

ORIGINAL RESEARCH

Health disparities, cultural awareness, and Indigenous health: Results from a health educator survey

Shaun C. Ewen¹, David Paul², Alice Wilkin¹

1. University of Melbourne, Australia. 2. University of Notre Dame, Fremantle, Australia.

Correspondence: Alice Wilkin. Address: University of Melbourne, Australia. Email: alice.wilkin@unimelb.edu.au

Received: June 3, 2014

Accepted: July 17, 2014

Online Published: August 4, 2014

DOI: 10.5430/jnep.v4n10p40

URL: <http://dx.doi.org/10.5430/jnep.v4n10p40>

Abstract

Indigenous peoples in multiple settings suffer an increased chronic disease burden compared to non-Indigenous peoples. Interpersonal “racism or discrimination on the part of health care providers” can contribute to this.

The Health Educator Survey tool investigates Australian and New Zealand health educator’s perspectives on health disparities between groups. Participants were asked to nominate the location of health disparities in the curriculum, including who was accountable for the content, and to nominate whether the content was placed within a health disparity context or separately.

Risks identified included a lack of consistency in teaching, and teaching in a prescriptive style that could lead to the stereotyping of people of different ethnicities. Participants also identified a lack of professional training in health disparities.

Key words

Aboriginal health, Culture, Health disparities, Health educators, Stereotypes in health

1 Introduction

Whilst the health disparities experienced by Indigenous peoples reflects the influence of multiple factors there is increasing evidence of the contribution of health practitioners to disparities in health care outcomes. This paper outlines implementation of The Health Educator Survey as part of the Educating for Equity (E4E) project. The Health Educator Survey was developed as a pilot study to investigate health educator’s understanding of the teaching of health disparities and how, if at all, they related this to Indigenous health. The survey aimed to find out where participants identified the location of health disparities content in the curriculum, including who was accountable for the teaching of health disparities content, and the method in which it was taught.

Indigenous people in multiple settings including Australia and New Zealand experience a greater burden of chronic diseases than non-Indigenous people^[1]. This disparity in health outcomes is partly due to “health professional factors”^[2] including, clinical decision making and client/health professional communication^[2].

Currently little is known to what extent educational pedagogy may influence health professionals and contribute to poor Indigenous health outcomes^[3]. The E4E project aims to contribute to improving health professionals' knowledge, attitudes and behaviours, plus share experiences and approaches to Indigenous health teaching and learning in the area of chronic disease^[1]. Whilst the E4E project is a tri nation initiative this project participants were from universities in New Zealand and Australia.

1.1 Background

The relationship between health disparities, cultural training, and Indigenous health in medical education: Health disparity between population groups is often a key aspect of cultural competency training^[4-6]. Indeed, it has been argued that inclusion of cultural competency in health professional education has been driven by the belief that this will remove ongoing health disparities^[7].

Numerous papers have highlighted the importance of training health professional students and physicians about health disparities to reduce health outcome gaps between population groups^[5, 7-12]. The effectiveness of teaching health professional students about health disparities between population groups is an under researched area^[9, 14, 15]. This includes evaluation of the way in which curricula may influence patient outcomes. Furthermore, one study found that many cultural competency courses lacked evaluation and were not developed on a grounded basis^[14].

Other criticisms include that while the teaching about health discrepancies between population groups within health professional curricula is predominately titled 'Cultural Competency', there are few other consistencies between medical and health science schools^[7, 16]. Smith *et al.*^[7] also found that there were inconsistencies in curriculum design. In the literature the structure of the content varied from an intensive five day course^[17] to numerous articles suggesting integrated curricula is the most effective structure to teach the content^[8, 18-20]. The importance of how the content is delivered is best described as:

An integrated approach to cultural competence requires a whole-of-school approach...without a meaningfully integrated approach, cultural competence curricula is at risk of being perceived by students and faculty alike as an 'add-on' to the important core curricula^[9, p22].

Cultural competency training/education is quite often relegated to the domain of Indigenous organisations^[21-23], implying culture is not inherent across communities, work places, clubs, and in all other human activity. This can lead to a discourse that essentialises Indigenous culture. For example, in Australia there have been high profile campaigns that specifically target health disparities between Indigenous and non-Indigenous Australians^[23].

Health disparities are defined as a "difference in health that is closely linked with social or economic disadvantage"^[23] and that "people who live in areas with poorer socioeconomic conditions tend to have worse health than people from other areas"^[11]. Such definitions do not relate health disparities with Indigeneity. However, the public discourse of health disparities often depicts a causal relationship with ethnicity^[24]. For example, the Australian Government and Diabetes Australia have delivered 'The National Diabetes Services Scheme'^[24]. On the website for the initiative there is a section titled "Why Me? (Risk Factors)" and states:

You have more chance of getting it when you are Aboriginal or Torres Strait Islander but not all Aboriginal and Torres Strait Islander people have diabetes.

Aboriginal and Torres Strait Islander people live different to how they used to live. Changes that add to your chances of getting diabetes are:

- Not as active
- More overweight
- Eating fatty salty, sugary foods.

This statement conflates the health disparities with Aboriginality and attributing risk factors to ‘modern’ Aboriginal culture, whereas these risk factors can occur in any population group.

This conflation was also highlighted by Jaiger whose study into cultural discourse in public health revealed that in a majority of public health texts, ethnic minority lifestyle and cultural practices were cast as being detrimental to health ^[27]. Similarly, Briggs ^[28], in a discourse analysis around epidemics, found that there was an implied association that bacteria and viruses only affected populations based on racial background. This attribution of disease to a culture can reinforce stereotypes further marginalising some communities.

1.2 Creating ‘the Other’

It has been argued that cultural competency is a key strategy aimed at the reduction of health disparities ^[5], however this can erroneously associate the cause of the health disparity to the patient's culture. This approach can ignore the societal impacts on health such as racism ^[6], historical factors ^[30, 31], and accessibility of health care service systems ^[6, 30, 31].

Several issues have been identified that reinforce the potential negative impacts misguided teaching may have in shaping a student’s perception of health disparities. This can include essentialising a culture, creating a construct of non-dominant cultures being ‘the Other’, and only recognising culture to be along racial or ethnic spectrum ^[9, 12, 20, 32, 33].

Prescriptive teaching, when ‘taken-for-granted’ assumptions about a culture are taught ^[34], can also lead to essentialism where one ascribes an essential set of characteristics to a particular population ^[32]. The implication of this is that culture is static ^[12, 20]. This static approach provides knowledge to the students, and later physicians, “with a narrow, stereotypical understanding of what ‘Indigenous culture’ is” ^[32]. Furthermore this prescriptive style insufficiently recognises individuals within groups ^[20].

One of the problems with teaching culture as static, prescriptive, and essentialising ‘the other’ is that it can lead to a patient/clinician relationship where patients are blamed for non-adherence of health advice ^[20]. This project was developed to explore the above factors and the extent to which they reflected current tertiary health professional educators. The health educator survey was developed to investigate these issues and pilot the survey tool.

2 Methods

The Health Educator Survey was framed in the qualitative methodology of hermeneutic phenomenology. This methodology was utilised as this research was not about finding out how health disparities between population groups is taught, it is about the health educator's perspective of how, by whom, and where in the curriculum it is taught.

Hermeneutic phenomenology is a framework that aims to use the terms and meanings of the participant to understand the participants lived experience from their perspective ^[35]. Within this framework the methods of semi-structured interviews and thematic analysis were utilised to analyse key meanings across interviews to show a trend in health educator’s perspectives. Interview questions were developed by experts in qualitative research and who were part of the E4E team. There were six main questions in the interview schedule that prompted participants to discuss how their university taught health professional students about health disparities between population groups. The questions were:

- Does your School have particular curricula which is focused on addressing disparities in health outcomes between different population groups?
- Who is responsible for, or has taken a lead, on its inclusion within your School?
- What are the main aims/proposed outcomes for the inclusion of this content?
- Are these aims/outcomes being achieved through this course?

- Is this content assessed at all, and if so, can you please describe where and how.
- How has your professional experience informed your own learning of the disparities in health outcomes between population groups?

The interviews were semi structured and varied in length depending on the participant's knowledge of their own institutional curricula context. The questions specifically asked participants to explain how they thought health disparities between population groups is taught, where it is placed in the curricula, and how they were trained/informed to teach this content.

Thematic analysis of the data was employed by coding the interviews to ascertain themes that occurred across all of the transcripts^[36]. The themes and subthemes that emerged were professional experience, curriculum description, integrated curricula, curriculum assessment, input and responsibility for content, evaluation and aims, prescriptive teaching/othering and essentialising cultures.

Sampling and population

The participants of this pilot Health Educator Survey were academics currently teaching health professional students. All twenty participants were employees of a university medical or health science faculty. The participants of the survey were attending the Australian & New Zealand Association for Health Professional Educators conference that attracted an international audience. From the conference program ninety people were identified as health educators from 27 different universities. A purposive sampling method was applied to the 90 potential participants. The subsets of the stratified sample were the different Universities being represented at the conference. There were 20 participants who completed the survey representing nine different universities. The representatives of the Universities were predominately from Australia (15 participants), and five participants from New Zealand.

Fifteen of the participants were female and five were male. Twelve of the participants said they were between the ages of 50-59, three identified as older than this and five identified as younger. The participants held various positions at their respective universities. Six were health science and/or medical lecturers, three were research fellows, three were senior lecturers, three were course coordinators, three were Deans or Associate Deans, two were professors, and one was a tutor and research assistant. The average time the participants had been in their current position was 4 years with a range from 3 weeks to 20 years (median of 2.75 years).

Ethics approval for this survey is from the Human Research Ethics Committee at the University of Western Australia (RA/4/1/4771).

3 Results

3.1 Professional experience

All the participants answered the question "how has your professional experience informed your own learning of the disparities in health outcomes between population groups?"

Fifty percent of the participants had learned about health disparities through their previous employment in the health system. Twenty five per cent learned about the issues during their undergraduate education; some of these participants said they had learned via biomedical statistics while others had learned via an arts degree within subjects such as sociology and feminism. Fifteen per cent learned via their own life experience which ranged from their own, or a family member's, ethnicity. Ten per cent of the participants learned via Indigenous colleagues.

In summary 75% of the health educators had received no formal education regarding health disparities despite teaching the topic to health professional students.

3.2 Curriculum description

A range of curriculum frameworks were discussed when the participants were asked how health disparity between population groups is taught within their University. The methods ranged from a workshop and seminar the length of one day hosting guest lecturers, to immersion programs with clinical and academic learning approaches.

The latter ranged from programs that had the students move to a rural community, to students following the health journey of a patient who was not from their own cultural background, to students learning about health disparities through an allied health immersion program.

3.3 "Integrated"

The most discussed model of how the content, regarding health disparities, is delivered to students was an integrated model. Sixty per cent of the participants stated that the content was delivered via an integrated model. However, as discussed later there was some diversity in what was meant by integrated teaching. For example, half of this 60% described content as being incidental and not deliberately integrated. Fifteen per cent of the participant's curricula did not have integrated content, 15% were unsure and 10% were in the process of creating an integrated curricula model.

Incidental integration was considered to be when content regarding health disparities between population groups was discussed via special guest lectures, discussions around social determinants, or epidemiological demographics of some diseases, and was not a formal part of the subject structure. Additionally, the majority of the interviewees stated that this type of content was not assessed and/or part of the learning outcomes. The following is an example of incidental content.

It doesn't say understanding health disparity but within that is has been raised a lot, incidentally. For example, we had someone come and talk about the social determinants of health and she talked about inequity, we had someone talk about the economic determinants of health and I hadn't cued them in but they talked about the massive disparities (participant no. 11).

Other issues raised by participants regarding this pedagogical approach was that they were unable to ensure the content is actually being delivered across the subjects. Additionally, one participant mentioned that there is a risk that the content is integrated into nothing. As one participant explained there needs to be mechanisms to ensure the content is being integrated into the teaching and learning forums via lectures and tutorials.

Some of the participants had differing answers in regard to integrated curricula indicating that perhaps they did not have knowledge of this area. For example one of the participants described integrated curricula as the reduction of the content, as opposed to the content occurring over the course and throughout all years.

They learn a bit [about health disparities] in 3rd semester 3rd year but after that the course changes significantly and it becomes a more integrated course. So there is some discussion around health disparities in relation to different conditions but not quite the same emphasis. And so that's one of my initial concerns might be how much are they still thinking about it by the time they are out into the community unless they are particularly interested in it (participant no. 12).

3.4 Curriculum assessment

In relation to assessment, 45% of the participants said that content was formally assessed, 25% were unsure, and 30% stated that the assessment was not specific to content regarding health disparities between population groups. The latter participants' responses varied from the assessment being a pass/fail learning hurdle, to the content being assessed only

“some of the time”, to the assessment being based on the learnings of a specific culture and not on health disparities between population groups.

3.5 Input and responsibility for content

When asked who was responsible for the inclusion of this content there was a range of responses including:

- Academic boards
- Chair/Head of School
- Associate Deans
- Teams of teaching staff
- Community engagement/input

Twenty per cent of the participants discussed how health disparities between population groups were taught via community engagement. However, one participant perceived community engagement to mean talking about community in the course content. Another participant perceived community engagement to mean recruiting more Indigenous students to the university. Thirty five per cent of the participants said the content was developed with Indigenous input, which was mostly at an academic level, and consultation at a community level did not occur. Further, ten per cent of the participants stated that the curricula had significant student input in the development.

3.6 Evaluation and aims

There was a considerable variation between the participants' perceptions of the aims for including health disparities between population groups in curricula. Of those interviewed, fifty per cent stated that the aims were to equip the students with knowledge about a range of issues including inequity, cultural awareness, and primary health care issues. Fifteen per cent of the participants said that the aim was to help the underserved community/ies in Australia. Other responses included: to improve doctors' health literacy; to teach the students about class in society; and, to increase the Indigenous health workforce.

Only one of the participants could comment on whether these aims were being achieved. The interviewee said that increased Indigenous enrolment meant that their aims were being achieved. The other participants stated that they did not know if the aims were being achieved as they did not conduct evaluations of the content/course, they did not conduct evaluations on the proposed outcomes/aims, or they were in the process of developing an evaluation. One interviewee said they had heard no feedback from the community about the students so believed this to be 'good news'.

3.7 Prescriptive teaching/othering

Some of participants used prescriptive teaching methods where they told the students how to 'adapt' their behavior when treating people of different ethnicities. The following are just some examples provided by the participants:

We want them to enroll a patient that is culturally diverse to them as possible. So whether that be ethnically, socioeconomically, sexuality, religions, whatever, age even, we want them to pick someone who is different (participant no. 4).

If it's an Indian woman you may have to speak to her husband and those sorts of things. Different requirements and you feel for students because they have to learn all that (participant no. 8).

Some of the comments by the participants suggested associated assumptions regarding patient's ethnicity/culture. For example:

You don't need to be an academic to know that if someone says what's a disadvantaged culture that people will say Aboriginal (participant no. 2)

4 Discussion

The results of the Health Educator Survey revealed some key insights into the health educators' perspective on how the participants and their faculty or school delivered teaching about health disparities. The results also revealed how the participants' professional training or experiences have influenced how they deliver this content. The following section discusses the research results and their implications in regards to medical and health science education.

4.1 Course description

There was a wide variation between the models of teaching about health disparities which emerged from the interviews. The structure of the curriculum ranged from a one day intensive workshop under the title of 'cultural competency', to community immersion programs where the students lived and learned within a rural/remote community. There were a variety of ways in which the participants described their model of teaching. This was consistent with findings elsewhere which conclude that colleges and schools do not implement consistent methods that evaluate whether cultural competency outcomes are achieved^[7]. Further, the effectiveness of educational programs can be compromised when there is a lack of consistent or explicit guidelines along with limited knowledge of the detail of the content being taught^[35].

The participants also used different descriptive terminology regarding the model of teaching and implementation of the content. Additionally, assessment of this content varied from formal examination to no assessment of the content. The latter may be an indication of how unimportant the inclusion of this content was to their faculty. Hafferty^[37] reminds us of the importance of assessment, noting that:

Tools of evaluation, however, are not simply instruments of assessment. They also are vehicles for conveying what is and is not important within the organization^(p.405).

The lack of consistency, assessment, and evaluation in the way the participants described the teaching of health disparities between population groups, may be an indicator of the university system having the content lower on the hierarchy of teaching and learning importance.

4.2 Essentialising cultures

The results of the Health Educator Survey showed a difference in the pedagogical approach adopted by the health educators. This included prescriptive teaching, where academics told the students how to 'adapt' their behavior when treating people of different ethnicities. As highlighted in literature, prescriptive teaching may lead to essentialism where a patient's ethnicity is seen to represent a set of behavioural characteristics^[32], implying that culture is static^[12, 20], and leading to a "stereotypical understanding"^[31] of Indigenous cultures. The participant comments listed in the results section (see 'Prescriptive teaching/othering' section of this paper) aligned with the literature, which highlighted that language can reflect the stereotyping and essentialising of some cultures^[9, 12, 20, 32]. This essentialising of culture could lead to the patient and patient's family feeling a breach of confidence from the clinician^[32]. For example, the clinician may have been told that in some ethnicities it is culturally appropriate to address the male in regard to his wife's health, but that behavior may actually be highly offensive. Essentialising a culture can also lead to inappropriate communication and lead to broad assumptions about an individual's situation and health perspectives. The following statement by one of the participants is a case where the patient and the patient's culture are being blamed for non-compliance. For example,

What would happen is a patient that doesn't really understand what the doctor wants or whatever who is then requested to go over to the pathology lab and have some blood or urine taken often won't come, they won't do their follow ups. And that's because of their culture; I'm not sure how it all ties in because I'm not an expert at that. But once again it puts them at a disadvantage (participant no. 8).

This can create a discourse that health disparities are explicitly linked to one culture. Such a discourse can lead to the dismissal of important causal factors of health issues as culturally based explanations are mobilised. Further, some

patient's health issues may be overlooked as the health professional does not associate a particular issue with that patient's cultural background.

4.3 Professional influence

All the participants were asked "how has your professional experience informed your own learning of the disparities in health outcomes between population groups?" Seventy five percent of the health educators had received no formal education regarding health disparities, despite teaching the topic to health professional students. Half of the participants described that they had learned about health disparities through their previous employment in the health system. Therefore, the health system which has struggled to reduce health disparities may be influencing health educators, who in-turn teach the next generation of health professionals. In other words, this informal training and then teaching is reinforcing the hidden curriculum which often works against the formal curriculum^[37].

4.4 New contribution to the literature

Reducing the health burden in marginalised communities has led to health care systems integrating cultural safety into health professional training^[8-10, 12, 13, 39]. However, there has been very little investigation regarding the opinions of those who undertake this teaching. The Health Educator Survey contributes to this knowledge gap in the literature and found that the health educators' opinions were associating negative stereotypes, which could impact on the way the students perceived some cultures.

5 Conclusion

The Health Educator Survey investigated health educators' understandings of the teaching of health disparities and how, if at all, they related this to Indigenous health. One of the key findings was the inconsistency in the development and implementation of teaching about health disparities within and between universities.

Numerous studies purport the importance of teaching health professional students and physicians about health disparities to reduce health outcome gaps between population groups^[9, 10, 12, 13]. Additionally, cultural diversity, Indigenous health, and cultural competency are part of the Australian Medical Council (AMC) guidelines^[39]. Despite this there are no recommendations as to how this content is delivered and this may be why the participants described a variety of teaching models and terms.

There may not be a 'one size fits all' framework. However, the variety in structures, assessment and definitions that were raised in the participant interviews suggest there would be merit in investigating best practice models for curricula development and delivery regarding health disparities between population groups.

The Health Educator Survey revealed that some of the teaching styles were of a prescriptive method that essentialised cultures with particular behaviours. The assumption that a patient's cultural background dictated their behaviour and health highlighted a lack of meaningful communication with the patient and could be perceived as stereotyping the patient's ethnicity. This can lead to a community or individual being marginalised because of being associated with misleading essential aspects, such as being blamed for medical non compliance. Additionally, essentialising culture is one of the ways that racism is expressed in health care^[30].

Given the considerable diversity in cultural norms and practices across communities, essentialism is not an appropriate approach. In some settings "not looking Aboriginal patients in the eye" (participant no. 2) may be the correct approach, but other settings this may be inappropriate. Having particular knowledge about a specific ethnic group is not sufficient to understand all members of that group or a particular client^[40].

Half of the participants had become informed about health disparities through working in the health system. Therefore, they learned via a clinical setting, a system that is yet to eliminate health outcome inequalities between population groups,

and can be embedded with informal and hidden curriculum^[37] in the teaching process. This study indicates that the health professional education system is yet to recognise culture beyond ethnic groupings. This was highlighted by the way the health educator's themselves discussed their methods of teaching about health disparities and how and where their universities placed this content in the curriculum and whether it was evaluation and/or assessed.

Further, the results highlight that the health education system is still reflecting culture as someone not from the dominant 'normal' culture via essentialisation and a lack of consistent content. The medical and health science tertiary level education system appears to be failing to recognise adequately the culture of the dominant, the culture of medicine and health professions, the culture of the education system, and still predominately teaches about culture by focusing on 'other' cultures and assigning them with a set of health issues.

Limitations

The Health Educator Survey was intended to be an international representation. However, due to the skewed numbers at the data collection setting there is an overrepresentation of participants from the east coast of Australia. However, as a pilot survey this has provided useful information in relation to the scope of understandings from a range of universities and health disciplines across Australia and New Zealand.

Acknowledgements

The authors would like to acknowledge our Australian and international colleagues involved in the Educating for Equity project. See www.educating4equity.net for more details of the project and team members. This project is supported by funding from the National Health and Medical Research Council, grant ID 634586.

References

- [1] Bramley D, Hebert P, Jackson R, Chassin M. Indigenous disparities in disease-specific mortality, a cross-country comparison: New Zealand, Australia, Canada, and the United States. *New Zealand Medical Journal*. 2004; 117(1207). Available from: <http://www.nzma.org.nz/journal/117-1207/1215/>
- [2] E4E: Educating for Equity [Internet]. Melbourne: Educating for Equity: [cited 2014 July]. Available from: <http://www.educating4equity.net/>
- [3] Klonoff EA. Disparities in the provision of medical care: an outcome in search of an explanation. *Journal of Behavioral Medicine*. 2009; 32(1): 48-63. <http://dx.doi.org/10.1007/s10865-008-9192-1>
- [4] Diez Roux AV. Conceptual approaches to the study of health disparities. *Annual Review Public Health*. 2012; 33: 41-58. <http://dx.doi.org/10.1146/annurev-publhealth-031811-124534>
- [5] Kagawa-Singer M, Dadia AV, Yu MC, Surbone A. Cancer, culture, and health disparities- time to chart a new course? *CA: A Cancer Journal for Clinicians*. 2010; 60: 12-39. <http://dx.doi.org/10.3322/caac.20051>
- [6] Durey A. Reducing racism in Aboriginal health care in Australia: where does cultural education fit? *Australian and New Zealand Journal of Public Health*. 2010; 34, Issue Supplement s1. <http://dx.doi.org/10.1111/j.1753-6405.2010.00560.x>
- [7] Smith WT, Roth J, Okoro O, Kimberlin C, Odedina F. Disability in cultural competency pharmacy education. *American Journal of Pharmaceutical Education*. 2011; 75(2): 26. Available from: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3073100/> PMID:21519416 <http://dx.doi.org/10.5688/ajpe75226>
- [8] Australian Medical Council. Assessment and Accreditation of Medical Schools: Standards and Procedures, 2011. Available from: <http://www.medicalboard.gov.au/documents/default.aspx?record=WD10 percent2f4304&dbid=AP&chksum=s percent2fiKOfSxflZW8H percent2bq77JuiQ percent3d percent3d>
- [9] Ewen SC. Cultural competence in medical education: A University case study. University of Melbourne. 2011. Available from: <http://dtl.unimelb.edu.au/>
- [10] Thompson B, Haidet P, Casanova R., Vivo R., Gomez A, Brown A, et al. Medical student's perceptions of their teachers' and their own cultural competency: Implications for education. *Journal of General Internal Medicine*. 2010; 25(2): 91-4. <http://dx.doi.org/10.1007/s11606-009-1245-9>
- [11] Australia Bureau of Statistics. Health and economic disadvantage (no. 4102.0). 2010. Available from: <http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4102.0Main+Features30Mar+2010>

- [12] Kumagai A, Lyson M. Beyond cultural competence: Critical consciousness, social justice, and multicultural education. *Academic Medicine*. 2009; 84(6): 782-787. Available from: <http://www.ncbi.nlm.nih.gov/pubmed/19474560> PMID:19474560 <http://dx.doi.org/10.1097/ACM.0b013e3181a42398>
- [13] Macaulay A. Improving aboriginal health: How can health care professionals contribute? *Canadian Family Physician*. 2009; 55(4): 334-336. Available from: <http://www.cfp.ca/content/55/4/334.short> PMID:19366932
- [14] Paluck E, Green D. Prejudice Reduction: What works? A review and assessment of research and practice. *Annual Review and Psychology*. 2009; 60: 339-367. <http://dx.doi.org/10.1146/annurev.psych.60.110707.163607>
- [15] Beach M, Price E, Gary T, Robinson K, Gozu A, Palacio A, et al. Cultural competency: A systematic review of health care provider educational interventions. *Medical Care*. 2005; 43(4): 356-373. Available from: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3137284/> PMID:15778639 <http://dx.doi.org/10.1097/01.mlr.0000156861.58905.96>
- [16] Johnson Y, Munch S. Fundamental Contradictions in Cultural Competence. *Social Work*. 2009; 54(3): 220-231. <http://dx.doi.org/10.1093/sw/54.3.220>
- [17] Vela M, Kim K, Tang H, Chin M. Innovative health care disparities curriculum for incoming medical students. *Journal of General Internal Medicine*. 2008; 23(7): 1028-32. <http://dx.doi.org/10.1007/s11606-008-0584-2>
- [18] Donate-Bartfield E, Lobb WK, Roucka TM. Teaching culturally sensitive care to dental students: A multidisciplinary approach. *Journal of Dental Education*. 2014; 78(3): 454-464. Available from: <http://www.ncbi.nlm.nih.gov/pubmed/24609347> PMID:24609347
- [19] Seeleman C, Suurmond J, Stronks K. Cultural competence: a conceptual framework for teaching and learning. *Medical Education*. 2009; 43(3): 229-237. <http://dx.doi.org/10.1111/j.1365-2923.2008.03269.x>
- [20] Boutin-Foster C, Forster J, Konopasek L. Physician, know thyself: The professional culture of medicine as a framework for teaching cultural competence. *Academic Medicine*. 2008; 83(1). <http://dx.doi.org/10.1097/ACM.0b013e31815c6753>
- [21] Australian Indigenous HealthInfoNet. Cultural competence training. 2012. Available from: <http://www.healthinfonet.ecu.edu.au/cultural-ways-home/cultural-ways-workforce/training>
- [22] Farrelly T, Lumby B. A best practice approach to cultural competence training. *Aboriginal and Island Health Worker Journal*. 2009; 33(5). Available from: <http://www.ccca.com.au/>
- [23] CCCA: Closing the gap through education [Internet]. NSW: Center for Cultural Competence Australia; c2013 [cited 2014 Jun]. Available from: <http://ccca.com.au/>
- [24] NDSS: National Diabetes Services Scheme [Internet]. Canberra: Diabetes Australia; [cited 2014 Jun]. Available from: <http://www.ndss.com.au/>
- [25] Council of Australian Governments [COAG]. Closing the gap in Indigenous disadvantage. 2008. Available from: http://www.coag.gov.au/closing_the_gap_in_indigenous_disadvantage
- [26] Centers for Disease Control and Prevention [CDC]. Social determinants of health: Definitions. 2012. Available from: <http://www.cdc.gov/socialdeterminants/Definitions.html>
- [27] White K. *An Introduction to the Sociology of Health & Illness*. Canberra: Sage Publications; 2009.
- [28] Jaiger K. Assumptions about culture in discourse on ethnic minority health. *Communication & Medicine*. 2013; 10(2): 141-151. <http://dx.doi.org/10.1558/cam.v10i2.141>
- [29] Briggs CL. Communicability, Racial Discourse, and Disease. *Annual Review Anthropology*. 2005; 34: 269-91. <http://dx.doi.org/10.1146/annurev.anthro.34.081804.120618>
- [30] Durey A, Wynaden D, Thompson S, Davidson P, Bessarab D, Katzenellenbogen J. Owning solutions: A collaborative model to improve quality in hospital care for Aboriginal Australians. *Nursing Inquiry*. 2012; 19(2): 144-152. <http://dx.doi.org/10.1111/j.1440-1800.2011.00546.x>
- [31] Sherwood J. Who is not coping with colonization? Laying out the map for decolonization. *Australasian Psychiatry*. 2009; 17(s24). <http://dx.doi.org/10.1080/10398560902948662>
- [32] Downing R, Kowal E. A postcolonial analysis of Indigenous cultural awareness training for health workers. *Health Sociology Review*. 2011; 20(1): 5-15. <http://dx.doi.org/10.5172/hesr.2011.20.1.5>
- [33] Dogra N, Reitmanova S, Carter-Pokras O. Teaching cultural diversity: Current status in U.K., U.S., and Canadian medical schools. *Journal of General Internal Medicine*. 2009; 25(2): 164-168. <http://dx.doi.org/10.1007/s11606-009-1202-7>
- [34] Shattell M, Hogan B. Facilitating communication: How to truly understand what patients mean. *Journal of Psychosocial Nursing and Mental Health Services*. 2005; 43(10): 29-32. Available from: http://works.bepress.com/mona_shattell/32 PMID:16294835
- [35] Spencer C, Macdonald R, Archer F. Surveys of Cultural Competency in Health Professional Education: A literature review. *Journal of Emergency Primary Health Care*. 2008; 6(2). Available from: http://www.jephc.com/full_article.cfm?content_id=475

- [36] Liamputtong P, Serry T. Making sense of qualitative data. In: Liamputtong P, editor. Research methods in health: Foundations for evidence-based practice. 2nd ed. Melbourne: Oxford University Press; 2013.
- [37] Hafferty F. Beyond curriculum reform: Confronting medicine's hidden curriculum. *Academic Medicine*. 1998; 73(4): 403-407. <http://dx.doi.org/10.1097/00001888-199804000-00013>
- [38] Australian Medical Council. Accreditation of Specialist Medical Education and Training and Professional Development Programs: Standards and Procedures. 2010. Available from:
[http://www.medicalboard.gov.au/documents/default.aspx?record=WD10 percent2f4305&dbid=AP&chksum=NhvqoMXXCt0td percent2f4k7sIjew percent3d percent3d](http://www.medicalboard.gov.au/documents/default.aspx?record=WD10%20percent2f4305&dbid=AP&chksum=NhvqoMXXCt0td%20percent2f4k7sIjew%20percent3d%20percent3d)
- [39] Australian Medical Council. Standards for Assessment and Accreditation of Primary Medical Programs by the Australian Medical Council 2012. Canberra; AMC; 2012 Dec; 16.
- [40] Engebretson J, Mahoney J, Carlson E. Cultural competence in the era of evidence based practice. *Journal of Professional Nursing*. 2008; 3: 172-178. <http://dx.doi.org/10.1016/j.profnurs.2007.10.012>