Feagin (Eds.), *Handbooks of the sociology of racial and ethnic relations* (pp. 191-218). Springer US. https://doi.org/10.1007/978-0-387-70845-4_12