

# Lining up the ducks: Aligning the formal, informal and hidden curricula in an immersed learning environment

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## Abstract

**Introduction:** Incongruence between the formal, informal and hidden curricula of Aboriginal and Torres Strait Islander health education is a barrier to student learning and preparedness for delivering effective and culturally-safe healthcare to Aboriginal people. We investigated the impact of student and registrar immersion experiences in an urban Aboriginal and Torres Strait Islander primary healthcare service, where greater alignment between the formal, informal and hidden curricula is evident.

**Methods:** In 2014, 11 students and registrars participated in this qualitative study. At the commencement of their placement, they received a project-specific vignette describing a 46-year-old Aboriginal woman with type 2 diabetes, wrote responses to questions about her clinical care and participated in a semi-structured interview, which explored the assumptions underpinning their responses. Post-placement, participants reflected on their earlier responses and what they had learned from their placement about Aboriginal and Torres Strait Islander people and their health and healthcare.

**Results:** The placement negated many of the students' and registrars' previously held assumptions about Aboriginal people, for example, that Aboriginal people don't care about their health and will not engage with health professionals. Participants became aware of the benefits of long-term doctor-patient relationships based on trust and respect. Participants realised that doctors have a role in addressing social determinants of health.

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**Conclusions:** Our participants' shifts in thinking and knowing suggest that greater alignment between the formal, informal and hidden curricula can lead to deepened and more effective learning outcomes for medical students and registrars and, critically, to improved Aboriginal health outcomes. Identification and reproduction of the key elements of Aboriginal health services may enrich medical students' learning about culturally-safe and appropriate care for Aboriginal people.

**Keywords:** medical education; Aboriginal health; hidden curriculum.

## Introduction

To ensure effective health professional education in Australia, students must have meaningful learning opportunities in Aboriginal and Torres Strait Islander (respectfully referred to as Aboriginal hereafter) health and healthcare (Australian Medical Council, 2012), but graduates continue to lack the confidence and ability to effectively work cross-culturally (Ewen, Mazel, & Knoche, 2012). There is a growing body of evidence describing the role of practitioner bias in contributing to health disparities (Dovidio & Fiske, 2012). Incongruence between the formal, informal and hidden curricula of Aboriginal health education is recognised as a barrier to student learning and preparedness for delivering effective and culturally-safe healthcare to Aboriginal people (Paul, Ewen, & Jones, 2014). Students' negative assumptions, lack of knowledge and misinformation about Aboriginal people may be addressed in the formal curriculum in an effort to increase the cultural safety of Aboriginal healthcare; however, students also learn via the informal and hidden curricula.

The hidden curriculum includes "a set of influences that function at the level of organizational structure and culture" (Hafferty, 1998, p. 404). It is the space where a student's tacit inculcation into the culture of medicine occurs, through "the unstated, taken-for-granted, and sometimes unconscious group understandings about how things are done within the group" (O'Donnell, 2015, p. 7). Because of these factors, the hidden curricula is a powerful influence on students' conscious and unconscious biases towards Aboriginal people. However, it can be altered. Through ongoing identification and reflection on the hidden curriculum, opportunities exist for it to align with formal curriculum reforms that aim to address Aboriginal health disparities (Ewen et al., 2012). The relative absence of Aboriginal people in Australian medical schools results in dialogues about Aboriginal health disparities occurring largely in the absence of Aboriginal people; however, Aboriginal primary healthcare services can be seen as educational spaces where Aboriginal representation is privileged and, therefore, form important learning sites.

In this paper, we progress discussion about the need to align the formal, informal and hidden curricula in Aboriginal health education, which we argue is a critical means for addressing the serious health disparities experienced by Aboriginal people (Paul et al., 2014). Specifically, we document our investigation of the impact of clinical placements in an urban Aboriginal primary healthcare service—a site where the formal, informal and hidden curricula are aligned—on medical students' and registrars' clinical decision making.

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## Methods

This qualitative pre-post pilot study involved 11 clinicians (seven medical students, three general practice registrars and one psychiatric registrar) undertaking clinical placements at the Southern Queensland Centre of Excellence in Aboriginal and Torres Strait Islander Primary Health Care (COE), previously known as the Inala Indigenous Health Service, during 2014. The methods for this study have been presented in detail elsewhere and are summarised here (Askew, Paul, & Ewen, 2017).

A written scenario describing a fictitious case of an Aboriginal patient was developed, informed by expert input and trialled with both students and graduates prior to conducting the research. At the commencement of the medical students' and registrars' placements with the COE, they were invited to take part in this research. Participants answered five questions (in writing) requiring clinical decisions and were then interviewed to elicit their decision-making processes. At the end of their placement, participants were presented with their written responses and interview transcripts and asked to reflect on their initial responses and consider what they had learned as a result of their immersion experience in an Aboriginal and Torres Strait Islander primary health service context. All pre- and post-placement interviews were conducted by clinical education researchers external to the author team, professionally transcribed and thematically analysed (Braun & Clark, 2006). One author (VL) initially read and reread all transcripts (to become familiar with the data), generated initial codes and identified broad themes. During face-to-face meetings of the research team, these themes were reviewed, defined and named. Any divergence in conceptualising the broad themes were resolved through discussion and further reviewing the interview transcripts.

### *Ethics*

The Inala Community Jury for Aboriginal and Torres Strait Islander Health Research (a group of Aboriginal people who guide all research undertaken by the COE) provided support for the project (Bond, Foley, & Askew, 2016). Ethical approval was obtained from the Metro South Human Research Ethics Committee. Results were disseminated back to the community jury at project completion and to the COE staff at a staff forum.

## Results

### *Participants*

All medical students and four of the five registrars placed at the COE during 2014 (the study period) participated in this study. One paediatric registrar declined to participate as she doubted the relevance of the fictitious case (a 46-year-old woman with type 2 diabetes) to her clinical practice.

### *The imperative of a holistic approach*

While most participants initially spoke of the necessity of a holistic approach, their understandings of what this meant were largely theoretical. Through their placements, they gained experiential knowledge around the relevance of a holistic approach and how

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this is critical for Aboriginal people, enabling a practitioner to “see” and “hear” their patients as people and respond to them in their unique sociocultural, emotional and economic contexts. Specifically, participants understood the interconnectedness of health, family and community for Aboriginal people. As one participant reflected:

*Definitely just a sense of community within the practice itself, and a lot of people come with family members and ... not just for support but for the same consult. There's lots of family members come into the doctor at the same time ... I guess I've always gone to the doctor by myself and in a ... suburban mostly Caucasian practice. That's what I see people doing. It's very, very different here ... I didn't really expect that at all ... It gets very busy ... but then you really get to understand what else is going on that may be affecting each family member's health, I guess, in terms of family stressors and other external stressors. (Medical student 5)*

Participants also developed greater understanding of how the social determinants of health (for example, access to financial resources and transportation) can impact on patients' ability to access healthcare. Understanding these realities challenged prior held negative assumptions and expectations of Aboriginal patients not caring about their health, not attending healthcare services and not adhering to healthcare advice or treatment regimens.

*I've seen a fair few patients that will come in with family issues as well and problems accessing medical care due to the family issues ... not having anyone to look after the children, or unable to go to hospital because they've got someone at home that they need to take care of and things like that, or can't get to hospital because they don't have a car and there's nobody to drive them, and don't have money today for the bus and things like that. So, it's still the context of the medical care, but we're getting in touch with all of that as well.” (GP registrar 7)*

Most participants developed more subtle skills for facilitating a holistic approach to care. Participants gained an understanding of how exercising patience and being nonjudgemental was crucial for developing practitioner–patient trust and rapport. These skills were also found to be critical in helping to create a safe space for patients to share information important for formulating treatment plans, including the impact of their social, emotional and economic wellbeing on their health and any access problems or issues impacting upon their ability to continue treatment. Critical to enabling space for a more holistic and patient-centred approach to be exercised was flexibility in the length of appointment times. Several participants discussed the advantage of having time to allow patients to comfortably explore what was going on for them, which was unique to this clinic's practice, and how this contrasted with time-pressured short consultations at other practices.

*Removing that time pressure ... makes it easier for everybody. The doctors can listen better; the patients feel more comfortable to talk better. They don't feel like they're being rushed out the door; and while there's always time pressures, you can't deal with a thousand issues in one session. There's always, seems to me to have been, adequate time to deal with issues that have needed to be dealt with. (GP registrar 6)*

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***From patient to person—the humanising of Aboriginal healthcare***

Participants revealed an increased appreciation of the vital nature of prioritising the development of a relationship with patients. Specifically, the reality and necessity of person-centred approaches to care were reflected in the sentiments of all participants as being critical for achieving optimal health outcomes with Aboriginal people. Several discussed their learning from practitioners at the service, who demonstrated listening without judgement and allowing care to be led by patient priorities. Overall, participants' perceptions of the role of a practitioner in relation to their patient shifted. One student reflected:

*Being flexible in terms of your approach to patients ... maybe letting them take the lead a little bit more and just going in the direction they want to go, even if a consultation takes a little bit longer. I think the outcome is potentially far greater if you let that happen. So they might spend 20 minutes talking about something seemingly unrelated, but they're really getting you down to an important issue, something that's important to them. And also ... it's sort of about communication, but just listening to them and their concerns and ... what's important to them ... I think sometimes even if it seems like you're not getting anywhere, I think even just allowing someone to sort of talk and vent, then not only is it going to make them feel better, but also it helps build relationship, which seems to be really critical in this arena. (Medical student 11)*

Participants also discussed other important factors related to delivering person-centred care, including nonverbal interpersonal skills, getting to know patients as people, caring for the whole person in their social context and devolving traditional practitioner–patient power imbalances by giving patients time and being respectful of patients' lived experiences.

*I think it just makes the doctor–patient relationship more trusting and more—because there's always the power imbalance between the doctor and the patient. Just talking to them like a normal person rather than I'm the doctor and you're the patient. It cuts that negative thing out. (Medical student 9)*

**Discussion**

The normalisation of diverse and positive representations of Aboriginality at the COE challenged participants' previously unrecognised negative assumptions and stereotypes about Aboriginal people. Their perceptions of Aboriginal people became more strengths based, and they gained greater understanding of the impact of social determinants on Aboriginal health (Brough, Bond, & Hunt, 2004).

The importance of attending to the social, cultural and economic dimensions of Aboriginal health has been written about extensively and, to varying degrees, is discussed in Aboriginal health education (Carson, Dunbar, Chenhall, & Bailie, 2007; Milroy, n.d.). However, its criticalness in providing responsive and relevant care to Aboriginal people remains largely unappreciated and, to varying degrees, unrecognised in mainstream education and clinical settings (Lacey, Huria, Beckert, Gilles, & Pitama, 2011). Without a platform of adequate understanding, health practitioners have limited capacity to hear and respond

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to Aboriginal patients' priorities and barriers governing their health—a problem that is pervasive and a consequence of the dominance of a biomedical care focus (Cass et al., 2002). Furthermore, misunderstandings about the realities of Aboriginal health negatively impact clinical decision making and contribute to practitioner bias towards Aboriginal patients (Paul, Hill, & Ewen, 2012). Alignment of the formal, informal and hidden curricula has the capacity to reduce clinical bias and increase practitioners' ability to provide more holistic, meaningful and relevant care (Paul et al., 2014)

The humanising effects of relational, person-centred, holistic care with Aboriginal people was evident in the shifting perspectives reported by our participants. While such approaches to care currently reside at the periphery of medical practice, their utility for reducing practitioner bias and health disparities has been suggested (Cooper, Beach, Johnson, & Inui, 2006). Similarly, the provision of high-quality and equitable healthcare depends on clinicians having interpersonal skills to build relationships with their patients (Burgess, Fu, & van Ryn, 2004).

Participants in our study became aware of differences, self and power in their relationships with their patients—a care approach that is imperative to culturally-safe cross-cultural practitioner–patient relationships (Beagan, 2003). The function of practitioner self-awareness and reflection cannot be understated in the pursuit of cultural safety in one's practice, as it is only “by seeing oneself as an other that the clinician can achieve greater empathy and understanding” (Kirmayer, 2013, p. 370). While greater awareness of the social determinants of Aboriginal health aided participants' self-reflection, understanding the historical interplay in Aboriginal–non-Aboriginal relations is also critical for practitioners to gain perspective of the ways in which we construct one another (Saha, Beach, & Cooper, 2008).

A key part of becoming a doctor is being enculturated into the medical profession—“figuring out what is expected versus stated” (O'Donnell, 2015, p. 10). The hidden curriculum plays a central role in this learning process and, therefore, should not be viewed as an inherently negative set of influences. On the contrary, it can be a powerful factor in learning what it takes to be a “good doctor” for Aboriginal people. The hidden curriculum, however, is experienced differently, often depending on one's ethnicity and prior learning; what may be hidden to non-Aboriginal practitioners and staff can be experienced overtly by Aboriginal people, who continue to be recipients of inequity, bias and different forms of racism and prejudice (Kelaher, Ferdinand, & Paradies, 2014). Furthermore, it is often overlooked that medical students and registrars are already enculturated into the practice of mainstream medicine through educational and clinic-based experiences. Practitioners are often highly sensitive to different approaches when immersed in new environments (Hafferty, Gaufer, & O'Donnell, 2015). In the case of participants' immersion at the COE, it was evident that all participants experienced substantial shifts in their perceptions of their professional identity as doctors and their relationships with Aboriginal patients.

Greater alignment of formal, informal and hidden curricula in Aboriginal healthcare has been most evident in services where Aboriginal leadership and community representation are prioritised. Aboriginal community controlled health services, such as the Kimberley



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Satellite Dialysis Centre, have reported high patient attendance rates and significantly improved health outcomes for Aboriginal patients (Marley, Moore, Fitzclarence, Warr, & Atkinson, 2014). These positive outcomes have been attributed to a range of factors, including a strong sense of ownership by Aboriginal patients of the service, a high representation of Aboriginal people in staffing roles, from senior leadership to community drivers, and the normalisation of Aboriginal culture in their service. Likewise, improved outcomes have been experienced at the COE, where its often-repeated history revolves around a growth in Aboriginal patients, from 12 in 1994 to over 10,000 adult patients in 2014, through engaging with the community and identifying strategies to ensure that the health service provided culturally-appropriate care for Aboriginal and Torres Strait Islander people (Hayman, Askew, & Spurling, 2014; Hayman, White, & Spurling, 2009).

The positive health outcomes, patient attendance rates and high level of community involvement and sense of ownership observed in Aboriginal primary health clinics such as the COE suggests the presence of cultural safety for Aboriginal people in these spaces. This presence, we opine, extends from the workings of the hidden curriculum and its alignment with the formal and informal curricula of medical education. This is achieved through the subtle, yet powerful, reorientations in practitioner approaches to care that address a holistic array of patient concerns and prioritise personalised relationships built on trust, continuity, equity and respect for Aboriginality.

Our study was not without limitations. The small sample size and research in a single site potentially limit the generalisability of the results. However, the congruence between our findings reported here and findings from our previous work (Askew et al., 2017; Ewen et al., 2015) suggests the utility of the research presented here. Further research would be required to determine if medical students and registrars experienced similar shifts in understanding in different settings. In relation to this and the relatively small number of clinical placements available in Aboriginal primary healthcare settings, the authors are undertaking another research project investigating the utility of an online activity to enable longer-term shifts in bias.

## Conclusions

From the shifts in thinking and knowing by our participants, we know that greater alignment between the formal, informal and hidden curricula can lead to deepened and more effective learning outcomes for medical students and registrars and, critically, to improved Aboriginal health outcomes. The unique organisational structures and cultures of the COE and Aboriginal-community-controlled health organisations such as the Kimberley Satellite Dialysis Service, referred to above, provide learning environments with Aboriginal representation and holistic, person-centred approaches to care, which often stand in contrast to practices found in mainstream clinics. As such, the health and learning outcomes from these spaces cannot be ignored if we are to seriously address some of the access barriers to quality care that Aboriginal people experience. However, given the relatively small number of these services across Australia and the pressing demands and resource shortages they already face, it is both unrealistic and irresponsible to promote them as potential primary learning vehicles for medical students. Rather, a

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more appropriate avenue is to reproduce key elements of these services in order to enrich health students' learning about culturally-safe and appropriate care for Aboriginal people. Identification of these key elements and the development of strategies for their replication in other settings is the goal of Aboriginal health professional education research.

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