8. van Knippenberg D, Schippers MC. Work group diversity. *Annu Rev Psychol*. 2007;58(1):515-541. doi:10.1146/annurev.psych.58.110405.085546

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Colonial shapeshifting: Re-remembering medical education's burden on Indigenous peoples

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Moreton-Robinson[1] describes colonisation as a shapeshifter. In this way, attempts to disestablish colonisation will often result in new formations of it making the colonial past and present inseparable. Examples of colonial shapeshifting appear in recently published articles about Indigenous medical trainees[2] and non-Indigenous medical educators.[3] However, to understand this shapeshifting it helps to re-remember a little about medical education's colonial past.

Moreton-Robinson[1] describes colonisation as a shapeshifter.

During the 1800s in Australia, Canada and New Zealand, Indigenous peoples were working hard to navigate the violence and genocide of colonisation. Simultaneously, colonial medical schools were being established. The black and white photos of the time celebrate newly erected medical education buildings (built on lands taken from Indigenous peoples) and formally dressed White men. Within these schools, it has been well documented that educators were often involved in the discredited, and inhumane, theories of eugenics[4] (the systematic effort to breed a superior group of people) and biological race.[5] Eugenicists plotted varying evils to conduct genocide on Indigenous peoples. For instance, breeding out Indigenous peoples, assimilation, creating and changing definitions of who is (and is not) Indigenous, removing children from their families and Country, sterilisation, segregation and even a lethal chamber. To help justify the discredited sciences, medical researchers desecrated Indigenous ancestorial remains and conducted unethical experiments.[5] Some of the first medical school education leaders in Australia, Canada and New Zealand were active in Eugenics societies[4,6] and conducted wrongs towards Indigenous peoples.[4,6,7] But this unsavoury story goes deeper than colonial medical school beginnings.

Some of the first medical school education leaders in Australia, Canada and New Zealand were active in Eugenics societies[4,6] and conducted wrongs towards Indigenous peoples.[4,6,7]

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The medical profession was entangled in colonisation from the beginning. Early medical practitioners arriving in the colonies were often disinterested in providing health care for Indigenous peoples[5,8] and saw Indigenous healthcare systems as inferior. Racial destiny was a common (and incorrect) colonial belief of the time. This espoused that a biologically superior white settler race would naturally replace biologically weaker Indigenous peoples, who were considered unable to survive colonisation (with colonisation explained as civilisation).[5,8] Therefore, although colonists or invaders caused the genocide of Indigenous peoples this was conveniently articulated as Indigenous people's fault. For these types of reasons, medical practitioners of this time often saw health care provision for Indigenous peoples as difficult and irrelevant.[5,8] It was these inhumane beliefs that were informing the first colonial medical schools and educators.

The medical profession was entangled in colonisation from the beginning.

This terrible past appears to have shapeshifted into medical education's present. For instance, Indigenous medical trainees in Canada describe tensions regarding their 'identity as an Indigenous person and as a medical trainee, with these tensions sometimes compromising their perceived sense of belonging within both Indigenous and academic circles'.[2 p8] Indeed, medical education was never conceived with an Indigenous paradigm. Therefore, Indigenous medical trainees are largely expected to 'fit in' or assimilate into a medical education programme predominantly informed by colonial epistemology and ontology. It is not only medical trainees who are expected to 'fit in' as Indigenous patients in Australia describe similar expectations to assimilate into a colonial informed medical model.[9] This shapeshifted form of assimilation promotes an unspoken power imbalance whereby a colonial paradigm is consistently fore fronted and Indigenous knowledge systems are largely disregarded and therefore eroded. Medical educators are often complicit in this. For example, in Australia medical educators were found to lack reflexivity about self, including profession.[3] Educators may teach that colonisation has caused harm to Indigenous peoples in the past; however, simultaneously lack critical self-reflexivity regarding their own cultural immersion and training within a colonial paradigm and thus fail to see how their teachings can also promote colonisation.

There is further shapeshifting. The Indigenous medical trainees in Canada also described a burden of responsibility to address educators who did not give the topic of Indigenous health justice, stereotyped Indigenous people or provided incorrect information.[2] Similarly, Indigenous patients in Australia described medical practitioners failing to consider colonisation impacts and perpetuating and being unresponsive to racism.[9] Mirroring the trainee and patient experience, non-Indigenous medical educators in Australia minimised teaching Indigenous health concepts by questioning their relevance, thought the concepts were difficult to teach, lacked skill and pedagogy to teach about race and anti-racism, misrepresented Indigeneity as pathology (promoting race as biological, rather than, social) and located inequity within Indigenous peoples rather than society.[3] It seems the past difficulty and irrelevancy of health care provision for Indigenous peoples has shapeshifted into the present, whereby, teaching Indigenous health concepts is seen as difficult and/or irrelevant. Additionally, blatant teaching on biological race has shapeshifted to misrepresenting Indigeneity as pathology and, a racial destiny to 'die out' has shapeshifted to a racial destiny for 'inequity'. But there is yet more colonial shapeshifting afoot.

The anti-hero medical educators of the past have shapeshifted into perplexing memorial. For example, the (aforementioned) early medical school leaders have medical education buildings and a library named after them. Further, medical schools can be located within institutions memorialising colonial leaders and this memorial can continue into health care institutions and services where medical learners train. Therefore, without a sentence said, medical learners and educators are often culturally immersed in spaces that celebrate a violent and difficult past. Some may rationalise that the memorialised were just products of their time; however, their memorial promotes a non-collective history, does not tell the entire truth and prevents people from fully comprehending the present.

Anti-hero medical educators of the past have shapeshifted into perplexing memorial.

On a more positive note, medical education's colonial shapeshifting is being tested. Indigenous medical trainees in Canada resist colonial medical education burdens (albeit with the need to resist another burden) by being Indigenous and connecting to culture, community and Indigenous peers.[2] Indigenous patients in Australia note some medical practitioners practicing anti-racism.[9] Medical educators can desire to improve their teaching.[3] Statues and building names of several problematic colonial medical educators have been removed. Some ancestorial remains have been repatriated and a few Universities document public apologies for past wrongs. More of this is needed.

A challenge for medical education is to create better 'approaches to education that theorize, revitalize, enhance, and produce Indigenous educational experiences that support Indigenous futures'.[10 p6] What will help is re-remembering the past, developing Indigenous scholar communities[10] and amplifying Indigenous voices.[2]

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We acknowledge the people of the Kulin Nations, on whose lands this article was written on. We pay respects to their Elders, past and present.

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REFERENCES

1. Moreton-Robinson A. *The White Possessive: Property, Power and Indigenous Sovereignty*. University of Minnesota Press; 2015. doi:10.5749/minnesota/9780816692149.001.0001
2. Burm S, Deagle S, Watling CJ, Wylie L, Alcock D. Navigating the burden of proof and responsibility: a narrative inquiry into Indigenous medical learners' experiences. *Med Educ*. 2022;57(6):556-565. doi:10.1111/medu.15000
3. Vass A, Adams K. Educator perceptions on teaching Indigenous health: racism, privilege and self-reflexivity. *Med Educ*. 2021;55(2):213-221. doi:10.1111/medu.14344
4. Carmody J. Doctors, academics and eugenics: a truly unsavoury mixture. In: *Sydney University Seminar Friday 16th April 2021*. The Royal Society of New South Wales Southern Highlands; 2021. https://www.royalsocietyhighlands.org.au/events-lectures/doctors-academics-and-eugenics-a-truly-unsavoury-mixture
5. Anderson W. *The Cultivation of Whiteness: Science, Health and Racial Destiny in Australia*. Basic Books; 2003.
6. Fine P. *Osler in Perspective*. McGill University; 2021. https://www.mcgill.ca/facmed-alumni/article/osler-perspective
7. Buckley HR, Petchey P. Human skeletal remains and bioarchaeology in New Zealand. In: O'Donnabhain B, Lozada M, eds. *Archaeological Human Remains*. Springer; 2018. doi:10.1007/978-3-319-89984-8_7
8. Salesa TD. "The power of the physician": doctors and the "dying Maori" in Early Colonial New Zealand. *Health History*. 2021;3(1):13-40. doi:10.2307/40111391
9. Atkinson P, Baird M, Adams K. Aboriginal health consumers experiences of an aboriginal health curriculum framework. *Austr Indigenous Health Bull*. 2021;2(3):3. doi:10.14221/aihjournal.v2n3.3
10. Smith LT, Tuck E, Yang W. *Indigenous and Decolonizing Studies in Education*. 1st ed. Routledge; 2019. doi:10.4324/9780429505010

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Who is the 'standard' patient?

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Two articles published in this issue of Medical Education deconstruct and examine how oppression exists and is reinforced within undergraduate medical education and pharmacy training. In doing so, these investigators provide evidence of a crucial barrier to meaningful anti-oppressive work in health professions education which has been described in multiple other settings[1]—namely, that current medical education pedagogy enforces that the 'normal', default patient is a white, cisgender, heterosexual able-bodied man, and that all other identities are deviations from this standard. These studies highlight the pervasiveness of the Eurocentric, colonialist and patriarchal influences that have shaped health systems and continue to be perpetuated in teaching and practice. Yet the *majority* of patients do not identify as this 'normal'. Our healthcare systems' and health professions education's default setting is inaccurate for most of the population.

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