Having the Hard Conversations

The Poche Centre for Indigenous Health and Wellbeing
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Summary

Purpose
This discussion paper brings together lessons from the literature and preliminary insights of those working in the field to explore the issues, strategies and outcomes of cross-cultural training approaches with a focus on Indigenous health and cultures. In order to gain a deeper understanding of “what works” in Indigenous cultural training we have drawn on the principles of realist evaluation, a theory based approach which seeks not only description but also explanation. A realist approach asks the questions, what works (or fails), for whom and in what circumstances, in what respects and how? (Pawson, Greenhalgh et al. 2005) A realist review does not promise simple answers but can provide a “rich, detailed and highly practical understanding of complex social interventions (Pawson, Greenhalgh et al. 2005, pS1:21)."

The authors critically examined the literature to identify mechanisms used and the contexts in which Indigenous cultural training brings about favourable or disappointing results. A range of program theories were identified.

Uncovering program theory
Differing terminology was used to describe interventions and a range of conceptual models employed. Whilst there is some overlap and terms are sometimes used interchangeably, program theories about how the program is supposed to work are embedded in the various models. The theories rely on assumptions e.g. that imparting knowledge and skills, experiential learning and reflection will have a substantial influence on students’ knowledge, attitudes and behaviours and will ultimately result in culturally safe (or culturally-informed or culturally competent) practice. The theories also encompass a particular framing of the “problem(s) (Knowlton and Phillips 2013)” and differing endpoints.

Fundamental to program theory in cross-cultural training is the understanding of culture that informs the program development and implementation. Two broad approaches to culture and culturally appropriate care are discussed. The first is a cognitive approach focusing on building knowledge of beliefs, customs and traditions. The second approach is a more critical approach that engages with processes of identity formation, power relationships and resource distribution and the role of historical and social factors in producing these.

Mechanisms capture the ideas about how change will be achieved in an intervention (Greenhalgh, Humphrey et al. 2009 p 396). They detail the logic of an intervention and take into consideration how an intervention strategy is implemented and received by subjects. Uncovering these potential processes is the starting point for realist evaluation.

At least eight broad and inter-related mechanisms were identified in the programs described:
- Impart knowledge regarding health inequities as a foundation for cross-cultural training
- Impart knowledge about cultural groups
- Provide cultural encounters
- Encourage reflection on individual and societal attitudes, practices and culture
- Teach cross-cultural skills
- Challenge beliefs
- Invoke empathy
- Address organisational/institutional factors
A range of strategies and activities were employed in the implementation of these mechanisms:

- Didactic: on-line presentations; audio visual presentations; lectures; tutorials
- Interactive: brainstorming; discussion; on-line fora; case scenarios; role-playing; simulated patient sessions
- Reflective: journals; cultural autobiography; discussion; narratives
- Engagement: community service; outreach; field trip; hearing from community members; interviewing community members; cultural mentorship; cultural immersion

A range of enabling and constraining factors shape the implementation and outcomes achieved by these factors. Some factors may be specific to a mechanism, others relate across mechanisms.

**Resistance**

We also sought to identify how and why mechanisms may bring about resistance rather than the desired changes.

There appears to be a spectrum of responses to Indigenous cultural training spanning positive, supportive responses, to anger, resentment and resistance.

Resistance has been defined as "an unwillingness to consider research or theories that contradict one's sense of social order (Moore 1997)." In this context resistance often occurs in response to presentation of structural inequality or power differentials (Wear and Aultman 2005). Resistant behaviour can include challenging of the legitimacy of course materials and teaching staff; disengagement, silence, joking, disruption and absence. Students may express resistance through denial, discounting or distancing and different responses to each strategy may be required.

In unpacking mechanisms we found that significant discomfort can be invoked as part of the learning experience. Discomfort and dissonance may also be pathways to desired changes, thus managing resistance implies a balancing act for educators. Creating and maintaining safe spaces for discussion is seen as one response to this.

A number of authors focus on the role of institutions and the interaction of student culture, medical culture and organisational culture. Here student resistance can be understood, at least in part, as a response to leadership and organisational failure in engaging and valuing Indigenous health. The formal curriculum may be misaligned with the powerful influences of what Hafferty (1998, cited in Ewen, Mazel et al. 2012) has termed the informal and hidden curriculum. Students may respond to curricula with resistance because it is not supported by the dominant values, beliefs and practices that are communicated to them via the informal and hidden curricula.

A fundamental challenge to Indigenous cross-cultural curricula may be made in regards to the need for ongoing negotiation of space for its place in the medical curriculum. Claims have been made that such content is unnecessary as culture issues are not a major problem in clinical practice (Macdonald, Carnevale et al. 2007). Johnstone points to ‘the healthcare illusion of non-racism’, the belief that racism no longer exists or doesn’t exist in this space. Others report faculty questioning its relevance and concerns raised about an already full curriculum (Roberts, Sanders et al. 2010).
Outcomes
There seems broad agreement that the “big picture” goal of Indigenous cultural training is an improvement in health equity. Achievement of this goal is predicated on outcomes that have been variously described as a culturally informed workforce, culturally competent professional or cultural humility. What constitutes ‘cultural competence’ is however, contested and difficult to measure.

Short-term and intermediate outcomes are important to detail and link - they are a critical part of the causal pathway that explains how the program is supposed to work. A sound program theory also requires that the short-term outcomes are linked in a sound, plausible manner with the desired longer–term outcomes.

Many evaluations consider short-term outcomes e.g. student reactions, changes in knowledge, attitudes, intention to change – fewer examine actual changes in practice, patient experiences of practice or other outcomes such as increased equity of access.

Dwyer et al (2004) outline the causal pathway in this way, …a theoretical causal pathway where desired outcomes such as improved health status and wellbeing are premised on the generation of certain impacts, such as changes in modifiable risk and protective factors operating in individuals and environments. These impacts are premised on changes in processes and/or structures such as improved capacity and higher quality or better coordination of services and programs. In turn, the implementation of new processes and structures requires a range of inputs or activities such as supporting policy directions, workforce development and funding. These chains of inputs and effects take place in a wider social and political context that mediates the effectiveness of all elements.

and make clear the relationship of such a model to evaluation, … if empirical evidence of change can be seen for each of the points along the continuum, then it can be reasonably predicted that the outcomes are at least in part attributable to the program’

Good practice
The purpose of this paper is to inform discussion about ‘good practice’ and development of a good practice model.

The review demonstrates that design and implementation of Indigenous cross-cultural training is not a straightforward or easy task.

There is a growing consensus that underpinning notions of culture need to encompass a more critical approach that engages with processes of identity formation, power relationships and resource distribution and the role of historical and social factors in producing these.

Although many programs are proposed as a means of improving health equity the shorter-term and intermediate outcomes they seek vary, and the causal pathway between levels of outcomes is not always clearly articulated. A model of good practice needs to make explicit the links between program inputs, resources and activities, what short–term changes may be brought about, how they contribute to intermediate outcomes, and in turn the contribution to the ultimate goal.

A range of possible mechanisms for change have been identified, each influenced by layers of context and constraining and enabling factors. A number of the programs included in the review implemented multiple strategies and activities. These encompassed a range of mechanisms and hence possible pathways for change. They provide a starting point for educators and evaluators to uncover program theory, consider the relationships between mechanisms and explicate the expected outcomes.
Importantly constructing models which provide that a sound a rationale for how a program is supposed to work can provide a framework for evaluation and research in a field that requires significant study.
Having the Hard Conversations

*Developing a good practice framework to reduce resistance to Indigenous health and cultural safety training and foster sustained engagement*

**About the study**

Developing a health workforce that not only has the appropriate skills but is also culturally-safe, is central to the task of ‘Closing the Gap’ in Indigenous/non-Indigenous health outcomes. The content of Indigenous health and cultural safety training, along with the potentially-disquieting degree of critical analysis involved, challenges many students and health professionals on personal, professional, organisational and political levels. Where students or practitioners respond with resistance – and in particular with disengagement - teaching and learning can fail. The development of a workforce that is genuinely effective in Indigenous health settings is jeopardised. Institutions, such as universities, hospitals or government departments, can also resist. The comprehensiveness of Indigenous health subjects may be diluted, Indigenous perspectives can be discounted and core subject status dismantled.

This study seeks to better understand the challenges involved – both to the person and the institution or organisation – to identify the most promising approaches, formulate strategies, and incorporate them into a Good Practice Framework that the researchers will generate. The draft Framework will be presented to a number of other collaborators with appropriate expertise, for refining, before being made widely available – along with accompanying resources, practical workshops and measures to overcome institutional resistance, as identified.

This study is part of a larger programme of activities related to a National Senior Teaching Fellowship (funded by the Australian Government’s Office of Learning and Teaching) entitled ‘Having the Hard Conversations: Strengthening pedagogical effectiveness by working with student and institutional resistance to Indigenous health curriculum’. This Fellowship is supported by Flinders University’s Poche Centre for Indigenous Health & Well-Being.
Introduction

Inequities in health systematically put groups of people who are already socially disadvantaged (for example, by virtue of being poor, female, and/or members of a disenfranchised racial, ethnic, or religious group) at further disadvantage with respect to their health; health is essential to wellbeing and to overcoming other effects of social disadvantage. Equity is an ethical principle; it also is consonant with and closely related to human rights principles (Braveman and Gruskin 2003 p 254).

There are significant health inequities between Indigenous and non-Indigenous Australians, which are shaped by the by broader social and economic conditions and systematic inequities are reported by other indigenous groups globally. Health services are themselves, a social determinant of health. With compelling evidence of poorer health outcomes and acknowledgement of the role of interpersonal and institutional racism there is growing interest and investment in Indigenous cultural training for health professionals (Downing, Kowal et al. 2011, Paul, Ewen et al. 2014). Different curriculum and methods of delivery have been developed and there is evidence that training has positive impacts on measures such as professional knowledge, attitudes, and skills but there is a dearth of evidence on the impacts of such training on the health outcomes of patients (Beach, Price et al. 2005). There are also concerns about how cultural training interventions are evaluated and what it is that is being measured (Kumas-Tan, Beagan et al. 2007).

Traditional methods of evaluation and review seek to examine program effectiveness through the assessment of often pre-identified outcomes (Salter and Kothari 2014). This provides little insight into how and why an intervention works (or doesn’t) and does little to account for mixed results in differing circumstances (Pawson, Greenhalgh et al. 2005). A systematic review undertaken by Beach, Price et al (2005) found it difficult to conclude “which types of training interventions are most effective on which types of outcomes due to the heterogeneity and intermingling of curricular content and methods (p 7).” Thus there are calls for further research to evaluate the impacts of training more generally, including comparison of different methods of teaching (Beach, Price et al. 2005).

In order to gain a deeper understanding of “what works” in Indigenous cultural training we have drawn on the principles of realist evaluation, a theory based approach which seeks not only description but also explanation. A realist approach asks the questions, what works (or fails), for whom and in what circumstances, in what respects and how? (Pawson, Greenhalgh et al. 2005). It “is intended to reveal the inner mechanisms by which a program operates (Salter and Kothari 2014).” A realist review seeks to uncover the program
theory(ies) underpinning cross-cultural training programs. This directs our attention to the interaction of context, mechanisms and outcomes. Context includes factors such as the organisational setting, the policy environment and resources available. The mechanisms are the ways in which changes are brought about. Outcomes include both the intended and unintended consequences.

A realist approach draws on a range of data sources in a “pragmatic and reflexive manner (Greenhalgh Humphrey et al 2009)” to build a picture of how and why a program is thought to work.

**Methods**

We undertook a rapid evidence assessment using guidelines developed by the UK Government (n.d.). These include limiting the search by using less extensive search strings, a focus on finding reviews wherever possible, using ‘grey’ sources less extensively. A key word search was undertaken using electronic databases (Medline, PubMed, Scopus and CINAHL). Three groups of words were used to search the databases and are shown below. The first group of key words reflects variations in the terminology of the topic being reviewed, as well as the different paradigms that underpin some of these terms. For example, cultural competence is a favoured term in the US and reflects a paradigm based on multiculturalism, whereas the term cultural safety was first developed in New Zealand and reflects bi-racial and post-colonial contexts (DeSouza, 2008). However, terminology is inconsistent and different terms and definitions do exist, with terms often being used interchangeably. The second group of key words were included to ensure that the focus was on health professions students, training strategies and effectiveness. Finally, the third group of key words allowed the researchers to focus the literature primarily regarding Indigenous populations.

<table>
<thead>
<tr>
<th>Group 1 Terms</th>
<th>Group 2 Education</th>
<th>Group 3 Indigenous focus</th>
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<tbody>
<tr>
<td>Cultural safety</td>
<td>Pedagogy</td>
<td>Aboriginal</td>
</tr>
<tr>
<td>Cultural security</td>
<td>Training</td>
<td>Indigenous</td>
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<tr>
<td>Cultural competence</td>
<td>Teaching</td>
<td>First Nations</td>
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<tr>
<td>Cultural humility</td>
<td>Learning</td>
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<td>Cultural ease</td>
<td>Curriculum</td>
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<tr>
<td>Cultural diversity</td>
<td>Medical Education</td>
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<tr>
<td>Cultural awareness</td>
<td>Nursing / Midwifery</td>
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<td>Cultural proficiency</td>
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<td>Culturally appropriate care</td>
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<td>Cultural sensitivity</td>
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With the assistance of a subject librarian a number of search strings were developed. To keep the review ‘rapid’ searches were limited to papers written in English and to papers and reports published since 2005.

Key authors were also identified by two researchers who are subject matter experts at the Poche Centre for Indigenous Health and Well-being, Flinders University.

The searches generated 823 papers. An initial sift based on titles to determine relevance resulted in 476 papers being excluded. Papers were excluded if they were primarily about:

- physical safety rather than cultural safety
- not about health professional education
- about training medical staff to work internationally
- about multiculturalism, CALD about LGBT communities
• overseas recruitment of medical staff
• health inequity generally
• standardised assessment of medical staff

This reduced the total papers for the second sift to 347.

Researchers 1 & 2 then read through 20 abstracts together to ensure consistency in recording the content:

• Review (strategic review, review of reviews)
• Problem (statement of, evidence for)
• Literature review
• Strategy (e.g. classroom training, case studies, cultural immersion)
• Outcomes (of training / educational initiative)
• Key terms used (e.g. cultural competence, cultural humility, cultural safety, etc)
• Location
• Education specific (in an educational setting, educational placement)
• Rural and remote
• On job training for medical professionals
• Nursing
• Conceptual discussion (concept or model)
• Theory (underlying theory used to inform educational design)
• Student resistance/challenges

Researcher 2 then completed reviewing the abstracts to determine inclusion or exclusion. Hands searches of reference lists revealed other useful papers. Some XX articles were then reviewed in detail with a view to identifying the program theory used.

Program theories are not necessarily made explicit in journal articles or evaluations. In many cases however, an implicit program theory can be gleaned from program descriptions: “the reviewer must enter the literature with the explicit purpose of searching it for the theories, the hunches, the expectations, the rationales and the rationalisations for why the intervention might work (Pawson, Greenhalgh et al (2005) pS1:26).” Information was extracted on: model and assumptions; context; mechanisms, strategies and activities; short-term and longer term outcomes; evaluation and any discussion of challenges and student resistance.

These components form part of a causal chain and each will have a theory regarding how it is supposed to work and how it relates to other components. The process of theory mapping also reveals potential mechanisms for resisting the intervention. The extent to which an intervention runs to plan and the extent and nature of resistance met shapes the success or failure of the intervention.
As well as papers describing interventions, other papers provided descriptions and critiques of conceptual models that underpin Indigenous cultural training, or explorations of student and faculty perspectives on training as well as discussion of enablers and including the notion of resistance.

Synthesis of the literature supplemented with preliminary interviews with experts in the field allowed identification and refinement of a range of different program theories. As Pawson et al (2005) warn a realist review does not promise simple answers but can provide a “rich, detailed and highly practical understanding of complex social interventions (p. S1:21)"

**Limitations**

This paper has a number of limitations. Whilst the searches and review were undertaken in a systematic manner it was limited in scope and focus and is not an exhaustive review of the background literature or program evaluations of Indigenous cultural training or cross-cultural training more broadly. We have focused on uncovering the theories embedded in various initiatives and information about relative success or lack of it and an examination of factors affecting this. It provides a starting point for discussion rather than a comprehensive review of the field. Undoubtedly, there are many other papers and sources of data and part of the role of symposium will be to gather examples that will add to this discussion of good practice and resistance.
Section 1: Uncovering program theory

Models and assumptions

There is much discussion in the literature of differing terminology and conceptual models used to describe various interventions. Whilst there is some overlap and terms are sometimes used interchangeably, program theories about how the program is supposed to work are embedded in the various models. The theories rely on assumptions e.g. that imparting knowledge and skills, experiential learning and reflection will have a substantial influence on students' knowledge, attitudes and behaviours and will ultimately result in culturally safe (or culturally-informed or culturally competent) practice. The theories also encompass a particular framing of the “problem(s)” (Knowlton and Phillips 2013).” The foundations of the program may differ as may the endpoints.

Fundamental to program theory in cross-cultural training is the understanding of culture that informs the program development and implementation. Williamson and Harrison (2010) undertook a review of the nursing and midwifery literature and identified two approaches to culture and culturally appropriate care. The first is a cognitive approach focusing on building knowledge of beliefs, customs and traditions and may include a focus on the health professionals own culture as well as that of specific cultural groups. The second approach broadens the focus to factors such as social position, education and socioeconomic status and is influenced by the work of postcolonial scholars. Cultural safety is given as an example of this second approach. Similar distinctions are drawn by other authors. A major critique of the first approach is that it renders culture static and runs the risk of reinforcing stereotyping (Williamson and Harrison 2010, Paul, Ewen et al. 2014). The second approach is a critical one which directs attention to issues of power and social relationships. The notions of culture adopted will shape not only the mechanisms employed in training but also the desired outcomes.

A review undertaken by Downing et al (2011) identified six models through which cultural training can be conceptualized; ‘cultural competence, transcultural care, cultural safety, cultural awareness, cultural security and cultural respect’. These can be located on two continuums: individual to systemic change; and understanding of own culture and processes of identity versus understanding the culture of others (see Figure 1 below).

This type of examination of models can help uncover both the explicit and the unstated assumptions that are embedded in interventions e.g. Is the “problem” lack of cultural knowledge? Or lack of understanding of processes of culture and identity including a focus on power and relationships? Or both? Differing understandings are embedded in the different models.
Cultural humility has been presented as both process and outcome and provides another model which encompasses a lifelong process of self-reflection and self-critique. It has been described as a “process that requires humility as individuals continually engage in self-reflection and self-critique as lifelong learners and reflective practitioners, it requires humility in how physicians bring into check the power imbalances that exist in the dynamics of physician-patient communication by using patient-focused interviewing and care, and it is a process that requires humility to develop and maintain mutually respectful and dynamic partnerships with communities on behalf of individual patients and communities in the context of community-based clinical and training models (Tervalon and Murray-Garcia 1998 p.118) Cultural humility requires practitioners to give reflexive attention to their assumptions and beliefs in order to develop a respectful partnership with each client rather than identifying the cultural traits of clients.

Some programs draw on more than one of these models, seeing them as building one on the other or as complementary. For example, De Souza (2008) argues that a “triangulation of approaches is required that addresses not only the theory and practice demands of the nursing profession but also the social and ethical imperatives that can rectify the unfair burden of health inequalities (p 125).” Coffin (2007) suggests cultural security is about the meeting of Western and Aboriginal approaches in health, and sees cultural security being built on both cultural awareness and cultural safety – with the two approaches linking understanding with action.

In terms of program theory we would expect to see empirical evidence of differences in the models in terms of the strategies chosen, the way they are implemented and the outcomes they seek to bring about. As Paul, Carr et al. (2006) put it, “An approach designed to understand a static other will be different from an approach designed to facilitate students’ awareness of, and ability to respond to, disparity in health care outcomes (p 753).” It appears however, that this is not always the case. In examining examples of Australian Indigenous cultural training, Downing, Kowal et al. (Downing, Kowal et al. 2011) note that despite significant differences espoused by the models, those differences are not necessarily evident in the operationalisation of the concepts and “indigenous cultural training
Mechanisms
Mechanisms have been described as “ideas about how change will be achieved in an intervention (Greenhalgh, Humphrey et al. 2009 p 396).” Pawson and Tilley (2004) have likened mechanisms to the workings of a clock which cannot necessarily be seen but drive the movements of the hands. “Mechanisms thus explicate the logic of an intervention; they trace the destiny of a programme theory, they pinpoint the ways in which the resources on offer may permeate into the reasoning of the subjects (Pawson and Tilley 2004).” How an intervention strategy is implemented and received by subjects constitutes the ‘mechanism’ and uncovering these potential processes is the starting point for realist evaluation.

At least eight broad and inter-related mechanisms were identified in the programs described:

- Impart knowledge regarding health inequities as a foundation for cross-cultural training
- Impart knowledge about cultural groups
- Provide cultural encounters
- Encourage reflection on individual and societal attitudes, practices and culture
- Teach cross-cultural skills
- Challenge beliefs
- Invoke empathy
- Address organisational/institutional factors

The mechanisms were made explicit in some accounts and were implicit in the strategies and activities described in others. The success or otherwise of the mechanisms in bringing about the desired changes is influenced by enabling and constraining contextual factors, some of which were explicitly identified.

A range of strategies were employed singly or in combination across the mechanisms. Examples of strategies include:

- Didactic: on-line presentations; audio visual presentations; lectures; tutorials
- Interactive: brainstorming; discussion; on-line fora; case scenarios; role-playing; simulated patient sessions
- Reflective: journals; cultural autobiography, discussion, narratives
- Engagement: community service; outreach; field trip; hearing from community members; interviewing community members; cultural mentorship; cultural immersion

Strategies that actively engage the audience were seen as more successful than more didactic activities (Pedersen, Walker et al 2005 (Pedersen, Walker et al. 2005, Macdonald, Carnevale et al. 2007 )

A strategy may be employed in the service of, or trigger various mechanisms. For example an audio-visual presentation may impart knowledge regarding health inequities, or encourage reflection, or both.

We present a summary of each of the theorised mechanisms and a discussion of key enabling and constraining factors that make it more or less likely that either favourable outcomes will be achieved or resistance will be met.
Mechanism 1: Impart knowledge regarding health inequities as a foundation for cross-cultural training

Much of the discussion regarding the need for cultural training is grounded in the evidence regarding health inequities. Thackrah and Thompson (2013) suggest there is now widespread inclusion of compulsory content on Indigenous health in Australia as a response to “recognition that a culturally informed workforce can contribute towards reducing health inequities (p113).” The evidence regarding health inequities (unfair, systematic differences in health outcomes) was presented as a strong ethical and practical basis for Indigenous cultural training. Most articles reviewed included a discussion of health inequities in their introduction. Some linked this to a human rights or social justice perspective and others noted that it is also required as a pragmatic public health strategy (Pedersen and Barlow 2008). Many papers quote studies illustrating both the higher rates of adverse outcomes for Indigenous peoples compared to non-Indigenous peoples and discrimination in health care settings and in interactions with health professionals and systems.

Paul, Ewen et al. (2014) assert that addressing health care disparities should be the primary reason for curricular intervention. They note that such disparities are influenced by a complex interaction of system, professional and patient factors. Health professional factors include psychological processes such as unconscious bias and stereotyping. They argue that simply knowing more about the ‘other’ will do little to address disparities and that strategies are needed to develop self reflexivity, promote an understanding of the historical and social context that constructs cultural identity and develop communication skills. This returns to the conceptions of culture discussed earlier and points to the necessary interaction of mechanisms that may be required to produce desired results.

Whilst imparting knowledge regarding health inequalities and their social determinants is a key mechanism for many programs there is evidence that this will be met by denial by at least some students. Browne, Pitner et al (2013) examined online comments about media stories highlighting health inequities research projects in the US. They found that many respondents did not believe that health disparities were real. Four types of responses were identified: (a) naming health disparities was seen as a media tool for dividing racial/ethnic groups; (b) structural racism does not exist; was not relevant ot the US (c) naming of health disparities is about pushing a political agenda; and (d) health disparities exist because of individual-level deficiencies. They note that other research (Benz, Espinoza et al cited in Browne Pitner 2011) found only 59% of US citizens surveyed understood racial or ethnic health disparities existed. This points to a need for pedagogical strategies “to unpack the reality of health disparities and their underlying causes (Browne, Pitner et al. 2013 p226)” but also points to possible areas of student resistance. Wear and Aultman (2005) cite the the work of Titus (2000) who suggests that denial is a strategy resistance whichis is linked to victim-blaming – individual deficiencies rather than structural factors are seen as the root of problems.

Mechanism 2: Impart knowledge about cultural groups

As discussed above imparting cultural knowledge in the form of cultural awareness programs appears to remain a dominant strategy in Australia. Downing et al (2011) suggest the underlying assumption is that such knowledge will promote tolerance and prompt people to change their practices. Beach et al (2005) found that curricula teaching about specific cultures were associated with positive outcomes but noted one of the studies included in their review found that students were more likely to believe that Aboriginal people were all alike having received specific cultural information.
There is significant critique of this approach, particularly when used in isolation as it has been implicated in perpetuating stereotyping, oversimplifying complex issues and homogenizing difference. For example Clear (2008) warns against reductionist approaches that reduce people to characteristics and categories. Others point to the risk of stereotypes being incorporated in case presentations (Jacklin, Strasser et al. 2014), or generic approaches leading to failures in individual care (Williamson and Harrison 2010).

It seems this mechanism has at times been employed as an end in itself (e.g. providing cultural checklists) but has also been used as a complementary mechanism or one that facilitates other mechanisms e.g. informing critical reflection. A number of the papers reviewed included the mechanism imparting knowledge about Indigenous culture(s), although often in tandem with other mechanisms. Indigenous stakeholders themselves have suggested some specific cultural knowledge should be an important component of training (Kamaka 2010, Abbott, Dave et al. 2014). Wain, Sim et al (2012) suggest that the critique of knowledge-based curricula focusing on the characteristics of cultural groups and the emergence of patient-centred care and narrative-based medicine means that attention is shifting to transformational pedagogical approaches.

Descriptions of knowledge based programs suggest a program theory that conforms to the information/education archetype proposed by Funnell and Rogers. The theory here is expressed as a chain of expected outcomes (see Fig 2)

![Fig 2: Generic outcomes chain for Advisory, Information & Education Programs Archetype](Source: Funnell and Rogers 2011)

Whilst some studies (e.g. as reviewed by Beach et al 2005) demonstrate achievement of outcomes to level 4, the evidence for Level 5 or 6 is lacking.
Mechanism 3: Providing cultural encounters

Interaction with individuals and communities from specific cultural groups is promoted as a means for students to become more aware of cultural issues, develop cultural sensitivity and skills. Cultural encounters forms one of the constructs in Campinha-Bacote’s (2002) model ‘The Process of Cultural Competence’. It is described as “the process that encourages the health care provider to directly engage in cross-cultural interactions with clients from culturally diverse backgrounds. Directly interacting with clients from diverse cultural groups will refine or modify one’s existing beliefs about a cultural group (p. 182).”

Activities providing cultural encounters were included in several of the curricula described and include patient-provider interactions, community outreach services, interviewing community members, cultural mentorship and cultural immersion. The use of video podcasts to deliver “authentic learning experiences through hearing directly from a range of Indigenous people about the impact of colonisation, past and current practices and policies, and racism on health and well-being (Kickett, Hoffman et al. 2014 p 39)” was reported as a significant innovation in a large-scale medical school program.

Like the provision of cultural knowledge, exposure to other cultural groups does not necessarily directly facilitate culturally competent care. It is in combination with strategies that encourage reflexivity that positive outcomes are more likely (Durey 2010). The number, type and duration of cultural encounters may mediate the effectiveness of this mechanism with a risk that generalisations may be made from a small number of encounters (Campinha-Bacote 2002). Pedersen, Walker et al (2005) warn that while positive results of inter-group contact to decrease racism have been documented, intergroup contact alone may do more harm than good.
A number of the programs note they are implemented by Aboriginal teaching staff or facilitators. A large scale program reported the importance of providing a diversity of speakers to challenge commonly held stereotypes of Aboriginal people and the success of engaging large numbers of Aboriginal tutors providing students with “the opportunity to meet professional Aboriginal people (Kickett, Hoffman et al. 2014).” The lack of diversity in the medical workplace overall means the majority demographic comprise the majority of role models and exert significant influence on the broader school context and culture (Paul, Ewen et al. 2014).

Mechanism 4: Encourage reflection on own attitudes and practices and culture

Encouraging reflection on one’s own attitudes and practices was a widely employed mechanism to surface and challenge judgmental and racist attitudes and make visible the influence of one’s own culture on interactions and understandings. Promotion of reflection and self-awareness is seen as critical in health professionals acknowledging the ways in which belief systems and cultural values shape patient encounters (Anderson, Ewen et al. 2009) and is also seen as a means to enhance empathy (Wear and Aultman 2005). Others suggest that reflection can change behaviour and improve practice (Cooney 1999 cited in Cultural Safety Research Group 2006). Self-reflection formed an important part of the interventions that cited cultural humility as an underpinning concept.

Terminology used in the literature included reflection, self-reflection, reflexivity and critical reflection. The Cultural Safety Research Group (2006) in their review and critique of reflection note there are varying interpretations encompassing differing origins and emphases. For some reflection has a greater focus on 'what is done' rather than the assumptions and practices that are shaped by the broader sociocultural context. A paper by D’Cruz (2007) unpacks these terms as used in social work education and identifies three major variations of the term reflexivity. The first variation has a focus on the individual and the way in which knowledge is used to guide individual choice. The second and third variations imply a critical approach in which the individual understands knowledge to be socially constructed and has a critical awareness of the relational nature of knowledge. The third variation is seen as distinct from the second in that it allows for an acknowledgement and reflection on the emotional responses of practitioners. These may be considered as separate mechanisms or sub-mechanisms. One study (Macdonald, Carnevale et al. 2007) found descriptive reflection was an easier task for students than reflection requiring a more critical stance. A workshop designed to teach a more anthropologically based understanding of culture and encourage self-reflection, including reflection on the scientific culture of medicine, invoked a defensive stand rather than a critical one.

Critical self-reflection encompasses examination of wider societal influences and the dominant discourses that produce and reproduce inequities. Analysis of discourse draws attention to the socially constructed nature of self, culture and race. Whiteness studies’ are an area of study that critically examines the role of dominant white culture. Race is understood as a social construction and dominant cultural groups are encouraged to reflect on their own values and practices when working with Indigenous or minority populations (Durey 2010).

Activities to encourage reflection were designed to examine dominant discourse, question assumptions and understand the way beliefs, practices and institutions are shaped by discourse. They included open discussion, teaching through humanities e.g. reading and interpreting literary texts, cultural autobiography and journals

One of the consequences of incorporating reflective practices in the curriculum was the creation of a level of discomfort for students and faculty. Acknowledgement of privilege,
power imbalances, racializing discourses and marginalising practices were seen as significant sources of discomfort. There is potential that alongside discomfort there may also be resentment towards those vulnerable to these discourses (Briscoe 2013). Several authors pointed out that such reflection requires openness to views and experiences of others and the ability to consider different beliefs and perspectives with empathy. Campinha-Bacote (2002) refers to 'cultural desire' whereby students want to, rather than have to engage in the learning processes. She links this to the disposition toward lifelong learning described in the cultural humility model. Durey (2010) suggests that whilst white Australians may understand that Aboriginal Australians are disadvantaged there may be little willingness to reflect on one’s own advantage. Difficulties were reported for students and educators alike, particularly those from Western backgrounds (Kickett, Hoffman et al. 2014). Non-Indigenous teaching and clinical colleagues may be unaware of, or unable to acknowledge their “white privilege and colonised notions” (Jackson, Power et al. 2013).

Many authors presented the promotion of reflection in the curriculum as necessary and perhaps necessarily uncomfortable. “Critical reflection creates a vehicle that is able to transport the learner from embedded ideas to a more considered opinion, but this may be uncomfortable and even painful at times (Briscoe 2013p 563).” Disengagement, hostility, guilt, defensiveness, grief and anger were amongst the reactions noted. These reactions were often referred to as examples of resistance which will be discussed further in Section 2.

Pedersen and Barlow (2008) advise avoiding inducing collective guilt. Although they report that there is a negative correlation between prejudice and collective guilt, they suggest collective guilt is an aversive emotion “and people tend to avoid aversive emotions”.

The discomfort experienced may be an example of cognitive dissonance – psychological discomfort stemming from a perceived incompatibility of beliefs – which has been found to be a means of reducing racism and prejudice (Pedersen, Walker et al. 2005). Dissonance may be stimulated by recognition that one holds contradictory beliefs or ideas or the introduction of new information that conflicts with one’s existing beliefs or ideas.

*Mechanism 5: Teach cross-cultural skills*

The teaching of cross-cultural skills was suggested in a number of papers (see for example Campinha-Bacote 2002, Lacey, Huria et al. 2011, Abbott, Dave et al. 2014) and included communication and consultation skills.

Campinha-Bacote (2002) defines cultural skills as “the ability to collect relevant cultural data regarding the client’s presenting problem as well as accurately performing a culturally based physical assessment. This process involves learning how to conduct cultural assessments and culturally based physical assessments (p 182).”

Abbott, Dave et al (2014) note that many of the skills required for cross-cultural consultations are those required for any effective consultation – “respect and management of the patient as an individual in their sociocultural context (p.60)”. Skills specific to consultations with Indigenous people included sensitivity to language used regarding Aboriginality and culture, avoidance of oversimplification of language, building trust and rapport over time, strategies to manage complex consultations and multimorbidities and application of knowledge regarding Aboriginal history and lived experience.

Lacey, Huria et al. (2011) provide an example of teaching culturally specific principles to guide clinical interaction with Maori people. The Hui process applies traditional principles of greeting, introduction, starting a relationship and closure of an encounter to medical consultations. The complementary “Meihana” model was based on the Maori Health model.
(Te Whare Tapa Wha) and describes ways in which attending to the purpose of the encounter can provide a broader understanding of Maori patients’ presentations. Each component of the model has clinical applications and aims to influence practitioner’s history taking and management techniques. The model includes understanding of processes of colonisation, racism, migration and marginalisation and how this understanding can be applied in a clinical context. Evaluation suggests that use of the ‘Hui Process’ and “Meihana” model has been well-received and supports an effective therapeutic relationship between clinicians and Maori patients and their whanua (family and community).

Pederson, Walker et al (Pedersen, Walker et al. 2005) suggest that a focus on changing attitudes is often based on the assumption that changes in attitudes will lead to changes in behaviour. They note however that there is evidence to show that changes in behaviour can lead to changes in attitudes and that a focus on behaviour change may be more useful than a focus on attitudes. Teaching and learning of non-racist, respectful behaviours may be an effective means of bringing about change. This was affirmed by interviewees with experience in teaching the Hui Process and Meihana model described above. The understanding of the interaction between thoughts and behaviour which underpins Cognitive Behaviour Therapy was seen as relevant to teaching and learning. Students learnt behaviours and skills that had immediate application and therefore high currency for the student. Through applying these behaviours they engaged in more positive and rewarding interactions with Maori patients which influenced their thoughts and attitudes.

**Mechanism 6: Challenge beliefs**

Many of the interventions challenged beliefs as an integral part of the program. The assumption here is that false and unhelpful beliefs need to be challenged "to reach the point of ethically sound transformation (Briscoe 2013)". Challenging beliefs is closely aligned to processes of reflection. A number of authors noted that educators needed to allow often racist assumptions and beliefs to surface in a safe environment. Again the experience of distress and discomfort on the part of both students and educators was noted.

Work by Pederson and colleagues (for example (Pedersen, Beven et al. 2004, Pedersen and Barlow 2008) noted the link between false beliefs and negativity toward Aboriginal Australians and other marginalised groups 1. In terms of a mechanism to bring about change Pederson and Barlow (2008) raise the question as to whether such false beliefs having been learnt can be unlearned. They cite evidence from Battersham (2001) which found that challenging false beliefs significantly reduced the acceptance of them and that participants whose false beliefs were challenged scored significantly lower on a prejudice measure compared with a control group.

Pederson et al (2008) also note that the notion of “false” beliefs fails to adequately capture a key characteristic of modern prejudice - the objection to “special treatment” for Aboriginal Australians and other marginalised groups. Here there is a failure to appreciate the need for additional support to redress historical and social factors that have created and reproduced disadvantage. They suggest that “in any anti-prejudice strategy, equal opportunity issues and the redressing of social disadvantage should be made clear”.

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1 An example of a false belief is given ‘Aboriginal people only have to make one car payment, and the Government will pay the rest’. Such beliefs were significantly more likely to be endorsed by prejudiced respondents. Pedersen, A. and F. K. Barlow (2008). “Theory to social action: A university-based strategy targeting prejudice against Aboriginal Australians.” *Australian Psychologist* **43**(3): 148-159.
Mechanism 7: Invoke empathy

A number of the interventions described noted that the strategies employed were designed to invoke or enhance empathy as a basis for reducing racism.

Use of various narratives or storytelling strategies were recounted. Linking with the tradition of storytelling within Indigenous cultures, stories were used to present views and experiences of others, encourage consideration of different beliefs and enhance empathy (Wain, Sim et al. 2012, Jackson, Power et al. 2013). The assumption regarding change was that these stories acted as the basis for collective discussions uncovering unconscious bias at the individual and societal level and encouraged self-reflection on assumptions, values and social justice (Wain, Sim et al. 2012).

Wear and Aultman (2005) raise questions about the efficacy of reflective exercises in generalising to other experiences – does the empathetic response “follow them out of the classroom door?” Whilst a student may empathise with an individual character or person it may not lead to reflection on the broader structural issues or their role in these.

Another program which sought to build empathy was reported by Wear and Aultman (2005). They employed interpretation of a literary text (The Color Purple) as a vehicle to explore issues of inequality and oppression. They found many students were unable or unwilling to engage critically with the text. They draw on Boler’s ‘pedagogy of discomfort’ (1999) to suggest there is a need to move beyond passive empathy, sympathetically connecting with another, to understanding one’s social position and power which implicates oneself in the issues raised in the text. This would suggest a role for critical reflection and challenging of beliefs in the curriculum.

Mechanism 8: Address organisational/institutional factors

Common to many of the programs described was a general observation that success was contingent upon a supportive institutional environment. A commitment to social accountability and community engagement were seen as important factors in the sustainability of a program in Aboriginal health at the Northern Ontario School of Medicine (Jacklin, Strasser et al. 2014).

Although the role of organisational and institutional factors was often acknowledged there was little written on interventions specifically addressing these factors. One example is the Critical Reflective Tool (CRT) which uses the notion of the ‘hidden’ curriculum to uncover ways in which institutions undermine or support the ‘formal’ curriculum (Ewen, Mazel et al. 2012)(Paul, Ewen et al. 2014). As well as the formal, officially endorsed curriculum the unscripted interpersonal teaching and learning interactions form an influential informal curriculum. Organisational practices, structures and processes contribute to the hidden curriculum which influences “what is learned at medical school rather than what is taught (Ewen, Mazel et al. 2012 p. 200).”

The CRT comprises eight domains:

- the context of the medical school,
- the outcomes of the medical course,
- the medical curriculum,
- teaching and learning,
- assessment of learning,
- monitoring and evaluation,
- Indigenous students, and
• implementing the curriculum.

The purpose of the CRT is defined as “to support Australian and New Zealand medical schools as they internally review their efforts to implement their Indigenous health curricula and initiatives for the recruitment and retention of Indigenous medical students. It was designed to address the broader contextual issues that have an impact on these areas, and it aims to encourage critical reflection and stimulate discussion (Ewen, Mazel et al. 2012).”

They describe a trial of the tool in which twelve of twenty possible medical schools participated. They used the tool to examine 4 domains: institutional policies, evaluation activities, resource allocation, and institutional “slang”. Overall feedback regarding the tool was positive but the utility of the tool was contingent on the process of implementation—executive-led and whole-school approaches yielded the most positive feedback. This reinforces fact that how institutions and leadership engage with and value Indigenous health is critical in the success of the programs.

Examination of the mechanisms employed in Indigenous cross-cultural training has revealed that there is no simple recipe or toolkit to follow. There is value in employing multiple mechanisms and strategies which can provide differing pathways to positive outcomes. Different mechanisms work in different ways in different contexts and different students will respond to mechanisms in different ways.

**Constraining and enabling factors**

Whilst surfacing program theories provides a useful starting point for analysing the programs it is also important to pay attention to the many possible constraining and enabling factors. For each mechanism there are factors that shape the outcomes and some of these have been identified in the summary of the mechanism.

Other factors were suggested as having contributed to successful programs and interventions overall and these are summarised below. The summary also draws on factors found to characterise successful programs relating to improving Indigenous outcomes and ‘closing the gap’ in terms of the key social determinants of health (Osborne, Baum et al. 2013) and suggestions for improving anti-racism strategies (Pedersen, Walker et al. 2005)

• Programs are underpinned by a nuanced understanding of culture that accounts for broader social, political, historical factors such as the legacy of colonisation, social position, education and socioeconomic status
• Indigenous peoples are involved in program planning, development and delivery
• Organisational contexts are supportive, including provision of appropriate resources,
• Indigenous knowledge and cultural beliefs and practices are explicitly valued
• There is high-level, committed leadership for programs, initiatives and interventions within schools and faculty.
• Indigenous staff are employed within a safe, supportive environment
• A whole-of-school (or organisation) approach is adopted
• There is a commitment to research and evaluation to inform program development and contribute to the knowledge base regarding Indigenous cultural training.

The emphasis on the broader institutional context fits with a realist approach to understanding how interventions work.
Section 2: Resistance

In the first section we were concerned with uncovering how programs were thought to bring about change. In this section we turn our attention to instances of where the mechanisms brought about resistance rather than the desired changes. Again we are seeking explanation rather than just description.

There appears to be a spectrum of responses to Indigenous cultural training. Students receptivity to content ranges from positive, supportive responses, an open disposition to feeling “moved, sorrowful, ashamed of our nation but not feeling personally blamed; uncertain, distressed, resentful, betrayed; and angry, rejecting (McDermott and Gabb 2010, Thackrah and Thompson 2013”).

Resistance has been defined as “an unwillingness to consider research or theories that contradict one’s sense of social order (Moore 1997).” In particular resistance can be manifested as challenges to course material and teaching staff when presenting dimensions of inequality as issues of structural inequality or power differentials (Wear and Aultman 2005). Resistant behaviour has been identified as “questioning the very premise of the course; challenging the legitimacy of the readings, assignments and lecture materials; or silence, joking, private conversations and absence (Wear and Aultman 2005).”

Student resistance can be expressed in many ways: non-engagement, discounting the authenticity of an Indigenous experience, prejudices and blatant racism. Students may fail to see the relevance of the curricula and resent it (Durey, Hill et al. 2008, Johnstone and Kanitsaki 2008, Ewen, Mazel et al. 2012). Ward Daniels et al. (2014) use the term the “groan zone” to characterise student resistance to decolonising pedagogy. As noted earlier significant discomfort can arise when encountering alternative worldviews, uncovering taken for granted prejudices and learning history from Aboriginal perspective. We have also previously noted however that discomfort and dissonance may also be pathways to desired changes. Thus managing resistance implies a balancing act for educators – provoking levels of discomfort and dissonance that facilitates change without students rejecting or retreating from the material all together. Maintaining ‘safety’ for those who do engage was seen as important as pedagogical strategies draw attention to personal processes and practices (Browne, Varcoe et al. 2009 p 173). One strategy suggested was the development of a safe space in which students can engage with challenging curriculum (Thackrah and Thompson 2013). Components of a safe place or space might include establishing ground rules that support trust, suspension of judgment and censorship, and active listening. Inclusion of non-Indigenous presenters may encourage more openness and encourage questioning (McDermott and Sjoberg 2012).

Wear and Aultman (2005) apply a typology of resistance developed by Titus (2000) that suggests students may express resistance through denial, discounting or distancing. We have already noted that when imparting knowledge about health inequities it is possible that at least some students will deny the evidence and question the motivations involved in presenting the evidence (Browne, Pitner et al. 2013). Students may reject evidence as it contradicts their own beliefs about inequities. Leach, Iyer et al. (2007) draw on research demonstrating that many of the structurally advantaged non-Aboriginal majority believe that the Aboriginal people unfairly benefit from government handouts. Thus, despite evidence to the contrary, they may position themselves as deprived relative to Aborigines who they perceive as unfairly advantaged by government benefits.

Johnstone and Kanitsaki (2008) describe educators “appealing to various moral, legal, professional, and/or economic arguments to ‘make their case’ and to ‘sell their ideas’
These included arguments reminding participants of patient rights, their own legal obligations and organisational requirements. The efficacy of these approaches has not been evaluated.

Students may express resistance through discounting - dismissing the content as irrelevant to medicine (or other profession). Medical students have described non-biomedical components of the curriculum as ‘filler’ (McDermott and Sjoberg 2012). Where educators were able to communicate relevance, students appear more likely to engage. Reflecting on student reactions to various strategies, educators found that students seeming to ‘wake up’ from their unengaged stance when a case narrative demonstrated the benefits using a ‘Culture of Medicine’ model (Macdonald, Carnevale et al. 2007) Kamaka (2010) undertook focus groups with stakeholder groups to inform program design in Hawaii. Medical students felt that in order for cultural issues to be taken seriously they needed to be “high yield” i.e. involve content that would be assessed in exams.

The third strategy of resistance is distancing whereby students believe that ‘big picture’ changes, changes in social structures or institutions, are beyond their influence. As pointed out by experienced educators during interview it is true that students are often in positions of limited power to challenge structures or processes and that concentrating on areas in which they have more agency, e.g. the clinical encounter, is more productive. McDermott and Sjoberg (2012) describe a workshop specifically designed to engage with student resistance which “unpacks preconceived ideas, stereotypes and myths about Aboriginal and Torres Strait Islander peoples.” One of the outcomes of these workshops has been the creation of two student groups; a ‘Health and Human Rights Group’ and a ‘Cultural Safety Group’ suggesting given appropriate structures students can engage in structural issues.

Whilst these strategies focus on student resistance a number of authors focus on the role of institutions and the interaction of student culture, medical culture and organisational culture.

Roberts, Sanders et al (2010) explored the views of second year students in two medical schools regarding cultural diversity training. They found that despite differing pedagogies the students’ views were remarkably similar. Three co-existing, conflicting discourses were identified. Firstly students claimed that although the training was important the schools marginalised its teaching. A second discourse suggested medical school was an “inappropriate setting” as the subject matter was not relevant to biomedicine. Thirdly it was felt that that cultural diversity experience should occur in the workplace and socially with their peers. The authors used Bourdieu’s (1977) concept of habitus to explore the findings of potentially conflicting discourses. They suggest within the social structures of the medical school conformity raises the chances of success. “Medical school’ and “student culture” are inextricably linked, each influencing the other. Failure of learning may be attributed to ‘resistance’ on the part of students rather than institutional failure in validating the learning.

Hafferty’s taxonomy (1998, cited in Ewen, Mazel et al. 2012) of formal, informal and hidden curricula provides a useful framework to examine often invisible but powerful influences on the teaching and learning of students. The informal curriculum comprises interperson

Policies, resource allocation, evaluation and institutional slang provide insights into the hidden curriculum (Paul, Ewen et al. 2014). Students may respond to curricula with resistance because it is not supported by the dominant values, beliefs and practices that are communicated to them via the informal and hidden curricula. For example in the Roberts et al study cited above (2010), they found that students believed medical schools marginalized and failed to adequately support effective teaching in the area of cultural diversity. This provides a powerful influence on how students react to the formal curriculum. Ewen, Mazel et al (2012) posit that the “greatest barrier… remains an essential part of the hidden
curriculum, which is how institutions and the leadership within those institutions engage and value Indigenous health (p 204)."

A fundamental challenge to Indigenous cross-cultural curricula may be made in regards to its place in the medical curriculum. Pointing to the need for system change Jacklin, Strasser et al (2014) suggest “negotiation of space will continue to be a problem for Aboriginal health curricula at all medical schools until there is greater acceptance of Aboriginal ways of knowing and Aboriginal health is given more prominence in the Medical Council of Canada Qualifying Examination and accreditation standards (p149).”. Claims have been made that such content is unnecessary as culture issues are not a major problem in clinical practice (Macdonald, Carnevale et al. 2007). Johnstone points to ‘the healthcare illusion of non-racism’, the belief that racism no longer exists or doesn’t exist in this space. Others report faculty questioning its relevance and concerns raised about an already full curriculum (Roberts, Sanders et al. 2010).

Another framework, developed by Essed (1991), was used to examine both personal and institutional resistance in a study of workplace training and identifies three areas of conflict (1) norms and values (2) societal resources (3) definitions of the social world (Johnstone and Kanitsaki 2008). Again findings point to ways in which organisations and leadership can compromise the effectiveness of training. In particular the authors point to the political nature of such training and suggest the politics of cultural diversity education and the ‘politics of resistance’ to such programs need to be better recognized and understood.

Outcomes
There seems broad agreement that the “big picture” goal of Indigenous cultural training is an improvement in health equity. Achievement of this goal is predicated on outcomes that have been variously described as a culturally informed workforce, culturally competent professional or cultural humility.

What constitutes ‘cultural competence’ for example, remains contested and difficult to measure. Kumas-Tan, Beagan et al. (2007) undertook a systematic review of frequently used cultural competence measures and in examining the ten most widely used measure identified six “problematic, unexamined” assumptions embedded in the measures.

1. Culture is equated with ethnicity and race
2. Culture is possessed by the “Other”; dominant groups are not seen as having a culture
3. Cultural incompetence stems from lack of familiarity with the Other
4. Cultural incompetence stems from practitioners discriminatory attitudes to the Other
5. Cross-cultural care is about Caucasian practitioners working with the Other
6. Cultural competencies about being comfortable with oneself and with others

Many evaluations consider short-term outcomes e.g. student reactions, changes in knowledge, attitudes, intention to change – fewer examine actual changes in practice, patient experiences of practice or other outcomes such as increased equity of access. Short-term and intermediate outcomes are important to detail and link - they are a critical part of the causal pathway that explains how the program is supposed to work.

Dwyer et al (2004) outline the causal pathway in this way, …a theoretical causal pathway where desired outcomes such as improved health status and wellbeing are premised on the generation of certain impacts, such as changes in modifiable risk and protective factors operating in individuals and environments. These impacts are premised on changes in processes and/or structures such as improved capacity and higher quality or better coordination of services and programs. In turn, the implementation of new processes and structures
requires a range of inputs or activities such as supporting policy directions, workforce development and funding. These chains of inputs and effects take place in a wider social and political context that mediates the effectiveness of all elements.

and make clear the relationship of such a model to evaluation,

… if empirical evidence of change can be seen for each of the points along the continuum, then it can be reasonably predicted that the outcomes are at least in part attributable to the program’

**Good practice**

The purpose of this paper is to inform discussion about ‘good practice’ and development of a good practice model. What then does this exercise contribute to our understanding of what works, for whom in what circumstances?

Firstly, and predictably, the review demonstrates that design and implementation of Indigenous cross-cultural training is not a straightforward or easy task.

Different programs have different starting points – they draw on different conceptions of culture and may draw on a range of evidence and theories. There is a growing consensus that underpinning notions of culture need to move away from a focus on knowledge of beliefs, customs and traditions towards a more critical approach that engages with processes of identity formation, power relationships and resource distribution and the role of historical and social factors in producing these.

Although many programs are proposed as a means of improving health equity the shorter-term and intermediate outcomes they seek vary, and the causal pathway between levels of outcomes is not always clearly articulated. A model of good practice needs to make explicit the links between program inputs, resources and activities, what short–term changes may be brought about, how they contribute to intermediate outcomes, and in turn the contribution to the ultimate goal.

A range of possible mechanisms for change have been identified and each of these is influenced by layers of context and a multitude of constraining and enabling factors. A number of the programs included in the review implemented multiple strategies and activities. These encompassed a range of mechanisms and hence possible pathways for change. Whilst it is likely that there may be debate regarding the identified mechanisms which are often “hard to nail” (Greenhalgh, Humphrey et al. 2009), they provide a starting point for educators and evaluators to uncover program theory, consider the relationships between mechanisms and explicate the expected outcomes.

Importantly constructing models which provide that a sound a rationale for how a program is supposed to work can provide a framework for evaluation and research in a field that requires significant study.
Cultural Safety Research Group (2006). Opening our eyes- shifting our thinking, Nursing Centre of Learning Whitirea Community Polytechnic, Graduate School of Nursing, Midwifery and Health, Victoria University of Wellington.


APPENDIX

Search Strings Used:

Medline/Eric
(Cultural safety OR culturally safe OR culturally unsafe OR Cultural security OR culturally secure OR culturally insecure OR Cultural competenc* OR culturally competent OR culturally incompeten* or Cultural respect OR culturally respect* OR culturally disrespect* OR cultural capabilit* OR culturally capable or culturally incapab* OR culturally appropriate* OR cultural humilit* OR culturally humble OR cultural ease OR cultural awareness or culturally aware OR Cultural proficienc* OR culturally proficient OR cultural identi* OR culturally identi* OR cultural immersion OR culturally immersed OR cultural care)

AND

((nurs* or health profession* or practitioner* or health care or healthcare or health worker* or medic* or clinic* or allied health* or student*) adj2 (pedagog* or educat* or train* or teach* or curricul* or learn* or school*))

AND

(Australia* or Queensland* or New south wales or victoria* or tasmania* or northern territory* or canad* or alberta* or british columbia* or manitoba* or new brunswick* or newfoundland* or labrador* or northwest territories or nova scotia* or nunavut* or ontario* or prince edward island* or quebec* or saskatchewan* or yukon territory* or New Zealand* or hawaii*)

PubMed:

Scopus:
( ( TITLE-ABS-KEY ( ( cultur*) W/2 ( safe* OR unsafe OR secur* OR insecure* OR competen* OR capab* OR incompeten* OR appropriate OR humble OR humility OR ease )) OR TITLE-ABS-KEY ( ( cultur*) W/2 ( aware* OR proficien* OR identi* OR immers* OR respect* OR care ))) AND ( TITLE-ABS-KEY ( ( ( nurs* OR "health
profession*" OR practitioner* OR "health care" OR healthcare OR "health worker*" OR medic* OR clinic* OR "allied health*" OR student* ) W/3 ( pedagog* OR educat* OR train* OR teach* OR curricul* OR learn* OR school* ) ) ) ) AND ( ( TITLE-ABS-KEY ( australia* OR queensland* OR "New south wales" OR victoria* OR tasmania* OR "northern territory*" OR canad* OR alberta* OR "british columbia*" OR manitoba* OR "new brunswick*" OR newfoundland* OR labrador* OR "northwest territories" ) ) OR TITLE-ABS-KEY ( "nova scotia*" OR nunavut* OR ontario* OR "prince edward island*" OR quebec* OR saskatchewan* OR "yukon territory*" OR "New Zealand*" OR hawaii* ) ) )

CINAHL:
((Culture or Cultural*) N2 (Safe* or Unsafe or Secur* or Insecur* or Competen* or capab* or Incompeten* or Appropriate or Humble or Humility or Ease or Divers* or Aware* or Proficien* or Identi* or Immers* or Respect* or care))

AND

((nurs* or "health profession*" or practitioner* or "health care" or healthcare or "health worker*" or medic* or clinic* or "allied health*" or student*) N3 (pedagog* or educat* or train* or teach* or curricul* or learn* or school*))

AND

(Australia* or Queensland* or "New south wales" or victoria* or tasmania* or "northern territory*" or canad* or alberta* or "british columbia*" or manitoba* or "new brunswick*" or newfoundland* or labrador* or "northwest territories" or "nova scotia*" or nunavut* or ontario* or "prince edward island*" or quebec* or saskatchewan* or "yukon territory*" or "New Zealand*" or hawaii*)