

**“IT’S ABOUT THE HUMANITY OF NURSING”
SHIFTING ABORIGINAL AND TORRES STRAIT
ISLANDER HEALTH EDUCATION BEYOND
WHITE POSSESSION AND TOWARDS A
RELATIONAL APPROACH**

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Submitted in fulfilment of the requirements for the degree of Doctor of Philosophy

School of Nursing

Faculty of Health

Queensland University of Technology

2022

Keywords

Aboriginal peoples
Colonisation
Cultural Competency
Cultural Safety
Curriculum
Decolonisation
Good relations
Incommensurability
Indigenous knowledges
Indigenous peoples
Indigenous perspectives
Nurse
Pedagogy
Performative Benevolence
Race
Racialisation
Racism
School of Nursing
Self-determination
Sovereignty
Whiteness
White possessive logic
Zenadh Kes Islanders (Torres Strait Islander peoples)

Abstract

We live in an Indigenous policy era where the institutions of health disciplines and universities are embracing the need to better service Indigenous peoples, or at least to be seen as doing so. Such initiatives for the nursing discipline include a commitment to better preparing nursing graduates to work with Indigenous peoples by embedding Indigenous health curricula into undergraduate nursing education. Since 2009, the inclusion of Indigenous health curricula within undergraduate nursing education became a discipline regulation requirement, and a strategic priority for the university sector. Standardising Indigenous health curricula within undergraduate nursing education should be celebrated, especially given that numerous Indigenous nurses have advocated for this for years. However, the history of the Australian nursing discipline as implementers of discriminatory government policies that harmed Indigenous peoples, suggests that caution should be exercised.

This thesis engages Indigenist research approaches to critically explore the experiences of Indigenous and non-Indigenous academics tasked with developing and delivering Indigenous health curricula. Deep listening complemented unstructured research yarning with 12 academics from three Schools of Nursing in Queensland, NSW, and South Australia conducted in 2019 and 2020. Data was analysed through an iterative assemblage process that engaged the participants' responses, the literature, other sources, and the theoretical framework.

This thesis produced three conceptual ideas. The first is the notion of never turning off, which highlights the problematic dominance of neocolonial and neoliberal logics of the institutions of the nursing discipline, Schools of Nursing, and universities, that bestows significant expectations upon academics to teach Indigenous health and to also address any associated inconsistencies that exist with the expectations of Indigenous peoples' communities.

The second thread elaborates on the operations of white possession of Indigenous health education by these institutions, as manifested in standardised frameworks that were intended

to support academics develop and deliver quality and safe Indigenous health education, but instead are weaponised against academics to enhance efficiencies. Such political, social, and material conditions nurture individual and institutional performative benevolence, that reproduce white supremacy.

The final idea is the strength and protection Indigenous and non-Indigenous academics draw from relational engagements with Indigenous peoples; a relational connection that aligns with Indigenous peoples' ways of knowing, being and doing relationality. A proposed relational pedagogy requires a shift for the institutions of the nursing discipline, Schools of Nursing, and universities, to share power with Indigenous peoples (staff, students, and other community members), and to commit to an ethic of incommensurability to address the complexity of ingrained institutional racism.

Cultural Safety provides a theoretical and epistemological framework to understanding how institutions of the nursing discipline, Schools of Nursing, and universities could strategise towards shifting/relinquishing power to Indigenous peoples, and actively resist investment in reproducing colonial power relations. This must be unsettling work, which is required to being of better service to Indigenous peoples, contributing to our intellectual and political sovereignty, on our terms.

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List of Abbreviations

ACCHO	Aboriginal Community Controlled Organisation
AIATSIS	Australian Institute of Aboriginal and Torres Strait Islander Studies
AIWST	Australian Indigenous Women's Standpoint Theory
ANMAC	Australian Nursing and Midwifery Accreditation Council
AMS	Aboriginal Medical Service
CATSINaM	Congress of Aboriginal and Torres Strait Islander Nurses and Midwives
HREC	Queensland University of Technology, Human Research Ethics Committee
HWA	Health Workforce Australia
IEU	Indigenous Education Unit
INEWG	Indigenous Nursing Education Working Group
LINMEN	Leaders in Nursing and Midwifery Education Network
NHMRC	National Health and Medical Research Council
NMBA	Nursing and Midwifery Board of Australia
PMS	Prison Medical Service
OATSISJC	Office of the Aboriginal and Torres Strait Islander Social Justice Commission
RCIADIC	Royal Commission into Aboriginal Deaths in Custody
PNG	Papua New Guinea
SON	Schools of Nursing
	School of Nursing and Midwifery
	College of Nursing

Acknowledgements

I respectfully acknowledge the sovereign First Nations peoples whose territories I have lived and studied on during the completion of this thesis. The *Yuggera*, and *Turrbal* peoples of *Meanjin*, and the *Ngunnawal* and *Ngambri* peoples of Canberra. I have been an uninvited guest on your unceded territories, and I am grateful for your hospitality. I respectfully acknowledge my own peoples, namely the *Meriam* and *Erubam Le of Zenadh Kes*, the *Wuthathi* of Cape York Peninsula. Being a good relation to traditional owners, to my kin, and respective Countries has been important to my thinking and writing about relationality and emplaced knowledge.

My family, who has grounded me while I complete this thesis, is my connection to our ways of knowing, being and doing. My grandparents, especially my Grandpop and Grandma, who both passed during the completion of this thesis, my Mum Laura and Dad Paul, and my siblings and our children have and continue to teach me of my relational obligation to my family and community.

The completion of my thesis could not have been possible without the thoughtful guidance of my supervision team, Dr Leonie Cox (Principal Supervisor), and Professor Mark Brough (Associate Supervisor). Your friendship, mentorship, and your unwavering support has been fundamental.

This research was supported by a QUT Indigenous Postgraduate Research Award scholarship. The support and challenges I have experienced at QUT, within the School of Nursing, Faculty of Health, and broader university, as an academic and student, has been influential to my thinking and writing for this thesis.

A community of thinkers, critical and caring, has also been essential. I wish to acknowledge a few critical friends, colleagues, and mentors: Professor Chelsea Watego, Associate Professor Lisa Whop, Dr Raglan Maddox, Dr Melinda Mann, Dr David Singh, Dr

Bryan Mukandi, Amy McQuire, Hayley McQuire, Anna Carlson, Cai Fong, Nayuka Gorrie, Helena Kajlich, Jamal Nabulsi, Janet Stajic, Kevin Yow Yeh, Natasha Lee, Luke Pearson, Anton Schirripa, Sissy Tyson, Sonya Egert, and Trudie Broderick.

Professional Editor, James Buckley, provided copyediting and proofreading services, according to the guidelines laid out in the university-endorsed national ‘guidelines for editing research theses’.

Finally, thank you to my partner Richie, for your unconditional love, support, and occasional proofreading.

Chapter 1: Introduction

‘Why are my Elders not named on the front cover as co-authors?’ (Drummond, 2021)

In December 2021 a book on Indigenous¹ knowledges of astronomy, that included *Meriam* knowledge, was published, and promoted on Twitter. I recognised the front cover immediately, as it glowed gold and red in the artistic style of my maternal Grandad’s younger cousin and *Meriam* Elder, Grandad Segar Passi, who is known for his vivid illustrations of *Meriam* seasons, as expressed by his depiction of our skies. The lead author, a white academic, was named on the front cover, the other co-authors, the majority being *Meriam* Elders, including an uncle and two younger cousins of my maternal Grandad, were acknowledged as “with Elders and Knowledge Holders”. My tweet response, in the epigraph above, was sent to the handle promoting the book (Appendix A).

This situation made me return to an IndigenousX article I co-wrote in 2019, “The Blackfulla Test”, which outlined the eleven “most common violations found in Indigenous research grants or publications”, which aimed to clarify how certain grant applications and publications should be critiqued, and why some should be rejected (Whop, 2019, para. 5). One common violation is the publications that “acknowledges the advisory role that Indigenous peoples have played” which reduces Indigenous peoples’ contribution to a role of advisory, as opposed to one of authority (Whop, 2019, para. 5: 15). In the example of the astronomy text, the Elders and Knowledge Holders were given the title of co-authors and not advisors or mentors, however, their contribution was not valuable enough for them to be named on the front cover. In fact, according to the response I received on Twitter, the risk of naming them properly to the aesthetic value of the publication was too significant; to which I responded with

¹ In this thesis I respectfully use the collective term ‘Indigenous peoples’, deliberately pluralised to acknowledge the many Aboriginal and *Zenadh Kes* nations of Australia. Where appropriate I will only refer to Aboriginal people or *Zenadh Kes* Islanders, or specific language group or tribal names.

the obvious statement, that this “book that only exists because of Elders’ knowledges” (Drummond, 2021). Last time I checked, there was only one other similar protest, and she was advised that the Elders are named in the inside cover, demonstrating a firm belief that this matter is only an editorial issue.

For me, this situation seemed a reproduction of the type of colonisations exercised by Alfred Haddon², and many other white anthropologists since the British invasion and colonisation of the region, who have extracted knowledge from *Zenadh Kes* peoples to become the knower, the experts in *Zenadh Kes* peoples and our ways of knowing, being and doing. Curators and commentators, these white scientists demonstrate their status as knowers by objectifying us. Historically, we were categorised as sub-humans, as noble savages needing explanation to the white public (Nakata, 2007); the astronomy text example suggests that some white academics continue to confuse our willingness to work in partnership, as permission to reproduce colonial power relations. In reproducing more palatable ways to colonise, contemporary academics, as agents of white discipline and university systems³, are susceptible to falling short of respectful power-sharing with Indigenous peoples. It is through sharing power, that white institutions and subsequently their agents relinquish their power⁴, thus

² Professor Sir Alfred Haddon was a zoologist when he first visited *Zenadh Kes* in 1887, returning as a budding anthropologist in 1897 leading the Cambridge Expedition of the Torres Straits. Their aim was to capture the culture and traditions of Torres Strait Islanders before it was consumed by British colonisation. Coincidentally, this was the same year the *Aboriginal Protection and Restriction on the Sale of Opium Act 1897* (Qld) was passed in Queensland, which clarified and legalised the Queensland government’s mechanisms of control over Aboriginal peoples; this Act was extended to formally include the control of Torres Strait Islanders following the 1903 amendments to the Act (Nakata, 2007).

³ ‘White disciplines and university systems’ refers to the white Anglo-Saxon foundations and traditions of these institutions in Australia; their insistence of maintaining the ‘purity’ and ‘integrity’ of their institutions, free from the influence of non-white ‘other’ people (including Indigenous peoples), evident in the support for and influence of the White Australian Policy (the *Immigration Act 1901* [Cth]), and the numerous segregation and assimilation policies of Australia. These systems remain loyal to white Anglo-Saxon ‘Australian’ ways of knowing, being, and doing, discursively perpetuating white superiority and Indigenous inferiority (Moreton-Robinson, 2015).

⁴ Moreton-Robinson’s (2020, p. 186) critique of white women feminists included the following statement in her closing words: “If Indigenous women’s interests are to be accorded some priority, white feminists will need to relinquish some power.” This position resonates with the example I have shared, and in my view, generally holds true.

forging partnerships which may better work for Indigenous peoples (Moreton-Robinson, 2020).

Furthermore, the knowledge gifted by the *Meriam* Elders to an astronomy text, is knowledge that I may have missed out on, because I have lived away from Country and Kin for over 15-years. I emphasise that I ‘may’ have missed out, as this knowledge may or may not have been knowledge that I would have been privy to, due to the relational nature of Indigenous knowledges, where one’s positioning within the family and community can determine what you are taught (Moreton-Robinson, 2017). However, the publication of such knowledges diminishes relational regulation of Indigenous knowledges. So, now I can access this knowledge without relational obligations, which feels very white.

The commentary in response to the promotional tweet about the astronomy text reveals how this knowledge is now available to everyone, free of relational obligations. There were multiple responses praising the named author for making this knowledge widely accessible; praise which coincidentally contradicted and silenced my concerns, despite me being a sovereign *Meriam le*. There were also academics from Turtle Island (specifically the United States of America) who tagged their fellow academics in their comments, which led to discussions about them including this astronomy text in their respective undergraduate/postgraduate curriculum content. The promptness with which Indigenous knowledge extraction can now be shared and exploited globally is historically unparalleled. Reflecting on the lack of relational obligations, I wondered if these academics from Turtle Island even knew about the location Mer.

I reflected too on whether I should share this experience publicly, as I do not want my objections and questions to be read as disrespect towards my Elders. On the contrary, I hold the utmost respect for them, and worry about getting in trouble for my disrespectful tweets at the named author, who I called a “curator and commentator” (Drummond, 2021). I don’t know

of the relational connection that they have developed with the named author or their expectations of him and this publication. Another risk for extracting knowledge beyond its knowledge holders, is that the extraction also compromises relational connection with the broader community of the knowledge holders. How do I relate to this knowledge now? How does it relate to me? Can I even claim this knowledge? My final Tweet comment goes unanswered, which suggests no protocols are in place that would require the named author to respond sufficiently to a sovereign *Meriam Le* who should have relational connection to the knowledge he has published.

I reflected on the exercise of white possessive logics (Moreton-Robinson, 2015) in this situation, namely the commodifying of my peoples' knowledges into a consumable package, sold for economic and academic gain, under the guise of celebrating Indigenous intellectualism. How do we ensure we are the primary beneficiary from our knowledges that we choose to share? How do we guarantee that any shared knowledge maintains its relational connection to us, so that we can continue to tend to them, our way? Our knowledges lose value, to us at least, without a relational connection to us (Nakata, 2007), but seemingly knowledge and relations take on new value and meaning for the extractors and their customers. How do we regulate who does and doesn't get to 'know' certain knowledge, because they have proven themselves to be a bad relation?

Such thoughts about Indigenous knowledges are not new for me, although this incident has brought the thinking home, literally. These contemplations have been part of the inquiry and thinking for this thesis which interrogates how Schools of Nursing (SON) can avoid reproducing colonial dominance in the context of developing and delivering Indigenous health curriculum. Indigenous health curriculum is embedded within undergraduate nursing education accreditation requirements, as a stand-alone unit, and as content scaffolded through the undergraduate nursing program (Australian Nursing and Midwifery Council [ANMAC],

2019). SON must also demonstrate that Indigenous people/s have been engaged as member/s the governance group that oversee the nursing curriculum (ANMAC, 2019). While these initiatives should be celebrated as an outcome of years of lobbying and advocacy by Indigenous peoples, namely Indigenous nurses, and midwives, my assessment is that the work is not yet complete. I propose that ANMAC's endorsement of embedding Indigenous health curriculum in nursing accreditation standards, without it being conditional on the discipline's accountability to Indigenous peoples on our terms (that is, not just agreed to by one person on a curriculum advisory committee), unnecessarily hands over more power to the nursing discipline to determine what is best for Indigenous peoples.

Currently, ultimate control over what is taught and how it is taught rests with the nursing discipline, including the terms of Indigenous peoples' engagement, and the use of Indigenous knowledges and perspectives that are shared by Indigenous peoples. Indigenous peoples' perspectives, often included in Indigenous health curriculum as stories and anecdotes, can help to contextualise the historical and statistical information, and 'prove' the disadvantage experienced by Indigenous peoples (Kickett et al., 2014). However, extractive practices highlight the vulnerability of Indigenous peoples' perspectives once they are shared. It appears that as Indigenous peoples we must relinquish our right to regulate our knowledges and perspectives on our terms, should we wish to benefit from challenging stereotypes about our apparent unintelligence. We must perform to the fanfare that is made, however trivial, when our intellect is seen as valuable. This is the price we are required to pay to potentially benefit from the global knowledge economy.

Indigenous and non-Indigenous nurse academics charged with developing and delivering Indigenous health curriculum are socially positioned at the intersection of these interests and aspirations. This thesis explores the social positions they occupy, and their practices of compliance with and resistance against institutional (SON, universities, and the nursing

discipline) demands regarding Indigenous health curriculum. The analysis provides insights into the preparedness and interests of these institutions to work in this space in considering a redistribution of power that would enable these institutions to better serve Indigenous peoples.

This doctoral program has taken me over six years to complete, mostly part-time. I worked as an academic in a SON, active in developing and delivering Indigenous health curriculum for undergraduate and postgraduate programs. In the context of my PhD research immersion, I articulate the tensions of this particular cultural interface (as per Nakata, 2007), where my embodied knowledge is my compass and protection from the perpetual colonial project and acts as a guide for regulating my practice and knowledge and my use of other Indigenous peoples' perspectives that lack the relational regulation they once had (Drummond, 2020).

The remainder of this introduction chapter discusses my theoretical orientation and social positioning as a Black man, a Black 'male nurse', as a 'native' academic and an Indigenist researcher (section [1.1](#)). I then outline the purpose of my research, which includes my research problem, research questions and aims (section [1.2](#)).

1.1 Social Positionings

Moreton-Robinson's (2013) Australian Indigenous Women's Standpoint Theory (AIWST) provides the framing for this discussion on my social positionings. AIWST values and wields the knowledges and lived experiences of Indigenous women to problematise the taken-for-granted norms and accepted social conventions of the multiple communities in which they live. The lived experiences of Indigenous women reflect the "intersecting oppressions produced under social, political, historical, and material conditions that [they] share consciously and unconsciously" (Moreton-Robinson, 2013, p. 332). Complicating the shared experiences are the cultural differences between women and the realising of "compliance and

resistance” within varied contexts “as Indigenous sovereign female subjects” (Moreton-Robinson, 2013, p. 332). While AIWST was obviously theorised for Indigenous women, I find myself constantly returning to Moreton-Robinson’s teachings on the value of the lived experience of the sovereign female subject, her framing of the conditions of the social positions Indigenous women are allocated, and the notion of compliance and resistance.

These teachings have been invaluable for my experience in co-creating knowledge with Indigenous women academics in the research yarns and analysing the respective research yarning transcripts. These teachings encouraged me to value my own lived experience and my embodied knowledge, and to be better at wielding both to support my work. They made me more conscious of my social positionings, the forms of oppression I share with others and those that I don’t (including gender inequity). Importantly, they taught me to be more accountable to myself regarding my compliance and resistance in my daily life, specifically regarding my relational contribution to the needs of my own people, to the needs of the Indigenous peoples whose land I live on, and the needs of the broader Indigenous community. I have found AIWST to be a guide for being a better relation to Indigenous women, and to others.

Given the pivotal role Moreton-Robinson’s teachings from her theorising on AIWST has played for me becoming an Indigenous sovereign male subject, it became impossible not to write it into my theoretical framework. However, I exercised caution with not taking what is not mine to take⁵, as this was designed for Indigenous women, to visibilise their intellectual and political sovereignty, that is so often dismissed, or weaponised to empower others against them. Black women have theorised about the invisibility that is imposed upon them in civil rights/antiracist and feminist movements; their erasure is despite their intersectional social positioning as the most disadvantaged within these assumed separated “single categorical axis

⁵ Malo, the ancient God of *Meriam le* (Murray Island people) established laws for my people to follow. One of them is not to take what is not yours. I do not have permission to articulate this law here.

of race and gender, and despite them being the most learned in the operations of multiple forms of oppressions that they navigate on a daily basis” (Crenshaw, 1989, p. 140; Huggins, 1998; Moreton-Robinson, 2020). Crenshaw’s (1989, p. 150) theorising of intersectionality privileges the experience of Black women because of ways that the “unique compoundedness of their situation” is exacerbated by the racism of white feminists, and the misogyny of civil rights movement. I remain unsettled about reproducing the latter. Just because AIWST is published, it doesn’t mean anyone can take it; reflecting the dilemma I discussed earlier regarding the access to *Meriam* astronomy knowledge.

This dilemma led me to reflect on my experiences learning from Indigenous women, particularly those in my family and community. Even professionally, I have been privileged to be nurtured relationally and intellectually by the women that I have mentioned in the acknowledgments in this thesis. Thus, my resolution to the dilemma of using Moreton-Robinson’s AIWST, is to be transparent as possible regarding how it has informed my thesis. This practice enables accountability by ‘showing my workings’ and being open to critique and correction.

The social and local political conditions of my childhood and young adulthood involve leadership by sovereign Indigenous women. I spent a great deal of time learning at the feet and on the lap of my grandmothers⁶, engaging with the lessons embedded in their stories and

⁶ *Zenadh Kes* ways of knowing, being and doing regarding families do not reflect white Australian understanding of family. There is also diversity in the *Zenadh Kes* between language groups. According to *Meriam* ways of knowing, being and doing, my siblings and the cousins of the same generations are brother and sister (respectively *kimiar berbet* and *neur berbet* in *Meriam Mir*, but I often use *bala* and *sisi* which is *Zenadh Kes* Creole), my mother’s sister and cousin sisters are my mothers too (*Apu* in *Meriam Mir*, but I often use Aunty or Mum as a prefix to their name, or *Ama* or Mumma as a suffix to their name), her brothers and cousin brothers are my uncles (*Nunei* in *Meriam Mir*, but I often *Awa* or Uncle as a prefix to their name). My grandparents include my maternal and paternal grandparents, their siblings, and their cousins (*Ata* in *Meriam Mir*, but this is more a personal choice for the grandparent now, e.g., my maternal grandparents are my Grandad and Grandma). My father’s family are *Wuthathi*, not *Meriam*. I did not learn *Wuthathi* language growing up, so I just call his brother, sisters (and cousins of the same generation) Uncle and Aunty respectively.

receiving the occasional *grauling*⁷ for not paying attention. The grandmothers who taught me to dance *kabkar*⁸ and *taibobo*⁹ emphasised the importance of adhering to protocol when it came to our knowledges and ways of knowing as embedded and expressed through our dances, the former being our most sacred. Some knowledge, even words are known to be imbued with sacredness and learners are often warned off using such knowledge carelessly or disrespectfully (e.g., Malo's laws). My mother, now the matriarch of our family, has been my life-long teacher about our ways of knowing, being and doing, and about the history of our family and community. She is less of a disciplinarian now, but her stern nature can still be heard through the phone or her text message. My other mothers, aunties and sisters are many, and as they were often my preferred company as a child and young adult, I have learnt a great deal from them, from games, to cooking, to caring. Included in the knowledges shared by all the women in my family are lessons about the gendered differences in lived experiences within my family and community, implicit in the nature of their relational positions. I share this background, not to claim being an expert on their lived experiences or that of other Indigenous women, but to acknowledge the gendered differences that often prejudice Indigenous women, and that learnings I received from the Indigenous women within my family and community have and continue to shape my understanding on how to be a better relation within intersectional disempowering conditions outside of and as well as inside my community and family.

Thus, I wove Moreton-Robinson's (2013) AIWST into my theoretical framework with the intention of learning from it, being sensitive to how people are racialised and gendered differently, as well as how we are allocated positions within other intersectional categories like ability and class and treated by institutions and their agents accordingly. The use of AIWST

⁷ *Zenadh Kes* creole word that means to 'get a stern talking to' (Watkin, 2009, p. 146).

⁸ Sacred dances of the Easter Islands of *Zenadh Kes*.

⁹ Dances from Rotuma, passed down from our ancestors who were Blackbirded. It means 'war cry'.

also requires an accountability from me, to be aware of my experience in the Australian colony as an Indigenous man, including gendered privileges that I enjoy. AIWST provides a framework to define my social positionings, which is a crucial step in finding myself as the subject/knower of my thesis.

In the following sections I commence my engagement with assemblage as the method of analysis in my thesis, to highlight some of the historical, social, political, and material conditions of my social positionings, at least the ones that I am conscious of, as a Black man, a Black ‘male nurse’, a ‘native’ academic, and Indigenist researcher. I describe these positions separately, but they are of course interrelated, reflecting the intersectional dynamics of my lived experience. I describe the tensions I experience in each of these social positions, which are attributable to the multiple intersecting, sometimes contradictory accountabilities that I inherit with these social positions. These accounts include relational roles and responsibilities to family and community, as well as professional and legal obligations to the multiple institutions of nursing, health, and education that I engage with as an employee or a member of them.

1.1.1 Black man

As is often the case, Indigenous PhD candidates and researchers start their thesis or articles by locating themselves relationally. Locating oneself is protocol when walking on Country, announcing to spirits and ancestors of the place who you are, your purpose, and who you may have brought with you (Martin, 2003; Geia et al., 2013). In the context of published work, locating oneself enables the reader to locate you within their relational network (Watson, 2014; Harvey, 2020; Drummond, 2020). One’s position within the family and community, or “social relations”, entails roles and responsibilities (thus knowledge) that one acquires (Moreton-Robinson, 2017, p. 72); such matters are what relationally connected readers interrogate as part of engaging with the content. Moreton-Robinson (2017, pp. 71-72) asserts

that for Indigenous peoples' relationality "shapes [our] ways of knowing, being and doing; to be connected is to know and knowing is embodied in and connected to country". So, in locating ourselves we are fulfilling our relational protocol. However, for people who are not relationally connected, this practice can seem merely performative, at best a demonstration of accurately applying the principles of the chosen methodology.

Here, I aim to locate myself sufficiently to meet the requirements of my chosen methodology and to honour my relational and intellectual accountabilities. These include those who I belong to (i.e., my family, community, and country), those whose work I engaged with to 'straighten'¹⁰ my thinking and discussion (reflecting the relational ethics proposed by Tynan, 2020), and those I have engaged in the development of this work (that is, the research participants). This practice goes beyond just performing a self-location. Balancing these expectations reflects the tensions that this thesis interrogates.

This work grapples with nursing regulation of Indigenous perspectives, shared by Indigenous peoples, with the hope of improving our life chances. The assumption is that by sharing more of our knowledges and perspectives, nurses will learn to work with us better in addressing our health needs. However, this assumption is intentionally ahistorical, dismissing decades of failed government policies that declared similar intentions, and excusing decades of ignorance from the nursing discipline (see [Chapter 2](#)). This assumption ignores the complexity and sophistication of Indigenous peoples' knowledges, that does not easily translate into Western knowledge and ways of knowing, let alone, fit neatly into a 13-week semester, academic timetables, online learning modules, or assessment marking rubrics. This assumption

¹⁰ Referencing the *Zenadh Kes* proverb: "A child is like a bamboo, you have to straighten it while it is young. Once it gets too old, the bamboo becomes too hard to straighten" (Drummond, 2020, p. 130). Straightening refers to educating and support the *prapa* (proper *Zenadh Kes* Creole [Watkin, 2009, p. 35]) way, according to our ways of knowing, being, and doing. In the context of this thesis, being straightened has required me to interrogate the commonalities and difference in ways of knowing, being and doing that underpins the scholarship that I have engaged with. Being a good relation means always aspiring towards doing things the *prapa* way.

also dismisses Indigenous peoples' intellectual sovereignty, specifically our accountability to maintaining the integrity of our knowledges. As discussed earlier, we continue to practice regulation of our knowledges, our ways, which presents a challenge for Indigenous academics who are expected to enable access to Indigenous peoples and their knowledges and perspectives (including the Indigenous academic's own) to benefit their discipline (Nakata, 2007; Andersen, 2016; Drummond, 2020) and their employer, and to satisfy the demands of white capitalist systems, specifically success in the global knowledge economy.

So, before I share knowledge of my self-location, as mooted in the title of the thesis, I invite readers to consider what it means to be a good relation when engaging with Indigenous peoples' and their knowledges and perspectives, and how the reader balances the expectations of being a good relation to Indigenous peoples with the expectations of their institutions. *Prapa*¹¹ way privileges responsibility to knowledge shared and knowledge holders, which overrides individual entitlement to access and use our knowledges and perspectives. My relational connections expand beyond what I present here, but as I have stated previously, 'those who need to know my connections know' (Drummond, 2019, para. 3).

My name is Ali Jimmy Drummond. I was named after grandfathers: My paternal Grandpop, *Wuthathi* man Mohammed Ali Drummond, and my maternal great-great Grandfather, *Dauareb* man, Jimmy Wailu. Drummond is a surname imposed onto my great-great grandfather¹² from the Scottish missionary who was sent to save the souls of the people of his village in Sarawak.¹³ I elaborate on my name, as names are often important sources of family history, they embed knowledge of history and points of relational connections for the benefit of the name holder and their relations.

¹¹ Meaning proper in *Zenadh Kes* Creole (Watkin, 2009, p. 35).

¹² It was not common for people in Southeast Asia to have surnames at the time.

¹³ The Missionary was obviously unsuccessful as my great-great Grandfather was a Muslim.

I belong to the *Dauareb* and *Komet* tribe of the *Meriam* nation, and the *Samsep* tribe of the *Erub* nation. I am a member of the *Wuthathi* native title group and know of connections to the *Badjala* of *K'gari*. My ancestors also connect me to Parem Village of Papua New Guinea (PNG), Rotuma (Fiji), Aru Islands (Indonesia), Philippines, and as mentioned before Sarawak (Malaysia).

I was intentional in how I described my relatedness to the different peoples and countries that I have relational connection to. I belong to the *Meriam* and *Erub* nations because this is where I am grounded ontologically. I was raised by my mother's family and community, have been and continue to be taught our ways of knowing, being, and doing, and have inherited the rights, roles, and responsibilities that is appropriate for me, according to my social positioning within our relational network.

My connection to *Wuthathi* Kin and Country is comparatively shallow. While I have flown over our Country many times, I am yet to physically be on Country. A recent successful native title agreement with the Queensland government was achieved following the completion of 99-year leases on a portion of *Wuthathi* peoples' Country. This agreement reflects how long we were legally prohibited from being on and engaging with most of our Country. Our current engagement with Country, however, will continue to be conditional, but this time according to the details of the native title agreement, which includes the establishment of National Parks. Ceremonies on Country are due to recommence soon.

I know of my connection to the *Badjala* people of *K'gari* and the Parem people of PNG through the stories of my maternal Grandma and conversations with my mothers. I reference them as relational connections respectfully, so as not to claim to be a knower of these Countries and ways of knowing, being, and doing. The relational reconnection with *Badjala* Kin and Country is a family matter that one of my mothers is leading. The relational connection with

Parem people is often referenced when engaging with other *Erubam* families with shared ancestors. I have heard grandparents, uncles and mothers saying things like, “we are from the same branch”, referencing the branch of a larger family tree that extends back generations connecting the *Zenadh Kes* Islands with Kin from PNG.

As an adult I learnt about my relational connection to Rotuma. Our ancestors were tricked onto a boat and brought to Queensland for cheap labour/slavery (known as Blackbirding). Many were sent back as part of the White Australian policy era; this included some families who my mother has since reconnected with in Fiji. The Rotuman ancestors who stayed taught their children songs and dances, which are still passed down today.

We have lost our relational connections to kin in Indonesia, Philippines, and Malaysia. My ancestors travelled to *Zenadh Kes* from these places to work as fishermen and pearl divers, to support the economic development of the Australian colony. They never returned to their homelands, despite the racial violence against them of the White Policy era.

This recital of family history reveals a diversity that reflects many families of *Zenadh Kes*. It tells of the various ways in which colonisation exercised by European empires of the Dutch, Portuguese, Spanish and British led to my ancestors being dispossessed and controlled by agents of respective crowns, governments, and commercial interests. It tells of how my ancestors have been punished for speaking their language and practicing their normal lives, including religion and spirituality (even today it is referred to as ‘traditional lifestyle’ which perpetuates the belief in our ways of life being sub-human/standard and frozen in time). It tells of how some of my ancestors were recruited and tricked into working in Queensland for a lower salary (sometimes none) than white English and Australian people. However, it also reminds me of the ways in which they found each other, had families and friends who shared,

loved, and cared, creating legacies of resilience and strength, despite the dehumanisation, the control and attempts of genocide.

As the oldest boy in patriarchal societies (of *Meriam*, *Zenadh Kes* and Australia) I inherit certain roles, responsibilities, as well as social and material capital with this social position. I am always well-cared for (sometimes fussed over) by my grandmothers, mothers, aunties, and sisters. I am expected to represent my family for certain things, which may include attending and participating in ceremonies. I have been privileged with being entrusted with certain knowledges.

As a Black man, who could be described as ‘cosmetically apparent’ (Huggins, 1998, p. 25), being racialised is a daily experience, with negative and positive consequences that vary in their impact on my well-being. People often avoid sitting next to me on a crowded bus (pre-COVID-19), I get followed in shops and hyper-monitored at self-check-outs, I am assumed to be the token Indigenous recruit, the student nurse and not the academic in the university context, I am fetishised by those who want to run their fingers through my curly black hair (some just do it without asking), I am sexualised, I am assumed to be good at sports and rapping, but otherwise I am consistently underestimated. It is exhausting; however, this is the expectation and experience of many Black men like me in contemporary Australia. But I have come to enjoy having two seats on the bus, of always having someone nearby at the shops to help locate an item and to assist me should I stuff up during self-check-out, I have taken advantage of targeted scholarships, cadetships, and employment schemes that I am interested in, which enables me to disrupt white-dominated spaces of health services, academia, boards, committees and working groups. Those who fetishise and sexualise Black men are often keen to support this disruption as well, if only to get noticed. I am also immediately identifiable by other Indigenous peoples, and we sometimes share a nod or a look, a moment that acknowledges our lives in yet “another day in the colony” (Watego, 2021).

1.1.2 Black 'male nurse'

I was one of the three inaugural nursing graduates for James Cook University's *Weibene* (Thursday Island) campus in 2005, and I became the inaugural recipient of the Sally Goold Prize¹⁴ at my graduation. My nursing career has since spanned clinical nursing, Indigenous health and nursing policy, health service administration, teaching VET and tertiary health and nursing programs, as well as research. I have worked in very remote, regional, and urban Australia, and have travelled the world as a nurse researcher and an envoy for the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM) to meet with the CEO of the International Council of Nurses in 2017. My success in the discipline is not just a result of personal skills, knowledge, and attributes, but is also due to how I am read, as a Black man in nursing.

Men make up approximately 14% of Australia's total nursing workforce (NMBA, 2021, p. 14); Indigenous men are a smaller minority, making up 10.4% of Australia's total Indigenous nursing and midwifery workforce (Commonwealth of Australia, 2019, p. 2). These figures may reflect the impact of the historical perspective of nursing as a female profession which limit the number of men pursuing a career as a nurse. The commonly used term of 'male nurse' for men in nursing, further consolidates the perception that to be a nurse is to be a woman. These dynamics perpetuate gender and sexuality stereotypes, i.e., men in nursing are seen as 'muscles' to help with heavy workloads and are assumed to be homosexuals (Sasa, 2019; Stanley et al., 2014). These stereotypes may be why men in nursing aspire for senior nursing positions, as powerful positions within the discipline become the logical social position that reproduces the male hegemonic masculinity within a traditionally female discipline (Kluczynska, 2016). In fact men are more likely than their female colleagues to work in

¹⁴ The Sally Goold Prize is JCU College of Nursing Science prize that is "awarded to the graduating Indigenous student who has the highest overall GPA in the Bachelor of Nursing Science" program for that cohort of graduates (James Cook University, n.d. para, 1).

‘higher-status nursing specialties’ (Smith et al., 2021, p. 2485) like Critical Care and Emergency Care, and occupy senior nursing positions, and thus earn a greater salary (Smith et al., 2021; Stanley et al., 2014). This situation demonstrates the pervasiveness of the patriarchal domination within the nursing discipline, which has historically established the gender segregation and thus gender-norms of the nursing discipline, and continues to influence the gender power dynamics within the profession (Smith et al., 2021).

As a Black ‘male nurse’, the manifestations of racism I endure has negative and positive implications in nursing, as in life. My personal experience includes enduring overt and covert racism from nurses such as questioning my qualifications, despite it being displayed on my registered nurse badge and the prior confirmation of nurse managers. Communication about scope of practice is an imperative to safe and quality care (NMBA, 2020), however such communications were sometimes hostile, and other times would not occur at all as the other nurse had already decided on my incompetence¹⁵. As a graduate nurse I thought I had to work hard at being better, to outperform¹⁶ and win the approval of my colleagues. This aspiration has followed me through my nursing career, as did the questions from ‘colleagues’ about my knowledge, skills, and attributes, and the hyper-surveillance of my work. Some days the racism I experience succeeds in convincing me that I don’t belong in the discipline.

¹⁵ I recall the first-time reading *Goenpul* women (of the Quandamooka people) Professor Aileen Moreton-Robinson’s (2015) account and analysis of Leesa’s (an Aboriginal woman and registered nurse) experience of racism in multiple wards and departments in the Townsville Health Service District and feeling seen. Some of the accounts of interpersonal and institutional racism that Leesa endured were familiar; some were visceral inducing memories of my own experiences and feeling the hate of my own perpetrators and my shame. Moreton-Robinson’s (2015) theorising of the manifestations of white possessive logic in these moments has been influential to my thinking of the nursing discipline and its racialisation of Indigenous peoples.

¹⁶ Resonating with how *Munanjahli* and South Sea Islander woman, Professor Chelsea Watego (2021, p. 116), describes how her and her siblings “grew up with the idea that racism was something we could withstand and outperform. We’d have to put our bodies on the line, but our revenge was to be in our excellence, never transcending, just chasing those blue-sky moments.” I remember having several blue-sky moments, but I don’t recall the details. Haunting my memory though are those moments where I couldn’t or didn’t outperform. Such is the long-term effect of this manifestation of racism.

One positive of being a Black ‘male nurse’ is that I occupy a niche position at a time when institutions are keen to increase the number of men and Indigenous peoples across the nursing workforce. This situation has created many career and professional development opportunities, while simultaneously, requiring me to perform as the Black ‘male nurse’. The ebb and flow between negative and positive experiences, and importantly my operations of personal agency in these situations reflect Moreton-Robinson (2013) description of the individual exercise of resistance and compliance from the social positions where we have been located in some contexts.

1.1.3 ‘Native’ academic

As an academic I am often allocated the Indigenous health unit in the undergraduate nursing programs, a role I initially refused as to avoid being pigeon-holed. I also didn’t want to be seen as just the generic Indigenous nurse, nor did I want my colleagues to expect me to do all the work related to Indigenous matters. However, I soon learnt about the need for Indigenous leadership in the development and delivery of the Indigenous health curriculum, supported by skilled and knowledgeable non-Indigenous colleagues.

At the 2019 CATSINaM conference the keynote, Māori Professor of medicine, Papaarangi Reid, conceptualised curriculum as a garden, and highlighted the “small spot at the back [of the garden] close to the compost... the only place where there’s natives¹⁷ in the garden” – the Indigenous health curriculum and the Indigenous academic (CATSINaM, 2019, 2:52). She reminded conference delegates, mostly Indigenous nurses, and midwives, that the small spot at the back of the garden “is precious, because the rest of the garden teaches the status quo, and the status quo teaches inequity... [that is] measured and felt by Indigenous

¹⁷ Native in this context, references the derogatory history of the term imposed upon Indigenous peoples, as subhuman, and closer to nature than other humans. It is used here, I believe, to reclaim the significance of being in relation with non-human entities, and to assert that our relations with our non-human Kin does not equate to our inferiority to other humans, nor does it permit white Western knowing of hierarchy of being and of humans.

bodies” (CATSINaM, 2019, 3:36). Professor Reid warned that choosing to be the “decorative or performative part of the garden” is also the status quo of inequity and injustice for Indigenous peoples (CATSINaM, 2019, 2:10).

The limitations and invasiveness of status quo is evident. It shows up in how some nursing academic colleagues assume that they can apply the same techniques and knowledge used in other parts of the curriculum in the Indigenous health unit/subject. I see it in how they often refuse to accept direction from the dedicated few experienced in Indigenous health curriculum. I notice it in how they opt to use any critique or constructive feedback directed to them as a reason to avoid teaching the Indigenous health curriculum. These examples are based on personal experience and reflect the disruption that is caused by the Indigenous health curriculum when it chooses not to be decorative or performative.

Accreditation requirements now insist on having a dedicated native spot in the garden, but very few are able and willing to tend to it. Professor Reid encouraged the Indigenous academics in the audience to take up space and reclaim sovereignty through the work of developing and delivering Indigenous health curriculum, and to push back against the “colonial ideologies and assumptions of white superiority” present in universities and our disciplines (CATSINaM, 2019, 3:23).

As the only Indigenous academic in a SON (the only native in the garden), this can be quite lonely work, despite the camaraderie of the dedicated few. This feeling is associated with the tension of this particular cultural interface. As an Indigenous person, I embody the tensions, the incommensurability, and contradictions of teaching about caring for Indigenous peoples, while unresolved issues of sovereignty and persistent racialisation continue to harm Indigenous peoples, including my family and community. The tensions also include the contradiction of teaching about anti-racism and decolonising within a colonial institution that can be harmful

for me and other Indigenous staff, students, and non-Indigenous accomplices. I also embody tensions associated with responding to expectations from the university and discipline to teach Indigenous ways of knowing, being and doing in their white domains that insists on distance from appropriate relational connection and short allocated timeframe to do the work (Drummond, 2020). It is in embodied Indigenous knowledges where I located my protection, compass, and map towards good relations that provide strength, clarity, and respite.

1.1.4 Indigenist researcher

My social position as a researcher resonates with the position as an academic. The exception is that I have found guidance towards liberation through Indigenous scholarship, some of which I have already cited, and another that I introduce now. Rigney's (1999) Indigenist research principles are woven into my theoretical framework, and they include: resistance as the emancipatory imperative, political integrity of Indigenist research, and privileging Indigenous peoples' voices.

The principle of resistance highlights the importance of survival and resilience of Indigenous peoples and demands that examples of historical and contemporary agency are highlighted in academic discourse by and about Indigenous peoples (Rigney, 1999, p.116-117). While some have criticised the notion of resistance as passive (Martin, 2003, p. 205), the omnipresence and persistence of colonial oppression speaks to the great strengths and active nature of the resistance that is exercised by Indigenous peoples. Resistance involves highlighting the ongoing operations of colonisation and racialisation of Indigenous peoples, theorising, and strategising against it. For me, it is also resisting the temptation of being the Black man in the tailored suit, a peculiar manifestation of colonisation, which Bond (2018, para. 11) describes as 'a cautionary tale rather than an aspirational goal' for Indigenous men. Bond tells of how Black men are often weaponised against Indigenous people, especially women. They are tricked into aspiring towards proximity to whiteness, demonstrating their

commitment through performances (e.g., moving and staying out of Black neighbourhoods; being the token Black and expert in the workplace, while insisting on being the exception; and, being preoccupied with suits, ties, and cufflinks) and as a reward, are touted by white colleagues, disciplines and industries as the saviour and hope for Indigenous peoples, as well as the exception (Bond, 2018). The argument here is that such men have emancipated themselves from their own people, and their family, in exchange for proximity to whiteness.

Political integrity highlights the imperative of Indigenous peoples being the enablers of the discourse about them. Rigney (1999, p. 117) states that “research by Indigenous Australians takes the research into the heart of the Indigenous struggle. In doing so, it makes the researcher responsible to the Indigenous communities and their struggle”. This is not to say that Indigenous peoples are the problem¹⁸, as historical and contemporary media and political institutions would have everyone believe. It highlights the fate of those in the social position of most subjugated, to experience the full blows of violent colonisation upon their body¹⁹, only to watch as media and political institutions convince the populace that this was for your own good. *Munanjahli* and South Sea Islander woman, Professor Chelsea Watego, renames these different subjugated social positions “vantage points” from which Indigenous peoples have learnt and continue to learn about the operations of colonisation; she proclaims that it is from

¹⁸ Rosalie Kunoth-Monks (2014, 0:15) who passed away at the time of writing, famously and sovereignly declared, “I am not something that fell out of the sky for the pleasure of somebody putting another culture into this cultured being. John [Pilger] shows what is an ongoing denial of me. I am not an Aboriginal or indeed Indigenous. I am Arrernte, Anmatjerre, First nations person. A sovereign person from this country... I didn’t come from overseas. I came from here. My language, in spite of whiteness trying to penetrate into my brain by assimilationists, I am alive. I am here and now, and I speak my language, I practice my cultural essence of me. Don’t try and suppress me, and don’t call me a problem. I am not the problem. I have never left my country, nor have I ceded any part of it. Nobody has entered into a treaty, or talked to me about who I am. I am Arrernte, Anmatjerre, female Elder from this country. Please remember that. I am not the problem.”

¹⁹ Watego (2021, para. 22) shares that “we must know that the violence they visit upon us in our fight against race is not reflective of a flaw in our strategising, but instead reflects the stuff of power bound up in notions of race. I now measure my success in the fight against race not by their awards or applause but by the weight of the blows levelled against my body.” This speaks to the colonial violence that Indigenous peoples are subjected to by colonial systems and their agents, as a requisite to the ongoing colonisation and occupation of the Australian continent. Watego also highlights how the colonial systems and their agents defend themselves against any assault, no matter how skewed the fight is in their favour.

these vantage points that we tell our stories, to counter the representations made about us, and to strategise against ongoing operations of colonisation (Daley, 2021). For me, fulfilling this second principle, requires a commitment to relational accountability (Tynan, 2020) to articulate the ways in which the violence of colonisation has manifested for my research participants. For this thesis I extended the commitment to relational accountability to non-Indigenous research participants who work in the native curriculum garden alongside Indigenous colleagues, as their proximity to ‘the natives’ can subject them to different experiences of disempowerment.

The third principle of privileging Indigenous peoples’ voices in Indigenist research, challenges the traditional research practice of scripting Indigenous peoples as an object of study. As Rigney put it “Indigenist research is research by Indigenous Australians whose primary informants are Indigenous Australians and whose goals are to serve and inform the Indigenous struggle for self-determination” (1999, p.118). This project intentionally privileges the engagement with Indigenous scholarship, reflecting what Tynan (2020, p. 164) described as an imperative to “challenge the hierarchy of knowledge implicit in research” and to privilege relatedness amongst Indigenous scholars through promoting Indigenous-led scholarship. Djaru Elder, nurse and scholar, Emeritus Professor Mary Ann Bin-Sallik, writes of the intellectual traditions of Indigenous philosophers and healers, who were decimated as part of British colonisation (Bin-Sallik, 1989). This history is also evident in Aotearoa (New Zealand) where Māori “tohunga [metaphysical leaders] ... experts in various kinds of Māori supraculture, including metaphysical benevolence and malevolence” had their practices banned by the colonising New Zealand government in 1907 (Hokowhitu, 2016, p. 97). Foucault (1976, p. 7) refers to knowledges that have been intentionally decimated and devalued by colonial hegemony as ‘subjugated knowledges’, defining them as “a whole series of knowledges that have been disqualified as nonconceptual knowledges, as insufficiently elaborated knowledges:

naïve knowledges, hierarchically inferior knowledges, knowledges that are below the required level of erudition or scientificity”.

Prohibiting the practice of these knowledges and disciplines and excluding Indigenous peoples from accessing Western education was intentionally designed to perpetuate the racist trope regarding the apparent unintelligibility and infidelity of Indigenous peoples (Bin-Sallik, 1989). Contemporary Indigenous peoples’ success in tertiary education, particularly those who are grounded in their own peoples’ ways of knowing, being and doing, will bring about, what Bin-Sallik (1989, p. 5) coins as the “Black educational Renaissance”. This assertion, however, assumes that Western education is capable of and willing to support such a renaissance.

Education is always positioned as the personal and collective liberator of the oppressed. In my lifetime, I have seen many and secured a few educational and employment pathway opportunities. A characterising feature of the policy era that I have grown up in as a young person and adult is the emphasis on education and employment participation. However, as I recently reflected, the formal education that I was ‘privileged’ to receive, including my nursing education, was intentionally divorced from my own peoples’ ways of knowing, being and doing, as if it is “not helpful to the Indigenous health agenda, and not conducive to Indigenous peoples’ health improvement” (Drummond, 2020, p. 128).

As Audre Lorde eloquently put it, “the master’s tools will never dismantle the master’s house. They may allow us temporarily to beat him at his own game, but they will never enable us to bring about genuine change”²⁰ (Lorde, 2003, p. 27). Freire (1972, p. 28) called this dynamic the false generosity of the oppressor “who oppress, exploit, and rape by virtue of their power, cannot find in this power the strength to liberate either the oppressed or themselves...

²⁰ Lorde (2003) was critiquing white feminism that reproduces patriarchal power structures, and in doing, perpetuate the oppression of women of colour, queer women, and transwomen. She clarifies that ‘women who still define their master’s house as their only source of support’ are the only ones who will find her message threatening (Lorde, 2003, p. 27).

[therefore] in order to have the continued opportunity to express their ‘generosity’, the oppressors must perpetuate injustice as well” (Freire, 1972, pp. 28-29). He believed that it is only the oppressed who can liberate themselves and their oppressors (Freire, 1972, p. 28), resonating with the words that are often attributed to Aunty Dr. Lilla Watson, but which she asserts are the collective efforts of Queensland Aboriginal activists in the 1970s: “if you have come to help me you are wasting your time. If you have come because your liberation is bound up with mine, then let us work together” (Aboriginal activists group Queensland 1970s, as cited in Watson, 2004).

As part of the program of work of this thesis, I published my analysis of the research yarns I had with Indigenous participants as a separate publication, prior to the completion of this thesis (Drummond et al., 2021). This aimed to fulfil Rigney’s (1999) third principle, to privilege the voices of the Indigenous participants. Furthermore, this initial publication became an important thread of the assemblage analysis of the non-Indigenous participants ([Chapter 5](#) and [Chapter 6](#)). The non-Indigenous participants’ voices and my analysis of their experiences complement what I wrote in this initial publication, providing further nuance to the social position of academics who develop and deliver Indigenous health curriculum, and expanding on the understanding of the conditions created by the institutions of the discipline, SON, and universities. Thus, this approach also honours the notion of our “bound liberation” (Aboriginal activists group Queensland 1970s, as cited in Watson, 2004).

This concludes my account of my social positionings as a Black man, the Black (male) nurse, a ‘native’ academic, and a researcher subject/knower. While not an exhaustive account of these social positionings, the aim was to demonstrate transparency and an accountability to the scholarship I engaged with for my theoretical framework, and to the Indigenous and non-Indigenous peoples I engaged with for this thesis. It is part of being a good relation. I turn my attention now to the purpose of this research.

1.2 Purposes

1.2.1 Research Problem

The research problem concerns the ways in which SON can be better relations to Indigenous peoples, by addressing the reproduction of colonial dominance in the context of developing and delivering Indigenous health curriculum. We live in a policy era in which universities are embracing the need to change to better service Indigenous peoples of the occupied lands and waters of the Australian nation-state (Universities Australia, 2017), or at least to be seen to be doing so. For example, while universities have ‘demonstrated’ their commitment to increase the proportion of their Indigenous staff and students to mirror their proportion in the general population (Universities Australia, 2017), their own reporting shows improvement only in student recruitment (but stagnating completion rates), while staff recruitment rates remain unremarkable (Universities Australia, 2021).

Amongst a list of commitments is also the aspiration that “by 2020, universities commit to have plans for, or have already in place, processes that ensure all students will encounter and engage with Aboriginal and Torres Strait Islander cultural content as integral parts of their course of study” (Universities Australia, 2017, p. 30). Their reporting on what to measure to determine progress against this goal is obscure, for example, using terms like Indigenous knowledge, Indigenisation of curriculum, Indigenous course content and Indigenous viewpoints interchangeably (Universities Australia, 2021, p. 56). Reporting structures are similarly ambiguous, for example, Universities Australia (2021) reports that 43% of universities have an “Indigenous-specific graduate attribute” (p. 12), that “Indigenous viewpoints are considered and incorporated when designing education” in 46% of universities, and that most of this content is in Indigenous courses (33% of universities reported this), compared to all courses on offer (15% of universities reported this) (Universities Australia, 2021, p. 56).

These measures demonstrate an interesting evolution of Indigenous affairs²¹ in the university sector. The neoliberal managerialism of the university sector “champion[s] the idea of economy, efficiency and effectiveness... and in doing so promote[s] marketization and performance measurement” (Harlow et al., 2012). In the context of Indigenous affairs, it manifests as these commitments to serve Indigenous peoples better, without any real accountability to fulfill the commitments (with the exception of being measured against each other’s ‘progress’, which regrettably may lead to being shamed). Furthermore, the convoluted reporting measures, which are subject to each university’s own interpretations, highlight the potential for hollow figures that shed the best light on each university. Simultaneously, these measures are likely to be interpreted internally as strict performance indicators for the universities’ own staff. The hollow yet overwhelming figures and factors presented above seem to function well as the smoke and mirrors that manipulate a reality that is perhaps unfit for the sober senses. Either way, the universities seem content with the progress so far (Universities Australia, 2021).

The nursing discipline is bound to these commitments, through university policy and strategy associated with the above, as well as professional regulation by ANMAC and the Nursing and Midwifery Board of Australia (NMBA). The ANMAC accreditation standards for

²¹ Neoliberalism is an ideology that believes that “the market is the most efficient way to organise human interaction, and that economic growth equals human improvement” (Bargh, 2007, p. 2). This ideology assumes that human relations are best when in competition, that citizens are best as consumers who drive the supply-demand binary of local and global markets, are apparently values-free and delivers on what people earn/deserve for their hard work. Neoliberalism calls for reducing government control, including their services, and for the latter to be privatised. The ideology champions a winners-and-losers binary and assumes that any material success is due to hard work; consequently poverty, poor health, and other outcomes, are believed to be the fault of the individual’s lack of capacity.

The neoliberalisation of Indigenous affairs has been a natural manifestation of colonisation of the Australian continent; “free market ideals became the dominant political philosophy” in the 1990s and continues (Walters, 2010, p. 122). Walters (2010, p. 134) believes that Indigenous peoples were seen as “a convenient borderlands group for experimental policy without the risk of political consequences.” It’s application to Indigenous affairs was also weaponised to “depower” Indigenous peoples (Walters, 2010, p. 122), convenient for Australian governments, given the political power that had been growing for Indigenous peoples nationally (consider the attention from the Royal Commission into Aboriginal Deaths in Custody and the Bringing them Home Report (I discuss these in [Chapter 2](#)), the establishment of the Aboriginal and Torres Strait Islander Commission (ATSIC), and the 1992 successful Mabo case, and proceeding Native Title legislation.

Australian SON mandates that “Aboriginal and Torres Strait Islander peoples’ history, culture and health [be] taught as a discrete subject and based on the Nursing and Midwifery Aboriginal and Torres Strait Islander Health Curriculum Framework” (ANMAC, 2019, p. 16). The goal of enhancing health curricula is to better prepare the next generation of nurses to work with Indigenous peoples seeking healthcare so that health service outcomes and ultimately Indigenous peoples’ health status are improved (Department of Health, 2014).

There are several assumptions made by the current ANMAC standards that are problematic. Firstly, that a deficit in knowledge regarding Indigenous peoples’ history, culture and health is the problem. Indigenous peoples’ appeal to white Australians to value our humanity is not a new strategy (Watego, 2021). What has changed recently to suggest that white Australians are ready to listen and to change? The history, referred to here, must also include the history of white British and Australian colonisation; framing it only as Indigenous peoples’ history only perpetuates the invisibility of whiteness, including violent colonisation and racism (Moreton-Robinson, 2004). Implicit in the invisibility of whiteness is the assumed benevolence of nursing as a caring profession, that historically complied with racist government policy that harmed Indigenous peoples (Forsyth, 2007; Cox et al., 2020; Best, 2021). In this context, the benevolence of nursing served the discipline and the Australian government, not Indigenous peoples. As Ramsden (2002) detailed in her model of Cultural Safety for Aotearoa (New Zealand), there is also a presumption in Transcultural Nursing approaches to matters of culture (Leininger, 1997), that teaching Indigenous peoples’ culture is even possible and appropriate. Applied in the Australian context, this presumption reproduces previous attempts to make white Australians experts in Indigenous peoples’ culture to better engage with Indigenous peoples. Finally, the framing of the accreditation standards diminishes the complex intersectional reality of the lived experience, including the experience of oppression of Indigenous peoples.

Indigenous and non-Indigenous academics who are tasked with developing, and delivering the prescribed Indigenous peoples' history, culture, and health curriculum are burdened with determining how much they address these incommensurabilities. This situation is one of the significant contrasts between an Indigenising approach and those working towards decolonisation²² (like Cultural Safety); the former “tends to be surface [level] and to shy away from delving into the painful deeper violence that... settler society... have enacted on Indigenous peoples and Indigenous lands” (Todd, 2018, para. 2). Nursing and health textbooks targeted at undergraduate health programs, are leading the discourse regarding the theoretical and practical application of Cultural Safety in the Indigenous health context (Cox et al., 2020; Best, 2021; Dune et al., 2021). However, the limited literature on the experience of non-Indigenous academics' teaching Indigenous health curriculum tells of them lacking in confidence in teaching approach of Cultural Safety (Doran et al., 2019; Fleming et al., 2020). Literature on the experience of Indigenous academics raises concerns about the isolation of doing this work and the embedded racism within SON and universities (Sherwood & Edwards 2006; Jackson et al., 2013; Drummond, 2020).

Andersen (2016) warns against disciplines who use Indigenous academics to colonise the physical and intellectual spaces of critical Indigenous studies units and departments for financial gain. He warns of their false generosity and performative benevolence. In Australia's nursing context it could be argued that Indigenous health curriculum in Australian undergraduate nursing curriculum has come about because of decades of advocacy led mostly by Indigenous nurses and midwives (National Aboriginal and Torres Strait Islander Nursing Forum, 1998; INEWG, 2002). However, the limited literature on the experience of Indigenous and non-Indigenous academics involved raises questions about the interest of the nursing

²² Todd (2018) articulates an important distinguishing feature between Indigenisation of the academy and decolonisation. Tuck and Yang (2012) impress that decolonisation cannot be a metaphor, hence the framing of 'working towards decolonisation', which I will discuss further in [Chapter 3](#).

discipline in Indigenous health curriculum, as well as about its relationship with the Indigenous peoples.

Andersen (2016) warns Indigenous academics from disciplines outside of critical Indigenous studies, of being cautious of being used as enablers for this ‘Indigenising’ agenda of disciplines, which of course is not just a discipline priority, but a sector priority (Universities Australia, 2017). However, Indigenous academics within nursing are not ignorant of these tensions, and some tell of their resistance (and their pragmatic complicity), operating relationally to support the resilience and success of Indigenous nursing students, engaging with relevant internal and external stakeholders and leading Indigenous health research and teaching (Sherwood & Edwards, 2006; Jackson et al., 2013; Best & Stuart, 2014; Drummond, 2020).

These tensions raise questions about the interest and preparedness of the discipline, SON, and universities to teach Indigenous peoples’ history, culture, and health. The current research on the experiences of academics who develop and deliver Indigenous peoples’ history, culture, and health curriculum in undergraduate nursing programs is limited. Greater insight into their experience will make conspicuous the weight of responsibility they carry on behalf of their institutions (discipline/SON/university), including the nature of support and direction (if any) they receive, in addressing the contradictions and assumptions embedded in the current regulation standards.

1.2.2 Research Question

How has the operation of neocolonialism and neoliberalism within Australia and its nursing discipline shaped the latter’s understanding of what it means to ‘care for’ Indigenous peoples, as demonstrated by how it both enables teaching Indigenous health and negotiates power with Indigenous peoples in determining the Cultural Safety of curricula and pedagogical approaches?

1.2.3 Aims of the study

There are two aims to this research project. They are:

1. To critically analyse historical and contemporary literature to elucidate the distal and immediate historical operations of neocolonialism and neoliberalism within the nursing discipline, particularly regarding the power dynamics and strategies used by Schools of Nursing to control Indigenous health education within undergraduate nursing programs.
2. To critically analyse the experiences of Indigenous and non-Indigenous academics who teach undergraduate nursing programs in terms of the social, political, historical, and material conditions in which they practice, and their exercise of compliance and resistance with and against neocolonial and neoliberal logics that dominate the institutions of discipline of nursing, Schools of Nursing, and universities.

1.3 Thesis overview

This thesis consists of seven chapters:

Following the introduction [Chapter One](#), [Chapter Two](#) is a genealogical analysis of historical government and nursing discipline reports that referenced the inclusion of Indigenous health curriculum in pre-registration training, undergraduate education, and in-service training for nurses. Using Moreton-Robinson's theory of white possessive logics, this section visibilises the manifestation of racism, including white settlers' move to innocence (Mawhinney, 1998), white ignorance (Martín, 2021), and White-Saviour Industrial Complex (WSIC) (Cole, 2021).

[Chapter Three](#) expands on the learnings about the manifestations of white possessive logics from the previous chapter which frames the intellectual territory of a contemporary social, political, and material conditions analysis. Firstly, I focus on the incongruence evident in the 'cultural' concepts, which presumes a lack of understanding of Indigenous peoples' culture as the problem, and not the culture of the nursing and university institutions, which asserts the innocence and benevolence of the latter. Secondly, I introduce the concept of performative

benevolence to problematise the assumption that standardising the acquiring of knowledge about Indigenous peoples' 'culture' will fix Indigenous health. I outline how the logics of neocolonialism and neoliberalism underpin discipline and sector standardised frameworks that reproduce colonial power relations, which is evident in the performative benevolence of nursing students undertaking Indigenous health education. Finally, I problematise the assumption that Indigenous peoples' participation within the institutions of discipline, SONs, and universities as academics, students, and community stakeholders will optimise the institutions' contribution of Indigenous peoples' health. I argue that whilst our participation within these institutions requires Indigenous peoples to compromise our terms of engagement, these institutions will continue to reproduce colonial power relations and conditions that we must continue to navigate with our compliance and resistance.

[Chapter Four](#) revisits the theoretical framework introduced in Chapter One and expands its specific application to the research project. Moreton-Robinson's (2013) AIWST and Rigney's (1999) Indigenist research principles are revisited, and I introduce Moreton-Robinson's (2017) relationality and Deleuze and Guattari's (1987) rhizome as part of the theoretical framework. The research methods enabling the research enquiry are discussed, including Bessarab and Ng'andu's (2010) research yarning, Ungunmerr-Baumann's (n.d.) *dadirri*, and Deleuze and Guattari's (2020) assemblage which collectively guided the development of the genealogical analysis, the contemporary social, political, and material conditions analysis, the research yarns, analysis, and presentation.

[Chapter Five](#) presents the first part of the analysis of the research yarning, informed by Deleuze and Guattari's (2020) assemblage, Bessarab and Ng'andu's (2010) research yarning and Ungunmerr-Baumann's (n.d.) *dadirri*. This chapter expands on a paper I published separate to this thesis, of my analysis of the research yarns I had with Indigenous participants (Drummond et al., 2021). In this chapter this initial publication is an important thread in the assemblage

analysis, guiding the analysis of the non-Indigenous participants. The notion of ‘it never turns off’ for Indigenous academics, which refers to the proximity of Indigenous academics to the reality described within Indigenous health curriculum, is expanded upon here with my analysis of non-Indigenous peoples’ experiences. The collective experiences of Indigenous and non-Indigenous academics enable the interrogation of the operations of white possessive logics by the discipline, SONs, and universities, highlighting the limitations of standardising practice that reinforce the institutional racism infrastructure of these institutions.

[Chapter Six](#) presents the second part of the analysis. This chapter discusses an alternative approach to Indigenous health curriculum, a relational pedagogy. The research yarns present ideas and activities that align with a relational approach to teaching Indigenous health curriculum, an approach that values Indigenous peoples’ ways of knowing, being and doing, and challenges the status quo that maintains the power and control of the discipline, SONs, and universities. Rather than prescribing a framework that is susceptible to standardisation, this chapter proposes ideas towards a relational pedagogy.

[Chapter Seven](#) summarises the key ideas of the research project.

Chapter 2: Genealogical Analysis

This chapter is a genealogical analysis²³ of government and discipline reports²⁴ that referenced the inclusion of Indigenous health curriculum in pre-registration training, undergraduate education, and in-service training of nurses. The genealogical analysis carries on with the assemblage method of analysis evident in the critical discussion of my standpoint. Working chronologically, this chapter commences with a critique of Florence Nightingale's interest in Indigenous peoples' health, followed by a brief scrutiny of nursing practice through the Australian government's Indigenous policy eras of segregation, protection, and assimilation. This chapter then interrogates several government and nursing discipline reports from the 1970's that reference Indigenous health curriculum. The chapter ends with a critique of the establishment and evaluation of ANMAC accreditation standards regarding Indigenous health curriculum, Indigenous student and staff support, and Indigenous community engagement.

In this chapter, I use Moreton-Robinson's theory of white possessive logics, to visibilise the manifestations of racism in these policy eras and nursing disciplinary reports. She theorises that white possessive logics are a "mode of racialisation... that [are] underpinned by an excessive desire to invest in reproducing and reaffirming the nation-state's ownership, control, and domination... [and] are operationalized within discourses to circulate sets of meaning about ownership of the nation, as part of commonsense knowledge, decision making, and socially produced conventions" (Moreton-Robinson, 2015, p. xii). In the following

²³ Foucault (1976, pp. 7-8) coined the term 'genealogical investigation' to describe the practice of engaging with "subjugated knowledge" or "the buried and disqualified knowledge". In using the term 'genealogical analysis' I am flagging that the nature of my critique of these historical conditions has intentionally focused on the racialised assertions and assumptions made by the institutions of the Australian governments and the nursing discipline, as well as the individual agents that represent them. Where possible, I have included the perspectives of Indigenous peoples to complement my critique.

²⁴ I have maintained original direct quotes that will only mention Aboriginal people; however, they assume the inclusion of Torres Strait Islander peoples. When discussing the reports, I will maintain using the term 'Indigenous peoples'.

genealogical analysis, this mode of racialisation is evident in the (in)action on addressing nursing and health institutional deficits that have negative implications of Indigenous peoples' health and well-being. I categorised the manifestations of white possessive logics in nursing practice history and education policy as: white settlers move to innocence, white ignorance, and White Saviour Industrial Complex. The arguments arising from this critique support the contemporary social, political, and material conditions analysis in [Chapter 3](#).

Mawhinney's (1998) theory of white settlers' move to innocence refers to tactics deployed by non-Indigenous peoples and institutions such as universities and their Schools of Nursing (SON) with which I am concerned, to justify their participation in antiracist advocacy and activism, without tending to their own complicity in racial oppression perpetuated by their institutions. The commitment to complicity enables racial oppression to continue, including the dispossession and oppression of Indigenous peoples (Mawhinney, 1998), which qualifies it as a manifestation of white possession logics. In the genealogical analysis I critique the history of assumed benevolence of the Australian nursing discipline.

White ignorance is said to "refer to patterns of ignorance... that are not merely coincidental or easily ascribable to the limits of finite beings, but instead systematically emerge from our social practices and are importantly related to the persistence of racial inequity... [it] is of great practical and moral concern because... it plays a role in sustaining racial injustice" (Martín, 2021, pp. 865-866). Sometimes it is referred to as wilful ignorance, deployed tactfully for apparently 'not knowing' as an attempt to excuse inaction, which enables the ongoing dispossession and oppression of Indigenous peoples, which qualifies patterns of ignorance as a manifestation of white possession logics (Martín, 2021). In the genealogical analysis, I illuminate the employment of white ignorance by different institutions of the nursing discipline, particularly in their considerations of recommendations regarding Indigenous peoples' health and wellbeing.

The White-Saviour Industrial Complex (WSIC) is a concept that refers to the industry of humanitarianism that wilfully ignores how their own nation-state is implicit, if not influential in the cause of the humanitarian crises they are attending to; commodifying humanitarian crises to meet the demands of the sentimental appetite of white people (Cole, 2021). In explaining the concept of WSIC Cole (2021, para. 4) tweeted: “white saviour supports brutal policies in the morning, founds charities in the afternoon, and receives awards in the evening”. Its dependency on the dispossession and violence of colonial nation-states certainly qualifies WSIC as a manifestation of white possession logics. In the genealogical analysis, I illustrate how WSIC operates within the nursing discipline, particularly in how the nursing discipline has demonstrated its care for Indigenous peoples.

2.1 Towards regulating Indigenous history, culture, and health curriculum

The last 50 years brought significant advancements in both the recognition of Indigenous peoples’ rights and their exercise of those rights, and in the professionalisation of Australia’s nursing profession. It is unsurprising then, that there are numerous intersections of these metamorphoses, usually conceived of as separate, during this timeframe. Several national government and professional reports capture these intersections as recommendations for both the inclusion of content on Indigenous peoples in pre-registration nursing training and undergraduate nursing education, and the engagement of Indigenous peoples in developing and delivering this content. The following section explores and critiques important milestones that set the foundation for the development of the current ANMAC (2019) accreditation standards.

2.2 Florence Nightingale (1860s)

“As for the [Indigenous] Australians, in their present state, very few of the human race are lower in the scale of civilisation than these poor people: excepting indeed, those who trample upon and oppress them, - who introduce among them the vices of European (so-called) civilisation” (Nightingale, 1865, p. 7).

Nightingale, in this opening epigraph, demonstrates a peculiar²⁵ manifestation of racism, one that perpetuates the belief in the racial hierarchy of human races and the subsequent lowest-rung positioning of Indigenous peoples, juxtaposed with suggestions of care and sympathy for our experiences of ‘bad’ forms of colonisation. Distinguishing the ‘bad apples’ of British colonisation who “trampled and oppressed” Indigenous peoples, and who “introduced European vices” to us, acts to validate a positioning of the bad apples as a lower form of human than Indigenous peoples. Apart from emphasising her racism against Indigenous peoples and reinforcing her apparent caring and innocent position, the blaming of ‘bad apples’²⁶ invisibilises the scale and brutality of the British imperial machine that exercised violent forms of oppression, even on their own subjects, including their invading forces and convict workers, to enforce discipline and control (Graham, 2021). These bad apples were British subjects, colonising according to the violence that was characteristic of British colonisation at the time (Graham, 2021). These contradictions within Nightingale’s assertion of care for Indigenous peoples is also reflected in her nursing advocacy for better civilising practices for Indigenous peoples.

In 1863, Nightingale reported on the sanitation of native colonial schools where she found that Western Australian schools reported the highest child death rates of the 143 schools within the British colonies (Nightingale, n.d.). Indigenous children’s mortality was part of a bigger picture of ‘depopulation’ of Indigenous peoples in some British colonies, which was the

²⁵As a member of the June 2015 ABC Q&A panel, Uncle Jack Charles described the racism that Australians expressed for Indigenous peoples as “peculiar”, that Indigenous peoples have come to expect this peculiar form of racism, and that other Australians sometimes deny awareness of it. Uncle Jack was responding to a question that specifically asked if AFL Sydney Swans player Adam Goodes, was being too sensitive when he reported racist abuse during a 2015 AFL game, which he disagreed with (abcqanda, 2015, 9:27). I invoke his characterisation of racism against Indigenous peoples here to entice your interest in racism that is juxtaposed with care and concern, as if the latter pardons the former.

²⁶The neoliberal logic that underpins the discourse of ‘bad apples’ asserts the assumption of atomised individualism, removed from any interdependence with one’s social world, emphasising one’s apparent freedom and choice. Thus, in the event that individuals commit an inappropriate, wrongful, and/or violent act, the blame falls upon the individual, maintaining the invisibility of their systemic nature and thus protecting associated institutions, including the state, who may sanction such acts via policies and legislation (Nguyen, 2016).

core interest for Nightingale (Rowse & Shellam, 2013). Nightingale's nursing advocacy is evident in this context in her critique of government agents who were positioned in the British colonies for their lack of a systemised approach to maintaining vital statistics and records (Rowse & Shellam, 2013). She believed that accurate and complete data would be the best evidence to challenge the dying race theory.²⁷ She was also critical of missionaries for their approach to civilising Indigenous peoples, specifically their privileging of religious and other education above practical training (Nightingale, 1865). Her partnership with Spanish Bishop Rosendo Salvado, who led the Aboriginal mission of New Norcia in Western Australia, provided her a case study and a reliable partner to develop evidence for better civilising practices (Nightingale, 1865). Nightingale was a respected nurse and budding statistician, who gained enough favour with the white patriarchal ruling class of the British empire to lobby for greater investment in better understanding the reasons for Indigenous peoples' depopulation, and to influence methods of civilising (Nightingale, 1863; Shellam, 2013).

During this time, scientific racism as manifested in social Darwinism²⁸ and human evolution theories²⁹ legitimised racialised understandings of humans and societies, which perpetuated the belief of a human racial hierarchy, and the apparent inferiority of Indigenous peoples (Levit & Hossfeld, 2019; Cox et al., 2020; Acton, 2021). This discourse permeated the

²⁷ The dying race theory promoted the belief that the inferiority of Indigenous peoples meant that their genocide was natural and inevitable.

²⁸ Herbert Spencer (1820 – 1903) was an English aristocrat, sociologist, and philosopher, a contemporary of Charles Darwin, who coined the mantra, 'survival of the fittest'. Although his work also spans ethics, physics, biology, and education, it is his application of biological evolutionary theory to the supposed evolution of societies and social class that he is remembered for. Specifically (and simply), he asserted that successful societies and individuals are good at adaptation (Acton, 2021). Social Darwinism theories then strengthened the alignment with the racist concept of the Great Chain of Being, which promotes a racial hierarchy of humans (Eckermann et al., 2014), which in the Australian context supported the assumption that Indigenous peoples' societies were comparatively less evolved, adding to the scientific and moral justification for the colonisation of the Australian continent (Cox et al., 2020).

²⁹ Professor Ernst Haeckel (1834-1919) was a German zoologist and champion for Darwin's theory of evolution. His work includes his attempts to turn Darwinism into a universal philosophy and in doing so challenge global religious doctrines; he developed numerous genealogical trees that depict the evolutionary path of numerous living creatures; and he theorised about the existence of 12 species of humans, which consisted of 36 human races who evolved from the one common ancestor, with the lowest forms of humans being Indigenous Australians and Papua New Guineans (Levit & Hossfeld, 2019).

political and social context, evident in the division amongst the British ruling class regarding what to do with the Indigenous depopulation problem of Australia. Many believed it futile to intervene, highlighting that either by science or God's-will Indigenous peoples were meant to die out. However, some, like Nightingale, were more optimistic about the ability to support Indigenous peoples to adapt to Western civilisation (Shellam, 2012). Because of this, Shellam (2012, p. 113) labels the latter "humanitarian optimists".

Nonetheless, both positions assert a sense of inevitability in the British colonisation of the Australian continent and its peoples. This idea demonstrates the limits of the imagination of the 'humanitarian optimists' and the falsehood of their generosity, evident in their avoidance of the obvious reality that problems were not limited to certain civilising practices but extended to British colonisation as a whole. Such false generosity highlights the performance of benevolent, innocent, and wilful ignorant advocacy as a façade to complicity with British colonisation. Nightingale does not question the British claim of the Australian continent, only the civility of its civilising practices. Furthermore, Nightingale prescribes to the popular dehumanising narratives about Indigenous peoples. For example, her belief in the inferiority of Indigenous peoples, and our apparent need for civilising, reflects an adherence to the extant racialised discourse about Indigenous peoples. Even the term 'depopulation' is deployed to whitewash the genocide of Indigenous peoples.

As opposed to overt expressions of support for the now debunked scientific racism such as Nightingale's, as I progress through the genealogical analysis towards ANMAC's regulation of Indigenous health, culture, and history, I draw attention to the different manifestations of white possessive logics by the nursing discipline and Australian governments I seek to highlight their strategising to maintain ownership and control (simultaneously maintaining the disempowerment of Indigenous peoples) which was often achieved covertly and discursively and bound to societal norms.

2.3 Early Indigenous policy and nursing care

In this section I briefly look at the government policies of protection and segregation, and assimilation, and examples of nursing practice during this time. This material provides essential historical contexts to government reports that were published in the 1970s-1990s, a political period that also saw a significant transformation of nursing, namely the move from hospital-based training to university undergraduate education preparation, discussed in the following sections.

The federation of the Australian nation-state in 1901 transferred overarching control over the continent to the new Commonwealth Government. Australian state governments had or would soon develop racist and draconian legislation that ensured the continuation of legal control of Indigenous peoples. These early policies aimed to segregate Indigenous peoples from Australia's largely white population. The belief of Indigenous peoples being a 'dying race' persisted, and Australian governments saw that it was their role to segregate, protect and palliate until death.

Alfred Deakin (2019, p. 40), Australia's inaugural Attorney-General and three-times Prime minister (1903-1910), wrote³⁰ an article for London's 'Morning Post' in 1905, titled "Last Days of the Blacks" that demonstrates the persistence of this belief. The article was about the 'depopulation' in Western Australia, in which he wrote:

In undertaking this work of justice they [the Western Australian Government] will have the unqualified encouragement of their neighbours [other Australian states], who have all of them adopted humanitarian principles in their dealings with the [Indigenous] race which everywhere, except perhaps in Central and Northern Australia, is dying out fast from natural causes, despite the efforts of the State Governments to prevent it. All

³⁰ Alfred Deakin was the secret Australian correspondent for London's 'Morning Post' from 1901-1914. He wrote under the pen name of Andrew Oliver (Deakin, 2019). This practice gave him significant power in determining the discourse of Australian affairs, including matters concerning Indigenous peoples.

that appears possible now is to mitigate as much as possible the trials of their closing years (Deakin, 2019, p. 40).

The 1905 Western Australian *Royal Commission on the conditions of the natives* contradict some of Deakin's assertions. In fact, Indigenous peoples were not dying out, nor were the state governments adopting humanitarian principles (Roth, 1905). The Chief Protector of Aborigines, who was established by the *Aborigines Act 1897* (WA) to lead the Aborigines Department of Western Australia, and thus implement the *Aborigines Act 1897* (WA), was essentially token, with no real power or resources to 'protect' Indigenous peoples (Roth, 1905).

Given the popular belief in the dying race theory, and the Australian government's interest in this being realised, it is thus unsurprising that minimal resources were invested in health care provision to Indigenous peoples (Forsyth, 2007). During this policy era nurses were also actively involved in stealing Indigenous children from their families and enforced segregation of Indigenous peoples from others within the hospital (Forsyth, 2007). Forsyth (2007) describes a palpable pervasiveness of interpersonal and institutional racism against Indigenous peoples, which influenced many nurses, creating conditions that readily accepted poor health treatment of Indigenous peoples as the norm.

As it became clear that Indigenous peoples were not, in fact, dying out, there was a shift in the Indigenous affairs policy space towards assimilating Indigenous peoples into Australia's white populace. This move began as early as the 1930s, although the official policy change did not occur until 1951 (Dow & Gardiner-Garden, 2011). The 1937 conference of Commonwealth and state authorities responsible for the protection of Indigenous peoples outlined the assimilation plan for Indigenous peoples, which varied according to the four castes of Indigenous peoples that were also agreed at the conference (Commonwealth of Australia, 1937). The lower caste was the uncivilised native or primitive nomad, who was considered an

unlikely subject for assimilation, and so their destiny was to be relocated to a designated government reserve in their respective states, if not already residing there (Commonwealth of Australia, 1937). The semi-civilised, or “those still living in a precarious existence on their own country” were also destined for relocation to reserves but were to be permitted to engage in supervised work and encouraged to aspire to be in a higher class (Commonwealth of Australia, 1937, pp. 3:6). The detribalised were destined to be permitted to live near white communities, access white-standard education and be employed in a job suitable for their caste (Commonwealth of Australia, 1937). Finally, the mixed Aboriginal blood, or cross breeds³¹, were destined for white standard education and employment opportunities, as they were expected to take ‘their place in the white community on an equal footing with the whites’ (Commonwealth of Australia, 1937, p. 3).

Despite the change in government policies the general attitudes of white health professionals and patients towards Indigenous peoples remained problematic, as manifestations of the persistent institutional racism that perpetuated negative stereotypes about Indigenous peoples. Nurses and doctors started to voice their concerns about the treatment of Indigenous peoples, however little critique of government policies that continued to control Indigenous peoples is evident (Forsyth, 2007). Indigenous peoples in some locations continued to be treated in segregated wards, and generally were provided with sub-standard care (Forsyth, 2007). Aboriginal nurse, Mary Ann Bin-Sallik, shared her experience working at the Darwin Hospital in the 1950s, where she found out that Aboriginal women were being sterilised without consent after childbirth. Those health professionals thought it best, as the gastroenteritis child mortality rates in the region suggested to them that Indigenous mothers

³¹ Four different ‘classes’ of crossbreeds were defined by the Chief and Board of Protectors: ‘1. Those with a preponderance of aboriginal blood and entirely aboriginal in character and leanings. 2. The cross with lower types of alien races such as Pacific Islanders, Malays, Africans. 3. The European-aboriginal cross or those with higher Asiatic types. 4. The quadroon and octoroon with preponderance of European blood.’ (Commonwealth of Australia, 1937, p. 6).

and families could not adequately care for their children. This idea conveniently excused the generations of government failure to ensure adequate housing and sanitation infrastructure for Indigenous communities that placed Indigenous families in these situations (Forsyth, 2007).

White possessive logics evident in Nightingale's practice were perpetuated within Australia's health services and the nursing discipline through compliance with various government policy eras (Goold, 2001; Cox, 2007). Generations of nurses refused to admit Indigenous peoples for care, enforced segregation, implemented care without consent, and provided other forms of sub-standard care, all while blaming the white patients, or government policy, with different degrees of acknowledgement of the race-based rationale (Forsyth, 2007). This assertion of the inevitability of white domination and Indigenous peoples' subordination, as well as the claim of innocence by nurses who are bound to comply, is a manifestation of white possession.

At the apparent end of the assimilation policy era, in 1967, a referendum was held where 90% of Australians voted 'yes' to amend the Australian Constitution to 'benefit' Indigenous peoples. These amendments, which remain in place today, removed the States' power to make laws for Indigenous peoples and vested this with the Commonwealth. These amendments also demanded the inclusion of Indigenous peoples in the national census (National Archives of Australia, n.d.) and highlighted a shift in the Australian community regarding the treatment of Indigenous peoples.

The policy eras of immediate interest over the last 50 years include self-determination (1972-75), self-management stage 1 (1975-88) and self-management stage 2 (1988-96). These eras formed the beginning of the 'accepted' assertion of Indigenous peoples' control and accountability for Indigenous affairs (Eckermann et al., 2014, pp. 22-23). During this policy era, the Aboriginal community-controlled sector emerged out of Indigenous protest for services

free of racism that meets the holistic needs of Indigenous peoples. The developments included community-controlled services in health, legal support, and housing.

By this time, health disciplines began to hypothesise that perhaps it was their lack of understanding of Indigenous peoples' culture that was the reason for the poor health of Indigenous peoples, and a barrier to Indigenous peoples attaining self-determination and self-management (Forsyth, 2007). The following sections explore several government reports that explicitly aimed to address Indigenous peoples' health needs and advocated for better education for nurses regarding Indigenous health.

2.4 Standing Committee on Aboriginal Affairs (1979)

In March 1978, the Australian Parliament's House of Representatives established the Standing Committee on Aboriginal Affairs³² (1979, pp. 1-2) to explore the health problems that were being experienced by Indigenous peoples, including the associated environmental, social, and institutional factors, to inquire into the effectiveness of current policies and programs to address Indigenous peoples' health needs, and to canvass effective alternative models of health service delivery. The Standing Committee on Aboriginal Affairs (1979, p. 3) received 136 submissions from organisations and individuals, heard from 136 witnesses and visited 21 Indigenous communities for informal discussions³³.

Their report highlighted several significant differences between how government health departments and Indigenous peoples conceptualised health. For example, the report proposed that Indigenous perspectives on health and well-being include cultural and social factors that are unfamiliar to non-Indigenous perspectives and that these also influenced how healthcare

³² Chair: Mr P.M. Ruddock MP; Deputy Chair: Mr A.C. Holding MP; Members: Mr S.E. Calder DFC MP, Mr J.S. Dawkins MP, The Hon. D.N. Everingham MP, Mr P.D. Falconer MP, Mr J.R. Johnston MP, and the Hon. R.C. Katter MP (Standing Committee on Aboriginal Affairs, 1979).

³³ The Standing Committee on Aboriginal Affairs (1979, p. 159) visited Bourke and Brewarrina in New South Wales; Gangan, Hermannsburg, Hooker Creek, Papunya, Port Keats, Wandawuy, Yirrkala and Yuendumu in the Northern Territory; Aurukun, Cherbourg, Hopevale, and Palm Island in Queensland; Pipalyatjara in South Australia; and Cundeelee, Fitzroy Crossing, Kalgoorlie, Warburton, and Wiluna in Western Australia. Communities in Victoria and Tasmania were not visited, nor the communities of *Zenadh Kes*.

was accessed. The example provided was the protocols and expectations associated with gender-specific health care services (Standing Committee on Aboriginal Affairs, 1979, pp. 9, 71). This insight led to the Standing Committee on Aboriginal Affairs (1979, p. 71) to express their belief that non-Indigenous health professionals should be “trained in Aboriginal culture, and, most importantly, that Aboriginals hold the responsibility for determining which people may or may not interact in the health care context”.

Furthermore, the Standing Committee on Aboriginal Affairs (1979, p. 74) recognised that while the above may be an ideal strategy, the best outcome is “Aboriginals themselves [having] the expertise and background which are necessary prerequisites for the successful design of culturally congruent health care programs.” However, there were multiple institutional and interpersonal challenges reported by Indigenous peoples who had failed their nursing training courses. These witnesses called for more emotional and financial support, they highlighted the ongoing impact of discrimination despite the general goodwill towards Indigenous peoples, and they highlighted the lack of understanding by management staff regarding individual obligations to community and family commitments that may compete with work commitments (Standing Committee on Aboriginal Affairs, 1979, p. 126).

This report identified numerous deficits in Australian health services including, the inability to address holistic needs of Indigenous peoples, and to ensure health care and nursing training free from racism. The Standing Committee believed that the inadequacy of health care professionals, including nurses to properly understand Indigenous peoples’ cultures contributed to inadequate care and poor health outcomes. This belief assumed that Indigenous people were culturally homogenous and that if the knowledge deficit regarding Indigenous peoples’ culture was addressed through education, it would address Indigenous peoples’ health. This assumption ignored the culture of the hospitals and health services that perpetuates the

racism that Indigenous peoples experienced; this strategy also assumed that hospital and health services were ready to change.

In their recommendations, the Standing Committee also proposed that increasing Indigenous professionals would lead to the creation of “culturally congruent health care programs”. This plan suggested that Indigenous health professions could address the racism problems of health services.

A specific definition of cultural congruency was not offered but given the context, it suggested the development of health programs that are compatible with both Indigenous peoples’ and Western/Australian perspectives of health. Without knowing the dimensions of the incongruence between these perspectives, and assuming the appetite of health services to change, this proposal on the part of the Standing Committee seems yet another partially thought through recommendation that Indigenous health professionals are expected to lead.

The aspirations of Indigenous people being empowered to determine which health professionals can work in relevant health care contexts, seemingly reflects the nature of self-determination and self-management. It also reflects Cultural Safety, where the recipient of care is entrusted with determining whether the care that is planned and received is safe for them (Ramsden 2002). Unfortunately, the lack of recommendations from the Standing Committee on Aboriginal Affairs to address institutional and interpersonal racism targeted at Indigenous peoples makes achieving this aspiration unlikely.

2.5 The Royal Commission into Aboriginal Deaths in Custody (1987-1990)

The *Royal Commission into Aboriginal Deaths in Custody* (RCIADIC), which took place between October 1987 and November 1990, investigated 99 cases of Indigenous peoples’ deaths while in police and prison custody over a timespan of nine (9) years and five (5) months (Whimp, 1991). The RCIADIC investigated each of these cases, reporting on the

“circumstances surrounding the deaths with recommendations for change relating to the custodial facilities and systems... but also examining the lives of each of those who died and the way in which their life was inextricably connected to their deaths” (Whimp, 1991). The latter point relates to the exploration of the associated social, cultural, and legal factors that contributed to each of these deaths.

The final reports of the RCIADIC included those of a National Commission and four State-specific Commissions; they were tabled in May 1991. Included in these reports was significant criticism of Prison Medical Services (PMS). The RCIADIC Commissioner, Elliot Johnston (1991, p. 251) stated that “(t)he deaths investigated have highlighted glaring deficiencies, at least in the past, in the provision of this care.” Poor access to medical care was identified in both police and prison institutions. Johnston (1991, pp. 199-200) found that Western Australia was the only state “that [had] considered the permanent placement of a medically trained personnel”, and Victoria had a state-wide service separate from Custodial Services that provided health support to individuals in police custody. Other states relied on the health knowledge and skills of police officers to determine the health status of people in custody and whether the health services should be accessed to maintain their well-being (Johnston, 1991, p. 200). Several states and territories reported that partnerships were developed or being sought with local Aboriginal Medical Services (AMSs) to ensure access to their services (Johnston, 1991, p. 201).

The RCIADIC proposed numerous recommendations associated with improving the training and education of the PMS staff. Johnston (1991) consistently noted the “vulnerability” of Indigenous peoples in prison, highlighting the often-poorer health of individuals who were likely to have contact with the police and prison system. However, he highlighted that despite the health needs of Indigenous peoples in custody and the physical accessibility of PMSs, they were not being utilised. Johnston (1991, pp. 267-268) states that “the system needs to be more

sensitive to the specific needs of Aboriginal people in the provision of health care”. It proposed that PMS staff should be educated to appreciate and understand “those issues which relate to Aboriginal health, including Aboriginal culture, and life-style (sic) so as to assist them in their dealings with Aboriginal people” (Office of the Aboriginal and Torres Strait Islander Social Justice Commission [OATSISJC], 1996).

Indigenous peoples’ participation as health professionals within the PMSs was proposed to “greatly enhance the acceptability of the PMSs for Aboriginal prisoners” (Johnston, 1991, p. 269). However, to support the education of the broader custodial personnel, police and prison services should be engaging local AMSs (Johnston, 1991, pp. 267-268).

In 1996, seven years after the RCIADIC, the OATSISJC (1996) published a report that critiqued the RCIADIC recommendations. It provided analyses of the failure of the initial report to fully address the harm experienced by incarcerated Indigenous peoples, it explored the deaths in custody since the initial report and proposed recommendations for improvement. OATSISJC (1996) looked specifically at the 96 Indigenous deaths in custody between the years 1989 and 1996, a rate twice that in the period investigated by the RCIADIC.

In their review of the recommendations associated with the training and education of the PMS staff, the OATSISJC (1996) asserted that more effort was required. They recommended that “Prison and Prison Medical Services review their cross-cultural health training for prison officers and medical staff having particular regard to content and the effectiveness of training” (OATSISJC, 1996). Furthermore, it reiterated the importance of local AMSs in the development of such education material, as well as the need to increase Indigenous peoples’ participation in their health workforce (OATSISJC, 1996).

The institutional deficits that were highlighted by the Standing Committee on Aboriginal Affairs can also be seen here in the institutes of police and prison services. Institutional and

interpersonal racism were suggested as significant factors in the high number of Indigenous peoples' deaths while in custody. Cox (2007) highlights an insidious correlation between the racism experienced by Indigenous peoples and poor treatment while under the care of health services and police and prison services. Despite the shift in political and policy rhetoric regarding Indigenous peoples' self-determination and self-management, government institutions remained unsafe places for Indigenous peoples.

The assumption that the problem is a lack of understanding by staff of Indigenous peoples' 'culture' appears again, as do the suggestions that it would be a good idea for Indigenous staff members to address this matter (whilst single-handedly also addressing institutional and interpersonal racism). There is also the suggestion that a partnership between police and prison services, and AMSs would alleviate the pressure on any Indigenous police and prison staff and could be support for them too. However, these recommendations assumed an appetite for the police and prison services to change which was not there.

The RCIADC stated that police and prison services should be more "sensitive" to the health needs of Aboriginal peoples, whereas the OATSIJC promoted "cross cultural" health training. No definitions are offered, however, given their respective contexts, I postulate that being sensitive entails a preparedness to respond to the health needs of Indigenous peoples, and cross-cultural relates to a context where peoples from different cultures are engaging from different perspectives based on their own culture. Both terms oversimplify the concept of culture, and seemingly ignore or downplay the significance of institutional *culture* of the police and prison services. This strategy asserts the neutrality and innocence of police and prison culture, and subsequently positions Indigenous peoples as the problem.

Despite their best efforts, the impetus for the RCIADIC was not the lobbying of Indigenous peoples. Authorities were prompted to act by concerns that international coverage

of celebrations of the bicentennial anniversary of the colonial invasion and occupation of Australia might highlight Australia's (mal)treatment of Indigenous peoples (Cox, 1993, p. 51). It is unsurprising then that several projects commenced during this time. The performance of benevolent humanitarianism reappears here, again positioning the settler colonialists as innocent (Mawhinney, 1998) and competent at addressing the needs of unfortunate Indigenous peoples, without any substantial change to colonial systems and processes.

2.6 A National Aboriginal Health Strategy (1987)

In December 1987, the same year the RCIADIC commenced, a working party was established by State, Territory and Commonwealth governments to develop a strategic response to the health and well-being needs of Indigenous peoples (Department of Health, 1994, p. 14). The working party developed the *National Aboriginal Health Strategy 1987* (NAHS) that highlighted the needs of Indigenous peoples and put forward broad recommendations to meet these needs (Department of Health, 1994). Pivotal to NAHS defined health as “not just the physical well-being of an individual but refers to the social, emotional and cultural well-being of the whole Community [sic] in which each individual is able to achieve their full potential as a human being thereby bringing about the total well-being of their Community [sic]. It is a whole of life view and includes the cyclical concept of life-death-life” (National Aboriginal Community Controlled Health Organisation [NACCHO], 2011, pp. 5-6). This definition reflects the concerns of Indigenous peoples identified in the consultations of the Standing Committee on Aboriginal Affairs (1979) regarding the different perspectives of health.

A recommendation of the NAHS report includes, “compulsory study of Aboriginal culture, history and health issues in formal coursework for undergraduate and postgraduate medical, nursing and paramedical courses” (Department of Health, 1994, p. 15). This recommendation was aimed at improving the ability of mainstream services to care for

Indigenous peoples, and to improve the capabilities of health professionals who were aspiring to work in an AMS or Aboriginal Community Controlled Health Organisations (ACCHO).

As per the previous reports, the NAHS report promotes the need for health professionals to be better educated in Indigenous peoples' culture, however they add history and health issues, which broadens the focus on the historical conditions and dimensions of poor health. Unfortunately, this recommendation ignores the role of white Australia, the culture of their institutions, the shared history with Indigenous peoples, and how these conditions impact on Indigenous peoples' health. The framing of this recommendation further asserts the innocence of white Australian institutions, but this time it is suggested by Indigenous peoples.

This observation reflects Moreton-Robinson's (2004) theorising about the invisibilising of whiteness. The normalised neutrality and invisibility reflect the racial superiority that is asserted by white peoples and their institutions. This idea is based upon their ways of knowing that presupposes a racial hierarchy and white supremacy as truths, and as *a priori*³⁴ to white epistemology (Moreton-Robinson, 2004). In this context, the white institution is presumed neutral, normalised and invisibilised, while Indigenous peoples are racialised; we are the exotic others, the lesser humans, as difference to Indigenous peoples cannot be known any other way by white systems (Moreton-Robinson, 2004).

The 1994 review of the NAHS implementation was unapologetically critical of Australian governments for their lack of progress in the implementation of recommendations, highlighting challenges regarding the partnerships between Commonwealth, State and Territory governments, specifically their financial investment in and coordination of services (Department of Health, 1994). The original recommendations to improve the undergraduate

³⁴ Latin for "from what is before", popularised by German Philosopher Immanuel Kant to refer to "knowledge that is acquired independent of any particular experience", emphasising the undeniable truth (Editors of Encyclopaedia Britannica, n.d.).

and postgraduate education of medical, nursing, and paramedical professionals was overlooked in this review. Instead, the emphasis is on the educational opportunities for Indigenous peoples to increase their participation in the health workforce and encouragement for mainstream health services to “develop appropriate procedural protocols to be followed in the course of those agencies’ interactions with Aboriginal and Torres Strait Islanders” (Department of Health, 1994, p. 81).

The lack of attention on the need to develop the capacity of all health staff in the 1994 review may reflect a broader failure by health disciplines and university institutes to include ‘Aboriginal culture, history and health issues’ in undergraduate curriculum. The emphasis to increase Indigenous peoples’ participation in the health workforce demonstrates the persistence of the expectation for Indigenous peoples to address the limitations of institutions.

The development and use of procedural protocols, recommended in the 1994 review, has more potential to compromise the engagement between health service providers and Indigenous peoples seeking care, as it is likely to promote essentialism of Indigenous peoples. This is where Indigenous peoples are reduced to prescribed characteristics and choreography, that health professionals must become experts in; thereby promoting the stereotyping of Indigenous peoples (Downing & Kowal, 2011). The standardisation of such a procedural protocol would thus consolidate what would usually just be a manifestation of individual interpersonal racism into the racist infrastructure of the health service.

2.7 Nursing education in Australian universities: Report of the national review of nurse education in the higher education sector 1994 and beyond

The transition of nursing education from hospital-based pre-registration training to university undergraduate education was a 9-year process that was completed in 1993. The main intent was to enable “wider professional preparation and career choices for nurses” (Steering

Committee for the National Review of Nursing Education in Higher Education Sector [Steering Committee: Nursing Education], 1994, p. xv). In 1993, the Commonwealth government established the Steering Committee: Nursing Education (1994, p. xii) to review the extent to which these objectives were achieved and to propose recommendations that would ‘improve the effectiveness of nurse education’.

The Steering Committee: Nursing Education (1994, pp. 293-294) received a submission from the Aboriginal and Torres Strait Islander Commission (ATSIC)³⁵ that proposed implementing several recommendations from the NAHS report. The interest that ATSIC had in the nursing workforce is unsurprising, given that the inaugural Chair was Lowitja O’Donoghue, an Aboriginal nurse who trained in the 1950s (Lowitja Institute, 2017). Their submission included increasing the participation of Indigenous peoples within the nursing profession, including a seamless articulation pathway for Indigenous health workers to nursing degrees and ensuring that nursing education “reinforce appropriate nursing roles and responsibilities in Aboriginal and Torres Strait Islander settings” (Steering Committee: Nursing Education, 1994, pp. 293-294).

The Steering Committee: Nursing Education (1994, pp. 298) included these recommendations in their report. They also endorsed the inclusion of ‘cross-cultural perspectives into nursing courses’, however this was focused broadly on the diversity of the Australian population and was not specific to Indigenous perspectives. The Steering Committee: Nursing Education (1994, pp. 297-298) found that only James Cook University had delivered a module on Indigenous health in their undergraduate program; the Steering Committee: Nursing Education believed that this particular education may not be relevant to

³⁵ ATSIC was the Commonwealth statutory body that was considered the peak representative group for Indigenous people. It was established in 1990, and its mandate was to administer Indigenous-specific programs, and a voice to the Commonwealth government. ATSIC was abolished in 2005 (Australian Broadcasting Corporation [ABC], 2010).

“those schools of nursing which are not based in areas with a substantial indigenous [sic] population.” It is perhaps for these reasons that despite their apparent endorsement, the Steering Committee: Nursing Education did not recommend the explicit inclusion of Indigenous health curriculum into all pre-registration undergraduate nursing education.

The location of the education and training was not a factor outlined by previous government reports. That is, this assertion contradicted recommendations from the Standing Committee of Aboriginal Affairs, the RCIADIC, and NAHS, that explicitly stated the importance of the inclusion of Indigenous health in nursing education. Firstly, it presumed to know better regarding the needs of Indigenous peoples, demonstrating discipline demarcation of the scope of practice of the general nurse (that is, qualifying what counts for general knowledge, skills and attributes that is taught to all nurses). This instance is perhaps the first time that the discipline was challenged to include knowledge, skills and attributes that would better prepare them to care for Indigenous peoples, and their rejection demonstrates their white possessiveness of their scope of practice.

Their assumption that they know better also assumes that Indigenous peoples only reside in regional and remote Australia and do not access care in urban areas (Cox et al., 2020). This belief is based on actual historical policy and practice of relocating Indigenous peoples from urbanised locations to government reserves and religious missions to essentially make way for the creation of the White Australian nation (Eckermann et al., 2014). The discreet way in which this history is sanitised for their inclusion within contemporary nursing regulation and standards (NMBA, 2018; ANMAC, 2019) demonstrates tactical ignorance on the behalf of the discipline, privileging ahistorical practices that are intuitively moves to innocence. History also tells of these government policies and practices evolved into new ways controlling Indigenous peoples, ones that at least enabled Indigenous peoples to move back to urban areas; for some this was a move back to Country, for others a move to access education and employment

opportunities. Thus, the Steering Committee: Nursing Education also assumes that Indigenous peoples that reside in urban areas do not have different needs than non-Indigenous, mostly white people, resonating with beliefs about assimilation. The briefest of considerations of how Indigenous peoples' historical and contemporary experiences of systematic racism in encounters with the inter-related health, corrections and welfare systems still impacts Indigenous peoples' relationships with these systems and their staff (Cox, 2007), demonstrating the need for a more nuanced approach on the part of those systems.

The Steering Committee: Nursing Education (1994, p. xv) decision not to recommend explicit inclusion of Indigenous health curriculum also contradicts their own objective to enable a "wider professional preparation and career choices for nurses". Even based on their own assumptions that Indigenous peoples only live in regional and remote Australia, their decision would logically limit any nurse who wanted to work in regional and remote Australia, where Indigenous peoples apparently reside.

The significance of this omission is immediately evident in Bennet's (1995) review, where there is no mention of the need for Indigenous health in nursing education. Bennett (1995, p. 20) reiterates the need for universities to increase Indigenous peoples' participation in Australia's nursing workforce. Unsurprisingly, she does not mention Indigenous health content, but the needs of a culturally diverse society being integrated into nursing courses through engaging with peoples from diverse background (Bennett, 1995, p. 20).

The move to assimilate and make invisible Indigenous peoples' experiences amongst the experience of 'the other'³⁶ diverse cultured peoples, that is, non-white Australian people, demonstrates an evolution in the assumption that it is a lack of understanding of the culture of

³⁶ 'Othering refers to a process where anyone perceived as different to the self (the other) is seen as inferior, suspicious, strange, exotic, unable to be understood, or considered not worth the effort of trying to understand' (Cox et al., 2020, p. 67).

the diverse/different/exotic/minority ‘other’ that is the problem. The ‘quick maths’³⁷ demonstrated by the discipline here declares the minority’s different needs as the problem, and nurses learning their ‘culture’ as the solution. In this logic, the institutions that continue to privilege the dominant white populace remain neutral and natural; much like the hospitals that enforced segregation as the norms, the discipline just accepts that ‘this is how things are done’.

The mustering of ‘the others’ together acknowledges the common experiences of racism but denies any difference in these experiences. For example, the momentous assault that colonisation has had on Indigenous peoples, an experience that was only endured by Indigenous peoples, and which continues to impact on individual and community well-being. This approach also dismisses other forms of discrimination, which culminate with race discrimination.

To assist the discipline in achieving these recommendations, especially the Indigenous health related recommendations (be it only in regional and remote areas, apparently), will be Indigenous nurses. This assumption reiterates a similar one made by the Standing Committee (1979), which is that Indigenous nurses are pivotal to this work. This notion ignores the institutional racism that informs the problematic status quos, an entrenched manifestation of racism that is designed to harm Indigenous peoples and ensure self-preservation.

2.8 Bringing them home: National Inquiry into the separation of Aboriginal and Torres Strait Islander children from their families (1997)

In 1997, the *report of the National Inquiry into the separation of Aboriginal and Torres Strait Islander children from their families called Bringing them home*: (Bringing Them Home

³⁷ Based on the lyrics of a rap song ‘Man’s not hot’ by artist Big Shaq, that became a famous meme, ‘quick maths’ (n.d.) has developed numerous meanings. It is invoked here sarcastically to emphasise the lack of thought about the problem of a racist workforce and health services, and a resulting inadequate recommendation for resolution.

Report) was published. It tells the stories of many Indigenous peoples who were taken away from their parents, families, and communities by state officials (health, welfare, and police staff working together) following government policies of ‘protection’ and assimilation (Commonwealth of Australia, 1997). This Human Rights and Equal Opportunity Commission had four broad objectives: to examine the laws and associated policies and practices that enabled the removal of children, a review of current laws and associated policies and practices that may enable the “locating and reunifying of families”, to explore the prospects of compensation as an exercise of reparation, and finally to review current laws and associated policies and practices regarding the placement and care of Indigenous children. The report proposed that potential “changes required taking into account the principle of self-determination by Aboriginal and Torres Strait Islander peoples” (Commonwealth of Australia, 1997, pp. 2-3).

The stories and supporting evidence included in this report found nurses to be active agents in the removal of Indigenous children from their families; extorting and neglecting Indigenous children were common in the nurses’ assimilation practices. Nurses took Indigenous babies and children away from their mothers and families and told lies about babies being too sick to go home with them or that they had died to cover up the stealing of babies and children (Forsyth, 2007). Nurses worked with police and other government agents to strategise and implement these operations, which soon informed the reputation of hospitals as a place to be feared by Indigenous peoples (Commonwealth of Australia, 1997, Cox, 2007).

Nursing matrons ran homes for stolen Indigenous children dispensing punitive measures for disobedience. Children in these homes were lied to about their parents not wanting them; they were taught to be shamed for their Indigenous heritage to subdue any positive feelings they may feel about their family and community; and they were subjected to Christian religious indoctrination (Commonwealth of Australia, 1997). Some Indigenous women shared with the

commission that as young girls and women, under the care of Matrons, they experienced sexual and physical abuse at the hands of farmers, farmhands, and foster parents. When these were reported to Matrons, some would punish and blame the Indigenous girls, others would promise to intervene to prevent other Indigenous girls from similar fates, however exposing young Indigenous girls and women to such harmful situations continued (Commonwealth of Australia, 1997).

The Bringing Them Home Report also identified that in recent times, nurses have become a common part of the health care team addressing the needs of children who were removed, particularly in providing mental health care (Commonwealth of Australia, 1997). This situation demonstrates that the social position of the nurse is subject to the prescribed political direction regarding Indigenous health of contemporaneous governments.

Two recommendations in the Bringing Them Home Report echo the recommendations of the Standing Committee of Aboriginal Affairs and the RCIADC that specifically targets the educational preparation of health professionals (Commonwealth of Australia, 1997, p. 346). Recommendation 34a calls for in-service education for employees of government health services, and recommendation 34b calls for education of undergraduate health students; the education should focus on “the history and effects of forcible removal” and partnerships should be sought with “Indigenous health services and family tracing and reunion services” in the development of the education curricula (Commonwealth of Australia, 1997, p. 346).

These recommendations call for undergraduate content that specifically focuses on the historical government endorsed actions that removed children from their families, and the effects of forcible removal on individuals, families, and communities (Commonwealth of Australia, 1997). Compared to previous recommendations, this one is understandably more

focused. Partnerships with appropriate Indigenous organisations is again recognised as essential to the development and delivery of accurate curriculum.

2.9 National Aboriginal and Torres Strait Islander Nursing Forum (1998)

In August 1997, the *National forum for the development of strategies to increase the numbers of Aboriginal and Torres Strait Islander peoples in nursing* was held. This important meeting saw the development of several strategies aimed at increasing Indigenous peoples' participation in Australia's nursing workforce. The gathering was an auspicious occasion, as it was the first official national gathering of Indigenous nurses who also celebrated the formation of the Congress of Aboriginal and Torres Strait Islander Nurses (CATSIN) (National Aboriginal and Torres Strait Islander Nursing Forum, 1998).

Over the course of the two-day workshop, Indigenous and supportive non-Indigenous nurses explored and reached consensus on several key positions that would provide the purpose and rationale for CATSIN. Most of these key positions related to Indigenous health inclusion in undergraduate nursing curriculum, including one that called for all nurses to undertake “mandatory subjects in Indigenous history, identity, culture, health and principles of self-determination and management” (National Aboriginal and Torres Strait Islander Nursing Forum, 1998, p. 28). Prior to this report, the focus of Indigenous health education was only directed at non-Indigenous health professionals, the gathering believed that the education must be consistent and not assume prior knowledge, to ensure everyone was on the same page.

A significant development with regards to this specific strategy was the proposition that Indigenous nurses should be engaged to teach this curriculum (National Aboriginal and Torres Strait Islander Nursing Forum, 1998, p. 28). Prior to this report, recommendations emphasised the need to engage Indigenous community members and/or health organisations to teach it.

This recommendation called on SON to show their commitment in investing in their internal capabilities.

The CATSIN meeting also commenced advocacy for Cultural Safety (Ramsden, 2002) to be taught to all nursing students and academics, creating safe environments for students (National Aboriginal and Torres Strait Islander Nursing Forum, 1998, p. 30). Cultural safety is one of the many theoretical and practice frameworks that have been taught and exercised in the Australian Indigenous health context. The contention associated with inconsistent understanding and use of these different frameworks is discussed later.

2.10 Indigenous Nursing Education Working Group (2002)

The Indigenous Nursing Education Working Group (INEWG) was established by the Commonwealth Office for Aboriginal and Torres Strait Islander Health (OATSIH) in the year 2000, six years after the Steering Committee: Nursing Education report. Its objective was to lead a project that aimed to increase Indigenous peoples' participation in Australia's nursing workforce, and to improve the capacity of all Australian nurses to care for Indigenous peoples (INEWG, 2002, p. ix). INEWG consisted of representatives from the Australian Council of Deans of Nursing and Sally Goold, the then Executive Director for the CATSIN (INEWG, 2002, p. ix). INEWG was one of several projects focused on improving Indigenous health through increasing Indigenous workforce participation. This broad reform was associated with the *Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework* (SCATSIH, 2002, in Turale & Miller, 2006, p. 174).

The INEWG project commenced with a national survey of Australian universities “to ascertain Indigenous content about health, history and culture in undergraduate and postgraduate nursing curricula; the involvement of Indigenous nurses in teaching and curriculum development; and the current recruitment and support strategies in place for

Indigenous students of nursing” (INEWG, 2002, p. x). Results from these surveys were collated and a discussion document was developed and circulated for stakeholder feedback to ensure a range of input into the final report (INEWG, 2002, p. x).

INEWG’s final report titled, ‘*Gettin Em n Keepin Em*’, was published in 2002. Centred in this report is a strategic framework that provides the structure to their proposed ingredients of success. The strategic framework consists of four aims, to: “increase the recruitment, retention and graduation of Indigenous students of nursing; promote the integration of Indigenous health issues into core nursing curricula; improve nurses’ health service delivery to Indigenous Australians; and monitor outcomes and revise strategies accordingly”. These became the goals for INEWG to achieve over the following five years, and they also provided the categories for their 32 recommendations (INEWG, 2002, p. xi).

Other outcomes from the *Getting Em n Keepin Em*’ report included a position statement developed and promoted by the Council of Deans of Nursing and Midwifery (Australia and New Zealand). Importantly this statement promoted the notion of nursing students being educated about Indigenous health, history, and culture and furthermore it emphasised that only nursing academics who ‘had developed an understanding of Indigenous content and cultural awareness should undertake’ this teaching (Turale & Miller, 2006, p. 175).

The outcomes from the ‘*Getting Em n Keepin Em*’ report attracted widespread support from Australian nursing professional organisations, including the Australian Council of Deans, CATSIN members, the Australian Council of Nursing, the Royal College of Nursing (RCNA) and state and territory nursing regulation authorities (Goold, 2006, p. 60). In 2003, the Australian Nursing and Midwifery Council (ANMC), who was responsible for setting national standards for nursing competency for undergraduate and graduating Australian nurses,

developed a position statement for the inclusion of Indigenous health issues in undergraduate nursing programs (Goold, 2006, p. 60).

The '*Getting Em n Keepin Em*' (as above) report also demonstrates the domination of neoliberal logics in determining the processes of change for the different institutions of Australian nursing. Specifically, neoliberal logics are evident in the interpretation of the desired change into modulated and calculable actions and measures and the assignment of accountability (Ball, 2012). This translation, and thus compliance with neoliberal logics, seemed essential for INEWG to prove their authenticity, and the authenticity of their change proposals.

In 2005, the INEWG was disbanded and CATSIN assumed responsibility for the ongoing project work, in particular the ongoing advocacy for the implementation and evaluation of the INEWG '*Getting Em n Keepin Em*' report (Turale & Miller, 2006, p. 176). While there had been some initial progress, Turale and Miller (2006) and Goold (2006, p. 60) believed that more needed to be done, including the participation of Indigenous nurses in SON, and more development in the discourse regarding the position of cultural safety in Australian nursing's professional standards.

Within the span of these four years, there is an articulation of how the Australian nursing profession should respond to the needs of Indigenous peoples, and commitment from all sectors of the nursing profession showed the success of this strategy. It required leadership that understood and valued what was required of the nursing discipline, information provided by CATSIN and its membership. The limitations of INEWG and CATSIN included the inability to enforce change within the broader nursing profession. ANMC's and RCNA's position statements would only ever be aspirational, as there were no real requirements for organisations or individuals to fulfil these statements. The disbanding of INEWG in 2005 essentially excused

the Council of Deans of Nursing and Midwifery (Australia and New Zealand) from monitoring and ensuring accountability of SON in fulfilling these recommendations. This outcome left CATSIN to fulfil this role, without any real power or sufficient resources to do so.

2.11 National Review of Nursing Education (2002)

In April 2001, the Commonwealth government announced the *National review of nursing education 2002: Our duty of care* (Heath, 2002). The intention of this review was to “examine the future nursing education needs of the health, community and aged care system and to advise on appropriate education policy and funding frameworks” (Heath, 2002, p. 1). CATSIN was invited to nominate a representative to the reference group, and Sally Goold took on this opportunity (Heath, 2002, p. 3).

Heath (2002) identified the efforts of INEWG and CATSIN, highlighting their aspirations of increasing Indigenous peoples’ participation in the nursing workforce, and their advocacy for including Indigenous health issues into core nursing curricula. Regarding the latter, it was recognised that the broad range of stakeholders had different demands of the nursing discipline, specifically the expectation of what knowledge and skills should be developed during undergraduate education (Heath, 2002, p. 261). This competition for space within undergraduate nursing curricula highlights a significant barrier for the inclusion of Indigenous health content. The onus remained on the discipline, specifically the Australian Nursing and Midwifery Council (ANMC) (ANMAC’s predecessor) to determine what is included within the demarcation of scope of practice for Australian graduate nurses.

Heath (2002) proposes several strategic initiatives to support the development of the nursing workforce. There was no mention of the other recommendations developed by CATSIN, nor any mention of the recommendations put forward by the consecutive Inquiries and Royal Commissions into Indigenous peoples’ health and well-being. It is evident that

INEWG was leading the Indigenous health and nursing agenda on behalf of the nursing discipline at the time of this report, and so it is surprising that INEWG's priorities are absent from Heath's (2002) recommendations. This history demonstrates uncertainty regarding the status of Indigenous health as a legitimate priority for the nursing discipline, given that despite the grand commitments made by some nursing discipline leaders to Indigenous health, a national report on the current and future 'duty of care' of Australian nurses contradict these commitments with silence on Indigenous health within their recommendations.

2.12 Report on the Inquiry into Nursing (2002)

A Senate Committee was established in April 2001, to inquire into a predicted shortage of nurses and the impact that would have on optimum health care delivery. It was also required to propose strategies to "improve current arrangements for the education and training of nurses, encompassing enrolled, registered and postgraduate nurses" (Commonwealth of Australia, 2002, p. 1). There was great interest, reflected in over 1000 submissions and numerous witness requests (Commonwealth of Australia, 2002, p. 2). CATSIN and INEWG provided a submission that reflected their priorities as previously stated (Commonwealth of Australia, 2002, pp. 176-179).

In their report, the Senate Committee outlined their support for increasing Indigenous peoples' participation in the nursing workforce believing that it would "improve the accessibility, quality and cultural appropriateness of health care for Indigenous communities. Increased participation in nursing will also extend an improved cultural awareness among non-indigenous[sic] members of the health workforce" (Commonwealth of Australia, 2002, p. xv). There was a suggestion here that it is up to Indigenous nurses to improve the health service and the nursing discipline.

Furthermore, the Senate Committee believed that increasing Indigenous peoples' participation in the nursing workforce would benefit Indigenous nurses, their family, and community. The Senate Committee proposed that "Indigenous nurses will become role models for the young Indigenous people [and lead to] improved employment opportunities for people from Aboriginal and Torres Strait Islander communities" (Commonwealth of Australia, 2002, p. 176). As if attending to the needs of the health system and the nursing discipline wasn't enough.

The Senate Committee mentions Indigenous health content in nursing education preparation, however, relates it specifically to rural and remote nursing (Commonwealth of Australia, 2002, p. 171). The assumption that 'real' Indigenous people only reside in regional and remote areas, as against the facts that most live on the Eastern seaboard, was made eight years earlier by the Steering Committee: Nursing Education. Furthermore, the Senate Committee defers commitment of this recommendation to the Australian Health Ministers' Conference (AHMC) (2004) *National Health Workforce Strategic Framework*.

It is however, in the associated *Aboriginal and Torres Strait Islander Health Workforce Strategic Framework* where there is emphasis on Indigenous health curriculum, which aims to "improve the effectiveness of training, recruitment and retention measures targeting both non-Indigenous Australians and Indigenous Australian health staff working within Aboriginal primary health services" (AHMC, 2004, p. 37). This statement reduces the scope to only those health professionals working within Aboriginal primary health services, which assumes that Indigenous peoples do not access tertiary health care services. This move by the Senate Committee to delegate responsibility for these recommendations to AHMC may appear ideal, in the sense that AHMC has resources and influence beyond the nursing discipline, however, it also seems somewhat antithetical to the recommendations of CATSIN and INEWG and the

support voiced from the various sectors of the profession; that is, to increase the nursing discipline's response to the needs of Indigenous peoples.

This contradiction was an imposition of federal government ministers and senators, powerful outsiders to the disciplines, with abilities to influence the discipline's demarcation of scope of practice without the usual defence from the discipline. The reproduction of false generosity is evident in the rhetoric of increasing the numbers of Indigenous nurses, in the questionable idea that this approach will fix the health system and the discipline, and in the assumption that these systems are willing and prepared for the required change. Reproducing the assertion that Indigenous health content is an Indigenous workforce matter, and only applies to regional and remote areas, rebuts the recommendations of previous reviews, reports and enquiries that privileged the voices of Indigenous peoples.

This and the previous nursing report on the workforce and education needs of contemporary and future nursing workforce demonstrates the operations of neoliberalism where Australia's nursing discipline is required to demonstrate its maturity as a professional discipline. Two separate reviews and reports on the nursing discipline in the same year reflects an interest in the nursing discipline, which creates opportunities as well as risks, depending on the appetite of the government, media, and Australian public. Thus, there is a degree of performativity required of the nursing discipline to ensure the desirable narrative for the nursing discipline dominates (Ball, 2012). This context emphasises the questionable status of Indigenous health as a legitimate priority for the nursing discipline at the time, shedding light on the social, political, and material conditions within the nursing discipline that INEWG's efforts had to navigate.

2.13 Australian Nursing and Midwifery Accreditation Council (ANMAC) (2009, 2012, 2019)

‘The injustice has been a common one, and so should be the remedy’ Nightingale (n.d., p. 19).

The epigraph statement from Florence Nightingale (circa 1860s) reflects her views regarding the requirement for a consistent approach to addressing the depopulation of Indigenous peoples. She highlights the consistent and contrasting interest in British governments and colonists in activities that caused “the injustice”, i.e., the colonisation of Australia. Her words are invoked here to emphasise that it took approximately 140 years for the nursing discipline to get to a point where our leaders could agree to include Indigenous health curriculum as standard knowledge, skills, and attributes for graduating nurses. This development is more of a start to remedying the injustices that have been and continue to be experienced by Indigenous peoples.

In this section I examine the evolving priorities within the ANMAC registered nurse accreditation standards from 2009, 2012 and 2019. The priority areas that ANMAC included in these iterations are: Indigenous health curriculum, Indigenous student participation, Indigenous academic participation, and engagement with Indigenous community members.

Unlike the largely aspirational ANMC and RCNA position statements, an accreditation standard establishes accountability for SONs to demonstrate the inclusion of Indigenous health curriculum in their undergraduate nursing program. In 2009, ANMAC enshrined the requirement of “Aboriginal and Torres Strait Islander Peoples history, health and culture and incorporate the principles of cultural safety” into Australian undergraduate nursing accreditation standards (ANMAC, 2009, p. 12).³⁸

³⁸ This requirement was included in: Domain 2 Curriculum: Standard 5 Curriculum Content: Criteria 3.

The 2012 ANMAC accreditation standards required SON to demonstrate the “inclusion of a discrete subject specifically addressing Aboriginal and Torres Strait Islander peoples’ history, health, wellness and culture” (ANMAC, 2012, p. 14). Wellness is added, and cultural safety is removed from direct reference to the Indigenous health context and is listed along five other qualities that are “expected of registered nurses” (ANMAC, 2012, p. 12). ANMAC also included the need for “health conditions prevalent among Aboriginal and Torres Strait Islander peoples... to be appropriately embedded into subjects within the curriculum” (ANMAC, 2012, p. 14). This criterion (criterion 4.6) is more prescriptive than its predecessor, requiring a stand-alone unit, and relevant content scaffolded throughout Bachelor of Nursing programs.

The 2019 ANMAC (2019, p. 16) accreditation standards mandate the inclusion of “Aboriginal and Torres Strait Islander history, culture, and health taught as a discrete subject and based on the Nursing and Midwifery Aboriginal and Torres Strait Islander Health Curriculum Framework.” Wellness is removed, and the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives’ (CATSINaM, formerly CATSIN) *Nursing and Midwifery Aboriginal and Torres Strait Islander Health Curriculum Framework* (Nursing and Midwifery Framework) (CATSINaM, 2017) is added. ANMAC continues to require SON to “include content relevant to health outcomes of Aboriginal and Torres Strait Islander peoples throughout the [undergraduate nursing] program” (ANMAC, 2019, p. 16), and requires the embedding of the principles of “cultural safety for all people” (ANMAC, 2019, p. 16)

Each iteration of the ANMAC accreditation standards is consistent with requiring Indigenous peoples’ “history, culture and health”, and as mentioned earlier, this invisibilises non-Indigenous (namely white) people. This move is a key dimension of racism, as it assumes that only Indigenous people have history of culture, rendering those in white domains innocent, ahistorical, cultureless, neutral and value free (Cox et al., 2020). As a result, this approach denies that the history that this curriculum required is a shared history following British

invasion and colonisation. It does not spell out that, in keeping with cultural safety, the culture that is most important to improving health services is the culture of the health service itself, and the cultures of health professionals (Ramsden, 2002; Cox et al., 2020). Highlighting this focus of Ramsden's in her articulation of cultural safety enables a culturally safe experience for all patients, including Indigenous patients (Cox et al., 2020). The Nursing and Midwifery Framework that is included in the 2019 ANMAC standards provides more detail and direction for the development and delivery of the Indigenous health curriculum required for ANMAC accreditation, which surpasses any details previously offered by ANMAC. However, on the matter of Indigenous student enrolments, ANMAC standards weaken over time.

In 2009, ANMAC required SON had to demonstrate "that Aboriginal and Torres Strait Islander students are encouraged to enrol" and "that the range of support needs are provided for Aboriginal and Torres Strait Islander students" (ANMAC, 2009, p. 10). This accreditation standard is included in the 2012 ANMAC (2012, p. 16) accreditation standards, however, is removed from the 2019 ANMAC accreditation standards. Instead, there are several standards that are related to the student experience (ANMAC, 2019, p. 17). The decision to remove a specific accreditation standard to ensure SON participate in Indigenous student recruitment and support activities is unclear; ANMAC's 2019 accreditation standards commences with a "Background" section that explains some of the major change, but it does not provide clear justification for this decision.

The decision to remove this specific accreditation standard essentially alleviates the requirement for SON to participate in targeted recruitment and support activities. Here we see the invisibilising of Indigenous students amongst the accreditation standards for all students, which functions differently to the invisibility of whiteness. As suggested already, the former results in marginalisation, while the latter "reinforces power and privilege"; take for an example the invisibility of whiteness in the discipline's ability to remove an accreditation

standard that has been lobbied for, for years, without any explanation (Hatchell, 2008, p. 33). Without any clarity from ANMAC, I propose that the decision to remove this accreditation standard suggests an unnegotiated and unagreed delegation of this responsibility to the Indigenous Education Units (IEU) of each university. This move constitutes a convenient relinquishing of responsibility from SON, onto an already overburdened underfunded and fragmented Indigenous department in the university.

The participation of Indigenous peoples as staff in SON made its début in the 2012 ANMAC accreditation standards (ANMAC, 2012, p. 17). However, the language used in its inscription seems aspirational, as SON were required to demonstrate “staff recruitment strategies [that] take affirmative action to encourage participation from Aboriginal and Torres Strait Islander peoples” (ANMAC, 2012, p. 17). This soft approach may be due to the low number of Indigenous nurses working within academia whilst at the same time perpetuating those low numbers. It may be the reason it does not appear in the 2019 ANMAC accreditation standards, but again this matter is not clarified by ANMAC in their 2019 accreditation standards.

As I have established, the agenda of improving participation of Indigenous peoples within the nursing discipline has been a long-standing recommendation that stakeholders agree could address the agenda of interpersonal and institutional racism of health and nursing services specifically. I specifically critiqued the link between these two different agendas, highlighting the preposterousness of having an approach to address institutional racism led by the usual racialised targets of institutional racism, especially without the support of institutional leaders. Increasing Indigenous peoples’ participation within the nursing discipline remains fundamental to self-determination of Indigenous peoples, so should still be pursued, however intentionally subjecting us to the racial violence of institutions that are unwilling to change is problematic.

Also debuting in 2012 was a criterion that required SON to engage Indigenous peoples in the development of associated curricula. ANMAC (2012, p. 11) required “partnerships with Aboriginal and Torres Strait Islander peoples, Indigenous health professionals and communities” to be explicit in the terms of reference of relevant accreditation committees. This ideal reappears in the 2019 ANMAC accreditation standards with ANMAC (2019, p. 15) prescribing the requirement for SON to undertake ‘consultation in the design and ongoing management of [their] program’ with Indigenous peoples amongst other external stakeholders.

As discussed earlier, there is potential for such engagement with Indigenous peoples to be a proxy for recruiting and supporting Indigenous peoples within the discipline and workplace. As such there is also the risk that Indigenous peoples being engaged to advise, or consult the SON, is seen as the sole solution to institutional racism. There is real risk of these arrangements being tokenistic, gestures of false generosity.

The ANMAC (2019) standards demonstrate a commitment to neoliberal logics in regulating SON, including their regulation of Indigenous health curriculum. The desired change regarding Indigenous health curriculum and Indigenous peoples’ participation was modulated and made calculable as performance indicators for SON, as evident within the ANMAC (2019) accreditation standards. SON must demonstrate the desirable performance against these measures to host an accredited Bachelor of Nursing program; this is work that is achieved by the academics within respective SON. Thus, any changes in ANMAC standards have direct implications on the practice of academics. So, should a standard change, or disappear completely, like the ANMAC standards regarding Indigenous nurse academics and Indigenous nursing students, then academic practice is likely to follow. The dominance of neoliberal logics thus also demonstrates a vulnerability of standardised practice, specifically regarding its susceptibility to the appetite of those who determine what, when, and how performance is measured.

2.14 Conclusion Historical conditions of the accreditation standards

Based on a genealogical analysis of government, and nursing-discipline specific reports associated with Indigenous peoples' health, several issues emerge. Firstly, the incongruence of concepts is a barrier to meaningful progress for Indigenous peoples; second, that the nursing disciplines' possession of our scope of practice assumes that the discipline is best placed to lead the development and delivery of Indigenous health curriculum; and thirdly, that the recruitment of Indigenous peoples into the discipline to do this work underestimates the interest of institutions to maintaining the status quo, and thus puts these Indigenous peoples in harm's way.

The inconsistency with terminology of proposed training and education is problematic (Cox 2016). The terms used so far include cultural congruency, sensitivity, cross-cultural training, cross cultural perspective, cultural appropriateness of healthcare, cultural awareness of non-Indigenous staff, and cultural safety. As addressed above, these terms vary in their underpinning assumptions, but consistently they are supposed to address the limitations of the health system to ensure better service for Indigenous peoples. Most of these terms are used in a context where the focus is on increasing nurses' understanding of Indigenous culture, with the assumption that better understanding of Indigenous peoples' culture is the problem, and not the culture of institutional racism of health disciplines and services. Furthermore, with exception of the theorised model of cultural safety, the other terms are superficial, and thus vulnerable to misinterpretation. White possessive logics are evident in these examples of settlers' moves to innocence and white ignorance.

Indigenous peoples have consistently called for better education of nurses (and other health professionals) so that they may be better equipped to work with Indigenous peoples. In response, the nursing discipline, in staking claim to its scope of practice, historically, consistently rejected the need for core Indigenous health education, asserting it was only

required for undergraduate nurses in regional and remote areas of Australia, a position also echoed by a federal Senate committee. The rationale for this approach is based on the stereotype that most Indigenous peoples reside in regional and remote areas. Furthermore, there is an assertion that the discipline knows best and therefore they, rather than Indigenous peoples, should decide how the profession responds to Indigenous peoples' health needs. The discipline's historical commitment to deny Indigenous health content as core curriculum is evidence of their white possession over nursing's scope of practice.

Institutional racism in government services, including workforces has been identified as harmful for Indigenous peoples. To address this matter, ANMAC embraced the notion that greater Indigenous peoples' participation in government workforces will fix the harmful aspects of these systems, a significant task, especially for the very same racialised people who are the targets of institutional racism. This strategy intentionally puts Indigenous nurses in harm's way. This dynamic demonstrates the false generosity of the discipline, health services and governments. This strategy appears to do something about Indigenous health and to support Indigenous nursing workforce, but then assume that this workforce can address the institutional racism, while not acknowledging that their institutions will resist change. These latest initiatives align with WSIC, highlighting that when the discipline finally agrees to contribute to address issues within its members and the health service, that responses are designed to make people feel good about changing superficial matters.

It would be remiss not to recognise the gains made historically, specifically in the forums where Indigenous peoples have been allowed to share their stories of living in the colony, and their perspectives on what should be done to address past and current harms on Indigenous peoples. While this genealogical analysis was limited to several key reports, it aimed to visibilise the pervasiveness of white possessive logic, as operated by the nursing discipline. Through moves to innocence, claiming white ignorance or committing to WSIC, the historical

conditions demonstrate how the nursing discipline has defended their scope of practice from others, with exception to Australian governments, agreeing to minimal change that prioritises sentimental currency, rather than structural change.

Chapter 3: Contemporary Social, Political, and Material conditions

Analysis

This chapter builds upon the genealogical analysis ([Chapter 2](#)), presenting an assemblage analysis of the contemporary social, political, and material conditions of Indigenous health education in undergraduate nursing education. This chapter includes the following subsections: Cultural ‘incongruence’, Preparedness of institutions, and Indigenous participation.

[Cultural ‘incongruence’](#) interrogates the multiple concepts (often starting with the word ‘culture’) used in the context of Indigenous health education. This section compares the most popular concepts, cultural competency, Transcultural Nursing, and *Kawa Whakaruruhau* (Cultural Safety) as mooted in [Chapter 2](#). Other concepts that are often misinterpreted are interrogated too, namely: Indigenising and decolonising approaches, Indigenous ways of knowing, being and doing, Indigenous knowledges, and Indigenous perspectives. I argue that the incongruences evident in the understanding of these concepts within the literature is evidence of white ignorance and the privileging of white settlers’ move to innocence over engaging with the ethic of incommensurability. These are characteristics of performative benevolence, a term I coined that captures these manifestations of white possession, and the intersecting neoliberal logics of the discipline, Schools of Nursing (SON), and universities.

[Preparedness of institutions](#) critically examines the contemporary regulatory practice of the nursing discipline, the SON, and the universities, regarding Indigenous health curriculum. This includes a comparative analysis of the *Aboriginal and Torres Strait Islander Health Curriculum Framework* (the National Framework) (Department of Health, 2014), and the *Nursing and Midwifery Aboriginal and Torres Strait Islander Health Curriculum Framework* (the Nursing and Midwifery Framework) (CATSINaM, 2017), focusing on their intersection with ANMAC’s priorities of Indigenous health curriculum and Indigenous participation

(students, staff, and engagement with community stakeholders). This subsection highlights the dynamics of institutional politics that found contemporary performative benevolence associated with Indigenous health education. Furthermore, I demonstrate how standardised national curriculum frameworks are reproducing colonial power relations as evident in the experience of student nurses.

[Indigenous participation](#) critiques the assumptions and expectations associated with increasing participation of: Indigenous nursing students in undergraduate nursing programs and in the discipline, Indigenous nursing academics in the SON and universities, and Indigenous community stakeholders in activities associated with the development and delivery of Indigenous health curriculum. I argue that Indigenous peoples' participation regarding Indigenous health curriculum, on our terms, serve us better, but achieving this outcome requires the institutions of the discipline, SON, and universities to negotiate their possession of Indigenous health education with Indigenous peoples. However, such relinquishing of power also compromises their adherence to the neoliberal logics that prescribe apparent progress of these institutions. This sub-section highlights the investment in performative benevolence by the institutions of discipline, SON, and university which adhere to the dominant neocolonial and neoliberal logics, that perpetuate Indigenous peoples' disadvantage while nourishing the sentimental appetite of white peoples and their institutions.

This chapter is an elaboration of the arguments made in the [Research Problem](#), which found the [Research Question](#) and the [Aims of the study](#), that were shared earlier. Thus, the chapter summary reiterates the key features of the research problem, providing essential foregrounding for my analysis and discussion of my research study ([Chapter 5](#) and [Chapter 6](#)).

3.1 Conceptual Incongruence

Numerous ‘cultural’ terms have come to be associated with improving the way organisations and workforces work with Indigenous peoples, including on Indigenous health curriculum in undergraduate nursing education. The language used to describe Indigenous health curriculum has changed regularly in the last 50 years, as explored in the Background chapter ([Chapter 2](#)). The National Framework identified that the contention with multiple terms used to describe Indigenous health curriculum has continued, differing between health professional groups, which essentially resulted in the National Framework perpetuating the incongruence in terminology (Department of Health, 2014). Such incongruence is also evident in a recent study by the Health Professions Accreditation Collaborative Forum (HPACF) that confirmed while 50% of their health professional research participants understood and taught cultural competency and cultural safety as different terms, many used these terms interchangeably, or used other terms such as: cultural awareness, cultural responsiveness, cultural capability, cultural security, and cultural contexts (HPACF, 2019, p. 19).

This section explores the different terms that are utilised in contemporary literature and the incongruence in the use of them. I first compare cultural competency, transcultural nursing, and cultural safety, and interrogate their use within the Indigenous health nursing education literature. I then compare Indigenising and decolonising approaches, terms that are often incorrectly used interchangeably. Finally, I compare Indigenous peoples’ ways of knowing, being, and doing, with Indigenous knowledges and Indigenous perspectives. The conceptual incongruence evident in this context sophisticates white ignorance and allows for the promotion of concepts that normalises settlers’ moves to innocence; these are key features of performative benevolence.

3.1.1 Cultural... adjective or theory

“The preparation of nurses to give culturally safe and competent care to Aboriginal people within culturally appropriate environments is a key component of the Bachelor of Nursing curriculum...” (Hart et al., 2015, p. 249).

In their literature review focused on “what helps and hinders development of curricula in the higher education sector to prepare entry level health science graduates to work respectfully and equitably in Aboriginal and Torres Strait islander health settings”, Taylor et al. (2014) found great contestation regarding associated terminology. These terminologies aim to “describe the qualities of safe and welcoming health services for Aboriginal and Torres Strait Islander peoples” (Australian Government, 2016, p. 2-22).

The epigraph above also demonstrates the perceived fluidity of these concepts, with the practice of interchanging concepts being quite common (Cox, 2016). Nash et al. (2006) voice their intent to negotiate this ‘contentious’ space and utilise 22 different ‘cultural’ terms in doing so. Likewise, Hart et al. (2015) uses 33 different ‘cultural’ concepts in their paper, which contradicts their earlier assertion that discussions on appropriate concepts take focus away from a pragmatic response to Indigenous health.

These examples demonstrate how cultural terms have become synonymous with Indigenous-related practice disavowing that everyone and all contexts are cultural, positioned, interested, political, value-laden, strategic, and enmeshed in historically informed power relations (Cox et al. 2020). The terms are used interchangeably with such ease, evidence of the false generosity, apathy, and carelessness that the institutions that endorse them offer, given that the terms encompass conflicting philosophies and practices to one another. This section takes a closer look at the common models and related concepts used in Indigenous health curriculum in undergraduate nursing programs, as described in the literature.

3.1.1.1 Cultural Competency

The origin of the concept cultural competency is unclear, with a multitude of tools developed since the 1970s in the USA to address the “complex social and healthcare needs” of their multicultural society (Frawley et al., 2020, p. 3). Cross et al. (1989) provides the earliest definition of cultural competency. They defined a cultural competence model “as a set of congruent behaviours, attitudes, and policies that come together in a system, agency, or amongst professionals and enables that system, agency, or those professions to work effectively in cross-cultural situations” (Cross et al., 1989, p. iv). Cross et al. (1989, p. v) proposed that cultural competence is one point along a continuum of “six possibilities”; starting from the worst extreme, these points on the continuum include: “cultural destructiveness, cultural incapacity, cultural blindness, cultural pre-competence, cultural competence, [and] cultural proficiency”. The focus of each point upon the cultural competence continuum is on individual practitioner and health service behaviours.³⁹ Cross et al. (1989, p. 19) proposes five ‘elements’ that “must function at every level of the system” to progress along their continuum of cultural competence, including: “1) valuing diversity; 2) have the capacity for cultural self-assessment; 3) be conscious of the dynamics of difference; 4) have institutionalized cultural knowledge; 5) have developed adaptations to diversity” (Cross et al. 1989, p. v).

³⁹ Cultural destructiveness is “represented by attitudes, policies, and practices that are destructive to culture and consequently to the individuals within the culture” (Cross et al., 1989, p. 14). Cultural incapacity is a “system or agency... [that does] not intentionally seek to be culturally destructive but rather lack the capacity to help minority clients or communities... [however, they remain] extremely biased, believes in the racial superiority of the dominant group” (Cross et al., 1989, p. 15). Cultural blindness is a “system and its agencies [that] provide services with the express philosophy of being unbiased... [functioning] with the belief that color [sic] or culture make no difference and that all people are the same” (Cross et al., 1989, p. 15). Cultural pre-competence “implies movement [and describes] an agency [that] realizes its weakness in serving minorities and attempts to improve some aspect of their services to a specific population” (Cross et al., 1989, p. 16). Cultural competence is demonstrated by “acceptance and respect for difference, continuing self-assessment regarding culture, careful attention to the dynamics of difference, continuous expansion of cultural knowledge and resources, and... adaptations to service models in order to better meet the needs of minority populations” (Cross et al., 1989, p. 17). Cultural proficiency is demonstrated when “agencies seek to add to the knowledge base of cultural competent practice by conducting research, developing new therapeutic approaches based on culture, and publishing and disseminating the results” (Cross et al., 1989, p. 17).

Since this original theorising, cultural competence has morphed into other terms, including “cultural capability, cultural responsiveness, cultural intelligence, and cultural proficiency” (Pecci et al., 2020, p. 60). Pecci et al. (2020, pp. 63-64) note that some manifestations of cultural competency have also been grounded in a range of critical theories, including Habermas’s reflexivity, positionality theory, and critical consciousness. The inconsistency in theoretical foundations is reflective of the ‘cultural’ incongruence that is observed in research and government publications as observed by Taylor et al. (2014), Cox (2016) and the National Framework (Department of Health, 2014). Pecci et al. (2020) notes that despite the inconsistencies, the common aims for contemporary cultural competence include organisational cultural change and transformation.

In the contemporary Australian Indigenous context Frawley et al. (2020, p. 4) state that cultural competence provides a “philosophical rights-based model and a pedagogical approach to improve the knowledge of providers in the areas of law, health, education, housing and welfare; and to reduce unconscious bias in order to enhance Indigenous peoples’ equitable access.” They also believe that cultural competency in the Australian Indigenous context is informed by Indigenous ways of knowing, being and doing, as defined by Martin (2003) (Frawley et al., 2020, p. 4). Their work suggests that learning about Indigenous peoples’ culture, that is, our ways of knowing, being, and doing, remains an important part of cultural competence, as evident in the steps of cultural competence and cultural proficiency in the continuum of cultural competence published by Cross et al. (1989, p. 17).

3.1.1.2 Transcultural Nursing

Madeleine Leininger (1997, p. 342), coined the concept of Transcultural Nursing in 1970, and defined it as the “formal areas of study and practice in the cultural beliefs, values and life ways of diverse cultures and in the use of knowledge to provide culture-specific or culture-universal care to individuals, families and groups of particular cultures”. Leininger’s nursing

missionary work with the Gadsup people of PNG in the 1960s inspired her scholarship, namely the combining of anthropological and nursing sciences to articulate an education pathway for contemporary nurses to “study toward understanding the cultural differences and commonalities in how people care for themselves and their families during health and illness” (McFarland, 2018, p. 26). The interest in the culture of others, including patients, resonates with cultural competency.

McFarland (2018, pp. 32-33) outlines three phases of transcultural nursing knowledge, as defined by Leininger, and proposes a fourth phase. Phase one is the phase where individual nurses gain “cultural awareness and sensitivity of culture care differences and similarities...” with sensitivity referring to the need of individual nurses to “gain evidence-based cultural knowledge to support culturally congruent nursing decisions and actions” (McFarland, 2018, p. 32). Phase two is the phase where individual nurses “gain in-depth knowledge about transcultural nursing concepts and principles to guide thinking and practice... [which is] essential for cultural assessment of clients” (McFarland, 2018, p. 32). Phase three is the phase where individual nurses “use observations, experiences, and knowledge documented with clients to provide culturally congruent care... [using] theory-based knowledge along with transcultural nursing principles and evidence-based research findings to provide meaningful, safe, beneficial, and culturally congruent care” (McFarland, 2018, pp. 32-33). Phase three requires the individual nurse to identify their own biases and weaknesses regarding the delivery of culturally congruent care (McFarland, 2018). McFarland (2018, pp. 33-34) proposes an “evolving” fourth phase which is “focused on evidence-based culturally congruent practice and translation science, which provides a basis for effective implementation care strategies to promote adoption of evidence-based transcultural practice in real-world clinical settings... [as well as] educational, and research settings.”

Transcultural Nursing appears to be yet another manifestation of cultural competency (Downing et al., 2011). Transcultural Nursing asserts that ‘culture’ is synonymous with ethnicity, which invisibilises the dominance of whiteness of the nursing discipline. Discursively, society has come to know and accept that “nurses and the culture of nurses are normal and commonsensical”, thus it escapes being seen as being inadequate or being the problem (Ramsden, 2002, p. 114). The emphasis of evidence-based practice in Transcultural Nurses highlights the problematic assumption that nurses must study the ‘cultures’ (i.e., race and ethnicity) of their patients to become experts, which is characteristic of cultural competency, particular its interest in Indigenous ways of knowing, being, and doing (Frawley et al., 2020).

In contrast with other cultural competency approaches, the scholarship of Transcultural Nursing, for a large part, has maintained better consistency. This situation is partially due to the continuity of Leininger’s leadership, which spanned from the 1970s up to 2012 when she passed (McFarland, 2018, p. 27). The consistent leadership has led to the development and uptake of Transcultural Nurses in the USA (McFarland, 2018); however, it remains not as popular in Australia (Downing et al., 2011) as evident in its absence from the nursing literature regarding Indigenous health curriculum in Australia which I discuss in a moment.

3.1.1.3 *Kawa Whakaruruhau* (Cultural Safety)

Cultural Safety was articulated at the *Hui Waimanawa*, a national New Zealand conference focused on supporting Māori nursing students, hosted by Māori nurse Irihapeti Ramsden. Ramsden (2002, p. 92) explained the significance of the gathering being held in her home region, which enabled her grandparents to attend the entire event. Her grandfather gifted the gathering with the name *Hui Waimanawa* “in recognition of the tears which had been shed over the years of colonisation and to recognise the importance of the *hui* being able to happen” (Ramsden, 2002, p. 92). It was at this *hui* that a first-year nursing student coined the term

Cultural Safety, posing to the gathering of over 100 participants, including nursing leaders and academics, “you people talk about legal safety, ethical safety, safety in clinical practice and a safe knowledge base, but what about Cultural Safety” (Ramsden, 2002, p. 1). Ramsden (2002) received permission from this student to use this term, which she developed into a theoretical and practical framework of *Kawa Whakaruruhau* (Cultural Safety).

Ramsden (2002) proposes three steps towards Cultural Safety including: cultural awareness, cultural sensitivity, and cultural safety. “Cultural awareness is a beginning step towards understanding that there is difference... [in the] emotional, social, economic and political context in which people exist”, highlighting the importance of understanding one’s own culture and the culture of the institution one belongs to (Ramsden, 2002, p. 117, Cox et al., 2020). “Cultural sensitivity alerts students to the legitimacy of difference and begins a process of self-exploration as the powerful bearers of their own life experience and realities and the impact this may have on others” (Ramsden, 2002, p. 117) This step involves reflection on the power and privilege that is afforded individuals because of their social positioning within society, including power afforded them by the institutions they belong to (Cox et al., 2020). “Cultural safety is an outcome of nursing and midwifery education that enables safe service to be defined by those that receive the service” (Ramsden, 2002, p. 117). Cultural Safety insists on nurses being more accountable to the people that they are working with, in the planning, implementation and evaluation of nursing care.

Ramsden (2002, p. 117) states that Cultural Safety nursing education has two goals:

First it aims to identify attitudes that may either consciously or unconsciously exist towards cultural/social differences in the provision of nursing care. Secondly it attempts to transform those attitudes by tracing them to their origins and enabling students to see their effects

on practice through a framework of practice related reflection and action (Ramsden, 2002, 121).

Tracing back attitudes can sometimes lead to racist, misogynist, ableist, homophobic stereotypes, as well as societal norms that covertly and overtly discriminate against certain racialised groups, women, people with different abilities or LGBTQI* people⁴⁰. The perpetuation of discriminatory attitudes may not be immediately obvious to nurses, but care recipients will be familiar with the discrimination that has been designed for them, that they are usually subjected to. The normalised nature of some of these forms of discrimination creates a barrier for care recipients to report unsafe care, their discomfort can be read as unwarranted behaviour, which may subject them to more discrimination or no changes in nursing practice. In the care provider – care recipient relationship, nurses hold a great deal of power in determining the cultural safety of the care that is provided; resolving this unequal distribution of power requires the care provider to share their power (Cox et al., 2020).

Cultural Safety is about power relationships in all nursing and midwifery service delivery... It investigates setting up systems which enables the less powerful [care recipient and their family in the health care setting; students in the university setting] to genuinely monitor the attitudes and services of the powerful [health professionals in the health care setting; academics in the university setting] to comment with safety, and ultimately, to create useful and positive change [which is essentially mutually beneficial] (Ramsden, 2002, p. 121).

⁴⁰ Cultural Safety is inherently responsive to intersectionality, as its critique of power cannot be limited to a single social category. However, it is often only used in the context of Indigenous issues, limiting its focus to the social category of race, which ironically perpetuates racialised understanding of Indigenous peoples as the exotic other, diminishes other forms of discrimination against Indigenous peoples, and inhibits everyone else from benefiting from Cultural Safety (Cox, 2016).

Cultural Safety is evidently less interested in becoming the expert in the culture of care recipients. It asserts that an understanding of one's own culture and the culture of the institutions that one belongs to can better inform nurses of the power in the care provider – care recipient relationship. Efficiency in this understanding, and the ability to share power with care recipients so that they may inform the safety of the care provided is central to Cultural Safety.

3.1.1.4 Contemporary practice implications

In practice, academics are confronted with conflicting requirements from different regulation framework. As established already the discipline requirements promote cultural safety (CATSINaM, 2017; ANMAC, 2019), and the National Framework which was designed for all Australian health disciplines promote numerous manifestations of cultural competency (Department of Health, 2014). Universities Australia's (2011) also champions cultural competency. They define cultural competence as “student and staff knowledge and understanding of Indigenous Australian cultures, histories and contemporary realities and awareness of Indigenous protocol, combined with the proficiency to engage and work effectively in Indigenous contexts congruent to the expectations of Indigenous Australian peoples” (Universities Australia, 2011, p. 3). They promote five guiding principles⁴¹ including one that explicitly states that “all graduates of Australian universities should be culturally competent” through the embedding of Indigenous knowledges in curriculum, graduate attributes, pedagogical framework, staff education and in quality assurance and accountability measures (Universities Australia, 2011, 9).⁴²

⁴¹ Universities Australia's five principles are as follows: “Indigenous people should be actively involved in university governance and management... all graduates of Australian universities should be culturally competent... university research should be conducted in a culturally competent way that empowers Indigenous participants and encourages collaboration with Indigenous communities... Indigenous staffing should be increased at all appointment levels and, for academic staff, should cover a wider variety of academic fields... [and] universities should operate in partnership with local Indigenous communities and should help disseminate culturally competent practices to the wider community” (Universities Australia, 2011, pp. 5:9:13:16:24).

⁴² Universities Australia (2011, p. 9) promote the following recommendations for achieving the cultural competency principles of ensuring that “all graduates of Australian universities should be culturally competent”.

It is thus unsurprising that the literature on Indigenous health curriculum in nursing undergraduate education explicitly or implicitly identify the perpetuation of conceptual incongruence. This situation seems mainly due to the undisciplined development of cultural competence theory and practice models, that Pecci et al. (2020, p. 61) generously liken to “cartography of sorts”. This is evident across the different manifestations of cultural competency (Downing et al., 2011), and in practice, like that of Nash et al. who redefine cultural competency to “incorporate the ideas of cultural safety” to better suit their project (2006, p. 301). While the evolution of theory and practice frameworks is a natural process, it seems that in the context of conceptual incongruence in Indigenous health curriculum, such practices exacerbate an already confusing context, perpetuating white ignorance and settler moves to innocence.

As proposed in the genealogical analysis of historical documents, the apparent flippancy in the over-conceptualisation of cultural competency suggests exercises of false generosity, performing benevolence, while not really changing systems; this is evident in the example of Nash et al. (2006). The intensity of the recreation of cultural competency reflects what Cox et al. (2020, p. 66) asserts as “an essential feature of power [which] is that those who dominate in imbalanced power relations work hard to maintain their position.” That is, the incongruence is by design, implemented systematically as normal and accepted approaches endorsed by

They are: “Embed Indigenous knowledges and perspectives in all university curricula to provide students with the knowledge, skills and understanding which form the foundations on Indigenous cultural competency; include Indigenous cultural competency as formal Graduate Attribute or Quality; incorporate Indigenous Australian knowledges and perspectives into programs according to a culturally competent pedagogical framework; train teaching staff in Indigenous pedagogy for teaching Indigenous Studies and students effectively, including developing appropriate content and learning resources, teaching strategies and assessment methods; [and] create reporting mechanisms and standards which provide quality assurance and accountability of Indigenous Studies curricula” (Universities Australia, 2011, p. 9).

institutions of health services, education, and disciplines, to maintain a façade of doing something to help minority groups (including Indigenous peoples apparently), which ultimately ensures that institutions maintain their power over Indigenous peoples. The limitations of cultural competency, including Transcultural Nursing, to account for these power differences highlight their complicity to maintaining the invisibility and power of white culture and institutions (Ramsden, 2002; McFarland, 2018).

According to cultural competency approaches the term culture and cultural have become synonymous with ethnicity, namely of ethnic minorities (Ramsden, 2002). In the Australian context culture is often associated with Indigenous peoples (Cox, 2016). This also invisibilises the problematic dominant cultures of non-Indigenous white peoples, deeming them normal, neutral, and problem free (Cox et al., 2020). Hart et al. (2015, p. 246) application of Cultural Safety in their immersive clinical placement initiative in an AMS aims to develop students' understanding of the history of white colonial culture and the "ongoing impacts of colonisation and racism upon health and culture of Indigenous peoples". They insist that "learning about the culture of Indigenous peoples was not their goal, rather the experience of oneself within an intercultural space, was paramount" (Hart et al., 2015, p. 248). While they turn the focus on culture of the minority on its head, Hart et al (2015) seem to remain focused on ethnic and racial difference. Cultural Safety promotes the broader understanding of culture that is not just synonymous with ethnicity; this broader understanding further challenges the ethnocentric belief that only non-white ethnic minority peoples have culture, and white people are acultural (Cox et al., 2021; Best, 2021).

In the development and delivery of Indigenous health curriculum, the learning experience of the student has become increasingly important (Nash et al., 2006; Hart et al., 2015; Mills & Creedy, 2019). Nash et al. (2006, p. 301) value Cultural Safety but state that it is not easily measurable, which makes it difficult to assess students' competency. They acknowledge

Ramsden's assertion that the care recipient determines the level of safety of the nursing care, which they believe is too difficult to design or simulate in an undergraduate nursing program (Nash et al., 2006, p. 301). Pecci et al. (2020, p. 74) argue that "quality indicators" for measuring the cultural competency of students remains a challenge too, as current measures are reliant on Western models, which can equate student discomfort to poor quality teaching. Mills and Creedy (2019) highlight the problem with the assumption about discomfort meaning poor quality Indigenous health education, as they found discomfort to be a necessary experience for students to progress through as part of transformational learning. Pecci et al. (2020) believe that student measures must be adapted to align with Indigenous pedagogies that better define and measure student learning experience.

The conceptual confusion compromises the broader transformation of institutions. While Usher et al (2005, p. 29) seemed quite confident in the ability of cultural awareness training to address the "insensitivity and inflexibility" of their university, Farrelly and Lumby (2009) found that such approaches resulted in sporadic implementation of the Indigenous agenda of universities. Fredericks' (2006) investigation of Indigenous women's perception of cross-cultural training⁴³, yet another manifestation of cultural competency, found that Indigenous women wanted more critical approaches. Anti-racism training and education about white privilege were proposed, but were often excluded from cross-cultural training, despite being essential knowledge to understanding Indigenous peoples' disadvantage (Fredericks, 2006). The women also proposed training that focused on "otherness... racism, sexism, class exploitation and oppression, homophobia, environmental degradation, and support multi-

⁴³ Fredericks (2006, p. 87) states that cross-cultural training aims to "improve nurses' knowledge and understanding of Indigenous peoples in Australia... and therefore improve service delivery and therapeutic care for them".

faceted struggles for social injustice” (Fredericks, 2006, p. 93, 95). These ideas appear to align better with Cultural Safety (Ramsden, 2002; Cox et al., 2020).

Downing et al. (2011) analysed several different ‘cultural training’ approaches that were designed for Australian health professionals, particularly regarding Indigenous health. They differentiated programs according to whether the cultural training focused more on individual practitioner behaviour change or health systems change, and whether the training focused on developing knowledge of the culture of other people or developing skills to improve understanding and awareness of “cultural identity formation and one’s own identity/positioning within this” (Downing et al., 2011, pp. 249). Downing et al. (2011) found that studies on the effectiveness of cultural training in the Australian context remains limited. However, they proposed that Cultural Safety was the ideal model to pursue given its balanced approach to individual and health system transformation that privileged greater understanding of the culture of the health professional, and the institutions that they belong to, including the health service, and the health discipline (Downing et al., 2011). This they believed was essential for delivering health care in a post-colonising⁴⁴ and diverse population setting (Downing et al., 2011).

Our context of being post-colonising with a diverse population brings me to the final critique for this comparative analysis, which relates to the desire and capacity to create change beyond equitable health care delivery. Cultural competency’s focus on addressing the needs of Australia’s multicultural population, including Indigenous peoples, invisibilises Indigenous peoples as an ethnic minority, and assumes that social justice and equity is the same for Indigenous peoples as it is for ethnic minority migrants and refugees. This erases the matter of competing sovereignty, between Indigenous peoples and the British Crown; and denies

⁴⁴ Moreton-Robinson (2015, p. 10) asserts that Australia is not post-colonial, as “the colonials did not go home, and ‘postcolonial’ remains based on whiteness”, like they did in “India, Malaysia, or Algeria.” Indigenous peoples remain ‘homeless’ on their own country, and the logic of white possession discursively continues to attempt to erase Indigenous peoples’ belongingness to our country; we embody an unsettling of white Australia (Moreton-Robinson, 2015, p. 17).

Indigenous peoples a future free from being subordinate to the needs of the majority white colonial settler, and ethnic minority migrant and refugee population (Tuck and Yang, 2012). Cultural safety, on the other hand, visibilises these tensions, at least in the *Aotearoa* (New Zealand) context. It recognises Māori sovereignty and thus privileges Māori people, theoretically through Ramsden's deployment of social constructionism and critical theory that reveals the functions of colonial power, and the structural disempowerment of Māori people, and practically through the embedding of *Te Tiriti o Waitangi* (Treaty of Waitangi) and its principles in practical framework of Cultural Safety (Ramsden, 2002; Nursing Council of New Zealand, 2011). Cultural Safety cannot have the same impact here, yet, as there are no treaties between Indigenous peoples and the British Crown, the Australian government remains intent on inhibiting work towards a co-existing sovereignty.⁴⁵ However, it does demonstrate potential to imagine more.

A comparative analysis of Cultural Safety and the manifestation of cultural competence, including Transcultural Nursing, highlight concerns about the latter's reproduction of white possessive logics by the institutions of health, universities, and the nursing discipline. The confusion that the manifestations of cultural competency create is evident in the National Framework and Universities Australia's strategy, as well as in the literature on Indigenous health curriculum in nursing undergraduate education. This literature demonstrates how this conceptual confusion is impacting on teaching and learning practice, and student learning experiences. While Cultural Safety seems the ideal model for Indigenous health education, the conceptual confusion in which it is bound to as a 'cultural' concept has become an effective barrier to realising its potential.

⁴⁵ The Uluru Statement (n.d.) calls for treaties to formally recognise co-existing sovereignties of Indigenous peoples and the British Crown over the Australian continent and the surrounding islands. Such an arrangement would reflect other British colonial nation-states, including Canada, USA, and New Zealand.

The following subsection takes a deeper look at the notions of Indigenising and decolonising the university sector, revisiting some ideas already introduced and offering new insights that push the imagination beyond the tedious task of clarifying ‘cultural’ concepts. It aims to expand the understanding of the contemporary political, social, and material conditions in which Indigenous curriculum development and delivery takes place.

3.1.2 Indigenising and decolonising approaches

Decolonising and Indigenising approaches are sometimes used interchangeably, but while they have some commonalities, they are distinctly different. McNamara and Naepi (2018, p. 340) propose simplistic definitions of decolonisation and Indigenisation, that the former is invested in “removing colonial influences”, and the latter is invested in “adding Indigenous elements to existing educational structures”. In this section I delve deeper into these concepts and critique their application to the context of Indigenous health curriculum in undergraduate nursing education. I draw parallels from the previous discussion on Cultural Safety and cultural competency approaches to postulate their alignment with decolonising and Indigenising approaches.

3.1.2.1 Indigenising approaches

Mohawk Professor Emeritus Marlene Brant Castellano provides the often-cited definition for Indigenising education. She states:

Indigenizing education means that every subject at every level is examined to consider how and to what extent current content and pedagogy reflect the presence of Indigenous/Aboriginal peoples and the valid contribution of Indigenous knowledge. Such an examination would shift the focus from remediating deficits in Aboriginal students to addressing bias and omissions in the education system (Castellano, 2014, para, 1).

Castellano argues Indigenous students are resisting “being absorbed in a world of knowledge and a society that appears to have no place for them or their people” and cites the ignorance of graduating secondary school students about the colonial history of Canada (2014, para, 1:2). She explains that while Aboriginal peoples’ knowledges have been recognised for their health and justice approaches, and while individual Aboriginal people have achieved great things in the arts, “the prevailing public perception is that we are problems resistant to solution and impediments to economic development” (Castellano, 2014, para, 3). Castellano believes that Indigenising education “could diffuse or dispel the residue of colonialist arrogance that maintains stereotypes and prejudice” (Castellano, 2014, para. 3).

The Indigenising agenda appears to align with the aims of cultural competency which is championed by Universities Australia and was advocated by a few key university sector reviews, namely the 2008 *Review of Australian Higher Education* (the Bradley Review) (Bradley et al., 2008) and the Indigenous led 2012 *Review of Higher Education access and outcomes for Aboriginal and Torres Strait Islander people* (the Behrendt Review) (Behrendt et al., 2012). The harmonious chorus calls for universities to standardise requirements that will enable greater understanding of Indigenous people’s culture by undergraduate students within all professional disciplines (Pecci et al., 2020).

While not an official recommendation to the Australian government, the Bradley Review asserted that “Indigenous knowledge should be embedded into the curriculum to ensure that all students have an understanding of Indigenous culture” (Bradley et al., 2008, p. xxvi). Compounding the problematic assumption that there is only one homogenous Indigenous culture that could be taught, is the issue that Indigenous knowledge is not specifically defined and yet is framed as “important” and a “unique element of higher education [that would contribute to] ...economic productivity by equipping graduates with the capacity to work across Australian society and in particular with Indigenous communities” (Bradley et al., 2008,

p. 33). The Bradley Review adds that "more significantly, as the academy has contact with and addresses the forms of Indigenous knowledge, underlying assumptions in some discipline areas may themselves be challenged" (Bradley et al., 2008, p. 33). This statement does highlight some insights into fundamental limitations of some disciplines to engage with Indigenous knowledges.

The Behrendt Review advocates for the inclusion of Indigenous perspectives and knowledges into "curriculum, teaching practices and graduate attributes" as the means to develop "relevant knowledge and... understanding of contemporary Indigenous issues" which will enable individuals and their professions to better address the needs of Indigenous peoples (Behrendt, 2008, p. 14). The recommendations of the Behrendt Review resonate with those of Universities Australia's (2011) *National Best Practice Framework for Indigenous Cultural Competency in Australian Universities*, as well as Universities Australia's (2017) more recently published *Indigenous Strategy 2017-2020*. The latter proposes that "universities commit to have plans for, or have already in place, processes that ensure all students will encounter and engage with Aboriginal and Torres Strait Islander cultural content as integral parts of their course of study" (Universities Australia, 2017, p. 30).

The Indigenising approach is optimistic in its advocacy for 'adding Indigenous elements' to university structures, namely Indigenous knowledges, and perspectives into the curricula of all disciplines. The logic here is that if students know more about Indigenous peoples' culture and issues, they will work better with Indigenous peoples. However, this logic seems ahistorical, as we see such strategies being proposed by Australian governments, professional groups, and Indigenous communities, with little reporting on planned change, and a lack of accountability. Indigenising approaches also resonate with the manifestations of cultural competency, which highlight the need to learn more about Indigenous peoples' culture, which

simultaneously invisibilises the dominant white neocolonial culture that Indigenous peoples are subjected to.

3.1.2.2 Decolonising approach and requisite incommensurabilities that unsettles innocence

The concept of decolonisation was coined in 1936 by German economist Moritz Julius Bonn. It became more commonly used following World War Two when “the political elites of Great Britain and France... believed that they could engineer the transfer of power to ‘trustworthy’ indigenous [sic] leaders in the colonial territories previously under their control” (Jansen & Osterhammel, 2017, pp. 4-5). Some believe that this period marked the end of European colonisation, and that the assumed completion of the ‘transfer of power’ processes would mark the end of decolonisation (Wesseling, 1987).

Wesseling (1987, p. 98) suggests that the nation-states of Canada, Australia, and *Aotearoa* (New Zealand) are a “true success story of British Empire”, as nation-states that went “from colonies to dominions and then to independent states”, the latter via ‘decolonisation’. The apparent decolonisation of Canada, Australia and *Aotearoa* (New Zealand) was “peaceful, supple and gradual”, compared to the violence associated with the decolonisation of some Asian and African countries, that were “often accompanied by war” (Wesseling, 1987, p. 98). Spivak (1996, p. 249) asserts this violence, disruption, and inability to ensure the “establishment of a civil society” marked the “failure of decolonization”, which she highlights disproportionately affected women more. Tuhiwai Smith (2012, p. 23) suggests that such failure of decolonisation could be the result of “replacing one corrupt elite with its mimic”, thus reproducing colonial hierarchy.

Perhaps the reason the ‘decolonisation’ of Canada, Australia, and *Aotearoa* (New Zealand) nation states were apparently ‘peaceful, supple and gradual’ is because the ‘transfer of power’ was not to ‘trustworthy Indigenous leaders’, but to British subjects who sought

independence from the British empire. Their apparent success reflects the maturing of colonisation, or neocolonialism, as opposed to a winding-back of colonial power. Nkrumah (1965) theorised about the operations of neo-colonialism within ‘independent’ African nation-states. He asserts that former colonial empires, and other influential nations (like the USA) now exert their power and control over the politics of these newly independent nation-states, through financial and ‘humanitarian’ means. “The result of neo-colonialism is that foreign capital is used for the exploitation rather than for the development of the less developed parts of the world. Investment under neo-colonialism increases rather than decreases the gap between the rich and the poor countries of the world” (Nkrumah, 1965, p. x).

This form of neo-colonialism in Australia is evident in the politicisation of Indigenous people’s health and well-being, namely the decades of government inaction or short-term actions on Indigenous peoples’ needs. A recent example is the failure of the initial National Partnership Agreement on Closing the Gap which “was effectively abandoned [by federal and state governments] after five-years” (Holland, 2018, p. 4), and ignored the persistence of institutional racism which manifested as limited-to-no engagement with Indigenous peoples at health services’ decision-making levels, and a significant lack of accountability of health departments for adequate resourcing and service delivery to Indigenous peoples (Marrie, 2017, Bourke et al., 2019). The difference between the Australian context and that of independent post-colonial nation-states is that the colonist remains the majority and in positions of power, and Indigenous peoples are mere citizens and minorities, thus our needs are framed as such. This is the success that Wesseling (1987) was referring to, not ours, but of the colonist. Thus, imperialism continues, in the form of neocolonialism, within the nation-states of Canada, Australia, and *Aotearoa* (New Zealand) (Tuhiwai Smith, 2012), because, as Moreton-Robinson bluntly puts it, “the colonials did not go home” (2015, p. 10).

Tuck and Yang (2012, p. 2:3) assert that “decolonization brings about the reparation of Indigenous land and life; it is not a metaphor for other things we want to do to improve our societies and schools... decolonization doesn’t have a synonym.” They raise their concern with “the ease with which the language of decolonization has been superficially adopted into education and other social sciences, supplanting prior ways of talking about social justice, critical methodologies, or approaches which decentre settler perspectives”; domesticating the concept of decolonisation (Tuck & Yang, 2012, pp. 2:3). They warn that the metaphorisation of decolonisation “kills the very possibility of decolonization; it recenters whiteness, it resettles theory, it extends innocence to the settler, [and] it entertains a settler future” (Tuck & Yang, 2012, p. 3).

Tuck and Yang (2012, pp. 3-4) argue that there are six ways in which settlers move to innocence through the metaphorisation of decolonisation. The moves to innocence that are relevant to our discussion include: colonial equivocation, free your mind and the rest will follow, and a(s)t(e)risk peoples (At risk-ing / Asterick-ing Indigenous peoples) (Tuck and Yang (2012, p. 4).⁴⁶ Their description of these moves to innocence will help define decolonisation and assist in identifying how the cultural competency approaches and cultural safety relate to decolonisation.

“Colonial equivocation... is the homogenizing of various experiences of oppression as colonization”, that is, different groups are referred to as ‘colonized’, but the context in which

⁴⁶ The other moves to innocence associated with the metaphorization of ‘decolonisation’ include: “settler nativism, fantasizing adoption, and re-occupation and urban homesteading” (Tuck & Yang, 2012, p. 4). Settler nativism is realised when “settlers locate or invest a long-lost ancestor who is rumored to have had ‘Indian blood,’ and they use this claim to mark themselves as blameless in the attempted eradication of Indigenous peoples” (Tuck & Yang, 2012, p. 10). Fantasizing adoption is enacted when settlers adopt “Indigenous practices and knowledge, but more, refer to those narratives in the settler colonial imagination in which the Native (understanding that he is becoming extinct) hands over his land, his claim to the land, his very Indian-ness to the settler for safe-keeping” (Tuck & Yang, 2012, p. 14). Re-occupation and urban homesteading refer specifically to the reproduction of colonial occupation through the recent 2011 Occupy movement in the USA that called for greater distribution of wealth. Such movements advocate for a form of social justice that perpetuates the dispossession and disadvantages of Indigenous peoples (Tuck & Yang, 2012, p. 23).

they were colonised is not interrogated (Tuck & Yang, 2012, p. 17). This practice is evident in pooling all ethnic minorities together and including Indigenous peoples amongst this pool of ‘other’ ethnic minorities groups. This practice of course invisibilises the different ethnic, gender, ability, sexuality and socio-economic needs of the individuals and communities pooled together and inhibits any specific focus on the needs of Indigenous peoples, as sovereign peoples of the land and sea territories that continue to be occupied.

“Free your mind and the rest will follow” focuses on “decolonizing the mind, or the cultivation of critical consciousness, as if it were the sole activity of decolonization; to allow *conscientization* to stand in for the more uncomfortable task of relinquishing stolen land” (Tuck & Yang, 2012, p. 19). This approach is evident in cultural education and training programs that only focus on developing individual critical consciousness, without considering the broader requirement for system change. The cultural education and training programs I have explored thus far do not address the issue of ‘relinquishing stolen land’, a point of incommensurability for cultural education and training programs that deploy decolonisation as a metaphor.

“A(s)t(e) risk peoples” is the final form of move to innocence that I chose to discuss, and it “is concerned with the ways in which Indigenous peoples are counted, codified, represented, and included/disincluded by education researchers and other social science researchers” (Tuck & Yang, 2012, p. 22). This practice is evident in the way Universities Australia (2021) has developed ways to count, codify, and represent Indigenous students’ recruitment, retention, and completion. Indigenous peoples are often measured as percentages and compared to non-Indigenous peoples’ percentages in the contexts of annual growth in applications and enrolments, yearly trends of applications and enrolments compared to total population, as well as applications and enrolments according to gender, and completion rates (Universities Australia, 2021, pp. 14-30). The universities and their student support services are not required to be made hyper-visible or calculable, suggesting that they are not the problem.

Tuck and Yang (2012, p. 22) warn that such moves to codify and calculate Indigenous peoples enables and “conceals the erasure of Indigenous peoples within the settler colonial nation-state and moves Indigenous nations as ‘populations’ to the margins of public discourse.” Like the initial example of move to innocence offered by Tuck and Yang, this example attempts to diminish the sovereign status of Indigenous peoples, discursively through narrating us as a problem population group to be fixed through ‘equity and diversity’ initiatives. This discourse is evident in how Indigenous peoples are narrated in the Bradley Review; whilst named with separate figures and placement in bar graphs and tables we are constantly located with the ‘under-represented’ groups, with ‘students from low socio-economic backgrounds’ and ‘students from regional and remote areas’ (Bradley et al., 2008).

The lack of attention to land relinquishment to Indigenous peoples within the university and discipline regulation standards highlight the tensions of using ‘decolonising’ within the context of my research. This situation may explain why McNamara and Naepi (2018) established decolonisation as a destination for curriculum work to develop towards, perhaps knowing that they cannot adequately address Tuck and Yang’s assertion of decolonisation. This notion of ‘working towards decolonisation’ seems useful however, as it provides direction that works towards privileging Indigenous peoples’ futurity, and a direction that insists on critique approaches that enables settlers’ moves to innocence.

This assertion brings me back to the closing comments on the previous subsections, namely the ability of Cultural Safety to engage with matters of co-existing sovereignty, at least in the *Aotearoa* (New Zealand) context. In the *Aotearoa* (New Zealand) context, the *Te Tiriti o Waitangi* has been used as leverage for negotiations between Māori people and the New Zealand government regarding sovereign Māori matters. Ramsden (2002) reiterates her point about the maldistribution of power between Māori people and the majority non-Māori, suggesting that engaging the *Te Tiriti o Waitangi* within her theorising would attend to the

issue of power at the highest level. She explains that “(a) treaty-based argument would support the position of Māori as a treaty partner with the (British) Crown and therefore place Māori in charge of determining and defining Māori concerns, irrespective of population numbers” (Ramsden, 2002, p. 103). This approach extends engagements with the health service and health professionals. Australia does not have a treaty/ies to negotiate such terms, we are treated as Australian citizens, and have several legislations and government policies that target Indigenous issues, such as land and sea management as well as cultural heritage legislations, and the National Partnership Agreement on Closing the Gap. The self-determination movement of the 1970s is embodied within the Indigenous community-controlled sector, namely the ACCHOs, that provide comprehensive primary health care, chronic disease care and rehabilitation services to Indigenous communities throughout Australia. This set of circumstances is not comparable to *Te Tiriti o Waitangi*. However, the precedent set by Ramsden in *Aotearoa* (New Zealand), demonstrates the potential for Cultural Safety in decolonising Australia, particularly regarding working towards a decolonising approach in Indigenous health curriculum in undergraduate nursing education.

To address these limitations, Tuck and Yang (2012, p. 30) assert the need to rethink how land and Indigenous sovereignty is taught, beyond being a stage upon which humans live or have lived. This may include teaching about Indigenous peoples’ sovereignty of land and water territory, as well as our relations to land, water, skies, and the living and inanimate entities we share Country with (Martin, 2003; Moreton-Robinson, 2017; Drummond, 2020). This relationship is incommensurable to Western understanding of land, as it is known via the logic of capital (Moreton-Robinson, 2015). Visibilising incommensurabilities is imperative to a decolonising approach.

In contrast to Indigenising, decolonisation does not aspire towards reconciliation, as “reconciliation is about rescuing the settler normalcy... [and] settler future”, whereas

decolonisation invests in “an ethic of incommensurability, which guides moves that unsettle innocence” (Tuck & Yang, 2012, p. 35). Incommensurability in the context of decolonisation, as described by Tuck and Yang (2012), refers to addressing significant incommensurable complexities that unsettle innocence. Moreton-Robinson (2015, p. 3) shares an example of incommensurability that goes to the core of Tuck and Yang’s argument, and that is “the sense of belonging, home and place enjoyed by the non-Indigenous subjects – colonizer/migrant – is based on the dispossession of the original owners of the land and the denial of our rights under international customary law”, which is incommensurable with Indigenous peoples’ sovereignty, including our connection to Country, as described earlier.

Incommensurabilities also exist between disciplines’ and Indigenous peoples’ knowledges and ways of knowing; thus, teaching about such incommensurabilities in a way that does not retreat to a racialised way of understanding differences, would align with a decolonisation approach (Drummond, 2020). Such an approach shifts the gaze from Indigenous dysfunction as the object of study, to the reality of Indigenous and non-Indigenous peoples co-existing within a neo-colonial nation-state that occupies Indigenous peoples’ territory. This approach may be more effective in avoiding the trappings of hopefulness and performative benevolence.

Rigney’s (2001, p. 8) concept of Indigenism focuses on these incommensurabilities, referring to them as “the journey of academic contradictions” that acknowledges that universities and Western sciences “has contributed to our own oppression on one hand, whilst raising our consciousness to the functions and location of oppression on the other. Without such a journey, emancipation from neo-colonial discourse falls victim to ongoing epistemic and cultural hegemony.” Indigenism is concerned with enquiries such as: ““can we participate in Western science without reinvesting the hegemonic colonial imagination about ourselves?” If Western scientific traditions and structures are intimately connected to ‘racialisation’ through

neo-colonialism, can the Indigenist scholar use such science for intellectual and political emancipation?” (Rigney, 2001, p. 7). Rigney (2001, p. 9) insists that attending to these incommensurabilities is the role of the modern-day Indigenist academic, and in doing this work they “push the boundaries [of their discipline] ...in order to make intellectual space for Indigenous cultural knowledge systems that were denied in the past.”

Hokowhitu (2016, p. 85) warns about the failure of decolonial work by Indigenous scholars within disciplines who unwittingly “enmesh... [themselves within] colonizer’s methods”, legitimise the coloniser’s presence, through critique of them, and “give them mana (power and prestige)” through resisting them. Because the ‘colonials did not go home’, their ways of knowing, being and doing remain the norm as the dominant cultural group, including within disciplines. Hokowhitu proposes conscious and strategic navigation of this reality, a journey of academic contradictions, that shifts our intellectual investment from critiquing the colonials towards “robust self-criticism” that develops into a “branch of study that might be termed post-Indigenous”, a futurity beyond the coloniser-colonised binary (Hokowhitu, 2016, p. 100). His assertions highlight the need for Indigenous academics to invest in ‘robust self-criticism’ of what has become of our ways of knowing, being and doing because of violent colonialism; an investment in “Indigenous intellectual sovereignty” as articulated by Warrior (1995, as cited in Rigney 2001, pp. 9-10)⁴⁷. Such an approach intuitively privileges Indigenous peoples’ futurity, beyond the superficial needs of our respective disciplines. As “Aunty Lilla

⁴⁷ Such Indigenous theorising reflects Warrior’s “four points that justify investment in Indigenous intellectual sovereignty” (1995, as cited in Rigney 2001, pp. 9-10). He proposed:

1. *“The need to capitalise on the gains made in the previous decade and solidify the process of the Indigenous communities taking control of their own destinies.*
2. *The responsibility which sovereignty creates is orientated primarily towards the existence and continuance of the group.*
3. *Intellectual sovereignty provides a framework for developing an Indigenous intellectual praxis that can help make sense of the spiritual, political and social lives of First peoples.*
4. *The diversity of First Nation intellectualism is now to proceed toward intellectual sovereignty and not simply interrogating non-Indigenous works of ourselves as Indigenous scholars”* (Warrior, 1995, as cited in Rigney 2001, pp. 9-10).

Watson [via Watego] reminds us... to imagine a future as long as the past behind us. As the oldest living culture in the world, survival has been central to our existence and must continue to be” (Watego, 2021, p. 209).

Obviously, this description of decolonisation goes well beyond the Indigenising agenda, that insisted on hope in performative benevolence. There is a dearth of Australian nursing literature specifically focused on decolonising nursing education programs, suggesting intellectual interest in other approaches. CATSIN (cited in Sherwood & Edwards, 2006, p. 188) believed their work to be decolonising including their insistence on a “mandatory subject in Indigenous history, culture, health and principles of self-determination and management”; that this is kept separate from “multi-cultural studies... [as we] are still being colonised”; that non-Indigenous “university staff must have colonisation and anti-racist workshops”; that Indigenous registered nurses are “engaged as consultants to [SON]... as educators and mentors”; and that Indigenous peoples are able to learn about our “own history for personal growth and development.” CATSIN’s position is endorsed by Sherwood and Edwards (2006). While some of these strategies engage with an ethic of incommensurability that is associated with decolonisation, some of these strategies seem to align more with an Indigenising approach.

There are many non-Indigenous peoples that believe in and contribute to decolonisation (Wallace, 2011). Given the task at hand, partnerships between Indigenous and non-Indigenous peoples are pivotal for mutual support (McGloin, 2015, p. 276). However, such solidarity must be built upon the incommensurabilities that decolonisation aims to address (Tuck & Yang, 2012). Tuck and Yang (2012, p. 3) warn that “solidarity is an uneasy, reserved and unsettled matter that neither reconciles present grievances nor forecloses future conflict.” Moreton-Robinson’s (2020, p. 186) advised white women feminists that “if Indigenous women’s interests are to be accorded some priority, white feminists will need to relinquish some power”.

This advice appears suitable for other forms of solidarity and being an accomplice that wish to restructure the current maldistribution of power in favour of Indigenous peoples (Land, 2015).

In investigating the difference between an Indigenising approach of Indigenous health curriculum development and delivery and decolonisation I argue that the former aligns with the approaches of cultural competency, and collectively they are promoted by key university sector reports and frameworks, as well as the National Framework. It perpetuates performative benevolence and insists on Indigenous peoples holding hope that eventually, things will change. Decolonising is an older concept, and interrogates the competing sovereignty of the Australian continent, and the associated perpetual racialisation of Indigenous peoples. Decolonisation risks being watered down as synonymous with other critical approaches, which risks perpetuating settler moves to innocence. Decolonising is seen by some as too radical and even impossible to achieve, which reflects the unsettling work that is required by this approach. Cultural Safety aligns with a decolonisation, however it could be further disruptive, in favour of Indigenous peoples, if it was able to leverage off a treaty/ies, as is the case in *Aotearoa* (New Zealand). The nursing literature is limited in this context, however, there seems to be support for Cultural Safety, evidenced by the embedding of Cultural Safety within ANMAC (2019) accreditation standards, CATSINaM's (2017) Nursing and Midwifery Framework, and the NMBA's (2018) Code of conduct for nurses.

3.1.2.3 Indigenous ways of knowing, being and doing; Indigenous knowledges and perspectives

Indigenous ways of knowing, being and doing, as well as Indigenous knowledges and perspectives are ill-defined yet often used terms. Like the other concepts discussed in this chapter these are often used interchangeably in the literature, reflecting a general lack of understanding and valuing of these concepts. This section deciphers the differences between these concepts, and then looks to the nursing literature to highlight how they are applied.

An important place to start is with the historical conditions of these concepts, namely, to acknowledge that Indigenous peoples' ways of knowing, being and doing, were targets for British colonialism. Indigenous peoples were forced to discontinue their ways of knowing, being, and doing. Western scientific racism asserted that we were the lowest form of human, and potentially the missing link between other human races and primates. Thus, our ways of knowing, being, and doing, knowledges, and perspectives were seen in this light as "inferior and irrational" (Rigney, 2001, p. 4), and mere evidence of what other human societies used to be, which assumes a linear path of human progress. This notion ignores our intellectual tradition that included philosophy, theology, sciences, and arts (Bin-Sallik, 1989). Rigney (2001, p. 4) coined the term *intellectual nullius*, based on the debunked claim of the Australian continent being *terra nullius* (Latin for land belonging to no one, or vacant land), to highlight the racist belief that Indigenous peoples were/are unintelligent, or vacant of any intellect.

Indigenous peoples were simultaneously denied access to Western education opportunities beyond Christian teachings (Bin-Sallik, 1989). Christian religion was introduced to indoctrinate Indigenous peoples into Western civilisation, which involved the prohibition of practicing our own religions or spirituality, including Indigenous languages, songs, and ceremony (Nightingale, 1865; Commonwealth of Australia, 1997). The prohibition to practice our own education as well as access British/Australian education also fuelled racist stereotypes about Indigenous peoples' apparent 'unintelligence' and our inability to contribute to contemporary societal problems with our ways of knowing, being, and doing. Some Indigenous communities were able to practice their ways of knowing, being, and doing in secret.

Western study of Indigenous peoples, led by anthropologists focused on racialised differences and peculiarities between Indigenous peoples, and Europeans; by the mid-twentieth century the focus changed to cultural attributes and peculiarities (Moreton-Robinson, 2016). Our engagement with education and research were as objects to be studied. An example shared

earlier was Professor Sir Alfred Haddon who was a zoologist turned anthropologist when he returned to the Torres Straits in the 1890s with colleagues who aimed to capture the culture of Torres Strait Islanders before it was consumed by British colonialism a practice known as ‘salvage anthropology’ (Nakata, 2007). His intentions were never to prevent colonisation and genocide, as he saw destruction as inevitable, his interest (and that of his discipline of anthropology) was to salvage artifacts and knowledge of what was about to be destroyed by their British colonialism (Drummond et al., 2021a).

Indigenous ways of knowing, being, and doing are interrelated concepts that elaborate on our ways of understanding our universe, our purpose within it, and how we realise our purpose. A common feature of these separate but interrelated ways is relationality/relatedness/kindredness (Moreton-Robinson, 2017; Martin, 2008; Dudgeon & Oxenham, 1990). These concepts, developed by Indigenous women scholars, explain the interconnectedness between human and non-human entities, including seemingly inanimate entities (e.g., rock formations, islands) and metaphysical entities (i.e., spirits and our ancestors), and Country (Martin, 2003; 2008). Our engagements with these relationships are contextual and dependent on where we are positioned in our life stages, our gender, and our role within our broader family networks. Our learning about these relationships and contextual factors is a lifelong journey (knowing); embedded in these learnings are protocols, respectful and proper ways to be a good relation to all entities (being); while both are manifested in our everyday actions (doing) (Martin, 2003).

Moreton-Robinson (2017, p. 71) proposes that relationality is a presupposition of contemporary Indigenous research that “is grounded in a holistic conception of the interconnectedness and inter-substantiation between and among all living things and the earth, which is inhabited by a world of ancestors and creator beings.” Relationality, as a methodology, values and validates Indigenous ways of knowing, being, and doing within contemporary

Indigenous research. It connects mind-body-country, which instinctively challenges the Cartesian dualism⁴⁸ and anthropocentrism of Western rational belief systems; so, it is also a critical approach (Moreton-Robinson, 2015; 2017; Drummond, 2020). I will return to relationality later, as it is an important part of my theoretical framework ([Chapter 4](#)).

Indigenous ways of knowing refers to what is known (knowledge), as well as how it came to be known (learning relationally from family members and from engagement with other entities) (Martin, 2003; Christie & Asmar, 2012). Indigenous peoples' ways of knowing are relational, as knowing is possible through our relationships with human and non-human entities (Martin, 2003). Our learning focuses on our roles and responsibilities to our family, community, and Country, and we often learn this from specific family members (e.g., gendered knowledge taught by specific aunties or uncles), at a time when we are ready to learn it (i.e., we are at the right life stage, and it is the season for the specific type of education). Engagement with non-human entities is part of the pedagogy and knowledge, and so our ability to engage grows with our knowing of how to be a good relation to all entities. Martin shares that "knowledge is reproduced through processes of: listening, sensing, viewing, reviewing, reading, watching, waiting, observing, exchanging, sharing, conceptualizing, assessing, modelling, engaging and applying" (2003, p. 209). So, the idea of Indigenous ways of knowing is synonymous with the concept of Indigenous knowledges; both are different from the concept of Indigenous perspectives. The latter two concepts are often used interchangeably, inaccurately of course. I will return to a discussion of their distinction in a moment.

Indigenous ways of being refers to our being interconnected relationally with our world, specifically referring to our ways of being a good relation to the human and non-human entities we are connected to, which is realised through us fulfilling roles and responsibilities, a

⁴⁸ Reference to French philosopher Renee Descartes theory of mind-body dualism.

reciprocal duty to the benefit of all (Martin, 2003). Martin (2003, p. 209) explains that the fulfilment of our roles and responsibilities grants “for us rights to be earned and bestowed as we carry out rites to country, self and to other... Our Ways of Being are about the rights we earn by fulfilling relations to Entities to country and self”.

Our ways of being are evident in our emphasis on family and community connections and responsibilities. Indigenous peoples speak of Country and non-human entities that reside on and in Country as relations; this too is evidence of our ways of being interconnected. From a young age we are taught about our interconnectedness, and how to be a good relation in this network, thus ways of knowing, precedes ways of being (Martin, 2003).

Indigenous ways of knowing and being inform our everyday actions, which are Indigenous ways of doing. Martin (2003, p. 210) explains that Indigenous ways of doing “are a synthesis and an articulation of our Ways of Knowing and Ways of Being. These are seen in our languages, art, imagery, technology, traditions and ceremonies, land management practices, social organisation and social control... these are life stage, gender and role specific”.

Our ways of knowing, being, and doing are not static, or stuck in the past, but are always contemporary to Indigenous peoples (Nakata et al., 2005). Our ways are bound to the relational network of human and non-human entities, thus changes in our ways of knowing, being, and doing impact this network. Being a good relation also means being aware of how changes to our ways of knowing, being, and doing can impact our relational network. The following discussion on Indigenous knowledges and perspectives highlights the difference between collective knowing, and individual perspectives, and the significance of proximity and engagement with the collective towards the regulation of Indigenous knowledges.

Indigenous knowledges refer to Indigenous ways of knowing, which includes knowledge content as well as ways of knowing (Christie & Asmar, 2012). Indigenous knowledges are

contextual and responsive to relational connections with human and non-human entities, and involves a complex interplay of “language, land and identity” (Christie & Amar, 2012, pp. 216-217; Martin, 2003). The significance of these dimensions, of language, land, and identity, is evident in how colonisation has influenced Indigenous knowledges via colonial implications on the health of our languages, the health of our connection to Country and kin, our belonging.

Different Indigenous groups collectively hold their own Indigenous knowledges, while individuals share perspectives informed by Indigenous knowledges and their individual experience of the social world (Christie & Asmar, 2012; Drummond, 2020). What is known in both cases is informed by “lived, historical experiences, ideas, traditions, dreams, interests, aspirations and struggles” (Rigney, 1999, p. 117). The former involves collective negotiations on how these factors inform knowledges, while in the latter case, the individual can exercise a degree of independence in determining their perspective, which may be based on their interpretations of Indigenous knowledges independent of the collective remembering, retelling, and negotiating (Drummond, 2020). This process highlights the dynamism and diversity of Indigenous perspectives, in its independence/isolation from the collective knowing and ways of knowing.

While completing this thesis, I was grateful to be able to have a few yarns with Aka Rose Elu, a Saibai and *Zenadh Kes* Elder, about it. When we were yarning about *Zenadh Kes* knowledges, she explained that while she is knowledgeable with our ways of knowing, being, and doing, including languages and customs, she frequently engages with other *Zenadh Kes* Elders to interrogate the collective understanding of our knowledges. This yarn deeply informed my understanding of the difference between Indigenous knowledges and perspectives.

Indigenous ways of knowing are evident in this example, in the collective practice of remembering, retelling, and negotiating, amongst knowledge holders, a process that follows the appropriate protocol. Thus, Indigenous ways of knowing are an essential part of Indigenous knowledges. Fixation on static knowledge content, assumes that Indigenous peoples' ways of knowing is commensurate with Western rationale thought traditions, and can limit one's understanding. Such fixation also risks essentialising Indigenous knowledges to a universal list of knowledge, which diminishes the different knowledges amongst the diverse Indigenous nations (Downing & Kowal, 2011).

The collective nature of Indigenous knowledges enables innate regulation of knowledge and ways of knowing, which manifests as protocol that is taught alongside knowledge (Nakata 2002). For example, as a child I learnt traditional *Zenadh Kes* songs and dances from numerous expert dancers, singers, and Elders from different *Zenadh Kes* communities; individuals who had recognised authority to share this knowledge. These songs and dances and associated lessons were of course scaffolded; we learnt *segurkab* (play dances) from Kindy to early primary school; then we learnt more complex dances including dances with choreography requiring partners, dances with boys and girls doing different choreography, and dances with equipment like *maraps*⁴⁹ and bow and arrows. In my 20s, I was privileged to learn *kabkar*, our most sacred expression of our knowledge via dance. Compared to earlier experiences of learning songs and dances, the lessons for *kabkar* had stricter protocols, which we learned with the songs and dances. My dance trainers were my grandparents, they were also the singers, the *wed le*, who held the knowledge and lessons of the story-songs⁵⁰, the choreography of the

⁴⁹ A cylindrical-shaped bamboo instrument that has been cut diametrical along one half of the height of the bamboo. The *marap* is held by its uncut half, and when the dancer moves their wrist as part of the dance choreography, the part of the *marap* that is cut claps, resulting in a clapping sound.

⁵⁰ Grandad Charles Passi, *Meriam* man, musician, actor, and my maternal Grandad's younger cousin, wrote a song dedicated to Eddie Koiki Mabo called *Nibe Nibe*, named after a sacred *Meriam kabkar* song, which he also weaved into the chorus. He tells of the power of *Meriam* story-songs, emphasising that our songs are not just superficial words with a tune, they are pedagogical tools that enable the condensing of knowledges into words

dances, and the protocols. They negotiated knowledge and processes every now and again amongst themselves. They were accountable for maintaining the protocols, the regulations, of the knowledge they were sharing, and if we, the dancers, breached any of them, including if we were not taking the lesson seriously, then we would have to answer to them.

Indigenous perspectives are not as bound to the collective remembering, retelling, negotiating and protocols of Indigenous knowledges. Indigenous perspectives allow individuals to share their understanding that may be based on Indigenous knowledges but may privilege their individual lived and historical experiences, ideas, traditions, dreams, interests, aspirations, and struggles. Similarly, Indigenous knowledges that are extracted from the collective knowers are severed relationally from the collective remembering, retelling, negotiating and protocol of the knowers (Nakata, 2002); thus, extracted knowledge becomes Indigenous perspectives. This process is common practice for agents of the university sector, including teaching academics and researchers such as the astronomy example with which I opened the thesis.

The inclusion of Indigenous perspectives within the daily operations of universities and Schools of Nursing is evident in Indigenous student support initiatives (Usher et al., 2005; Best & Stuart's, 2014) and Indigenous health curriculum (Nash et al., 2006; Jackson et al., 2013). Usher et al. (2005) demonstrate value for local Indigenous leadership and perspectives in the development and delivery of nursing education in a remote Indigenous community. Best and Stuart (2014) engage their own Indigenous perspectives to develop and deliver appropriate support services for Indigenous nursing and midwifery students. Nash et al. (2006) engage with Indigenous perspectives via the Indigenous working group that was established to oversee the

and words into stories and songs. These stories and songs are taught to us when we are deemed the right age, and we continue to learn about a new layer of interpreting these songs and stories as we grow old enough to learn more. Meriam Artist King Kadu did a cover of *Nibe Nibe* for his album, *Listen to my drum* (Passi, 2020).

development of Indigenous health curriculum. Jackson et al. (2013) shares the benefits of a group of Indigenous nurse academics developing and delivering Indigenous health curriculum, highlighting their ability to engage in remembering, retelling, and negotiating Indigenous perspectives as pedagogy and curricula. Sherwood and Edwards (2006) support investment in Indigenous peoples' historical perspectives, to counteract colonial-dominant accounts of Australian history.

According to my descriptions above, Cultural Safety would be considered an Indigenous perspective, as its popular use is not subject to the protocols of Irihapeti Ramsden's peoples. This does not diminish its value; in fact, it proves further usefulness in demonstrating the undisciplined use of knowledge without protocol. This highlights an example of incommensurability that academics developing and delivering Indigenous health curriculum must contend with.

The use and repository of Indigenous perspectives distal from the collective knowers of the respective community seems a reproduction of salvage anthropology, and likewise limits the control Indigenous communities have over knowledges that they share. Thus, the extraction of Indigenous knowledges from their relational connection to the collective knowers also conveniently limits the accountability of the extractors to the Indigenous community who owns/ed that knowledge. The past tense added to the word 'owned' is not an attempt to interpret the application of Australian intellectual property law in this context, but to highlight incommensurabilities regarding the relational connection to and regulation of Indigenous knowledges and Western ways of knowing in such circumstances.

The integration of Indigenous perspectives into Western institutions such as universities is not a new initiative, as individuals from outside Indigenous communities have a history of 'cherry-picking' and adopting perspectives that best suit their context (Nakata, 2002; Moreton-

Robinson, 2016). Disciplines can do this without accountability to Indigenous peoples. Discipline investment in particular Indigenous perspectives, used to legitimise non-Indigenous narratives about Indigenous peoples, can create contradictions and confusion, especially if reinterpretations of Indigenous perspectives vary. Indigenous knowledge systems are also dynamic and change through the normal operations of collective negotiations; such change highlights the vulnerability of any extracted Indigenous perspective to becoming obsolete (Nakata, 2002).

Extracted Indigenous perspectives are also vulnerable to (mis)appropriation, especially if such perspectives are ‘cherry-picked’ and manipulated by the discipline to meet their needs. Distinguishing between appropriation and misappropriation in this context is difficult; the lack of power afforded Indigenous peoples to regulate extracted Indigenous perspectives makes perspectives vulnerable to manipulation and misrepresentation by the discipline (appropriation), and for perspectives to only benefit the discipline and university despite promises made to Indigenous individuals and collectives during initial extraction (misappropriation).

Graveline (2000, p. 362) poses the question about who can/should speak on behalf of Indigenous peoples? The answer according to Rigney (1999) is that Indigenous peoples are the ideal people to share their own knowledges and perspectives, privileging their voice on issues that impact them. Indigenous nursing academics enable this currently, sharing their own perspectives and enabling other Indigenous peoples to share theirs; but there are not many of us Indigenous nursing academics (Sherwood & Edwards, 2006; Jackson et al., 2013; Best & Stuart’s, 2014). Universities Australia (2017) and the National Framework (Department of Health, 2014) aim to increase Indigenous academics. While increasing Indigenous academics for this work is ideal, the historical operations of disciplines and universities in extracting and (mis)appropriating Indigenous perspectives highlight systemic deficits that should not be

delegated to Indigenous academics to address (Sherwood & Edwards, 2006; Jackson et al., 2013; Best & Stuart's, 2014). I discuss this matter later.

Contemporary Indigenous health curriculum must engage with the ethic of incommensurability, aspiring towards greater understanding of the complexities inherent in Indigenous peoples' health. Our presence unsettles non-Indigenous peoples, because it is a reminder of the unfinished business of competing territorial sovereignty (Moreton-Robinson, 2015). The conceptual confusion evident in the context of Indigenous health curriculum acts as a barrier to engaging with the ethic of incommensurability. It also nurtures confusion regarding relationships between Indigenous peoples and the discipline, SON, and universities, creating numerous opportunities for misunderstandings and (mis)appropriating of Indigenous peoples' knowledges and perspectives. Cultural Safety is an approach that can work towards decolonisation, that makes visible the incommensurabilities in the context of Indigenous health, including those associated with engaging with Indigenous peoples and our knowledges and perspectives.

3.2 Preparedness of Institutions

This section interrogates the preparedness of institutions to develop and deliver Indigenous health curricula. This interrogation employs intersecting lines of critique of power within the institutions of the nursing discipline and universities, namely the operations of neoliberalisation, and white possessive logics (Moreton-Robinson, 2015). Both approaches are critical of privileging the logic of capital. The former is concerned with commodifying academic practice and knowledge and the latter is primarily concerned with the incommensurability of competing sovereign claims over the Australian continent, and the

associated manifestations of racism against Indigenous peoples, including the dominant logic of capital that operates to obfuscate and distract (Ball, 2012; Moreton-Robinson, 2015).

The neoliberalisation of the university sector operates at an institutional and an individual level. At an institutional level it involves “very real economic and political dynamic to the reform of [universities], a business dynamic which seeks profit from the buying and selling of education ‘services’ [essentially the] commodifying of our academic practice” (Ball, 2012, p. 18). This commodification enables, amongst other manifestations, the ‘calculability’ of academic practice, including teaching and research, creating discrete “pieces of work” that can be “put out to tender” (Ball, 2012, p. 20). At an individual level “neoliberalism gets into our minds and our souls, into the ways in which we think about what we do, and our social relation with others... how we relate to students and our colleagues... [and] our flexibility, malleability, innovation and productivity” in all our teaching and research practices (Ball, 2012, p. 18). This insight resonates with Moreton-Robinson’s (2015) description of the omnipresence of racism within our institutions and its normalisation discursively within societies’ understanding of common-sense.

Ball (2012, p. 19) coined the concept of *performativity* which he defines as “a powerful and insidious policy technology that is now at work at all levels and in all kinds of education and public service, a technology that links efforts, values, purposes and self-understanding to measure and comparison output.” Performativity is evident in the way academics spend less time ‘doing’ and more time reporting on the doing, which has required investment in presentation and inflation skills, to support better reporting (Ball, 2012). “More publications, more research grants, more students... strive to achieve the new and very more diverse targets...; confess and confront our weaknesses; undertake appropriate and value-enhancing professional development; and take up opportunities for making ourselves more productive” (Ball, 2012, p. 19). Neoliberalism nurtures the entrepreneurial academic (Ball, 2012), which

could explain the earlier discussion on research that privileges innovative academic practice. This situation raises concerns about the competing interest for academics in Indigenous health education regarding their exercise of performativity.

Ball's (2012) concept of performativity reflects the characteristics of performative benevolence discussed earlier. They both require a facade of desirable performance that privileges self-preservation, and there is a degree of compliance with the greater agenda of neoliberalism and neocolonialism, respectively. Institutional neoliberalism is evident in the Indigenising agenda of the university sector, namely the establishment of benchmarking and the manipulation of reporting data that performs some form of progress, as demonstrated by Universities Australia (2017). Individuals' performativity and neoliberalism is evident in individual performance against organisational Indigenising key performance indicators.

The commonsensical nature of neoliberalism and racialisation of Indigenous peoples invisibilises us, resulting in agents of the nursing discipline and universities being unaware of or ambivalent towards the problematic norms perpetuated by what is deemed normal practice (Ball, 2012; Moreton-Robinson, 2015). Even those who are aware are bound to the work of neoliberalising and neocolonising of the institutions that we belong to (Ball, 2012); reflecting the dynamics of compliance with and resistance to problematic norms made visible by AIWST (Moreton-Robinsons, 2013).

To resist the neoliberalisation of universities, academics must become more aware of the "relations of power within which we now find ourselves enmeshed and which shape our present" (Ball, 2012, p. 26). Neoliberalism is discursively powerful, not just evident in the obvious shift of universities to becoming leaders in national and international tertiary education markets, but in our everyday compliance and resistance to the key performance indicators that we, our colleagues, supervisors, and indeed institutional champions hold us to (Ball, 2012).

This need for greater awareness and strategising resonates with addressing neocolonialism, however that fight is greater than one institution or one sector, being about the unfinished business between Indigenous peoples and the Australian nation.

The appetite of the nursing discipline and universities for Indigenous health curricula has grown simultaneously with the increasing neoliberalisation of the university sector. This creates several incommensurabilities explored in the following interrogation of the nursing literature. I discuss the National Framework and the Nursing and Midwifery Framework, the experiences of nursing students engaging with Indigenous health curricula, the role, and limitations of accreditation standards in establishing and maintaining standards regarding Indigenous health curricula, and regulations associated with developing and maintaining relationships with Indigenous peoples, communities, and organisations. My interest is in the operations of neoliberalisation as manifestations of white possessive logic.

3.2.1 National curriculum frameworks

This section compares the Indigenous-led National Framework (Department of Health, 2014) and Nursing and Midwifery Framework (CATSINaM, 2017), specifically where they intersect with the priority areas outlined earlier in the ANMAC accreditation standards, including: Indigenous health curriculum and Indigenous participation (students, staff, as well as engagement with community stakeholders). Additionally, it explores the proposed preparedness of SON and universities to undertake Indigenous health education as presented in the National Framework and endorsed by the Nursing and Midwifery Framework. Incommensurabilities and assumptions will be highlighted for further exploration in this chapter.

The National Framework was designed to provide guidance to all Australian undergraduate health programs regarding the development and delivery of Indigenous health

curriculum (Department of Health, 2014). It is a comprehensive collection of material including background literature, a curriculum framework, an implementation guideline, and support for accreditation bodies. The curriculum framework itself is quite comprehensive, consisting of framework principles, graduate capabilities, primary learning outcomes, and curriculum content suggestions (Department of Health, 2014, p. 2.5).

The Nursing and Midwifery Framework, mentioned earlier when discussing ANMAC's accreditation standards ([Chapter 2](#)), was developed to complement the National Framework (CATSINaM, 2017, p. 1). As a 'complementary document' it essentially noted what it endorsed in the National Framework, and elaborated on proposed amendments to the National Framework, that would better suit the nursing and midwifery disciplines. The Nursing and Midwifery Framework offers commentary on what was and was not relevant (CATSINaM, 2017). The main critiques from the Nursing and Midwifery Framework about the National Framework are: the inconsistent use of theoretical approaches; the perpetuation of a myth that Indigenous peoples' participation in curriculum development and delivery will address the institutional and interpersonal racism reported in this context; and the assumption that universities and disciplines are equipped to engage with Indigenous communities and organisations.

The National Framework confirms that "there is diversity and interchangeability amongst terms used to describe... [what constitutes] safe and welcoming health services" for Indigenous peoples (Department of Health, 2014, p. 2.22); as seen earlier in the governmental inquiries and reports, and the previous section. The National Framework is consistent with the cultural terms they use; however, they assume theoretical coherence between the terms. The Nursing and Midwifery Framework critiqued the National Framework's graduate capabilities specifically regarding its use of the term 'cultural competency', despite the National Framework document identifying the "contentious" nature of cultural competency

(Department of Health, 2014, p. 2.22). The Nursing and Midwifery Framework insists on not using the term cultural competency at all, choosing to be strictly informed by the theory and practice framework of Cultural Safety (CATSINaM, 2017, p. 6).

Cultural Safety brings a critical approach that informs the teaching practice, as well as the curriculum content, and enables an interrogation of manifestations of interpersonal and institutional racism which is front and centre in the Nursing and Midwifery Framework (CATSINaM, 2017). The National Framework mentions racism as a “challenging content” (Department of Health, 2014, p. 3.20), and as an “environmental trigger” for Indigenous academics in the teaching space (Department of Health, 2014, p. 3.21). Critical race theory and critical whiteness theory are included in their discussion on “approaches to facilitating learning in the classroom” amongst eight other approaches (Department of Health, 2014, p. 3.22). This content is part of the guidelines of the National Framework. This indirect approach to clearly defining an approach for addressing racism within the curriculum reiterates what was discussed earlier regarding the lack of progress that results from nurturing inconsistencies of ‘cultural’ concepts in this space ([3.1 ‘Cultural’ Incongruence](#)).

The National Framework promotes the need for Indigenous peoples to teach Indigenous health, however, it acknowledges that there are too few Indigenous academics working within universities, and that non-Indigenous academics are essential to the teaching of Indigenous health curriculum, especially to the large cohort of students that are often enrolled in health programs (Department of Health, 2014). It suggests that non-Indigenous academics “must be educated in Aboriginal and Torres Strait Islander cultures, histories and contemporary realities... [they] must also understand protocol⁵¹ for being involved in Aboriginal and Torres

⁵¹ “These include: Acknowledgement and gaining of consent from Aboriginal and Torres Strait Islander peoples before telling their stories to students; (and) telling respectful accounts of content that privileges the stories and lives of Aboriginal and Torres Strait Islander peoples through a strength-based approach. Often the sensationalist and unpleasant stories are told, perpetuating stereotypes and missing key learning opportunities” (Department of Health, 2014, p. 3.18).

Strait Islander content delivery”, as well as engage Indigenous teaching approaches (Department of Health, 2014, p. 3.18). The National Framework proposes seven essential skills for any academic who teaches Indigenous health content, including:

Aboriginal and Torres Strait Islander content specific knowledge; self-reflexivity...; highly developed facilitation skills...; robust skills in cross cultural facilitation and the capacity to develop challenging yet ‘safe’ teaching and learning spaces... [that] explore multiple ‘intercultural’ perspectives...; Deep understanding of student learning journey specific to Aboriginal and Torres Strait Islander content; Ability to enact strategies of professional and personal self-care; [and] demonstrate intercultural partnerships, collaboration and engagement (Department of Health, 2014, p. 3.19).

The focus on Indigenous content in these essential skills also renders the dominant white ‘culture, histories, and contemporary realities’ invisible, neutral, and not related to the disadvantage experienced by Indigenous peoples. Finally, the insistence that Indigenous peoples are best to teach Indigenous health curriculum, reflects critiques I have already made, in that it burdens Indigenous academics with the task of addressing the institutional racism that is not made visible in these curriculum frameworks. These matters raise questions on the assumptions made about Indigenous participation in universities and in disciplines, specifically regarding the apparent responsibility of Indigenous people themselves to address the institutional racism of their respective place of employment and discipline, discussed further in this chapter ([3.3 Indigenous Participation](#)).

Even though the Nursing and Midwifery Framework states that the essential skills of the implementation guidelines of the National Framework “is applicable to a broad number of disciplines, including nursing and midwifery” its privileging of Cultural Safety suggests otherwise (CATSINaM, 2017, pp. 7:10). The Nursing and Midwifery Framework states that cultural safety “requires nurses and midwives to undertake an ongoing process of self-

reflection and cultural self-awareness, and an acknowledgement of how a nurse's/midwife's personal culture impacts on care" (CATSINaM, 2017, p. 10). Cultural safety education for all academics is likely to address both the invisibility of whiteness, and the burden placed upon Indigenous academics.

The National Framework encourages partnerships with other Indigenous peoples, namely Indigenous community members who are not their staff and Indigenous organisations like AMSs and ACCHOs (Department of Health 2014, p. 3.10). These partnerships can "create opportunities for students to be immersed in Aboriginal and Torres Strait Islander settings where they can interact with and learn directly from community members about Aboriginal and Torres Strait Islander experiences" (Department of Health, 2014, p. 3.34). Universities are encouraged to promote community events to their student body and explore partnership projects such as clinical placement and community immersion opportunities. However, the National Framework also notes that "Aboriginal and Torres Strait Islander communities have limited capacity to host students", underlying the importance of developing and implementing these initiatives in partnerships between universities and Indigenous communities (Department of Health, 2014, p. 3.34).

The Nursing and Midwifery Framework concurs with the National Framework regarding partnerships with Indigenous community members and organisations, with the addition of implementing "strategies that ensure or strengthen the cultural safety of Aboriginal and Torres Strait Islander people who participate" (CATSINaM, 2017, p. 7). Both frameworks assume the preparedness of the universities and disciplines to engage with Indigenous communities and organisations in a way that is at least mutually beneficial.

The National Framework proposes that universities use a tailor-made tool to measure "the readiness of their environment for implementing The Aboriginal and Torres Strait Islander

Health Curriculum Framework” (Department of Health, 2014, p. 3.37). The Organisational Commitment and Health Professional Program Readiness Assessment Compass (OCHPPRAC) tool aims to: “assess the nature and degree of leadership and commitment across the whole organisation and how this may in turn, affect the implementation of the [National] Framework, [and] identify [university] readiness, key enablers and possible barriers to effectively implementing the [National] Framework” (Department of Health, 2014, p. 3.37). The National Framework proposes four “critical success factors” of preparedness, each with several elements to measure; including: “organisational commitment to cultural competency, [university] leadership and commitment, structures and support for implementation, [and] partnerships and engagement” (Department of Health, 2014, p. 3.37). The OCHPPRAC is endorsed by the Nursing and Midwifery Framework despite not including cultural competency and that it is considered culturally unsafe (Ramsden 2002; Cox et al., 2021).

The OCHPPRAC tool is the perfect example of the neoliberalisation of Indigenous health education. Framed as the means to assess organisational readiness for improving Indigenous health education, the OCHPPRAC represents a modulation of key areas with key performance indicators, that supposedly are the sum of organisational preparedness. Such standardised tools diminish the sensible judgements of individuals, limit activities beyond the prescribed key areas and performance indicators, and empower managerial personnel to determine the value of their colleagues according to OCHPPRAC determined productivity. Performativity (Ball, 2012) achieved through strict adherence to the OCHPPRAC, and reporting a positive performance against the key areas and performance indicators, demonstrates a blind loyalty to the standards defined by institutions. And as previously discussed, the standardisation of tools that have not fully resolved their perpetuation of racialised logic, risks consolidating the existing institutional racism infrastructure, with more strategies to perform and normalise false generosities.

3.2.2 Nursing Students

The literature on the experience of nursing students who engage with Indigenous health education provides some insight into the operations of neoliberalism, particularly regarding the positing of students as consumers of an education product. This positioning seems to privilege their learning experience, particularly in ensuring that it is a positive one. This goal is incommensurable with the unsettling that is required of a decolonising approach to teaching Indigenous health curriculum.

Mills and Creedy (2019, p. 32) found that non-Indigenous health students in their study demonstrated “varying attitudes and beliefs towards First Peoples as well as First Peoples’ health.” These beliefs generally aligned with negative stereotypes about Indigenous peoples, such as the beliefs Indigenous peoples: “received everything for free”; “engage in risky health behaviours and violence”; “were unemployed”; “had a lack of interest in their own health”; “did not contribute to society”; and “held negative attitudes towards non-indigenous [sic] Australians” (Mills & Creedy, 2019, p. 33). Some students voiced their disagreement about needing to have positive feelings about Indigenous peoples to provide safe and good quality care (Bullen et al. 2017). These negative attitudes informed the value that students placed on Indigenous health curricula, manifesting as questions about the relevance of Indigenous health curricula, and pedagogical approaches (such as yarning) to contemporary clinical practice (Kickett et al., 2014; Mills and Creedy, 2019). Bullen et al. (2017) insist that at least these findings demonstrate certainty about the existence of negative attitudes of Indigenous peoples for students coming into university, including Bachelor of Nursing programs; a challenge that other undergraduate nursing subjects are unlikely to contend with (Drummond et al., 2021).

Students reported their socialised beliefs were informed “by friends, parents, and family... the influence of mainstream media and a lack of socio-cultural education” (Mills & Creedy, 2019, p. 33). Bullen et al. (2017, p. 79) found that students who have had previous

experience socialising with people from culturally diverse backgrounds were more likely to feel prepared for Indigenous health education, including clinical placement in an AMS. They were also more likely to report a “future commitment to Indigenous health” (Bullen et al., 2017, pp. 83).

The learning experience of Indigenous health curricula is as unsettling as it is challenging for non-Indigenous students. Learning about the historical conditions of Indigenous peoples’ disadvantage and white Australian advantage leads to questions about why historical knowledge has been kept from them via formal (schools) and informal (social circle) education, and about the application of white privilege to their family history and present life (Mills & Creedy, 2019). This learning experience leads to students developing what Mills and Creedy (2019) label as fragile identities. Such learning experiences can also lead to students expressing feelings of being victimised and blamed for historical wrongs (Kickett et al., 2014), which is a manifestation of racism, white privilege, and a rejection of the relevance to the student.

Bullen et al. (2017, pp. 82-82) found that domestic Australian nursing students were more likely than international nursing students to have a positive attitude towards Indigenous peoples and their health. Bullen et al. (2017) theorised that the latter were less likely to understand the requirement of being perceived as being “politically correct” regarding Indigenous matters. One could argue that they were less skilled in performing benevolence. There is a suggestion here of normalised behaviour, specifically of domestic students wanting to be perceived as being ‘good citizens’ relieving them of the need to address any negative attitudes they have toward Indigenous peoples and our health.

This situation creates uncertainty regarding the nature of student feedback. Courtney-Pratt et al. (2015) insist that desirable student satisfaction scores and feedback accurately reflect positive student experience and the achievement of desirable learning outcomes. However, due

to the challenging nature of Indigenous health curriculum, and the fluency with which students can already perform benevolence regarding Indigenous matters, these assumptions are too simplistic.

The literature provided several examples of evaluative tools used in nursing education to measure students' learning experience. Some of these tools respond to the emotional and performative defence mechanisms employed by student nurses. The assessment approach used by Courtney-Pratt et al. (2015) relied on student feedback and self-reporting to measure the success of their clinical simulation initiative. Hart et al., (2015) relied on student feedback to measure the success of their clinical placement immersion initiative. However, Bullen et al. (2017) critiqued several health students' self-reported tools and found that there was a risk that such tools would only garner socially desirable responses from students, portraying them as good citizens. Bullen et al. (2017) insist that measuring self-reported self-efficacy, without measuring knowledge and skills development is also evident, and I would argue it is deeply problematic to assume that the philosophical and cultural shift occasioned by the unsettling nature of learning experiences surrounding Indigenous matters, can be measured at all. Attempts to do so, especially when based solely on quantitative self-report tools, demonstrate moves to innocence that protect students from engaging with the learning experience and material.

West et al. (2017) developed a tool to measure the degree to which health students, including nursing students, developed the five cultural capabilities of the National Framework, as well as a student self-reporting tool. They used a 'validated-tool' developed by an Indigenous-majority research team, under the guidance of an Indigenous working group, and implemented in partnership with Indigenous students and tutors. While this approach would have enabled relational engagement amongst the Indigenous peoples involved, it is reliant on the accuracy of the five cultural capabilities of the National Framework, and consistency in

understanding theoretical and practice matters amongst the research team, concerns which were not discussed in the paper. Furthermore, the approach remains reliant on student reporting, and the subsequent socially desirable responses, suggesting that the researchers may underestimate the performative benevolence already exercised by the students.

The reliance on student reporting tools highlights the complicity of some tools with performative benevolence and to performativity, unnecessarily complying with the neocolonial and neoliberal agenda. These tools demonstrate “the first effect of performativity... to re-orientate pedagogical and scholarly activities towards those which are likely to have a positive impact on measurable performance outcomes” (Ball, 2012, p. 20). The privileging of students’ enjoyment (or lack of discomfort) of their learning experience reflects this dynamic. Further, such approaches come at a cost of failing to address “aspects of social, emotional or moral development that have no immediate measurable performative value” (Ball, 2012, p. 20). Following Ball (2012) I would argue that these tools at best demonstrate that health and nursing students enter undergraduate education with a degree of competence regarding performative benevolence. More concerning is that these tools may also be effective learning experiences for students to become more proficient in performative benevolence, leaving undone the need to confront the performative benevolence of students, as part of the Indigenous health education.

Mills and Creedy (2019) engage with the theory of the *Pedagogy of Discomfort* to explore transformative learning in the context of Indigenous health education. Transformative learning is achieved when students move from a position of ‘spectating’ to one of ‘witnessing’ (Mills & Creedy, 2019). Spectating is evident in “passive empathy or sympathy” expressed by students in their reflective assessment (Mills & Creedy, 2019, p. 34); this position is performing benevolence. Students may express interest in Indigenous peoples’ matters but fail to see themselves personally or professionally as part of the problem or solution (Mills & Creedy,

2019). “Witnessing often resulted in students expressing a 'call to action'. While some students initially found it difficult to acknowledge their individual role in [Indigenous peoples’] health, the Indigenous health subject enabled facilitated insights on how they could be part of the 'solution’” (Mills & Creedy, 2019, p. 34). Witnessing involves questioning the norms, including the dissemination of power and privilege within society; as a result, students can articulate how their learning impacts them, Indigenous peoples, their broader community, and society (Mills & Creedy, 2019). Mills and Creedy (2019) demonstrate that performative benevolence could be directly interrogated as part of the learning experience regarding Indigenous health curricula. These researchers continue to demonstrate the value of the students’ learning experience, but do not privilege it above the necessary unsettling of Indigenous health education.

The logic of neoliberalism is evident in some of the initiatives presented here that aim to quantify transformational learning of nursing students undertaking Indigenous health education. The researchers demonstrate an underestimation of nursing students and their ability to perform benevolence in the context of Indigenous health, as students have been socialised by their family and the broader community to pull off such performances (Bullen et al., 2017). Thus, these tools become a means for students to improve their performative benevolence, as well as a tool for SON and university managers to measure the apparent productivity of academics. These tools are inherently neocolonial, as they prove to be successful in reproducing colonialism.

In the context of Indigenous health curriculum, the National Framework and tools developed to measure transformational learning of nursing students undertaking Indigenous health education, demonstrate the effectiveness in which neoliberal and neocolonial logics have been embedded within the contemporary context of Indigenous health education. Such tools service SON and university managers, and students, through creating measures that academics

are assessed against. While the Nursing and Midwifery Framework demonstrates active resistance to neocolonial logics, evident in its adherence to Cultural Safety, it remains subjected to the neoliberal logics of the discipline and university sector. The benefit of realising consistency in Cultural Safety inform Indigenous health curriculum is at tension with the complicity with neoliberal logics of modularising curriculum and investing in performativity; this is evidence of necessary compliance and resistance exercised by academics working in Indigenous health education. This situation highlights the multiple interests and expectations associated with the social position of academics who develop and deliver Indigenous health curriculum. Furthermore, this situation raises questions about the interests and expectations of Indigenous peoples, organisations, and communities on the academic, nursing students, the SON and university. This is invisibilised by the logics of neocolonialism and neoliberalism.

3.3 Indigenous participation

Indigenous peoples' participation in the health and nursing workforce has long been seen as a strategy to improve the effectiveness of government, discipline, and university systems to meet the needs of Indigenous peoples (Committee on Aboriginal Affairs, 1979; Department of Health, 1994; INEWG, 2002 Behrendt et al., 2012; Universities Australia, 2017). The common belief is that Indigenous peoples bring 'unique' knowledge, skills, and understanding into the workforce to enable this goal; furthermore, that a critical mass of Indigenous staff is needed, particularly in leadership roles (Goold, 2001; West et al., 2014). However, this strategy seems hopeful in its assumption that the mentioned institutions are prepared and willing to be held accountable to ensure equity regarding Indigenous peoples' participation and to ensure that we are "valued and supported to take on leadership roles" (Bond et al., 2019, p. 389).

Bond et al. found ‘Indigenous health workforce pipelines’, to be a popular colloquialism for education pathways towards health professional careers, for disciplines and universities in their narrative about increasing Indigenous participation; pointedly, Bond and her colleagues assert that “if such pipelines exist, someone had forgotten to turn on the tap” (2019, p. 391). They found workforce participation numbers across all health professional groups as lacking and stagnating, with only nursing achieving a workforce representation above 2% of the total workforce; all health disciplines have demonstrated an inability to reach the different targets that has been set over the years⁵² (Bond et al., 2019). The pipeline analogy serves as proof of the performative benevolence of institutions, evident in the lack of self-critique and subsequent systemic change regarding Indigenous workforce participation. The pipeline analogy is also a manifestation of the neoliberal logic that modularises pathways of education and employment for Indigenous peoples, allocating key performance indicators and apparent accountability measures, but often this is just a performance to give a sense of priority and pragmatism. The modularised education and employment pathway also visibilises/creates institutional and interpersonal racism inherent in/of associated institutions, providing plenty of distractions for Indigenous peoples to attend to (Morrison, 1975).

Moreton-Robinson (2015) highlights that such manifestations of performative benevolence reflect the self-preserving and possessive nature of these institutions. Institutions and their agents claim race-blindness⁵³ to deny the existence or the severity of racism, enabling its perpetuation (Moreton-Robinson, 2015). Thus, Indigenous people who ‘participate’ in such

⁵² The *National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021-2031* (Department of Health, 2022, para, 5), yet to be launched, proposes a new target of 3.43% that reflects the proportion of Indigenous peoples in “the Australian working age population (age 15 to 64)”.

⁵³ Race-blindness or colour blindness asserts a transcendence of seeking or acknowledging racial difference. However, “it involves a selective engagement with difference rather than no engagement at all... it denies the existence of privileges conferred on white citizens through generations of white possession while simultaneously enhancing the benefits they enjoy” (Moreton-Robinson, 2015, p. 96).

work environments are expected to carry the burden and tension of not just experiencing racism, but of also being subjected to their white colleagues enjoying the “luxury of being race-blind and possessive” in response to any complaints about racism (Moreton-Robinson, 2015, p. 107). The social position of the Indigenous academic is a vantage point⁵⁴ where we learn about and strategise against institutional racism within the SON and university. From these social positions we learn knowledges, skills, and understanding that must be nurtured for institutional change that may lead to better service to Indigenous peoples (Bond et al., 2019). However, such strategies are the antithesis of the neoliberal and neocolonial logics embedded within SON and universities, which highlights a significant point of incommensurability that Indigenous peoples who choose to ‘participate’ in the SON and university workforce must contend with.

I turn now to a consideration of the assumptions and expectations associated with Indigenous participation, including the participation of Indigenous nursing students in undergraduate nursing programs and in the discipline, Indigenous nursing academics in SON and universities, and other Indigenous community representatives in activities associated with the development and delivery of Indigenous health curriculum. The experience of Indigenous researchers, communities, and organisation in knowledge (co)creation, suggests there are lessons to be learned and knowledge that can be shared through teaching Indigenous health curriculum. I argue that there are elements of performative benevolence on the part of the institutions of discipline, SON, and universities, in their promise of change, as it is grounded in the assumption that Indigenous academics and students will do this work; a peculiar manifestation of WSIC.

⁵⁴ A redefinition of the apparent subservient social positions designed for Indigenous peoples, coined by Professor Chelsea Watego (Daley, 2021).

3.3.1 Indigenous Nursing Students

The recruitment, retention, and completion of Indigenous students in undergraduate nursing programs has been a key objective for the nursing discipline since INEWG's (2002) *'Gettin Em' and 'Keepin Em'* report, and a priority for the university sector more recently. The Bradley Review recommended "that the Australian government regularly review the effectiveness of measures to improve higher education access and outcomes for Indigenous peoples" (Bradley et al., 2008, p. xxii). These measures include targeted scholarships, entry pathways, and student support (Bradley et al., 2008). The Behrendt Review supported these measures, as well as advocating for university wide strategies to support Indigenous students' success (as opposed to just relying on Indigenous Education Units [IEU] of each university), increased resourcing and infrastructure for the successful Indigenous tutoring program (Indigenous Tutorial Assistance Scheme – Tertiary Tuition), and for employers, universities and professional bodies to continue to innovate the way they support Indigenous students through "cadetships, scholarships and bursaries, beyond their existing efforts" (Behrendt, 2012, p. 13). The Behrendt Review envisioned that their work would better enable "higher education to become a natural pathway for [Indigenous] peoples", as they believed that "success in higher education will lay the foundations for an Aboriginal and Torres Strait Islander professional class that can contribute to closing the gap and to Australia's broader wellbeing and economic prosperity" (Behrendt et al., 2012, p. 11).

However, despite the recent interest and investment in increasing the number of Indigenous peoples in undergraduate education, including nursing, Indigenous peoples' retention, and completion of undergraduate degrees remains a challenge (Milne et al., 2016; Universities Australia, 2021). Milne et al. (2016) conducted an integrated systematic review to critique published literature on support strategies for Indigenous nursing students and identified that cultural, financial, and academic support remained a significant success factor for

Indigenous nursing students (identified earlier by INEWG [2002] and Behrendt et al. [2012]), and that the principles of respect, relationship, and responsibility were also imperative to improved Indigenous student retention and completion.

Cultural support refers to the needs of Indigenous students to engage with “support from family, community and other students/peers [as] pivotal to student success” (Milne et al., 2016, p. 391). Recognising the importance of family and community to the well-being of Indigenous nursing students and enabling this support to be accessed by the student is considered conducive to recruitment and retention of Indigenous students (Curtis et al., 2012, p. 13; Foxall, 2013; Best & Stuart, 2014). The support referred to here is reciprocal, that is the student both provides and receives support to/from their family (Usher et al., 2006). Their roles and the responsibilities that students hold to their family and communities supersedes obligations to the nursing program in which they are enrolled, thus students require support in balancing these commitments (Usher et al., 2005, p. 27).

IEUs are identified as a significant source of support, including “cultural, emotional and counselling support especially when coping with racism” (Milne et al., 2016, p. 391). To be successful, IEUs require support from all levels of the university, including adequate resourcing to enable tailored support for Indigenous students. IEUs also require guidance from the local Indigenous community, and effective relationships with faculties and schools to ensure seamless student support (Behrendt et al., 2012; Milne et al., 2016).

Financial support is needed to “address financial demands of students’ academic, literacy, travel, and living costs” (Milne et al., 2016, p. 391). Milne et al. (2016) also noted that the relational obligations of Indigenous students sometimes involved financial support to members of their broader family. This is a normal part of the reciprocal relationship Indigenous students have with their broader families (Usher et al., 2006). Financial support from

“government, universities, indigenous [sic] communities and philanthropic sources” needs to continue, and to explore more innovative ways to better support Indigenous students (Milne et al., 2016, p. 391; Behrendt et al., 2012).

Academic support refers to “practice support to address the academic needs of indigenous [sic] students” (Milne et al., 2016, p. 391). Being first-in-family to attend university means that Indigenous students are less prepared than non-Indigenous students who generally have better informed expectations (Milne et al., 2016). Indigenous students were also more likely to enter university via alternative entry programs, which suggest different pre-university academic preparation (Milne et al., 2016). Targeted tutorial support programs, that enable one-on-one support, were identified as a significant success factor (Behrendt et al., 2012; Milne et al., 2016).

The inclusion of Indigenous health curriculum within undergraduate nursing education has also been linked to improved recruitment, retention, and completion for Indigenous peoples in nursing programs. Curtis et al. (2012, p. 10) found that “commitment to (I)ndigenous/URM (under-represented minority) curriculum development” was a common retention and completion strategy. Usher et al. (2005, p. 27) found their Indigenous nursing student participants perceived the inclusion of Indigenous health curriculum as an indication of respect; that the School of Nursing not only acknowledged Indigenous content, but the institution of the university and the discipline saw it as important knowledge and skill for contemporary nurses. This finding reflects the Milne et al. (2016) principle of respect which emphasises the need for Indigenous nursing students to feel culturally safe, including safe from racism. They propose Indigenising undergraduate nursing programs and enabling Indigenous students to develop their Indigenous identity and resilience; however, they fall short of any proposal on institutions, the discipline and universities addressing interpersonal and institutional racism.

Beyond curriculum, applying Indigenous perspectives to recruiting and retaining strategies enables the value and incorporation of holistic views of health and well-being, and the importance of family and community in the provision of student support (Usher et al., 2005; Best & Stuart, 2014; Milne et al., 2016). This approach reflects the work of Milne et al. (2016) who identified the significance of relationships for Indigenous students, with their family and community, as well as with school and university staff and the importance of flexible delivery of undergraduate programs enabling students to fulfil their relational obligations to the former.

Usher et al. (2005, pp. 21-22; 29) labels some inadequate responses from universities to the “cultural issues” faced by Indigenous students as “insensitive and inflexible”. This observation reflects the principle of responsibility for the discipline and university to create a “welcoming environment that honours and celebrates [Indigenous students’] culture” (Milne et al., 2016, p. 392). However, both papers hesitate to point out the responsibility of the discipline and university to address institutional racism that Indigenous students must endure, and submit to, to succeed. Institutional racism works against the principles of respect, relationships, and responsibility. It is embedded in the history of the discipline, evident in how racism has operated as a barrier to Indigenous peoples entering and completing their pre-registration nursing training, (Committee on Aboriginal Affairs, 1979; Best & Gorman, 2016), and undergraduate nursing (INEWG, 2002; Goold, 2006).

The literature regarding Indigenous student participation in undergraduate nursing programs insists on continued support for investing in cultural, financial, and academic support. Milne et al. (2016) highlight the need to incorporate the principles of respect, relationships, and responsibility into designing and delivering Indigenous student nursing support. But “racism remains the elephant in the room” for Indigenous nursing student participation, and indeed for the broader agenda of Indigenous health workforce participation (Bond et al., 2019, p. 392).

3.3.2 Indigenous Nurses

The recruitment of Indigenous academics by Schools of Nursing is not a clear priority for the discipline. While recognised as a successful strategy for student recruitment and retention in the USA Native American context, and in Australia's medical context, recruitment of Indigenous academics by Australian Schools of Nursing is not a proposed strategy in the INEWG's (2002) *'Gettin Em' and 'Keepin Em'* report. INEWG does propose that all nursing academic staff should be appropriately educated "to ensure they are aware of the cultural and family issues which may impact on the progression of Indigenous students of nursing" (2002, p. 8). When it comes to curriculum development and delivery, Schools of Nursing are advised to develop "partnerships with Indigenous communities and stakeholders"; the latter includes Indigenous registered nurses (INEWG, 2002, pp. x: 5).

Following INEWG's lead, ANMAC demonstrates fickleness regarding their support for the inclusion of recruiting Indigenous academics as part of their accreditation standards for Schools of Nursing. This was discussed earlier ([2.13 ANMAC](#)). This lack of enthusiasm is reflected in the dearth of literature about the contemporary experiences of Indigenous nurses. Jackson et al. (2013) and Sherwood and Edwards (2006) offer some valuable insights into the experiences of Indigenous nurse academics, who work in Schools of Nursing and teach Indigenous health.

Jackson et al. (2013) describes the significance of safe teaching environments for Indigenous academics teaching Indigenous health in nursing programs. This safety is found in numbers in their case, four Indigenous nurse academics and one non-Indigenous nurse academic. "Indigenous academics learned from each other's teachings, *'held'* one another's spirits, comforted and supported each other with an affirming look or a touch on the hand or the shoulder" (Jackson et al., 2013, p. 110). Their practice created a safe place for their teaching, as well as a safe learning environment for students (Jackson et al., 2013). The

Indigenous nurse academics do not claim to know everything about Indigenous health but assert that through their stories they are able to contextualise the theoretical content (Jackson et al., 2013). Their experience highlights the challenge that Indigenous nurse academics can experience in teaching Indigenous health curriculum, sharing stories that are personally challenging for them, as well as being concerned about the risk of experiencing racism in the classroom, matters that are confirmed in the findings of my research.

Sherwood and Edwards (the former being an author in both articles), share their disappointment in the lack of value afforded Indigenous health curricula and nursing practice by their colleagues in the School of Nursing, creating a sense of isolation they felt at Indigenous nurse academics and experienced in Indigenous health nursing (2006). Their experience, and that of Jackson's Indigenous colleagues⁵⁵ reflect the manifestations of white possessive logic within the nursing workforce (Moreton-Robinson, 2015). Indigenous nurses are made to feel inferior to and excluded from their non-Indigenous 'colleagues' in a "professional domain owned and controlled by white people", in this case the School of Nursing (Moreton-Robinson, 2015, p. 102). The normalised nature of racism, as manifested in these experiences, is especially evident in the work that Jackson et al. (2013) must do to prevent, limit, and be prepared for racism, reflecting unsafe work environments for Indigenous peoples.

Sherwood and Edwards (2006) describe the challenge for them and other Indigenous peoples who are forced to 'live in two worlds', highlighting the way in which Indigenous peoples must become fluent in Australian and our own Indigenous ways of knowing, being and doing. We are made to navigate the incommensurabilities between the ways of knowing, being, and doing, while non-Indigenous colleagues are none the wiser, demonstrating their white privilege and possession of the norm (Drummond, 2020). This perspective includes the

⁵⁵ Author Jackson is the non-Indigenous colleague in the group.

experiences and lessons learnt at the vantage point of our social positioning; observing the operations of racism, strategising against racism, and providing insightful stories about the racism of the university and discipline institutions (Sherwood & Edwards, 2006; Bond et al., 2019).

The narrative of being positioned between two worlds is a common one for Indigenous peoples and came into prominence during Australia's Assimilation Policy era (McCoy, 2009, p. S21) which took place during the 1950s-1960s and was characterised by government policies and practices that aimed to support the assimilation of Indigenous peoples into white Australian culture (ways of knowing, being, and doing) (Eckermann et al., 2014, p. 27-28). During this period, Indigenous children were stolen/taken from their families to be brought up by white families, with the aim of teaching Indigenous children to be just like white Australians (Eckermann et al., 2014). These children are described by some commentators as growing up and living in two worlds (McCoy, 2009).

The notion of 'living in two worlds' represents a commitment by Indigenous peoples to not assimilate, and to maintain our own ways of knowing, being, and doing, that may adopt learnings, but never assimilation (McCoy, 2009). Furthermore, the notion also reflects the operations of racism by Australian institutions that discursively asserts white Australian ways of knowing, being, and doing as the norm, as neutral, which logically rejects other peoples' ways of knowing, being, and doing (McCoy, 2009).

Goold (2001, p. 98) agrees with certain incommensurabilities between white Australian and Indigenous ways of knowing, being and doing, stating that "Indigenous culture is the antithesis of Western ideology". She believes that aspects of Western culture do not correlate with Indigenous culture, such as: individualism, capitalism, a dichotomised view of spiritual and worldly realities, and significantly the devaluing of relationships between peoples (Goold,

2001). Hanze and Vanett (1993, p. 191) warn against the implied simplicity of ‘two worlds’, highlighting the “complexity of choices” that individuals must contend with daily, when struggling with different ways of knowing, being, and doing; especially if there are concerns about assimilation if the dominant ways are followed faithfully. The experience of Indigenous nurse academics of ‘living in two worlds’ presents another point of incommensurability that Indigenous nurse academics must contend with.

Indigenous peoples’ participation in the nursing workforce, particularly in the nursing academic workforce highlight numerous incommensurabilities associated with navigating the dominant ways of knowing, being, and doing held by the institutions of university and discipline. The experience of Indigenous nurse academics indicates how we unsettle the norms of these institutions, evident in the manifestations of racism that we observe and endure. The notion of ‘living in two worlds’ simplifies the complex nature of Indigenous nurse academics strategising in SON.

The literature on the experiences of non-Indigenous nurse academics teaching Indigenous health curriculum is comparably more limited, which may reflect a generally greater interest in the increased participation of Indigenous nurse academics. Even so, the lack of research into this context invisibilises the role and impact of non-Indigenous nurse academics. The collaboration between Indigenous and non-Indigenous nurse academics is vital, especially given the number of undergraduate students and the lack of Indigenous academics (Department of Health, 2014; Taylor et al., 2014). These partnerships enable the navigation of complex and contentious issues; however, the partnerships remain susceptible to individuals expressing interpersonal racism (Hart et al., 2015; Nash et al., 2006).

3.3.3 Indigenous Pedagogy

The inclusion of Indigenous perspectives as curricula and their inclusion in student support mechanisms has already been discussed. This section explores how Indigenous perspectives have informed pedagogical approaches in undergraduate nursing education. There is a dearth of literature on pedagogical approaches deployed in undergraduate nursing programs. The few approaches that have been published are innovative, in the sense that they are exploring pedagogical approaches outside the traditional lecture theatre and tutorial room and focus on creating an engaging learning experience for students.

Cultural immersion was implemented by Hart et al. (2015) and Courtney-Pratt et al. (2015). The former believed that an immersive experience based on Cultural Safety, in partnership with an AMS, would enable third-year students to “develop a critically reflective view of themselves and of the place [the AMS] as health professionals within the differences and inequalities of Aboriginal health and healthcare” (Hart et al., 2015, p. 246). The latter aimed to “enhance the cultural competency of [second year] nursing students and aid their understanding of the health care experience” (Courtney-Pratt et al., 2015, p. 531).

Relationships with Indigenous communities and organisations is imperative for immersion experiences within Indigenous communities (Dowell et al., 2001; Department of Health, 2014; Hart et al. 2015). However, even with good relationships, AMSs are not able to facilitate the learning of hundreds of undergraduate nursing students each year, due to the lack of resourcing (funding and skills staff) and space (Department of Health, 2014; Taylor et al. 2014). It may also be burdensome for Indigenous community members to be expected to develop relationships with new students each time they need to access care (Hart et al., 2015). So, practically an immersive experience in Indigenous communities and organisations is not viable for all undergraduate nursing students.

A common alternative or supplement to actual clinical experience is simulation learning. Courtney-Pratt et al. (2015, p. 531) explored the effectiveness of immersion teaching using three-dimensional (3D) simulation. Problematically positing white people as the acultural norm, their study looked at peoples from culturally and linguistically diverse (CALD) backgrounds, including Indigenous peoples. In this case, the simulation was being used in nursing education to augment the learning experience through providing students with case studies to experience and analyse. The most vital part of the learning experience, however, was the debriefing that followed the simulation session.

The use of simulation education for Indigenous health education is problematic, as it risks perpetuating stereotypes through uncritical or intentionally racist case studies. Gorman (2017, p. 695) shared his experience as a student who noticed and raised concerns about how the dark complexion simulation mannequins “were labelled Indigenous on their control panel”. Gorman (2017, p. 694) shared that “as [he has] a light skin tone [he is] not immediately recognisable as an Aboriginal person”, which means that he is frequently subjected to racist comments from people who assume that he is a ‘safe’ non-Indigenous person. The case of the dark complexion mannequins clearly demonstrates the belief by the simulation learning designers that their Indigenous simulated patients must be “cosmetically apparent”, meaning that they must look like a stereotypical Indigenous person (Huggins, 1998, p. 25). Gorman’s experience demonstrates the ease in which racialisation of Indigenous peoples may be perpetuated through uncritical or intentionally racist simulation case studies.

These examples of immersion and simulation pedagogies aspire to create a learning experience where nursing students can see Indigenous health in action. While the proposed primary purpose of these approaches is to test students’ self-reflection abilities, there also appears a need to prove the disadvantage and dysfunction of Indigenous peoples to nursing students, and to test their performance in such contexts. This deficit approach is problematic in

its perpetuation of racialised stereotypes about ‘the Indigenous problem resistant to change’, however it seems also logical to prepare student nurses for working in the complex context of Indigenous health. This situation raises another point of incommensurability associated with developing and delivering Indigenous health curriculum.

3.3.4 Indigenous Community Partnership and Engagement

One of the eight principles of the National Framework is “respectful partnerships and collaboration with shared responsibility between [Indigenous] peoples and non-Indigenous peoples” (Department of Health, 2014, p. 2.6). Indigenous stakeholders identified in the National Framework include staff of local IEUs, Indigenous peoples from the local Indigenous community, and Indigenous health services (Department of Health, 2014, pp. 3.11-3.12). These are the likely stakeholders that SON are expected to engage with in the development and delivery of Indigenous health curriculum, as per ANMAC (2019) regulation requirements.

There is particular interest in the nursing literature about partnering with Indigenous organisations to enable clinical placement. The National Framework sets out guidelines to enable this outcome but warns of the limits in resources and capacity for Indigenous organisations to meet the education demands of whole cohorts of undergraduate health students (Department of Health, 2014). There is also concern about the impact on Indigenous peoples accessing these services, and the burden of being the education case study for undergraduate health professionals (Hart et al., 2015).

The nursing literature demonstrate enthusiasm in developing relationships with Indigenous communities and organisations, however, the degree to which Schools are willing to be accountable to proposed Indigenous community partners is lacking. In validating their immersion approach to nursing clinical placement Hart et al. (2015, p. 247) state that, “learning takes place organizationally, within the relationships of primary health care. It was these

relationships that were seen as crucial to the students building and sustaining collaborative cross-cultural practices in their future professional lives.” However, they go on to say that “it is also uncertain as to whether transformative outcomes are sustained over time, and whether cultural immersion programs have an ongoing influence on health care professionals’ practices and professional pathways” (Hart et al., 2015, p. 248). This contradiction raises questions about the value of their immersion program for students, the AMS, and the Indigenous peoples who access the AMS for care.

Nash et al. (2006) engaged the local Indigenous community, including Indigenous health professionals, in a few ways to support the SON’s efforts to develop and deliver Indigenous perspectives into undergraduate nursing curricula. Firstly, an Indigenous nurse academic from the local community was recruited to the project team. Secondly, the project had a reference committee that consisted of several local Indigenous peoples who provided strategic and operational guidance and advice, and finally a few Indigenous health professionals were engaged in the development and delivery of Indigenous health curricula (Nash et al., 2006, pp. 304, 309).

While the Indigenous community engagement exercise of this project seemed quite successful, the lack of longevity of the program raises concerns. As this project took place in the institute that I most recently worked at, I am aware of some of its fate. Without dedicated resources, including a project team, the reference group ceased working with the School of Nursing. While the materials that were developed under the guidance and direction of the reference group remain accessible to staff members, they are on an old platform, and require updating, resourcing, and reengagement with any available original reference group members. The Indigenous health curricula has continued to evolve under new leadership and with new material. However, this example reiterates concerns about the longevity of collaborative curriculum work, especially if Indigenous perspectives are shared, and raises questions about

the nature of collaborative relationships between SON and Indigenous peoples, specifically regarding power dynamics and reciprocity.

The National Framework highlights that engaging local Indigenous peoples in the development and delivery of Indigenous health curricula is essential, however it is burdened by the mistrust of the intentions of non-Indigenous peoples and their institutions (Department of Health, 2014). Current nursing literature shows that SON often privilege their own needs when engaging Indigenous peoples, evident in the lack of reciprocity and power afforded Indigenous peoples. The National Framework proposes that universities should allocate resources to relationship development and maintenance (Department of Health, 2014).

This section demonstrates that while the discipline, SON, and universities are enthusiastic with their positive rhetoric regarding Indigenous peoples' participation within their institutions, there remain several points of incommensurabilities that Indigenous peoples are required to endure as part of their participation. This is most obvious for Indigenous academics who must carry the burden of multiple expectations and accountabilities, which at times contradict one another. Engaging with Indigenous pedagogies and community members also present points of incommensurabilities that both Indigenous and non-Indigenous academics must contend with.

3.4 Summary and Implications

This contemporary social, political, and material conditions analysis of the intellectual territory informed by my genealogical analysis of historical government and discipline reports on Indigenous health curriculum, interrogated the issues of conceptual incongruence, preparedness of the institutions of discipline, SON, and universities, and Indigenous participation within these institutions. My analysis explored the manifestations of white

possessive logic within these contexts, particularly its manifestation as performative benevolence by individuals and institutions.

Performative benevolence is evident in the perpetuation of neocolonialism within the discipline, SON, and universities, that continues to invest in reproducing colonial power relations. It is also evident in the perpetuation of neoliberalism within these institutions, that continue to mutate their economic and performance efficiency measures that insist on modularising Indigenous health curriculum and micro-managing associated academic practice. Performative benevolence is evident in the promotion and investment of an Indigenising approach within these institutions, and championing manifestations of cultural competency in Indigenous ‘cultural’ education. These approaches perpetuate colonial racialised logics about Indigenous peoples and assume that if students and staff knew about Indigenous ‘culture’, then they will be able to be better at working with Indigenous peoples. This assumption is ahistorical, and problematically ignores the power of white Australians and their institutions.

Cultural Safety presents an approach towards decolonisation. It promotes resistance to neocolonial logics about Indigenous peoples. It can enable greater engagement with the ethics of incommensurability, that insists on interrogating the complexity of Indigenous health, a complexity denied or made palatable by an Indigenising approach. Cultural Safety could be more unsettling, should Australia ever treaty with Indigenous peoples here, as evident in *Aotearoa* (New Zealand).

The National Framework has failed in its attempt to clarify the conceptual incongruence, instead it has endorsed the confusion. The Nursing and Midwifery Framework has addressed the conceptual incongruence and provides an opportunity for the discipline to be consistent in its approach to Indigenous health curriculum. However, both frameworks are essentially compliant with neoliberal logics. Neoliberal logics are also evident in frameworks that attempt

to assess student learning in Indigenous health curriculum, however these frameworks underestimate the performative benevolence abilities of students. In fact, they risk providing learning opportunities for students to enhance their performative benevolent practices.

The institutions of discipline, SON, and universities are well versed in performative benevolence, evident in this prolific positive rhetoric regarding increasing Indigenous participation as academics, students, and community stakeholders. Such performances of false generosity conceal the operations of neocolonialism and neoliberalism that champion an Indigenising approach. This situation creates conflicting conditions for academics developing and delivering Indigenous health curriculum. It also raises questions about the preparedness of the discipline, SON, and universities to engage with Indigenous peoples and their knowledges and perspectives.

Current literature on the experiences of Indigenous and non-Indigenous academics tasked with developing and delivering Indigenous health curriculum in Australian undergraduate programs is limited. Better understanding of the operations of neocolonialism and neoliberalism by the discipline, SON, and universities, as experienced by these academics, would be valuable knowledge to inform institutional and individual change that could improve Indigenous health education, and the work of academics in this space. This knowledge could inform the way in which the discipline, SON, universities, and individual academics could better relations with Indigenous peoples.

Chapter 4: Theoretical Framework and Research Design

Before I discuss the research design for my research project, it is important to first take a brief account of the social, historical, political, and material conditions in which Indigenous research is positioned. Research is never neutral or unbiased and has proven a faithful tool to colonial institutions and their agents in the oppression of Indigenous peoples (Tuhiwai Smith, 2012; Moreton-Robinson, 2017). While research practice has changed, which includes the development of research ethics principles that aim to standardise best ethical research practice with Indigenous peoples (National Health and Medical Research Council [NHMRC], 2018; Australian Institute of Aboriginal and Torres Strait Islander Studies [AIATSIS], 2020), unethical practices that exploit Indigenous peoples via research practice continues (Whop et al., 2019).

The historical conditions of Indigenous research highlight how research has been a tool for the colonial masters, designed to validate their colonisation and their oppression of Indigenous peoples, while narrating their benevolence (Tuhiwai Smith, 2012). Tuhiwai Smith (2012, p. 21) states that research has long been “a set of ideas, practices and privileges that were embedded in imperial expansionism and colonization and institutionalized in academic disciplines, schools, curricula, universities and power”.

Nakata (2002) described the customary practice of academic researchers excluding Indigenous peoples. He tells of how *Zenadh Kes* Islanders were excluded from analysing their experiences, objectifying, disempowering us from genuine control of our present and future circumstances (Nakata, 2002). Instead, historically, the narratives ‘about’ *Zenadh Kes* Islanders were informed by the perceptions of colonial agents, who actively suppressed and forcefully redefined *Zenadh Kes* Islanders’ religious practices, and economic and social organisations (Nakata, 2002). “Terra nullius research,” a term coined by Martin (2003, p. 203), emphasises

the white supremacy evident in these historical conditions of colonial research on Indigenous peoples.

It should not be a mystery then that Indigenous peoples believe that “‘research,’ is probably one of the dirtiest words in the indigenous [sic] world’s vocabulary,” because it historically has never served Indigenous peoples, but weaponised against our sovereignty and survival (Tuhiwai Smith, 2012, p. 1). These are the historical conditions that contemporary Indigenous researchers inherit and must overcome with the Indigenous peoples that they intend to do research work with and for (Tuhiwai Smith, 2012). To do this, Indigenous researchers must actively reject the social position of the performative benevolent researcher, and preference an approach that disrupts the status quo of contemporary research, as part of their work to primarily serve Indigenous peoples.

Being grounded in history is imperative to working towards decolonisation, specifically the notion of privileging Indigenous peoples’ futurity. This is demonstrated with the teachings of the late Elder and previous Chief of the Wagadagam tribe of Mabuiag Island, Athe Ephraim Bani, when he said, “the past must exist, for a present, to create a future” (Gab Titui Cultural Centre, 2020). From my perspective, Athe Ephraim is referring to the need to address these historical conditions that oppressed Indigenous peoples, including in research, to plan for and realise a better future for Indigenous peoples. Knowing his broader teachings about cultural revival for all *Zenadh Kes* tribes and islands, this work must be grounded in our own ways of knowing, being, and doing.

The theoretical framework woven together for my research project was designed to honour and privilege service to Indigenous peoples. In challenging the historical and contemporary colonial narratives about Indigenous peoples, it intentionally “foregrounds [our] sovereignty over equity” (Watego, 2021, p. 107). This position is achieved through adhering

“to a research agenda informed by our respective cultural knowledges, ethics and protocols” (Moreton-Robinson, 2017, p. 69).

This chapter introduces the theoretical framework, research methods, and discusses their relevance to the research question. Then it explains the design and operations of data generation, analysis, and presentation.

4.1 Theoretical Framework

The purpose of this research project was to investigate the experiences of Indigenous and non-Indigenous academics tasked with developing and delivering Indigenous health curriculum in Australian Bachelor of Nursing programs. In investigating their experiences, I aimed to learn more about the institutions that they work within and belong to, namely the Schools of Nursing (SON), universities, the nursing discipline, and their regulatory bodies including ANMAC. The latter regulates the requirement to include Indigenous health curriculum in undergraduate nursing programs, and the SONs are required to comply with these regulations. The experiences of participants are considered in terms of the operations of neoliberalism and neocolonialism within these institutions, namely the social, political, and material conditions that frames their work of developing and delivering Indigenous health curriculum. Furthermore, my investigations of participants’ accounts consider the participants’ exercises of compliance and resistance within these conditions, including examples of performative benevolence.

The inclusion of Indigenous and non-Indigenous academic participants is necessary to investigating the normative operations of racism within these institutions, namely the ominous-presence⁵⁶ of institutional racism and its impact on Indigenous academics, community members, and the perspectives they share with the SON. My research aims to interrogate the

⁵⁶ Insinuating that institutional racism is ominous and omnipresent.

experience of Indigenous academics using Indigenous-led critical race scholarship, which enables a deeper understanding of the operations of racism in this context. As discussed earlier, non-Indigenous academics may also be subject to institutional racism. Thus, my work enquires about the factors of proximity and degree of commitment to the mentioned institutions, in relation to non-Indigenous academics' experiences of institutional racism.

This project requires a theoretical framework that enables a critical approach that privileges Indigenous peoples' ways of knowing, being, and doing. A critical approach is necessary for interrogating problematic normative institutional operations and individual practices. A critical approach works towards decolonisation, privileging the futurity of Indigenous peoples and pursuing the identification and interrogation of the incommensurabilities between the neocolonial and neoliberal agenda of performative benevolence regarding Indigenous peoples' health and the aspirations of Indigenous peoples in this research context (Tuck & Yang, 2012). Privileging Indigenous peoples' ways of knowing, being, and doing enables the inclusion of Indigenous research theories and methods to create new knowledge and understanding of matters previously explored with the research 'tools of the colonial masters.'

To achieve this work, I look primarily to Indigenous peoples' scholarship, to intentionally "challenge the knowledge hierarchy implicit in research" and invest in Indigenous intellectual relations (Tynan, 2020, p. 164). I introduced two of the four theories and research principles of my theoretical framework earlier ([Chapter 1](#)) to frame of my social positionings; they were Moreton-Robinson's (2013) theorising towards an Australian Indigenous Women's Standpoint Theory (AIWST) and Rigney's (1999) Indigenist research principles. In this chapter I introduce Moreton-Robinson's (2017) relationality, as well as Deleuze and Guattari's (2020) Rhizome.

This theoretical framework enables the operationalisation of three (primarily Indigenous) research methods. Bessarab and Ng'andu's (2010) research yarning, Ungunmerr-Baumann's (n.d.) *dadirri*, and Deleuze and Guattari's (2020) assemblage woven together to enable the data generation, analysis, and presentation of my research project.

4.1.1 Relationality

Moreton-Robinson (2017, p. 71) states that “relationality is grounded in a holistic conception of the inter-connectedness and inter-substantiation between and among all living things and the earth, which is inhabited by a world of ancestors and creator beings”. Martin (2008) identifies living and non-living entities, who share country with us, as inter-connected relations. Our “Knowledge systems are grounded in [these] relations to land, place, entities, ancestors, creators and people” (Moreton-Robinson, 2017, p. 73). Thus, our ways of knowing, being, and doing are shaped by our relational connections, as discussed earlier ([Chapter 1](#)). Moreton-Robinson (2017, p. 72) reminds us that “to be connected is to know and knowing is embodied in and connected to country”.

However, “not all knowledge is accessible... there are rules that are enmeshed in social relations and bloodline to country, determined by ancestors and creator beings that guide who can be a knower and of what knowledge” (Moreton-Robinson, 2017, p. 72). A concern that I have regarding sharing Indigenous peoples' perspectives within teaching spaces and in publications, is specifically that there are limited regulations, beyond the relational regulations of our communities that can protect Indigenous peoples' perspectives (Drummond, 2020). It often falls upon individual Indigenous people, working (often in isolation) within the white-dominated cultural institutions of universities, to regulate their practice distal to the authority of a collective of Indigenous knowers (Drummond, 2020).

The lack of regulation of Indigenous knowledges and perspectives is the reason I did not pursue the articulation of a *Meriam* or *Wuthathi* research methodology for this research project.

In the context of contemporary Indigenous research, Moreton-Robinson proposes that relationality is “the core presupposition of the Indigenous social research paradigm” (Moreton-Robinson, 2017, p. 71). The inclusion of ‘social’ is designed to emphasise the imperative of relationality, which is evident in Indigenous research in numerous nation-states (Moreton-Robinson, 2017). Privileging relationships amongst humans, and with non-human entities, including Country, reflects Indigenous ways of knowing, being, and doing, while simultaneously challenging “Western methodological presupposition of nature as servant to humanity and humanity as master of nature” (Moreton-Robinson, 2017, p. 75).

According to Moreton-Robinson “relationality is the interpretive and epistemic scaffolding shaping and supporting Indigenous social research”, and as noted earlier, we are taught to interpret relational interactions, and co-create knowledge via relational engagements (2017, p. 69). Learning via relationality is also dependent on “time, place and land”, it requires learners to be ready to learn when these factors align (Moreton-Robinson, 2017, p. 71). Relationality values the agency of non-human entities, including Country, which engage with us when the time, place and land is right (Drummond, 2020). This dynamic speaks to the reciprocity between entities, or the “inter-substantiated” nature of “proper relations” (Moreton-Robinson, 2017, p. 72). Relationality “provides a network of ideas for perception within which thought, communication and action occur in research” (Moreton-Robinson, 2017, p. 71). I explore relationality further when I discuss the theoretical concept of rhizomes.

Having relationality as part of the theoretical framework allows me to engage with Indigenous ways of knowing, being, and doing, which includes the use of Indigenous methodologies and methods. This foundation also enables sharing stories and anecdotes of

relational engagements which tell of lessons that helped me think through different matters associated with my thesis. This approach challenges Western hegemonic ways of knowing. Relationality creates potential for novel approaches to ongoing or difficult problems, especially those of importance to Indigenous peoples' futurity.

4.1.1.1 Being a good relation

Relationality insists on ethical practice, conducting oneself *prapa way* (Watkin, 2009), in being a good relation. Being a good relation begins with “an awareness of our proper relationship with the world we inhabit,” and is maintained through conducting ourselves with “respect, responsibility, generosity, obligation, and reciprocity” (Moreton-Robinson, 2017, p. 71).

In my research project, being a good relation is achieved through adherence to relational protocol and obligations, to the best of my ability. This practice involved respectful engagement with the literature and other sources for the genealogical analysis, contemporary social, political, and material conditions analysis, and the analysis of the research yarning. Respectful engagement also extended to my work with colleagues with whom I have established relationships (key colleagues) to start conversations about conducting my research at their SON; formally engaging with respective Heads of School, requesting permission to engage their SON as a site for my research project; being guided by key colleagues regarding travel and site visit logistics; presenting to SON staff to self-locate myself, promote my project, and invite participation; intentionally trying to limit any negative implications on key colleagues and research participants in their workplace; and maintaining the privacy of participants and our research yarns while on site and in the development of my thesis and journal publications.

Being a good relation is not an easy task, and there is no clean binary between being a good or bad relation. Being a good relation requires an ongoing commitment to constantly learn about what the immediate context requires of you.

4.1.2 Rhizomes

Gilles Deleuze, a French philosopher, and Felix Guattari, a French psychoanalyst and political philosopher, proposed that the purpose of philosophy was to create theoretical concepts (Deleuze & Guattari, 1996). Prolific concept creation is evident in their work that aimed to challenge the hierarchical structures of Western knowledge and its assumed dominance, which they argued limited the capability of philosophy (Deleuze & Guattari, 2020). They insist that the concepts that they created in arguing and strategising against established structures of Western knowledge are tools that philosophers could include in their toolkit to support new theorising, not bound to old rules, pathways, and genealogies (Deleuze & Guattari, 2020). For my thesis, I chose to weave into my theoretical framework their theoretical concept of the rhizome given alignments with the critique of hierarchy and assumed dominance of Western intellectualism, and subsequent suppression of other ways of knowing. Further there is cohesion regarding the “interpretive and epistemic scaffolding shaping and supporting” nature of relationality (Moreton-Robinson, 2017, p. 69) and the rhizome, which I discuss. Later, I introduce another theoretical concept of Deleuze and Guattari (2020), assemblage, which I use with other methods for data generation, analysis, and presentation.

Deleuze and Guattari’s (2020) concept of the rhizome was designed to represent a different way of knowing, one not based on established and predictable structures of past theorising, which they likened to a tree (i.e., Western ways of knowing). The growth and reproduction of this tree is linear; its growth is bound to a hierarchy innate in trees (Adkins, 2015); thus, growth and reproduction avoids multiplicity in meaning-making, preferring certainty in linear rational logic (Deleuze & Guattari, 2020). The linear nature of Western

theorising is evident within books, which, Deleuze and Guattari (2020, p. 5) argue, represents the “oldest and weariest kind of thought”. They assert that human “thought lags behind nature... in nature roots are taproots with a more multiple, lateral, and circular system of ramification, rather than a dichotomous one” (Deleuze & Guattari, 2020, p. 5). So, even the use of the analogy of the tree is generous for describing the linear nature of Western knowledge growth and reproduction, as the tree demonstrates more potential for experimenting on new ways.

The analogy of the rhizome is used to contrast against the structure and apparent predictability of the tree. “Rhizomes do not propagate by the way of clearly delineated hierarchies but by underground stems in which any part may send additional shoots upwards, downwards, or laterally. There is no hierarchy. There are no clear lines of descent” (Adkins, 2015, p. 23). Deleuze and Guattari (2020, p. 7) propose several examples of rhizomes in nature, “bulbs and tubers are rhizomes... rats are rhizomes [when they swarm over each other] ... burrows are too, in all their functions of shelter, supply, movement, evasion and breakout... potato and couchgrass, or the weed.” These examples are designed to enable the imagining of the rhizome.

Deleuze and Guattari (2020) insist that the introduction of the rhizome as an alternative way of understanding and realising knowing is not designed to assert dualism between the rhizome and the tree. They insist that both are required. Their theorising aims to promote greater understanding of rhizomatic thinking that is necessary to create new thinking, ideas, and approaches (Adkins, 2015; Deleuze & Guattari, 2020).

The rhizome is enlisted into my theoretical framework for numerous reasons. Primarily, it challenges Western intellectual hegemony, which, as explained earlier, has decimated, and devalued what Foucault (1976, p. 7) labels “subjugated knowledges”. These subjugated

knowledges of course include Indigenous knowledges, which brings me to the next reason, that the theory of rhizomes, I argue, encourages engagement with different ways of knowing, without the need of validation via precise tracings of a genealogical link to some point of Western intellectualism. The contradiction between challenging Western intellectualism and its abandonment of Indigenous knowledges, and enlisting the scholarship of French philosophers as methodology and method in my research that aims to challenge is not lost on me. I argue that this is direction that I had intended, an approach towards the post-Indigenous (Hokowhitu, 2016), investing in intellectual relational engagement amongst Indigenous communities (Tynan, 2020); the support from Deleuze and Guattari's rhizome is a useful coincidence, a rhizomatic connection. This also demonstrates my tactful compliance with Western intellectualism.

I also mentioned the coherence between Deleuze and Guattari's (2020) rhizome and relationality (Moreton-Robinson, 2017), which is another reason. Deleuze and Guattari's principles of a rhizome has helped me to explain the operations of relationality as a way of knowing. I explore this coherence now to demonstrate the usefulness of the concept of the rhizome to elaborate interpretive scaffolding and support of relational knowledge, particularly via engagement with human and non-human entities that take place at particular times, places, and land. I use a personal testimony and Deleuze and Guattari's six principles of a rhizome to help explain this coherence. The principles of the rhizome are connection, heterogeneity, multiplicity, asignifying rupture, cartography, and decalcomania (Deleuze & Guattari, 2020, pp. 7-13).

My testimony is of an experience early in my PhD journey when we lost someone in our family. I was on holidays just north of Cairns and was considering whether I should return home to be with family or return to Brisbane as planned. As I looked out towards the ocean, thinking about what to do, I saw a big mackerel jump high into the air and back into the ocean.

Now, I have been taught by my Grandpop that mackerels do this when it's windy. He shared this knowledge with me several times while out fishing with him on the boat. He explained that the mackerels can do serious damage to boats, even break through the bottom of boats if they were to land nose-first in the boat. The mackerel is also one of my Grandad's totems. My engagement with the mackerel encouraged me to go home to be with family. My interpretation of my engagement with the mackerel, in the moment of decision making, was a rhizomatic connection and is reflective of some of the ways of knowing that I have been taught by my people.

The first principle of connection innately challenges the established hierarchical structures of knowing and pursues new connections. These new connections are referred to as lines of flight (Deleuze & Guattari, 2020). Deleuze and Guattari (2020, p. 7) state that "any point of rhizome can be connected to anything other, and must be. This is very different from the tree or root, which plots a point, fixes an order."

Connection is evident in my interpretation of the relational interaction with the mackerel, a personal totem, an indicator of the weather, and in that very moment a guide for me to resolving the problem I was contending with. My exercise of Indigenous ways of knowing, challenges the Western anthropocentric ways of knowing that promotes a body-mind-living earth separation (Moreton-Robinson, 2017, p. 71). Additionally, the example promotes Indigenous ways of knowing, which is not hierarchical in structure, like Western ways of knowing and knowledges (Moreton-Robinson, 2017; Deleuze & Guattari, 2020).

The principle of heterogeneity promotes assemblage, that is experimental connections of "wildly diverse things" (Adkins, 2015, p. 24). Deleuze and Guattari (2020, p. 7) and states that "a rhizome ceaselessly establishes connections between semiotic chains⁵⁷, organisations of

⁵⁷ "'Semiotic chain' refers to a process of sign-making in which the meaning is materialized in a range of different but linked texts. It is based on the assumption that meaning-making is ongoing and continuous rather

power, and circumstances relative to the arts, sciences, and social struggles” (Deleuze & Guattari, 2020, p. 7). This characteristic asserts that connection via assemblage is not bound to traditional or known connection between things; in fact, this principle encourages experimentation with connections.

Heterogeneity is evident in the type of things that were connected in my testimony. The mackerel and its multiple meanings, the weather, my Grandad and Grandpop, loss in my family, my work. These things are not immediately connected using Western rational logic. The meaning-making evident here demonstrates an understanding of the ongoing nature of meaning-making via relational knowledge co-creation.

The principles of multiplicity explain the potential of rhizomatic connections, which are regulated by the determination, magnitude, and dimensions of the rhizomatic connections (Deleuze & Guattari, 2020). Determination refers to the capability of the rhizomatic connection; magnitude refers to the degree to which the rhizomatic connection is used/exercised; dimension refers to “the number of connections to other multiplicities that are made possible by its determination and magnitude” (Adkins, 2015, p. 26). Assemblage encourages an “increase in the dimensions of the multiplicity” or rhizomatic connections, which inevitably increases and changes the understanding of what is being connected (Deleuze & Guattari, 2020, p. 8).

“A multiplicity... is not a discrete, static unity, but something constantly entering into and breaking off combinations with other multiplicities” (Adkins, 2015, p. 26). The existence of discrete and static unities suggests what Deleuze and Guattari describe as a power takeover or a supplementary dimension (2020, p. 8). “A power takeover would be the restriction of the determination and magnitude of the multiplicity to a certain range” (Adkins, 2015, p. 26). The

than limited to one moment in time” (Jewitt & Newfield, n.d., para. 1). In the context of rhizomes, this does not seem to be limited to text, but include “wildly diverse things” (Adkins, 2015, p. 24).

“restriction of determination and magnitude is organised by [a] supplementary dimension (e.g., state’s judicial apparatus that appears to exist over and above individual ‘criminals’ that it creates)” (Adkins, 2015, pp. 26-27).

Multiplicity is evident in the contextual interpretation of the relational engagement with the mackerel. The determination of this rhizomatic connection was informed by my different understandings of the mackerel, the magnitude was informed by which understandings of the mackerel were connected, which was determined by the problem I was contemplating; collectively this resulted in the dimensions of the rhizomatic connection. A power takeover is evident in the Western knowing of the mackerel, and my Grandpop’s teaching of the mackerel’s behaviour during windy weather. It is also evident in my relational connection to the mackerel as one of my Grandad’s totems. I challenge this power takeover by intersecting these established knowledges, with the problem that I was contemplating at the time, which enabled a ‘line of flight’. The dominant Western way of knowing is the supplementary dimension, that constantly diminishes different ways of knowing.

While the previously discussed principle promotes connections, the principle of asignifying rupture promotes division, and together they “are the two basic tendencies of assemblages... what gets collected or divided” (Adkins, 2015, p. 27). Similarly, the practice of division is encouraged to be unorthodox, or as Adkins (2015, p. 27) puts it, “refusing to carve nature at the joints and instead creating a rhizome... [as] the drive to divide nature neatly at the joints obscures a rhizomatic account of the same process” (Adkins, 2015, p. 27).

As someone who has hunted and butchered pig, deer, and turtle, this example drives home the message about asignifying rupture, while simultaneously challenges me deeply. Cutting at the joints is not only easy for the butchering process, but is also easier on your knife,

easier for cooking, and is also synonymous with your competence as a hunter and butcher. The principle of asignifying rupture is meant to generate such disruption.

Adkins (2015, p. 28) advises that “making a rhizome does not seek clear lines of descent, it seeks to scramble the codes and make new connections [lines of flight].” In describing the making of a rhizome, Deleuze and Guattari (2020, p. 11) use the analogy of a plant growing close to a waterway, whose line of flight is a rhizomic relation between its seeds and the waterways in which it is located. Following the line of flight requires following the diverse flow of the water, the multiplicities, to see where the seeds end up, and what comes of them. The rhizomic connections, and what may come of them, good or bad, helpful, or not, “can never be known beforehand; it can only be discovered through experimentation” (Adkins, 2015, p. 29).

Asignifying rupture is evident in the discontinuation of my line of thought of the mackerel as just being a sign of the weather or the totem of my Grandad. In the moment, lines of thought that may be considered logical were severed from my meaning-making of the experience. The rhizomatic connection was made between the mackerel and the problem I was contemplating. The discomfort of following the principle of asignifying rupture is felt now as I write it, as I didn’t have to explain my reasoning at the time. Even now, I am considering using a different example that centres someone else. But this example will remain, for now.

The final principles of cartography and decalcomania are discussed together. Cartography or mapping refers to the “creation of a rhizome”, decalcomania or tracing, refers to the reproduction of trees “everywhere and out of everything” (Adkins, 2015, p. 29). Deleuze and Guattari (2020, p. 12) insist that in creating rhizomes we must “make a map, not a tracing,” highlighting that “the map is open and connectable... detachable, reversible, susceptible to constant modification. It can be... reworked by an individual, group or social formation...

conceived of in a work of art, constructed as a political action or as a meditation” (Deleuze & Guattari, 2020, p. 12).

A tracing on the other hand is a mere copying of an original image, idea, or thought. Adkins (2015, p. 29) likens stickers to modern day examples of Deleuze and Guattari’s tracing, and he insists that “stickers are safe. They do not risk anything, but they keep reproducing the same image of thought over and over again.” Tracings (and stickers) thus perpetuate the hierarchies of the original source that is being copied (Deleuze & Guattari, 2020, p. 12).

It is important to note that “any assemblage will evidence tendencies towards both stability (tracing) and change (mapping)” (Adkins, 2015, p. 30). Adkins (2015, p. 30) provides such an example, of needing an image of a dragon and using a sticker of a dinosaur and drawing on the wings and flames to achieve this. However, in creating new things, new thoughts and theories, mapping must take precedence (Deleuze & Guattari, 2020).

Cartography and decalcomania are evident in my testimony. Decalcomania (tracing) is evident in the orthodox knowledge of the mackerel which likes to jump into the air when it is windy, the risk this poses to boats, and the knowledge of the mackerel as my Grandad’s totem. Cartography (mapping) is evident in how this relational interaction became relevant to the problem that I was contending with regarding whether I should visit my family following the death of a family member. The tracings take on new meaning when applied to the mapping, providing guidance to resolve the problem I was contending with.

Deleuze and Guattari’s (2020) theoretical concept of the rhizome critique the hierarchy and subsequent hegemony of Western knowledge and ways of knowing and provides principles that can enable experimenting/exercising unorthodox approaches to find new things, new knowledges, and new ideas. The concept of the rhizome demonstrates that when “everything conforms to a pre-existing idea [everything] reproduces that pre-existing idea *ad infinitum*”

(Adkins, 2015, p. 30). The principles of the rhizome also helps to demonstrate the operations of relationality when engaging with entities.

The inclusion of the concept of the rhizome in my theoretical framework supports the experimenting of connections to find new knowledge and ideas, and the inclusion of testimonies about relational engagements and interpretation that challenges Western rational logic. Both are achieved through the practice of assemblage as a research method in the data generation, analysis, and presentation.

4.1.2.1 Assemblage

The concept of assemblage is associated with the functions of the rhizome, specifically the experimental connecting with “wildly diverse things” and disconnecting of orthodox connections, as essential to co-creating new ideas and knowledges (Adkins, 2015, p. 24; Deleuze & Guattari, 2020). This characteristic also challenges the tendencies to “grasp things as stable and complete rather than in the process of transformation” (Adkins, 2015, pp. 31- 32). This tendency doesn’t exclude the requirement for stable connection in the practice of assemblage, rather it insists on always being ready to explore new connections (Adkins, 2015; Deleuze & Guattari, 2020).

In philosophy, assemblage is used to create new concepts, which is an essential part of philosophy (Deleuze & Guattari, 1996). Assemblage as a research method supports innovative approaches to data generation, analysis, and presentation, that intentionally challenge traditional research practices (Augustine, 2014; Jervis, 2018). My use of assemblage aims to support Indigenous research methods and to experiment on new ways of using them, particularly the use of research yarning and deep listening as methods of data analysis and presentation. I discuss these later.

4.1.3 Australian Indigenous Women's Standpoint Theory (AIWST)

Feminist Standpoint Theory has been fertile ground for the emergence of Indigenous theorising about Indigenous standpoint theories (Rigney, 2001; Nakata, 2007; Moreton-Robinson, 2013). It has a long history of highlighting the problematics of the relations between power and knowledge production, particularly in “exposing the partiality of the universal male standpoint [and] challenging patriarchal knowledge production” (Moreton-Robinson, 2013, p. 332). However, Feminist Standpoint Theory is not immune to perpetuating problematic assumptions of patriarchal dominated Western ways of knowing, including the body-mind-living earth split, white possessive logics via their complex relations to capital as colonial subjects, and the disregard for the significance of the intersecting racialised experiences of Black and Indigenous women (Moreton-Robinson, 2013; 2016; 2020; Crenshaw, 1989; Huggins, 1998).

In the Australian context, the inequality of power distribution between Indigenous and non-Indigenous peoples is determined by the latter and is maintained through multiple means. Institutions of religion, politics, and capitalism are significant factors in maintaining the subordinate status of Indigenous peoples (Nakata, 2005). However, the experiences of colonisation and racial violence are different for Indigenous men and women, an important feature that must be privileged in any adoption of Feminist Standpoint Theory to our context (Moreton-Robinson, 2013). Moreton-Robinson (2013) warns against a gender-blind approach to applying Feminist Standpoint Theory to our Indigenous context. In her critique of Uncle Martin Nakata's Indigenous standpoint theory, she warns that “by omitting gender from his standpoint theory Nakata universalises Indigenous men's experience, thus producing an Indigenous form of patriarchal knowledge that mimics the kind of patriarchal knowledge production feminist standpoint theorists have critiqued” (Moreton-Robinson, 2013, p. 339).

Earlier, I discussed the theoretical and practical elements of Moreton-Robinson's (2013) AIWST, the reasoning for my use of it; despite it being designed specifically for Indigenous women researchers I used its elements to guide my self-location articulating my standpoint as a Black man, a Black 'male nurse', a 'native' academic, and an Indigenist researcher ([Chapter 1](#)). In this section I discuss the application of AIWST to my research project, including: its emphasis on self-locating at appropriate moments as part of my research practice; highlighting racialised and gendered differences in experiences, knowing that my understanding is limited to my gendered and racialised lived experiences; and, optimising enquiry into participants' accounts through the use of AIWST's social, historical, political, and material conditions that participants and I have been subject to.

Self-location is a protocol that advises others of who you are, and who you belong to. It enables relational connections, as well as functions as accountability for me to the people that I claim as my family, community, and colleagues. Self-location is not necessarily a recital of my standpoint, which would be performative and not respectful of the time and interest of others. In practice, I self-locate when meeting others for the first time, or if someone realises a relational connection with me that was not initially made. Self-location is included at the beginning of any publications, including this thesis, and takes the form of a more robust reflection of my standpoint. This practice is associated with informing readers about who I claim to be, and who claims me.

Highlighting racialised and gendered differences in experience is an important part of my research enquiry. While I cannot know the lived experiences of women, and of the social positions they occupy, my analyses of their accounts of these from the social positionings that I am relegated to remain valuable, telling of my frame of analysis, and what I see (and don't see). In practice, highlighting racialised and gendered differences was part of research planning, and part of the implementation of the research project, including data generation,

analysis, and presentation. The elements of AIWST enable a structured approach to this practice. Furthermore, my supervisors provide a valuable sounding board and multiple sets of fresh eyes that help identify and problematise assumptions that I make about racialised and gendered differences.

Moreton-Robinson's (2013) AIWST highlights the significance of the social, historical, political, and material conditions that Indigenous women are subjected to, in the different social positions that they are allocated. This framing provides a more holistic illustration of these social positions, and thus incorporating an enquiry interested in social, historical, political, and material conditions benefits my learnings from research participants' experience (including women, men, Indigenous and non-Indigenous participants), and supported a more thorough self-location practice. In practice, I incorporated the elements of social, historical, political, and material conditions into this thesis, including in my self-location ([Chapter 1](#)), in the genealogical analysis of the current practice of Indigenous health curricula inclusion in contemporary undergraduate nursing education ([Chapter 2](#)), in the contemporary social, political and material conditions analysis of the current practice of Indigenous health curricula inclusion in undergraduate nursing education ([Chapter 3](#)), as well as in the research yarning, analysis, and presentation of findings ([Chapter 5](#) & [Chapter 6](#)).

It is important to note that AIWST provides a framework from which Indigenous women researchers can develop a research methodology based on their own peoples' ways of knowing, being, and doing. For this research project, as already noted, I have intentionally not pursued the articulation of *Meriam* or *Wuthathi* research methodology for my research project, as I am not comfortable with the lack of protocol regarding the protection of Indigenous knowledges and perspectives once they are published. Additionally, while I feel that the focus of the

research is important to the Australian nursing discipline, and to Indigenous academics in nursing schools, it is not necessarily a priority for my community⁵⁸.

4.1.3 Indigenist Research Principles

Indigenist research refers to the research methodological approaches used by Indigenist scholars who are invested in the intellectual and political sovereignty of Indigenous peoples (Rigney, 2001). Rigney (2001, p. 9) states that “the goal of the Indigenist methodological revolution is to overcome alterity by producing counter-narratives through alternative investigative methods” (Rigney, 2001, p. 9). The counter narratives refer to those developed by Indigenous peoples, researchers, and research participants. The alternative investigative methods refer to the investment in Indigenous peoples’ research approaches. According to Rigney’s definition, this would encompass Moreton-Robinson’s theorising on relationality and AIWST, as well as Bessarab and Ng’andu’s (2010) research yarning, and Ungunmerr-Baumann’s (n.d.) *dadirri*. However, it would exclude Hokowhitu’s (2016) theorising towards a post-Indigenous, because an Indigenist approach remains interested in the colonising experiences of Indigenous peoples (Rigney, 2001).

The scope of disciplines and approaches that can engage in Indigenist research is broad, and thus the origins of Indigenist research reflects this breadth. Rigney (2001, pp. 1-2) states that while “the rise of the movements such as feminism, postmodernism, and postcolonialism” were the catalyst of earlier Indigenist research, he proposes that “there is a fundamental need for Indigenous scholars to map this field [of Indigenist research] further to bring different perspectives, expertise, and political orientations to this movement”.

Indigenist critiques, enabled through Indigenist methodologies, “seek to locate tensions, conflicts and contradictions within investigative methods... [which aims] to overcome the

⁵⁸ I am currently co-leading another research project within *Zenadh Kes* that is of more importance to my community, which is addressing some of the implications of climate change.

‘epistemic violence’ forced upon Indigenous peoples” (Rigney, 2001, p. 7). Indigenist researchers are interested in the extent to which the colonial masters’ tools can contribute to liberating us, seeking answers to questions like, “can we participate in Western science without reinvesting the hegemonic colonial imagination about ourselves? [Or] if Western scientific traditions and structures are intimately connected to ‘racialisation’ through neo-colonialism, can the Indigenist scholar use such science for intellectual and political emancipation?” (Rigney, 2001, p. 7). The scholarship of Indigenist scholars is invested in undermining “the monological authority of Western narrative of representation with regards to Indigenous nationhood... [which] reject the universalist tendency of Western research traditions to homogenise Indigenous identities and cultures” (Rigney, 2001, p. 7). The criticality of the Indigenist approach is imperative, otherwise it is just Indigenous peoples conducting research according to discipline rules and expectations, complicitly reinforcing ‘hegemonic colonial imaginations’ about us.

For my research project, I am specifically engaging with Rigney’s (1999) Indigenist research principles as part of my research ethics of practice, embedding the criticality within my practice of being a good relation. These principles were introduced earlier and used as a framework to describe my social position as an Indigenist researcher ([Chapter 1](#)). Here, I wish to focus on discussing the relevance of Rigney’s (1999) Indigenist research principles to my research project.

Rigney’s Indigenist research principles are interrelated, they promote the value of Indigenous peoples’ aspirations and voices in challenging colonial imaginations and control of us and embody the emancipatory imperative necessary against the omnipresence of white colonial supremacy and associated Indigenous dispossession (Rigney, 1999; Saunders et al., 2010). The Indigenist principles include resistance as the emancipatory imperative, political integrity, and privileging Indigenous voices (Rigney, 1999).

The first principle, resistance as the emancipatory imperative in Indigenist research, asserts the need to tell the truth about the realities of Indigenous peoples, including the generations of British and Australian colonial racialised violence and oppression exercised upon Indigenous peoples. This principle highlights the importance of our survival and resistance and the inclusion of these stories in the discourse by and about Indigenous peoples (Rigney, 1999, p.116-117).

The second principle, political integrity in Indigenist research, highlights the political nature of Indigenist research, and the fallacy of a social position that is apolitical when it comes to Indigenous peoples' intellectual and political sovereignty. In fulfilling these principles an Indigenist researcher "takes the research into the heart of the Indigenous struggle", implying that Indigenist researchers are knowledgeable and confident to know where the 'heart of the struggle' is and how to conduct oneself as a good relation while undertaking this work (Rigney, 1999, p. 117).

The third principle, privileging Indigenous voices in Indigenist research, insists on just that. This principle is a reminder of the historical and contemporary practice of silencing or manipulating our voices, that is our perspectives and knowledges, by colonial institutions and their agents, to service the needs of the colonial institutions. This principle asserts that Indigenous peoples are knowers, and have always been; additionally, it reminds us of the sophisticated understanding that Indigenous peoples have of the neocolonial apparatus, especially the way in which colonial institutions reproduce new ways of maintaining power and control over Indigenous peoples. No other voices can speak from the vantage point that Indigenous peoples are confined to, hence the need to privilege our voices.

In practice, I have consistently applied these principles throughout this research project, including in associated publications. These principles are part of my ethics of practice as an

Indigenist researcher and a good relation. They informed the way in which I: engaged with the literature when developing the genealogical analysis and contemporary social, political, and material conditions analysis; engaged with relevant stakeholders in planning my research site visits; conducted myself onsite, especially when engaging participants during the research yarns; and, when I attended to the analysis of my research findings and the presentations of research outputs.

It is important to note that I engaged Indigenous and non-Indigenous research participants. The first and second principles informed all research yarning, analysis, and presentation. The third principle applies to non-Indigenous people in a way that is conscious of the need to privilege Indigenous peoples' voices, while not reproducing the colonial violence of silencing the voices of others (in this case non-Indigenous people). The perspectives of non-Indigenous people complement that of Indigenous peoples, who all share their view of the colonial institutions and their operations from their social positionings.

4.1.3.1 Research Yarning

Yarning is an English word used by Indigenous peoples to describe Indigenous peoples' ways of knowing, being and doing specifically regarding the relational sharing of knowledge (Ungunmerr-Baumann, n.d.; Bessarab & Ng'andu, 2010; Geia et al., 2013; Drummond, 2020). Some Indigenous peoples maintain their own words to describe these ways of knowing, being and doing. *Yatdjuligin* for example, is a word from the Wakgun people of the Gureng Gureng nation (Bundaberg and surrounding area) which means "talking in a good way" (Smallwood, 2021, p. 2). "The process of *Yatdjuligin* is deeply embedded in learning... [and] belongs to a traditional two-part process of passing on knowledge about Country, its resources and their uses... importantly *Yatdjuligin* can be confronting" (Smallwood, 2021, p. 2). The complexity of the meaning of the word *Yatdjuligin* may not exactly reflect similar words in other

Indigenous languages, however it does highlight the importance of yarning as an Indigenous way of knowing, being, and doing regarding relational knowledge development and sharing.

Yarning is the form of human (usually), verbal communication that enables engagement with other human and non-human entities. The nature of the yarn changes with the entities involved and the context of the engagement. Smallwood's (2021) example demonstrates the type of yarn that is focused on education and development, while Geia et al. (2013) shared about how her dad yarned with the spirits of the Country to announce that he and his family were coming into the forest, so that they would be protected. Oodgeroo Nunukul (1972) (Kath Walker) also writes about yarning that takes place between humans and other entities she and her family share Country with, in her stories and poems. Yarning is essential to developing and maintaining the connections within relational networks, thus an essential part to relationality.

It is perhaps unsurprising that yarning has been adopted by Indigenous researchers to be a research methodology. Bessarab and Ng'andu (2010) are credited for publishing on their use of yarning as a research method. This scholarship was a result of sharing learnings from Professor Dawn Bessarab's, a Bard/Yjindjabandi woman, research in Western Australia, and Bridget Ng'andu's work in Botswana; both identifying the lack of value afforded yarning as a legitimate method of data collection (Bessarab & Ng'andu, 2010). Their theorising resulted in the articulation of four types/stages of yarning that they employed as part of their research practice, including: social yarning, research topic yarning, collaborative yarning, and therapeutic yarning (Bessarab & Ng'andu, 2010).

Social yarning is defined as the "conversation that takes place before the research or topic yarn, is informal and often unstructured, follows a meandering course that is guided by the topic that both people choose to introduce into the discussion" (Bessarab & Ng'andu, 2010, p. 40). This is the point in which the researcher invests time into developing a trusting relationship

with the participant, and clarifies terms of the engagement, including measures of accountability (Bessarab & Ng'andu, 2010).

Research topic yarning is defined as a “yarn that takes place in a un- or semi-structured research interview... [with] the sole purpose... to gather information through participants’ stories that are related to the research topic” (Bessarab & Ng'andu, 2010, p. 40). This stage maintains the relaxed nature of the social yarning but is more focused on the purpose of the research, and on enabling the research participant to share their ideas and perspectives (Bessarab & Ng'andu, 2010).

Collaborative yarning is defined as the “yarn that occurs between two or more people where they are actively engaged in sharing information about the research project” (Bessarab & Ng'andu, 2010, p. 40). This stage is like the previous type of yarning but involves the researcher sharing their ideas and perspectives as well (Bessarab & Ng'andu, 2010).

Therapeutic yarning is employed if the participant “discloses information that is traumatic or intensely personal and emotional. The researcher switches... to the role of a listener where the participant is supported in giving voice to their story, is assisted to make sense of and have their story affirmed” (Bessarab & Ng'andu, 2010, p. 40). This practice demonstrates care for the research participant and can strengthen trust. It creates potential to have a positive impact on the participants’ comfort to continue sharing their ideas and perspectives, and even delve deeper (Bessarab & Ng'andu, 2010).

Relationship development and maintenance during the different types/stages of yarning as a research method is unsurprisingly imperative. Reflecting on my use of yarning in the classroom, the quality of the relationships is reflected in the comfort of those involved, and the depth of ideas and perspectives shared (Drummond, 2020). Relationships are particularly important when it comes to yarning about difficult topics, including those that require a

therapeutic yarning approach, but also challenging topics like discussing experiences of institutional racism. Such situations may be more challenging for non-Indigenous participants than Indigenous participants. Thus, the use of yarning in the research context requires attending to the relational obligations between the researcher and research participants. Trust is developed not just by being nice and polite, but requires a shared understanding of the relational protocols, and fulfilling these. Thus, my use of yarning as a research method is founded upon the Moreton-Robinson's (2017) relationality.

Bessarab and Ng'andu (2010) categorisations of the different yarning types/stages is useful to understanding the different needs regarding the researcher-research participant/s relationship development and maintenance throughout the yarn. However, this categorisation is problematic, as it creates a rigidity to yarning that seems contradictory to the complexity and fluctuations of yarns. For example, at times the researcher and research participant/s may be engaging in so-called social, collaborative, and therapeutic yarns simultaneously. Additionally, the categorisation also assumes that the research topic and collaborative yarns can be separated from the social and the therapeutic yarns. This assumption suggests that attending to the researcher-research participant/s relationship is supplementary to the research enquiry, and that this relationship can maintain a neutral unbiased status during the research topic and collaborative yarns.

In practice, my focus was on being a good relation, employing a yarning approach that strategically deployed social, research topic, collaborative, and therapeutic yarning as required, which collectively I refer to as research yarn/ing. Social yarning with research participants started from the moment I met them, was attended to throughout our research yarns and will continue should I engage with them again. The research topic yarn started when I spoke to all interested staff about my research project and invited them to be research participants, which is evident in the way several research participants referenced my presentation in our research

yarns. Collaborative yarning is evident throughout the research yarn, as I was an active participant in co-creating knowledge with research participants. Therapeutic yarning was deployed as needed throughout and following the research yarn.

It is important to note that wherever there were relationships to develop and maintain for this research project, yarning was deployed to enable this. For example, in the development and maintenance of relationships with key colleagues, with their respective Head of School and other School leaders, with multiple ethics committees, scholarship administrators, and with colleagues within my own administering university including student support personnel.

Another contrast to Bessarab & Ng'andu's (2010) articulation of research yarning practice was my use of yarning for engaging with the literature and other sources. The assemblage practice of engaging with literature and other sources involved immersive and iterative reading/listening/watching, contemplating, writing, re-reading/listening/watching, re-contemplating, and re-writing, and so on. I often felt like I was in conversation with writers and artists, learning about them as one would via social yarning with another person, and engaging them in deep conversation about the research topic, as one would in a research yarn. Although their yarn would remain the same, I would come back to their yarn (via re-reading) with different perspectives that enabled me to see different things, and further shape my understanding (via re-writing). This particular exercise of research yarning was essential to the genealogical analysis, the contemporary social, political, and material conditions analysis, as well as data analysis and presentation.

Yarning emphasises sharing perspectives and knowledges and assumes the responsiveness of the other. To ensure the optimisation of yarning, there must also be listening.

4.1.3.2 Dadirri and Deep listening

Dadirri is a “spiritual gift”, a *Ngangikurungkurr*⁵⁹ word meaning “contemplation” or “inner deep listening and quiet still awareness” as “to be still brings peace – it brings understanding” (Ungunmerr-Baumann, n.d., p. 1:3). Education leader and *Ngangikurungkurr* Elder Miriam-Rose Ungunmerr-Baumann shared

To know me, is to breathe with me. To breathe with me, is to listen deeply. To listen deeply, is to connect.

It’s a sound, the sound of deep calling to deep. Dadirri, the deep inner spring inside us.

We call on it, and it calls on us (MiriamRoseFoundation, 2017, 0:19).

In defining *dadirri*, Ungunmerr-Baumann’s (n.d.) explains that “when I experience *dadirri*, I am made whole again... there is no need of words. A big part of *dadirri* is listening”. *Dadirri* is essential to the *Ngangikurungkurr* people’s ways of knowing, particularly in their education practice via stories. Ungunmerr-Baumann’s (n.d., p. 2) shares that “as we grow older, we ourselves become the storytellers. We pass on to the young ones all they must know. The stories and songs sink quietly into our minds, and we hold them deep inside”. She articulates the nurturing of embodied Indigenous knowledges in young people, resonating with my own teachings with my family and community in the *Zenadh Kes* (Drummond, 2020).

Dadirri also promotes waiting which acknowledges that things happen at certain times and places. Ungunmerr-Baumann (n.d., p. 2) states “we do not try to hurry things up. We let them follow their natural course – like the seasons”. Waiting is also important to ceremonies and meetings, she states “we wait for the right time for our ceremonies and our meetings... Everything must be done in a proper way. Careful preparation must be made. We don’t mind waiting, because we want things to be done with care” (Ungunmerr-Baumann, n.d., p. 2).

⁵⁹ *Ngangikurungkurr* are sovereign people of the Daly River region in the Northern Territory. *Ngangikurungkurr* is translated to mean “‘Deep Water Sound’ or ‘Sounds of the Deep’” (Ungunmerr-Baumann, n.d., p. 1).

Ungunmerr-Baumann's (n.d., p. 1) gifting *dadirri* to all Australians, asserts that Indigenous peoples have been waiting for non-Indigenous Australians to be ready to listen to us; she believed that we have arrived at the time, hence the gifting of *dadirri*.

One significant part of Ungunmerr-Baumann's (n.d., p. 2) articulation of *dadirri*, that is sometimes ignored, is her positioning of the Christian God as the "great Living-Giving Spirit". She likens the silence of *dadirri* to experiencing "God's presence" (Ungunmerr-Baumann's, n.d., p. 2). This characteristic demonstrates an adoption of Christian faith into *Ngangikurungkurr* ways of knowing, being, and doing, as described by Ungunmerr-Baumann. This is also familiar to me, given the influence of Christianity of *Zenadh Kes* ways of knowing, being, and doing (Nakata, 2007; Drummond et al., 2021a).

Dadirri appears to resonate with relationality, where the deep spring within each of us calls for the deep spring within others that may represent relational connection. Ungunmerr-Baumann's (n.d.) articulation of *dadirri* suggests that urge for deep connection amongst humans as well as with non-human entities, an urge that cannot be forced, but achieved from 'quiet still awareness'. Ungunmerr-Baumann's (n.d.) positioning of the Christian God, resonates with the centrality of the ancestors and creator beings in Martin's (2008) articulation of relatedness in her Quampie story.

My understanding of *dadirri* is that of a practice that is essential for relational engagement, of listening and being receptive to relational connection. Ungunmerr-Baumann's focus is on the preparedness of non-Indigenous Australians to listen to Indigenous peoples, however her description of *dadirri* appears to be applicable beyond this context. That is, the need to make time and space to listen deeply, connecting with other human and non-human entities, and being prepared to connect.

In interpreting Ungunmerr-Baumann's articulation of *dadirri*, Atkinson (2002, p. 16) proposes six "principles and functions of *dadirri*. They include:

A knowledge and consideration of community and the diversity and unique nature that each individual brings to community; ways of relating and acting within community; a non-intrusive observation, or quietly aware watching; a deep listening and hearing with more than the ears; a reflective non-judgemental consideration of what is being seen and heard; and, having learnt from the listening, a purposeful plan to act, with actions informed by learning, wisdom, and the informed responsibility that comes with knowledge (Atkinson, 2002, p. 16).

West et al. (2012) proposes six very similar principles of *dadirri*⁶⁰ to Atkinson, demonstrating an agreement in their understanding of the Ungunmerr-Baumann's (n.d.) articulation of *dadirri*; principles that appear to expand the original articulation. The focus on listening and deep connection is supplemented with the need to consider the diversity and uniqueness of individuals, appropriate ways of practice within an Indigenous community, and developing a plan of action (Atkinson, 2002; West et al., 2012). These interpretations suggest the devaluing of the importance of listening, assuming that listening is not enough. The lack of recognition of relational connections beyond human connections, including spiritual connection, is another notable point of departure in their interpretation.

Atkinson's (2002, p. 15) conceptualisation of *dadirri* as a research approach informed her "investigative processes, and ethical cultural behaviour (in research)". She proposed five assumptions that guide her use of *dadirri* as a methodology (Atkinson, 2002). The first is honouring the integrity, fidelity, diversity and complexity of Indigenous communities; second

⁶⁰ West et al (2012, p. 1586) propose six "principles and functions" of *dadirri* include: "(a) *Dadirri* involves knowledge and consideration of the community and the diversity and uniqueness each individual brings to the community; (b) it encompasses ways of relating and acting within the community; (c) it is a nonintrusive observation, or quiet, aware, watching; (d) it is deeply listening; (e) it is a reflective, nonjudgmental consideration of what is, and what is heard; and (f) based on what is learned from listening, it is a purposeful plan to act informed by wisdom and the responsibility that comes with knowledge".

is to exercise “reciprocity in ways of relating and behaving, and in sharing information” within Indigenous communities; third is for researchers to constantly exercise self-reflection; fourth is being responsible with and committed to learning “from listening and witnessing, without judgement or prejudice”; and the final assumption is to value Indigenous peoples’ worldview, acting “with integrity and fidelity” as a learner (Atkinson, 2002, p. 20).

West et al. (2012, p. 1585) considers *dadirri* an Indigenist research approach, and use “Freire’s (1972) transformative education process and Habermas’s (1984) theory of communicative action” to theorise about *dadirri* as a methodology. In fact, they assert that *dadirri* is a critical theory based on correlations that they drew with the critical pedagogy and social theory scholarship of Freire and Habermas respectively (West et al., 2012).

West et al. (2012, p. 1585) believe that *dadirri* humanises Indigenous peoples by “dehumanizing Western research methodologies”. However, the oppression enabled through Western research methodologies is not due to its apparent humanness, or any binary between it and Indigenous peoples, rather its functions as a colonial tool wielded by researchers who are socialised to reinforce the power of colonial institutions and their agents, and the subsequent disempowerment of Indigenous peoples. This interpretation would better reflect Freire’s (1972) critique of education as a tool or means of dehumanising as well as humanising Indigenous peoples.

West et al. (2012) highlight the relevance of Habermas’s (1984) theorising on lifeworlds, specifically the operations of colonisation that aim to discontinue traditions and the social organisation and integration of peoples. Additionally, when it comes to addressing the problems of Indigenous peoples, it is often Indigenous peoples and their lifeworlds that is narrated as the problem, not the colonial systems and processes (West et al., 2012). This reality reflects a constructed power imbalance between colonial institutions and their agents, and

Indigenous peoples; an imbalance that West et al. (2012) believe *dadirri* can resolve, at least in the context of researchers working with Indigenous people.

West et al. (2012) promote seven characteristics of *dadirri* as a research method that relate to the different stages of research.

- a) *obtaining permission from the communities involved to work with them as research partners;*
- b) *honoring the principle of reciprocity by sharing information with all those involved;*
- c) *acting with sincere integrity towards the stories that are shared;*
- d) *viewing research as an educational transformative process, with the transformation not imposed by researchers, but rather coming from the communities in partnership with the researchers;*
- e) *honoring the lifeworld of the communities, including its oral traditions and appreciating the role of storytelling in the research process;*
- f) *guarding against the imposition of values by the researchers of the inadvertent recreation of the notion of ‘other’ and behaving as oppressors; and,*
- g) *avoiding “forms of cultural action with which... [oppressors] manipulate people by giving them the impression that they are being helped” (Freire, 1972, p. 111) (West et al., 2012, p. 1587).*

The promotion of *dadirri* as a research approach or methodology by Atkinson (2002) and West et al. (2012) is problematic. Atkinson (2002, p. 15) insists that her practice of reinterpreting *dadirri* and adoption as a research method is not cultural appropriation as she “approached both the author [Ungunmerr-Baumann] ...and the Aboriginal people of Central Queensland [who she was conducting research with]” early in her research design. However, Atkinson’s (2002) conceptualising and West’s et al. (2012) theorising seemed to necessitate a significant reinterpretation of Ungunmerr-Baumann’s (n.d.) articulation of *dadirri*. While they are not incorrect in their assertion of need for ethical research practices when working with Indigenous peoples, their expectation of *dadirri* to holistically encompass ethical practice

seems an exaggeration. Additionally, and importantly, it diminishes the significance of deep listening, the still awareness, and the connecting with the deep spring within other human and non-human entities; the lessons that Ungunmerr-Baumann's (n.d.) emphasised in her articulation of *dadirri*.

The experience of these scholars demonstrates the risk for me in misinterpreting *dadirri* as well (and other Indigenous knowledges and perspectives for that matter) and relates to my concerns in the lack of regulation of Indigenous knowledges and perspectives once they are shared beyond the collective knowers of origin. Maintaining the integrity of such gifts is essential to my practice as a good relation. However, I remain concerned about my ability to do this, distal from the collective knowledge holders of *dadirri*. Hence, for my research project, I decided to use the term 'deep listening' and exercise a practice based on the teachings about *dadirri*. This practice is not aimed to be extractive, but to be mindful of the risk of misinterpretation of *dadirri* if I claim to use *dadirri*.

In practice, I engaged with deep listening for administrative activities (e.g., engaging with key colleagues in organising my visit, which required careful attendance to existing and new relationships), for data generation (i.e., an essential part of engagement with literature and other sources, and of research yarning, was deep listening to what was said and what was not said, which guided my analysis and contribution to the research yarning respectively), and for data analysis (i.e., immersion in the audio recordings of the research yarns and transcripts, listening deeply to what was said, and what wasn't; and in the exercise of assemblage when engaging with other sources of information like journal articles, grey literature, podcasts, music, presentations).

My theoretical framework consists of majority Indigenist research theories, principles, and approaches, complemented with Deleuze and Guattari's theoretical concepts of the

rhizome and assemblage. Collectively they provide a theoretical position that honours and invests in Indigenous peoples' ways of knowing, being, and doing, which innately challenges Western intellectual hegemony. Harking back to Prof. Papaarangi Reid's (CATSINaM, 2019) analogy of the garden, my theoretical framework prepared the soil for the knowledge co-creation of my research project. The following section describes the tools I used and how I used them when tending to the garden, to ensure that the garden bears fruit.

4.2 Research Methods

In this section I elaborate on the operationalisation of the theoretical framework, in the administration (site selection, participant recruitment and ethics), data generation, analysis, and presentation of my research project.

4.2.1 Site selection and participants recruitment

I exercised relationality to determine SON sites for my research project. Conscious of the potential discomfort that such a research project may cause fellow academics and SON, I knew that academics and SONs that I had an established relationships with would be more trusting of me. As a member of CATSINaM and the Leaders in Nursing and Midwifery Education Network (LINMEN) I had established relationships with numerous academics working in several SONs across Australia. I yarned with a few colleagues, and three of them expressed an interest for their SON to be a research site. They facilitated informal support from their Head of School, which initiated a formal letter from myself requesting in principle support from the Head of School to support my ethics application. Of the three SONs sites one was a metropolitan-based School and two were regional-based SON; the three SONs sites were in three different Australian states.

The recruitment process commenced once ethical approval was granted. My first step was to formalise my relationship with my key colleague from each SON with a formal email requesting that they be my key colleague and outlining expectations, which they all agreed to. They agreed to assist with logistics regarding travel and timing of my site visits, and to assist with participant recruitment. My key colleagues were invaluable.

Electronic copies of my participant information sheet were sent to my key colleagues to be circulated via the internal SON emails weeks before my site visit. At the beginning of my site visit, I presented in person to two SONs, and via videoconference to one of the SONs, to promote my research project, answer any questions, and to encourage participation. A total of 12 participants were recruited, 10 of which were academics and nurses, and two were non-nursing academics. All participants had current or previous experience in developing and delivering Indigenous health curricula at their SON. Of the 12, two participants identified as Indigenous. Five participants (including one Indigenous participant) held leadership roles within their respective SON, including in Indigenous health.

Key colleagues provided me with an orientation to their SON, helped to organise access cards to the SON, as well as a room for me to host the research yarns. At times research participants invited me to host the research yarn in their office. Key colleagues were often the coordinator for the Indigenous health unit, so they were also the first to volunteer as research participants. This was a relationship I had to care for, given my dependency on them.

4.2.2 Data Generation

Data generation for my research project included engagement with the historical and contemporary sources, research yarning, researcher memos, and yarning transcripts. Deep listening, assemblage and being a good relation were essential to these processes.

4.2.2.1 Research yarning and deep listening with literature and other sources

As explained earlier, exercising assemblage as part of data generation required immersive and iterative engagement with literature and other sources. Following Augustine's (2014) approach, I read/listened/watched, contemplated, wrote, re-read/listened/watched, contemplated then re-wrote, and repeated this. My supervisors then reviewed and provided feedback. Eventually, chapters began to emerge. Critique of distal historical, social, political, and material conditions were tightly woven into the genealogical analysis ([Chapter 2](#)), and critique of more recent conditions were tightly woven into the contemporary social, political and material conditions analysis ([Chapter 3](#)). The analytical assemblage practice also extended to the analysis of the research yarning.

4.2.2.2 Research yarns and deep listening with research participants

Each participant was invited to engage in research yarning with me. The research yarns were unstructured, and audio recorded. The length of the research yarns varied, depending on the flow of ideas in the yarn, but I tried to keep the research yarns capped at one hour. As mentioned earlier, my research yarning was based on Bessarab and Ng'andu's (2010) yarning as a research method, and complemented with deep listening, based on Ungunmerr-Baumann's (n.d.) *dadirri*, and Deleuze and Guattari's (2020) assemblage.

Each research yarn started with introductions and acknowledgement of Country. I then started with opening questions like, "what is your role regarding the development and delivery of Indigenous health curriculum?" Or "Can you talk about our connection?"

The former question aimed to start where I thought research participants would feel most comfortable, essentially asking them about what they do in the context of Indigenous health curriculum. This question also aimed to found our research yarn with a question that is immediately relevant, which seemed helpful for research participants who were uncomfortable with an unstructured research yarning approach.

One participant answered with, *“I hope it’s ok, just reflecting on something that you mentioned in your presentation earlier today about differences between Indigenous perspectives and Indigenous knowledges”*.

The latter question was used for research participants I had a relationship with, and it was used to found our research yarn in our established relationship.

One participant answered with, *“so we’ve connected in a few different ways... most recently walking along the river in Brisbane, which was amazing.”*

The line of questioning followed the yarn, lingering on topics of interest to both or either party/ies, returning to topics previously mentioned, proposing a different perspective on a topic, and moving on to other topics that are yet to be explored.

Lingering and delving deeper into topics is evident in such questioning like, *“you were saying that you’re not sure... whether that’s a general experience [nursing students having negative view of Indigenous peoples], what are students coming into your unit with, in regard to... personal experience [with Indigenous peoples]?”*

Returning to previous topics is evident in such questioning like, *“So [earlier] you talked about individuals... being the reason why things happen...”*

Proposing a different perspective on a topic was achieved by changing the line of questioning with statements like, *“I’m going to flip that [question/perspective shared] over now...”*

Moving on to other topics was achieved by starting a new line of questioning with, *“I want to move on to...”*

My contribution to most of the research yarn were brief affirmative response tokens, *“mm-hmm”* or *“mm”* or *“Okay”* or *“yeah”*. Confirming that I am paying attention, that I am

understanding what the research participant has said, and that they are answering the question. This practice also limited disrupting the research participants' line of thought and acknowledges that there are limited spaces and time allocated for such conversations.

Other times, I was more active in co-creating better understanding with the research participants. For example, in one research yarn when we were yarning about all the different cultural concepts, I contributed with, *"and that's one of the things that I've come through with the literature, was that there's so many terms out there that people just use...without any desire to be true to the theory..."*.

Engaging with deep listening, I listened out for what participants were saying and what they were avoiding, which supported the line of questioning. Engaging in deep listening is also evident in summarising main points shared and expressing empathy towards the research participant.

Nearing the end of one research yarn, I acknowledge the leadership work of the research participant regarding her contribution to Indigenous health curriculum development and delivery (which she alluded to through our yarns), in a context with multiple demands for resourcing and space within undergraduate nursing curriculum. I stated, *"you have quite a challenging role in balancing all of this and understanding [teaching academics'] strengths and what opportunities may come from above [senior management] in regard to resourcing, and what needs to be delivered in the undergraduate program."*

Engaging with assemblage created flexibility within the research yarn, allowing the research yarn to be as flexible as the imagination of participants. This thinking enabled the engagement with Indigenous ways of knowing, being, and doing as well.

One non-Indigenous participant interrupted her yarn to acknowledge the totem of a late Aboriginal Aunty as it flew by. She had just spoken about how the late Aboriginal Aunty had

helped develop a deeper understanding of her role as a non-Indigenous nurse working with and for Indigenous peoples. She said, *“one of the things that’s worked really well was in framing up what this new course would look like [pause]. Mm, [points out the window to a pelican flying close by] there goes a pelican, that’s one of Aunty’s totems. Ha! That’s beautiful.”*

This engagement created comfort for her, knowing that she had permission to share what she shared earlier about her lessons from the late Aboriginal Aunty.

The research yarns ended at a mutually agreed time, with some participants clarifying their preference for an end time at the beginning of the research yarn.

At the end of one research yarn, the research participant and I checked with each other to see if we had yarned enough.

Me: *“We’ve come to the end... Is there anything else you wanted to share?”*

Research participant: *“No... if you’re happy with what we’ve chatted about, I’m happy enough.”*

Me: *“If you’re happy with it, I am very happy...”*

Other yarns ended when there appeared to be nothing else to yarn about.

Me: *Mm.*

Research participant: *Mm.*

Me: *Alright. I think that’s us.*

Research participant: *That’s it.*

Me: *Thank you so much. Thank you for sharing everything.*

Research participant: *There we go. Deep and meaningful.*

4.2.2.3 Researcher memo

After each research yarn I engaged in researcher memo writing about my experience as a research participant. The research yarns were the commencement of my immersion into the stories, perspectives, and ideas of research participants, and immediately reflecting on the research yarn, created the time and place to capture arborescent and rhizomic connections between what a research participant shared with the literature, theories, stories, and memories of personal and professional experiences. This process was the commencement of analysis of the research yarns.

Following is an extract from a research memo where I reflected on a particular part of my research yarn with a non-Indigenous female research participant. She shared an experience where she faced a dilemma of being forced by her manager to speak on men's business to a group of Indigenous men, knowing that she would have to be accountable to the Indigenous Elder women she worked with. If she refused her manager would have forced her Indigenous female colleague to do it instead, which would have been a worse situation. Here I focus on the non-Indigenous participant's decision, and the assumptions about the caring nature of Indigenous institutions, even when they are holding people to account.

“Power afforded Western institutions far surpass those afforded Indigenous institutions (our communities, women's group etc.). So, when confronted with such a dilemma, employees are likely to do less harm to themselves. Indigenous institutions may be more caring and understanding? Which may reflect Indigenous ways of knowing, being, and doing? May also reflect the importance of Indigenous peoples caring for the rare non-Indigenous individuals who prove to be good relations?”

4.2.2.4 Yarning transcripts

The transcripts for the research yarning were transcribed verbatim. This practice included “response tokens (‘mmm’), pauses and overlaps” which Silverman says are “basic features of interviewer-interviewee talk” that must be included in transcripts to support “robust analysis

of interview data” (2017, pp. 149). For Indigenous participants, such detailed transcribing also supports privileging their voices, as it requires the researcher to immerse themselves in the research yarn that they shared (Rigney, 1999). Due to time restraints, I transcribed four of the 12 transcripts, including the yarns with the Indigenous participants, and outsourced the remaining eight.

The completed transcripts were put in a two-column table, with a narrow empty column on the left-hand-side. The empty column was designed to allow for making notes on the margins as I read the transcripts and listened to the audio recording. The yarning transcripts were printed and bound. My initial reading of the transcripts was to confirm their accuracy, by listening to the audio recordings simultaneously.

4.2.3 Data analysis and presentation

The analysis of my research project is framed by my standpoint, as a Black man, Black ‘male nurse’, native academic, and Indigenist researcher. This is the position from which I have engaged the literature, worked with research participants, and analysed the research yarns that we shared. The criticality of my analyses was enabled through Moreton-Robinson’s (2013) AIWST and Rigney’s (1999) Indigenist research principles. The engagement of Indigenous ways of knowing, being, and doing was enabled through Moreton-Robinson’s (2017) relationality and Deleuze and Guattari’s (2020) rhizome.

Practically, research yarning and deep listening were exercised in the re-reading and note-taking in the margins of the transcripts. While the research yarn (via the audio recording and transcripts) remained the same, successive immersion in the yarn brought forward different topics that may not have been immediately obvious. In a way, I was able to return to the research yarn with the participant and exercise a deeper listening each time I returned. Each

time I added to the notes in the margin, which turned into a yarn with myself about what meaning I was making out of the research yarnning text.

Assemblage was an important part of connecting ideas and perspectives from the research yarnning transcripts, and from my own writing on the margins. Sources used to connect with the research yarnning transcripts and margin notes include: my researcher memos; journal articles and grey literature referenced in the genealogical analysis ([Chapter 2](#)) and contemporary social, political and material conditions analysis ([Chapter 3](#)); articles on new topics that emerged during analysis; podcasts, radio programs, TV programs, movies, or art pieces (e.g., audio pieces, visual pieces, dances, songs etc.). The more unorthodox sources subject to assemblage often resulted from unplanned engagement.

An example of an unplanned engagement is when I was listening to a song while I was walking home from a PhD writing day at uni. That day I was thinking and writing about the partnerships between SON and Indigenous communities, which was inspired by a statement by one of the Indigenous participants who said, “*we need that strong partnership with community. Community being part of maybe, the teaching staff.*” I got a bit stuck thinking about current models of partnerships, like the ones shared in the contemporary social, political, and material conditions analysis. As I walked home listening to a random playlist on my Spotify, *Yorta Yorta* rapper, Briggs, came on with his 2014 track titled ‘The Children Came Back’, a sequel to *Gunditjmara* and *Bundjalung* artist’s Archie Roach song, ‘Took the children away’ (Booth, 2015, July 3). The lines from his second verse struck me, “Now Mr abbott [sic], think about it – me and you we feel the same. That might sound strange, I’m just saying. We both unsettled when the boats came” (Booth, 2015, July 3, para. 15). Tony Abbott was the Australia Prime Minister when Briggs wrote this song, and thus this message was directed at his office. The boats are a reference to the 1788 first fleet, the first British convict ships to arrive on this continent, on the shores of Botany Bay. Briggs highlights the impact of British colonisation on

both Indigenous and non-Indigenous Australians, not just the former, which is the usual focus. Briggs' lyrics reminded me of Freire's (1972, p. 28) assertion that dehumanisation, "marks not only those whose humanity has been stolen, but also (though in a different way) those who have stolen it". Which brought me to the well-known quote I shared earlier by Queensland Aboriginal activists in the 1970s, "if you have come to help me you are wasting your time. If you have come because your liberation is bound up with mine, then let us work together" (Aboriginal activists group Queensland 1970s, as cited in Watson, 2004). I returned to my writing as soon as I got home. This assemblage guided me to look beyond current models or imaginations of what partnerships between Indigenous communities and SONs could be, and encouraged me to think broader, and differently.

As the margins of the transcript began to fill and become coherent with references to other sources, I started to synthesise these notes into a Word document. I initially included extracts from the transcripts and all relevant sources, including page numbers to ensure easy return to the original sources. The main sections of the contemporary social, political, and material conditions analysis provided a good initial framework for the fragmented flow of this transplanting process. This Word document became the beginnings of my interpretative chapter/s (originally two chapters, then one chapter, then two chapters again).

The interpretative chapters became the template for all thinking, and assemblage. As I re-immersed in the research yarning transcripts, or re/engaged with other sources, I took notes which were eventually included in the interpretative chapters, where they seemed to fit in the 'logical flow' of conversation. I emphasise logical flow because these chapters were fragmented most times.

My PhD supervisors were important support for this process. They read drafts of my interpretative chapters and provided feedback on statements and questions I would raise, on

the logical flow of the chapters, and suggest other sources that I could explore as part of the assemblage practice. Their different perspectives on stories and ideas, nurtured deeper thinking and often highlighted a line of flight to other sources.

My assemblage practice also created numerous opportunities for me to reflect on my own professional and personal experience that were conjured from my lines of thought. I wrote out several stories/testimonies of my own, which meant that they could be engaged through ongoing assemblage with the research yarnning transcripts and other sources.

The assemblage decreased as the yarnning in the interpretative chapters started to consolidate, becoming more coherent. Timing was also a key factor here, as assemblage and deeper/different thinking could have continued.

4.2.4 Ethics and Limitations

Moreover, I was reminded to 'make sure you do things prapa'. I understood this to mean adhering to cultural protocol, being respectful, being open and honest and knowing, most importantly, there is a right and a wrong way of going about things (Watkins, 2009, p. 146).

Zenadh Kes researcher Dr Felecia Watkin Lui (2009) shared the epigraph statement in her PhD thesis regarding her need to 'do things prapa' when she conducted her research in the *Zenadh Kes* region. Felecia's yarn is about her being a good relation, which is achieved through following protocols regarding relationships and regulations of the Indigenous community we are working with (Martin, 2003). Even though my research project was not with an Indigenous community, I was working on the unceded sovereign lands of several Indigenous communities, and with two academics who demonstrated close relational connections with local mobs. Being a good relation and 'doing things prapa' was imperative to ethical practice.

The National Health and Medical Research Council (NHMRC) guides research conducted with human participants, promoting the development and maintenance of a mutually trusting and respectful relationship between the researcher and the research participants. NHMRC (2018) champions six values and ethical principles to guide research undertaken with a focus on Indigenous peoples. These values and ethical principles apply to researchers, Human Research Ethics Committees (HREC), communities and other stakeholders. They include reciprocity, respect, equality, responsibility, survival and protection, and spirit and integrity (NHMRC, 2018).

As my research included Indigenous and non-Indigenous participants and related to Indigenous matters (i.e., Indigenous health curriculum), the application of values and ethical principles was necessary to my research practice. It was my responsibility as the researcher to ensure consideration for all these principles “in the conception, design and conduct of research” (NHMRC, 2003, p. 8). The foreseeable risks for this study, when developing my ethics applications, included discomfort and inconvenience.

Some participants demonstrated discomfort when discussing Indigenous peoples’ health and well-being, specifically regarding the teaching of this topic. Their experience of discomfort resonates with what was said before about the teachings from *Yatdjuligin*, specifically that some learning experiences are challenging and uncomfortable (Smallwood, 2021, p. 2). While this research project did not intend to ‘teach’ participants about the teaching of Indigenous curriculum, mutual learning took place simultaneously to knowledge co-creation in the research yarns. Thus, discomfort was unavoidable, however manageable. Discomfort was managed throughout the research yarn, where time was provided for the participant to reflect on issues discussed, had the choice to not answer questions that they were uncomfortable with, and had the option to pause or withdraw from the research yarn if required.

Inconvenience was associated with the time required of participant to engage in the research project, which included the research yarning. This risk was managed through yarns before the interviews. Participants were asked to propose a time for the research yarn that would be ideal for their schedule. This arrangement empowered participants to prioritise and plan their multiple personal and professional commitments and allow time to participate in the research yarning.

Ethics approval was received from the QUT's Human Research Ethics Committee (HREC), the Aboriginal Health Research Ethics Committee (AHREC) of the Aboriginal Health Council of South Australia, and the Aboriginal Health and Medical Research Council (AHMRC) of New South Wales.

Chapter 5: “Lovely stories”: standpoint, possessiveness, and relationality in the academy

This chapter presents the analyses of the co-created knowledge from the research yarns and data generated from assemblage with the literature and other sources. It builds on the genealogical analysis and contemporary social, political, and material conditions analysis and focuses on three main analytic ideas. For each idea, extracts of the participants’ research yarns are woven together to highlight significant aspects, drawing on the assumptions associated with relationality (Moreton-Robinson, 2017), Rhizomes (Deleuze & Guattari, 2020), AIWST (Moreton-Robinson, 2013) and the Indigenist research principles (Rigney, 1999) underpinning this study. The chapter results from an immersive assemblage practice (Deleuze & Guattari, 1996; Augustine, 2014; Adkins, 2015; Buchanan, 2020) of multiple (re)telling of my analysis which required numerous bouts of reading/listening/watching, contemplating, and writing.

The three analytic ideas are considered in the light of an interpretation and synthesis of literature that focuses on Indigenous and non-Indigenous people working together in the context of a burgeoning focus on Indigenous matters in the regulation of the nursing profession and consequently in nurse education. I tease out intersecting paradoxical dynamics of power imbalance, racisms, and apathy on the one hand, and of respect, support and interested mutual understanding on the other, that characterised the participants’ yarns.

Complementing the participant’s yarns are testimonies of my own, which were diarised by me during the PhD journey, reproduced as they reflected the arguments that developed. The title of this chapter is inspired by one of my testimonies that I include later. This specific testimony tells of the lack of value the other person afforded me while I elaborated on the complexity of relationality and how it impacts my professional role as a nursing leader; her response was to thank me for my ‘lovely story’. This is not a unique experience but reflects the

general lack of value afforded Indigenous peoples' knowledges and perspectives, often believed by others as myths and legends (Drummond, 2020); highlighting that the rhetoric of 'making space for' or 'including' Indigenous peoples' voices, does not equate to valuing the lessons to be learnt from Indigenous peoples. This chapter privileges the lessons from the Indigenous participants of my study, including me.

In line with Rigney's (1999) third Indigenist principle of privileging Indigenous voices in Indigenist research, I prioritised the analysis of the research yarns I had with the Indigenous participants of my research study. I published this work to highlight the experiences of Indigenous academics, that of my participants, and my own (Drummond et al., 2021). I have since analysed the research yarns of the non-Indigenous participants, whose experiences and perspectives have been brought together in the following chapters to expand on the analytical ideas that were assembled from my research yarns with the Indigenous participants. It is important to note that the ongoing assemblage analysis included re-immersion of my yarns with the Indigenous participants, which resulted in deeper thinking and writing of the analytical ideas that were initially published.

It never turns off, as an Indigenous participant said, investigates this very notion, that in different ways the focus on Indigenous health and their work, never really turns off. The yarns establish this experience as central to the social positioning of Indigenous academics within their SON and Indigenous communities. They elaborated on the paradox of their social position as both facilitator and object/subject of study, which has been raised before (Bond, 2014). Additionally, seeing the political and social conditions that confine Indigenous matters generally (re)produce themselves within the SON, further cement the experience of something that 'never turns off', just as Indigenous peoples must remember and retell of the violent colonial history of the Australian nation-state on behalf of all Australians (Huggins, 1998; Birch, 2021). I argue that these matters that 'never turn off' are a burden the Indigenous

academics carry and remember on behalf of the discipline, their SON, and university; an unimpeachable and at times impossibly conflictual social position to defend and to resolve.

This relentlessness is exacerbated by the demanding nature of academic work, made conspicuous by the yarns of the non-Indigenous participants, who were not burdened by constant racialisation like their Indigenous colleagues, and instead spoke of the significant expectations that SON and universities have of them. These expectations also don't turn off. Participants' yarns elaborated on how the logic of neoliberalism has enabled academic work to encroach upon the territory of non-work time. This analytic idea builds upon my earlier work about this unique space of contention between Western and Indigenous ways of knowing, and knowledges, including multiple and competing interests and expectations when it comes to developing and delivering Indigenous health curricula. Furthermore, it builds upon the notions of ethics of incommensurability, specifically how the research participants, especially Indigenous participants, must embody the tensions of being facilitator and object/subject of study, and of being the ones responsible for the SON and university meeting the profession's accreditation requirements.

So long as it looks on the surface like they're meeting accreditation needs, as an Indigenous participant said, reflected on performative benevolence demonstrated by her SON/Faculty leadership regarding the development and delivery of Indigenous health curricula. This section explores the neoliberal operations of the discipline, SONs, and universities, specifically the conditions that they create for the work of Indigenous and non-Indigenous academics tasked with developing and delivering Indigenous health curricula. This section argues that the logic of neoliberalism enables the discipline, SONs, and universities to accumulate capital and power in the context of Indigenous health curricula, including Indigenous knowledges, and perspectives, which essentially disempowers Indigenous peoples

as part of this extractive processes (Andersen, 2016). Such a miserly⁶¹ characteristic is innate to these institutions that seem to know no different. This aspiration can harness the power of disciplines to be productive, however the pervasiveness of white possessiveness will always limit this production and perpetuate subjugation of Indigenous peoples. Building on this conceptualisation, I argue in this section, that the institutions of the discipline, SONs, and universities systemically (re)produce colonialism and perpetuate white possession through their disciplinary knowledge and regulation mechanisms, evident in their claiming and commodifying Indigenous knowledges, perspectives, and peoples who are deployed primarily to advance their agenda.

Relational pedagogy ([Chapter 6](#)) investigates the current operations and potential of relationships and partnerships beyond the rhetoric of SONs undertaking ‘consultation’ with Indigenous peoples, as per ANMAC’s (2019, p. 15) accreditation standard on governance. Reciprocal relationships are key to working with Indigenous people (Moreton-Robinson, 2017). Participants describe how Indigenous academics, Elders and community members demonstrate enthusiasm to contribute to better preparing the next generation of nurses. Reciprocal enthusiasm is limited by the fear and uncertainty embodied by most non-Indigenous participants and the desire of the SONs and universities to prioritise their needs above that of Indigenous peoples. Building on Moreton-Robinson’s (2020, p. 186) critique of white feminism and her direction for them to start theorising about relinquishing power to Indigenous women to challenge the racial order not just gendered order, I argue that as institutions of predominantly white women, SON and the discipline must become more aware of their power in the context of developing and delivering Indigenous health curricula, including their lack of willingness to date to theorise and to strategise about relinquishing power to Indigenous

⁶¹ As a child we learnt to share as part of being relational (Drummond, 2020), and to be greedy was to be a miser, which is associated with being white and whiteness.

peoples so that our needs are prioritised (Cox et al., 2020). Current relationships are often facilitated by Indigenous academics and are limited to their immediate work. As discussed in [Chapter 3](#), Cultural Safety emphasises the significance of a relationship between the care provider and care recipient in ensuring safety for the latter. This arrangement emphasises a shift in the power dynamics where the care provider is held to account by the care recipient. Culturally safe partnerships resonate with the idea of being a good relation. In Chapter 6 I argue for a novel approach towards a relationship pedagogy to be employed by SON and supported by the discipline.

It never turns off – Embodying and confronting necessary tensions

According to Kickett et al. (2014), the value of having Indigenous academics teach Indigenous health curriculum in Bachelor of Nursing programs is recognised by nursing students. Indigenous academics can consolidate “clinical, cultural and lived knowledge” within the classroom space and operationalise Indigenous pedagogical principles (Mills & Creedy, 2019, p. 31; Drummond, 2020). This value is recognised in the strategic agendas of the discipline (CATSINaM, 2017) as well as the university sector (Universities Australia, 2017). However, Indigenous academics report that this apparent value is not reflected in their experiences, evident in their testimonies of feeling isolated and particularly in their advocacy for enabling better Indigenous health curriculum; both are associated with the racialisation of Indigenous health academics (Sherwood & Edwards, 2006; Jackson et al., 2013; Drummond, 2020).

Building on the discussion in the contemporary social, political, and material conditions analysis, this section of the analysis primarily explores the experiences of Indigenous academics who are tasked with developing and delivering Indigenous health curriculum. My

initial analysis identified that the notion of ‘never turning off’ related to Indigenous academics having to retell their trauma stories and that of others (including family members – referring to intergenerational trauma and legacy) as part of their academic practice, to convince students and colleagues to be better at caring for Indigenous peoples, and to see us as humans (Drummond et al., 2021). In the following section a deeper analysis offers further insights into the experience of Indigenous academics being proximal to the object/subject of study in the Indigenous health curriculum, a lived experience that seemed unfamiliar to non-Indigenous research participants. I also previously wrote about the susceptibility of Indigenous issues to being treated as the colloquial political football, and how that confines Indigenous academics and Indigenous health curriculum to being objects in the similar colonial politics (Drummond et al., 2021). The perspectives of non-Indigenous research participants on the experiences of Indigenous nursing students elaborate on SON politics, namely the operations of racism within the SON and associated with the Indigenous health curricula. I also wrote about the problematic legacy of nursing and its impact on Indigenous health, and how Indigenous participants saw themselves as inheritors of that legacy (Drummond et al., 2021). Engagement with the research yarns of the non-Indigenous academics demonstrate how most are aware of the problematic legacy they have been bequeathed, and some are demonstrating a real interest in not reproducing this. A new insight gained from analysing the yarns I had with the non-Indigenous participants was the operation of the logic of neoliberalism, particularly how it enables work time to encroach upon non-work time for the academics. This point highlights another dimension to work ‘never turning off’, that exacerbates the expectations already placed upon Indigenous academics. I elaborate on these threads of the first analytic idea now.

The prominent feature of the experiences of Indigenous participants in this study was their proximity to the Indigenous health curricula that they were required to develop and

deliver. The proximity to the objects/subjects of study is problematic, as an Indigenous participant highlighted,

One of the key things for us as academics, Black academics, is that we just don't turn off at home, you know. Our work within the Indigenous health space is carried over from professional to personal. Because, in most cases, we're actually living some of the experiences we teach about, you know, within our family and our community. So that's really quite another burden to carry, particularly when you're in an academic position in university and you're asked to teach this and read that. Um, and then you go home, and you have to deal with this and that at home. That just impacts, and yeah, it's like it, it never turns off. It never turns off.

In pointing out the obvious, that Indigenous academics belong to their Indigenous families and communities who are the objects/subjects of study in the Indigenous health curriculum, this participant suggests a general lack of understanding and subsequent lack of accommodating by discipline colleagues and the SON regarding the associated *burden* that Indigenous academics carry. Indigenous academics occupy similar social positions to other members of our family and community, with the exception to us occupying an *academic position in university*, which means we have/are/and will continue to be subject to similar historical, social, political, and material conditions defined for Indigenous peoples by the state and its institutions (Moreton-Robinson, 2013). We know from our lived experiences, and that of our family and community members, not just from textbooks, journal articles, written or print media, about the health conditions impacting us, the (in)effectiveness of health services and practices, the general lack of accountability, and the failure of successive political rhetoric to 'save us'.

This participant avows that “*we're actually living some of the experiences we teach about*”. This statement challenges the suggestion of a binary between Indigenous academics and their family and community, highlighting that having a professional role within a SON or

within the broader university does not remove Indigenous academics from the reality of being Indigenous in Australia. Bond (2014, p. 2) states that this matter often confuses students who “try to decipher whether [she is] an ‘authentic Aborigine’ or a ‘legitimate academic’, because [she] can’t possibly be both’; for some, [she] can’t be either”.

The participant’s statement also highlights the tensions of valuing and recognising our lived experience as a pivotal factor in the provision of a ‘real world’⁶² Indigenous health learning experience enabled by educators who have real and continuing experience as an Indigenous person who belong to their Indigenous community. The neoliberal logics that dominate the university sector would usually glamourise and inflate such capabilities, exercising performative benevolence to optimise its reputational and subsequent capital gains (Ball, 2012). However, there is tension in promoting the disadvantages experienced by Indigenous peoples, as told by Indigenous academics, who would be forced to recite a narrative about ‘saving’ our mob. We teach about the political conditions of Indigenous health, which is evident in our workplace.

The statement also asserts that we teach about and live a life where Indigenous peoples’ poor health and experiences of racism is normalised. We teach about Indigenous peoples’ understanding of health and well-being broadly encompassing the “social, emotional and cultural well-being of the whole Community” that enable each of us to realise our “full potential as a human being” (NACCHO, 2011, pp. 5-6), and believe this as a framework for our own wellbeing. We teach about how systematically, the institutions of health, education, housing, etc. continue to fail us, and we experience this with our families who we have had to support, and of course from our own experience being supported by our families.

⁶² ‘The real world’ is the slogan used by my administrating university, which is designed to promote the value of its teaching and research products and services.

Our reality of proximity to poor health was articulated by one participant, “*you know, I have Aboriginal and Torres Strait heritage... there’s chronic illness in my family, so I’m fortunate enough not to have... to be healthy with, you know, normal blood pressure, no blood sugar level.*” This participant’s proximity to health conditions and patient experiences that she teaches about is clear. Her social positioning as *fortunate* to be healthy was not immediately obvious for me, but through immersive practice and yarning with my supervisors, I soon realised what a strange social position it is to be lucky to have *normal blood pressure* and a *normal blood sugar level*; lucky to be ‘normal’ and healthy. Like the research participant, I thought that it seemed like a reasonable statement, but in fact it reflects the commonalities of our social world where poor health is seemingly normal. This insight highlights that there are likely other things in the social world of Indigenous academics not shared by non-Indigenous academic colleagues, including the omnipresence of the fight for social justice for Indigenous peoples.

For the Indigenous academic participants, advocating for some resolution of these tensions through education, is not limited to work hours and environments; the work never turns off. One Indigenous participant shared, “*the narrative around colonising, settler, invasion, um, progress... you see on social media when, um, you know, Black (Twitter) followers say, ‘Criticism the system’, and then you’ll get an answer from, you know, a white fella saying, ‘Well, why don’t you go back to the bush? ... this progress brought us into civilization. If you don’t like it, then go back to the bush.’ That’s just, it’s just a nonsensical, you know, response. We’ve been a part of the progress as well. You know, so, um, we still need to work together to get it to a place where, yeah, where it is... working for both of us.*”

The social positioning as sovereign Indigenous peoples inherits a mark or target for colonial violence, evident in such discourses. The yarns with the Indigenous academics tell of

an acknowledgement of this mark. The Indigenous participants spoke of their work outside of the SON, university, and discipline, as advocates and activists and as children of activists.

The social positioning as sovereign Indigenous peoples is also a vantage point from which Indigenous peoples learn about the operations of racialisation and racism (Daley, 2021). Thus, such racist rhetoric as, “*if you don't like it, then go back to the bush*”, is not new, but yet another manifestation of eugenics and ‘march of progress’ based racism that is “*nonsensical*” to this participant, because it is not new. She is evidently well informed of the established racialised propaganda perpetuated against Indigenous peoples for generations. It never turns off because racism persists.

The literature refers to the phenomena of Indigenous nurses’ proximity to the object/subject of study in the Indigenous health as working and living in ‘two worlds’. CATSIN asserted that “many [Indigenous] nurses are forced to live a ‘double life’. This living in two worlds and two cultures causes internal conflict. We see this as a continuation of the assimilation process and support all measures to reverse or challenge [it]” (1999, as cited in Sherwood and Edwards, 2006, p. 182). Sherwood and Edwards elaborated on this matter by describing the need for them to be well-versed in Australian and their own Indigenous ways of knowing, being, and doing.

However, Moreton-Robinson’s AIWST (2013) problematises the suggested simple binary of ‘two worlds and two cultures’, and the suggested homogeneity of ‘Indigenous culture’. She argues that Indigenous women occupy multiple social positions, that there are similarities as well as differences between the cultures of Indigenous women, and that such diversity is also reflected in individual exercise of compliance and resistance in their lived experience. This complexity was evident in how the Indigenous research participants described their social positions as academics, health professionals, students, mothers, daughters,

Indigenous community members, and visitors on the lands of other Aboriginal peoples. There were commonalities and differences in their experiences and in their exercise of compliance and resistance.

Our stories from our social positions, the vantage points we have been assigned, tell of the complexity of our social world and our meaning-making, and actions within it. Our stories are testimonies of the lived experience as authentic and legitimate Indigenous peoples, academics, health professionals, students, parents, children, community members, visitors, and sovereign persons. The research participants elaborated on their use of stories and testimonies in their practice as Indigenous academics.

The Indigenous participants spoke of using stories from their allocated social positions as part of the academic practice to humanise static sources, and to problematise the dangerous practice of promoting incomplete single stories that often perpetuate colonial imaginations about us (Adichie, 2009). The privilege of learning from these narratives is often not appreciated. For example, a Chief Nursing and Midwifery Officer once condescendingly thanked me for my ‘lovely story’ after I retold a personal family story to explain the complexity of relationality in Indigenous families and how this related to my professional role. This was before she returned to her list of questions, clearly showing that she saw little to no value in learning from my experience, let alone hearing a complete answer. This experience demonstrates that our stories are not often valued and are silenced because they are seen as irrelevant or too confronting. But they clearly tell a truth that unsettles in one way or another.

The problematics associated with Indigenous academics’ proximity to Indigenous health curriculum does not discount the possibility of non-Indigenous academics, including other academics of colour, identifying with experiences that are included in undergraduate nursing programs. For example, they may teach health conditions that they or a family member are

diagnosed with, and about nursing care they have experienced as a patient. Some non-Indigenous academics of colour may also have personal experiences of being racialised, and of experiencing colonial violence in Australia or in other countries.

While these experiences may share similarities, they are not the same, as one of the non-Indigenous participants shared, *“I’m really aware that as a non-Indigenous person, I think, I can close the computer and go home. I have different stuff at home. Different family stuff. Different community stuff. But not the same stuff... So, I’m aware of that privilege.”*

This participant declares her white privilege in her ability to clock-off from her engagement with the Indigenous health curriculum, and with Indigenous peoples’ lived experiences. She turns off her computer at the end of the day and goes home. Being able to treat Indigenous health curriculum as just that, and not as neatly scaffolded collections of information, including testimonies of past and continued colonial violence imposed upon your peoples, is white privilege. Being able to go home, a dwelling on the stolen land of sovereign Indigenous peoples, but not to be concerned with the latter, is white privilege. This luxury is not afforded Indigenous academics which is related to our social position in Australian society. It never turns off.

However, this participant also suggests that her usual academic work turns off, which she demonstrated in our engagement during and around our research yarn, as untrue. Firstly, she insisted on having our research yarn after the end of the usual workday (5pm), which would allow her to progress through her allocated marking load. During our research yarn we were interrupted by a phone call from her daughter, who seemed used to mum getting home late. Then after the interview, she shared that after dinner she would continue with her marking. So, while she may be able to disengage from the reality of Indigenous peoples, her work for the SON and university seems not to turn off. There seems a normalisation of this type of ‘never

turning off’ that is demanded of academics by the SON and university, as part of their neoliberal operations.

So when one of the Indigenous research participants said earlier, “*when you’re in... an academic position in university and you’re asked to teach this and read that... and then you go home, and you have to deal with this and that at home*”, she was not just referring to the proximity of her lived experience to the Indigenous health curriculum, but also emphasising the burden of the academic position. It never turns off.

Taking a closer look at teaching experience shows how teaching the Indigenous health curriculum can be confrontational and challenging for students and staff. One non-Indigenous participant shared a story about confronting racist rhetoric as part of her teaching practice. She shared,

“...we watched something on the Stolen Generation the other day. And I think one of the [student nurse’s] comments was... “Well, you know, that happened a long time ago and it’s, you know, it’s not really that much of a big deal” ...When they first went around [the yarnning circle] everyone had sort of gone, you know, “What the hell?!” And then by the time the end of that class came and that circle, the students had really learned from others... they had their eyes open... Not, not everyone likes it.’

The perspective that this non-Indigenous research participant used in telling her story suggests that she maintains some distance from Indigenous health. She retells the situation from the perspective of the students engaging with the learning experience; her re/action, including any emotional implications are invisible. This is a stark difference to the experiences of Indigenous academics whose bodies are read as Indigenous, and whose bodies become the target for such racist rhetoric.

The Indigenous health class thus becomes a frontier for confronting the racialised discourse that continues its harm on Indigenous peoples. In this example, the participant shared

how her students were learning about the Stolen Generation, which was an outcome of Australian governments' genocidal assimilation policy that aimed to extinguish Indigenous ways of knowing, being and doing, as embodied by Indigenous peoples. The nature of the invasion and colonisation of the many Indigenous countries of the Australian continent compromises the founding story of the Australian nation-state (Moreton-Robinson, 2015). Thus, self-preservation through redefining creation stories of the nation-state, and popularising defensive rhetoric that claim innocence is necessary, and evident in the student's defence above.

This is the work that academics who teach the Indigenous health curriculum are expected to do, confronting racialised discourse and logics through education. Non-Indigenous academics do this work alongside Indigenous colleagues, however they are not racialised by students, although they may experience violence for associating with Indigenous peoples. The ingrained nature of this self-persevering racialised logic means that challenging racism within the classroom never turns off.

The work of Indigenous and non-Indigenous academics goes beyond just teaching theory about Indigenous health, it requires facilitating students to sharpen their critical thinking skills so that they may better critique what is 'known' about Indigenous peoples and how racialised discourses are created and perpetuated by institutions and their agents to maintain their power, at the expense of Indigenous peoples.

Such institutions include students' families, as one non-Indigenous participant shared,

"[Indigenous clinical nurse colleague's] story gives a very personal South Australia [story], so it grounds them here It talks a lot about stuff here in the state and in fact students say that they've gone home and spoken to their parents and said: "You were growing up at that time, what were you doing at the time?""

Such critique appears to be deeply personal for students, highlighting that Indigenous health education nurtures personal, not just professional development. To prepare students to develop more nurturing relationships with Indigenous peoples as fellow humans, their education must confront bigger questions about the relationship between Indigenous and non-Indigenous peoples and these matters are now requirements in the regulation of the nursing profession (NMBA 2018; ANMAC 2019). As one Indigenous participant shared,

'it's not just by... developing a strategy around... a disease process... You're actually developing a strategy around being... vulnerable to be able to reflect and say, "Okay, this happened." ... and then saying, "Let's work together". ..., it all comes back to the relationship. What we do here, from my perspective... it's shaping a way of how we negotiate the bigger picture of living in this country together. Like the work that's done here, the teaching that you give to the non, non-Aboriginal [people]... how do they walk with us as First Nations people? But also, how do our mob, the [Indigenous] students here walk with, you know, them too?'

From her vantage point, this participant shared her perspective on the resolution to the tensions that she embodies as an Indigenous academic. These tensions are associated with the unfinished business of competing sovereign claims to the Australian continent, and the requisite violence to validate colonial dominance (Moreton-Robinson, 2015). In this yarn, she explains that teaching Indigenous health within the nursing program creates a learning opportunity for students, academics, and faculty/university leadership to learn about how to “negotiate the bigger picture of living in this country together”. She concludes by emphasising the need to support Indigenous nursing students to “walk with them too”, which requires Indigenous students to learn more about their vantage point and how to harness their learnings they receive from it.

Some participants highlighted that specific assistance is required to support Indigenous nursing students through their nursing program, because like the Indigenous academics, some

of the curriculum reflects their reality, their social positioning. One Indigenous participant shared,

“... a lot of our [Indigenous] students... are dealing with issues in community too and I think it's, it's [guidance and support] around... helping them get through... the nursing or midwifery degree or the health degree... acknowledging that those [challenges] are there but also not, not wrapping them up in cotton wool. I don't believe in that, I think it's about walking beside them so that they're able to develop resilience around, you know, walking through academia, walking through the university system. Having their supports where they can [succeed] ... academically, but also to be able to help them grow their character... you can just focus on going with them through academically and say, "You know, that's great!" But I'm always concerned about them as a person, how they negotiate that area, you know. How do they keep themselves strong? You can have great students, you know, Indigenous students that are doing well. But, inside, there's turmoil, there's a storm going on. How do you find words to calm the storm, you know, within them?

The embodied storm refers to the Indigenous nursing students' embodying the tensions included in the learning material. The curriculum includes re/visiting the colonial violence of different Indigenous policy eras and contemporary legacies, including the Stolen Generation predominantly of the assimilation era, which may have direct implication on the students (i.e., their parents, grandparents or great grandparents may have been stolen as children). While this material may challenge non-Indigenous students to question their sense of identity, values, beliefs, and knowledge about Indigenous peoples (Mills & Creedy, 2019), the impact on Indigenous students has potential to be arguably more devastating. The trauma that is taught and assessed, is also their trauma.

Much like the experience of Indigenous academics, who weave their stories into the curriculum, Indigenous students may resonate with these stories, and some will want to share stories of their own. The difference might be that Indigenous academics may have refined their

understanding and enhanced their capability to confront the tensions included in the curriculum. This participant does not believe in being over-protective of Indigenous students either, because she believes that they need to develop resilience to attend to these tensions independently, as part of their practice as a nurse. This work to master the language and skills to navigate the manifestations of racism, including preparation to carry the burden of remembering the colonial violent foundations of Indigenous peoples' poor health on behalf of the discipline, may be invisible to non-Indigenous people.

Consideration must also be afforded other Indigenous peoples who contribute to the development and delivery of Indigenous health curriculum, as they too are susceptible to embody the tensions specific to this context. One non-Indigenous participant shared her practice of working with her Indigenous nurse colleague to ensure she is able and ready to deliver guest lectures to nursing students. She shared,

"... each time beforehand I ring her up and check, 'is this a good time for you? Is it still ok [for you to deliver a guest lecture]? Is this something you would like to do? Is it a good time?' And she goes, 'Yes, yes it's, it's good.' And she says, 'You know, it's good, it's healing. It's good for me.' So, as long as she keeps saying that, then we'll keep the opportunities, but I'm always really careful to first check, 'How are things going? Is this a good time for you? Or is it not?' So that's really important coz, it's such a big thing, you know. That she, she does. And um, ah, the strength, you know."

The Indigenous nurse colleague of this participant sees her guest lecturing about her personal experience of being a member of the Stolen Generation as healing, as a remedy to the storm she embodies. There is healing in supporting the educational preparation of future nurses, so that they will not contribute to such discriminatory government policies again. The non-Indigenous participant demonstrates a thoughtful partnership with her Indigenous nurse colleague. Even in sharing her story, she vocalises an awareness of sharing the story of her

Indigenous nurse colleague, suggesting that she has negotiated permission to do so. Her practice of checking in on her colleague, ensuring that the invitation to deliver a guest lecture still benefits her colleague, and that it is logistically possible as well, may reflect a sense of ‘walking together’ between Indigenous and non-Indigenous people that was mentioned by another participant earlier.

This practice is evident in another engagement between a non-Indigenous academic (the research participant), an Indigenous academic, and an Indigenous person interested in contributing to the Indigenous health curriculum. The partnership between the academics navigates a complex situation where the interested Indigenous person is not offered an opportunity, as it was deemed unsafe for him. The non-Indigenous participant shared,

[Indigenous health academic colleague] and I both met, there's an older chap I know, he's really keen to be involved... he used to be a nurse assistant, and he really liked to be involved with the school. In the past he's had a stroke and so [Indigenous health academic colleague] and I invited him in and also to the skills lab... We did the walk around, we had a talk, and then we're all thinking about, how can we involve him in a way that would be really good for him and be really good for the students? And [Indigenous health academic colleague] and I am still thinking about it, but we jointly decided that we didn't have anything that was safe yet.

The level of preparation and planning to ensure the safety of Indigenous guest lecturers seems imperative. Indigenous and non-Indigenous academics act as a buffer between them and the SON, including the other staff and students. This engagement is temporary, thus facilitating this engagement to ensure its safety is temporary. This situation is a significant contrast to the experience of the Indigenous nursing student and Indigenous academic, who have a long-term commitment to the SON. For the latter, the need for a buffer never turns off.

In my academic experience, the SON, university, and discipline spaces are associated with me being on-edge whenever Indigenous health is discussed. This experience is heightened

when colleagues start to share their learnings and application of the Indigenous health curricula in their teaching practice. The following personal testimony recounts a work-related experience, between a colleague and me.

Personal testimony: Simulating racism

In the on-campus teaching of clinical practice in nursing, simulations are used to support student learning. Mannequins are used to allow students to practice their skills in these simulations. I have visited the clinical simulation classrooms of several Schools; it is often on the list of places to see when visiting a School. One time I was invited to observe the resources that were assembled to simulate an Indigenous health case study. As I was led into the room, I was shocked at what I thought was meant to be a patient with substantial burns to much of their body. I thought that the case study may have been about a house-fire victim, in the trauma ward. The mannequin's matted unsinged dreadlock wig made me think that perhaps he was meant to be homeless. However, when I queried the learning designer about the case study, they clarified that this was not a burns patient. Rather the availability of chocolate-coloured burns compression bandages was seen by the learning designer to simulate the Indigeneity of the patient.

Such experiences of racism within the SON reflect the experiences of the Indigenous research participant and tell of the enduring racialisation of Indigenous peoples (including Indigenous students), which informs the perceived value of Indigenous academics, and Indigenous-related curricula and pedagogy to the discipline and university colleagues. Although not always explicit, it is a constant reminder to Indigenous peoples that they are not welcomed and do not belong in the academy, at least not as anything other than the object of study (Mukandi & Bond, 2019). It is likely that good intentions were intended by the learning designer who came up with the idea of bandages to represent Indigeneity, in their attempt to fulfil their part of the ANMAC (2019) accreditation requirements ([Chapter 2](#)). However,

operations of performative benevolence in the context of Indigenous health are often flawed in their foundation, as the contemporary knowing and practice of performative benevolence remains infected by the racialised logic that diminishes the humanity of Indigenous peoples, while valuing their body parts that need fixing by contemporary health professionals (Bond et al., 2021).

This mannequin scenario highlights racialised imaginings of Indigenous people, that they must have dark skin, or they are not authentically Indigenous. Jackie Huggins (1998, p. 25) coined the term ‘cosmetically apparent’ to describe the essentialised appearance of an authentic Indigenous person, an imagination that reflects apathy towards, or at best, a superficial understanding of Indigenous peoples’ belonging to their country, the violence of colonisation and the complexity of contemporary Indigenous identity. Such a superficial marker as the hue of a person’s complexion is not a reasonable marker of Indigeneity. In fact, in other units within the same Bachelor of Nursing program, students are taught about the complexity of Indigenous peoples’ identity and belonging to their respective Countries and kin. Thus, this clinical scenario simultaneously contradicts the learning within these other units and undermines the legitimacy of the associated academics, which included an Indigenous academic. This too resonates with the experiences of the Indigenous academics, and the perception of SON/Faculty leaders of the Indigenous health curriculum in the Bachelor of Nursing, as reported by several research participants.

The perceived value of me as an academic in this scenario is also of interest. My initial response was about the potential clinical needs of the case study, specifically the needs of a burns patient, and their broader social determinants of health needs. However, the intellectual contribution sought from me was to confirm the physical manifestation of the Indigenous object as accurate. The mannequin fails to simulate the needs of the Indigenous people, because its destiny is dependent on the imagination of the educator. The mannequin is employed to

actualise the perpetuation of a racist trope about Indigenous peoples, of being different both in skin complexion (correctly cosmetically apparent), and in the socially acceptable level of hygiene. The assertion of never turning off speaks to such lived realities of Indigenous academics, as both object and facilitator of study (Bond, 2014). Attending to the manifestations of racism, be they institutional or interpersonal, is an everyday task, it never turns off.

The ANMAC (2019) accreditation standards that regulate SON, including the requirement of Indigenous health curriculum in undergraduate education makes certain that Indigenous academics within SON will experience the tensions of proximity to the Indigenous health curriculum, and associated social, political, and material conditions within their SON, including manifestations of interpersonal and institutional racism. Given the testimonies of the Indigenous research participants, and my own account, this is problematic. The neocolonial and neoliberal agenda continues to create unsafe environments and situations for Indigenous peoples. Indigenous peoples embody the subsequent tensions of the ongoing neocolonial violence that remains tactically unresolved.

This reality raises questions about the awareness of SON and university leaders and colleagues about this paradox, suggesting that they are either ignorant to or disregard the challenges associated with our proximity to the Indigenous health curricula. The stress that is caused by this work should register with the discipline, SON, and universities as a risk to our well-being. This reliance on the leaders of these institutions to acknowledge and realise change reflects the power they possess to influence the current conditions of Indigenous and non-Indigenous academics teaching Indigenous health curricula. This raises concerns about whether they currently use this power for good, given the experiences that participants shared.

“So long as it looks on the surface like they’re meeting accreditation needs” – White possession of Indigenous health curriculum

Metis scholar Chris Andersen’s (2016) critique of the domination of other disciplines over the Indigenous studies discipline regarding institutional territory (physical space), and intellectual territory (research and teaching opportunity), highlights the sustained power of the institutions of all disciplines, schools, and universities to determine who can know and thus teach about Indigenous matters. The teaching of Indigenous health curricula within undergraduate nursing programs reflects a growing appetite of disciplines in claiming intellectual territory from the Indigenous studies discipline, which is dedicated to critical scholarship regarding Indigenous matters. Andersen (2016) questions the preparedness of other disciplines to do this work without dedicated Indigenous studies scholars; prompting questions about how disciplines determine quality and safety regulation independent of the Indigenous studies discipline.

The perpetual power of the institutions of disciplines, SON, and universities is associated with white possession, which is the ongoing investment in the superiority of white Australia, and subsequent disempowerment of Indigenous peoples (Moreton-Robinson, 2015). Moreton-Robinson’s (2015) call for a more sophisticated critique of discipline knowledge and regulatory mechanisms aims to make conspicuous the operations of white possessive logics. In the health context these white institutions claim possession of the role of remedy for Indigenous health disadvantage, however they are simultaneously resolute in their reluctance to acknowledge their possession of the cause and the ‘causes of the causes’ (social determinants of health [Marmot, 2016]) of this harm. Moreton-Robinson (2015) advocates for theorising about Indigenous sovereignty free from white possession; this part of my analysis returns to Moreton-

Robinson's (2015) theorising on white possessive logics to the intellectual territory of Indigenous peoples' health and wellbeing in undergraduate nursing programs.

The following discussion deepens the notion of 'never turning off' to explore the pervasiveness of white possessive logic within the institutions of discipline, SON, and university, as described by research participants. This analysis also builds on what I have published earlier (Drummond et al., 2021). White possessive logics are evident in the racism experienced by Indigenous academics, which contrasts with the interest that the discipline and SON demonstrate in claiming the intellectual space of Indigenous health curriculum (Drummond et al., 2021). It is also evident in how racism manifests against the Indigenous health curriculum, and non-Indigenous academics who work in Indigenous health education, asserting a token status for all in this space. The historical white possessiveness that nurses exercise over the discipline's scope of practice ([Chapter 2](#)) continues to be reproduced, which insist that performative benevolence is a sufficient nursing response to Indigenous health.

I also wrote earlier about the lack of accountability that is required of the discipline, SON, and universities, which reflects a need for these institutions to improve the way they enable quality and safe Indigenous health education (Drummond et al., 2021). Indigenous academics highlight that current accreditation bodies and processes are not equipped to address the concerns of institutional racism that they experience (Drummond et al., 2021). These conditions mean that Indigenous academics must be resourceful, opportunistic, and tactful in their practice to enable accountability where they can (e.g., engaging Indigenous Elders and knowledge holders, and paying for their time), despite the barriers manifested from institutional racism. Further analysis below highlights how despite ANMAC's (2019) accreditation requirement, and the guidance from the National Framework and Nursing and Midwifery Framework, participants raise concerns about the lack of informed and confident SON and faculty leadership, which enables inconsistent support and academic practice in Indigenous

health education. There is an assumption that the discipline has the skills and knowledge, but lacks the will, which invisibilises racism, and assumes that addressing racism doesn't require new knowledge or skills. Accountability to Indigenous peoples, including those within the discipline, SON, and universities is highlighted as a potential mechanism that can address the limitations of these institutions; but this requires these institutions to relinquish power to Indigenous peoples.

White possession was evident in the way one of the Indigenous participants spoke about faculty and university leadership. When referring to the apathy of school and university leaders regarding Indigenous health curriculum work, this participant shared,

Um [pause] so I feel often [pause] ah, within some of the areas that [whispers the following three words] higher up people, such as [pause], I'm gonna [nervous laugh], [Ali: "You don't have to name names"] so like executives, like higher levels. Um, that is influencing the way that curriculum is delivered, I actually don't think they think about that too much, so long as it looks on the surface like they're meeting accreditation needs.

At times, this participant would whisper, laugh nervously, and pause frequently when referring to senior leaders within her SON and university. It was as though she feared that the walls had ears, and that they would expose any evidence of her disloyalty to these senior leaders. This reaction is despite the room we chose for our yarn being private. This self-censoring and whispering may relate to the sense of safety (or lack thereof) that this participant felt about critiquing her SON and university. Moreton-Robinson (2015) identifies how Indigenous peoples within the workplace are made to feel inferior, reminding us of the white cultural dominance of the workplace and the disciplines that we are employees and members of respectively.

The apprehension in her response was visceral for me, as I immediately felt anxious too. In this extract from our yarn, I tried to ease our shared concerns by reminding her that she didn't "*have to name names*", which seemed to help her get her point across. I am familiar with some of the manifestations of racism within SON and universities from my own experiences, that remind Indigenous peoples and people of colour that we do not belong in these places, at least not in the same way as our white colleagues (Mukandi & Bond, 2019).

The assertion of the inferiority of Indigenous academics was also evident in how Indigenous participants explained that they are often asked to do a one-off token Indigenous health lecture within health programs without too much notice. Indigenous health education is an afterthought, as are Indigenous academics. One participant explained her thoughts about the constant last-minute requests for her to do a guest lecture of Indigenous health,

I don't want to do that anymore coz I sit back and go, "What does that actually achieve? Anything?" I'm coming in without knowing what else they've done. I feel it's, again, I feel like it's just a token tick-box.

Such perfunctory attempts to 'include' Indigenous health curriculum is emblematic of performative benevolence exercised by academic colleagues. The apathy evident here, particularly regarding the interest in quality Indigenous health education, and in valuing the skills, knowledge, and experience of the Indigenous academic asserts the inferiority of Indigenous academics, and the Indigenous health curriculum. These are 'colleagues' within the SON and university that Indigenous academics must work with. Thus, Indigenous academics are also expected to embody their frustration in the lack of value and interest, but eventually, like this participant, Indigenous academics say 'no'.

The lack of value and interest reflect the exclusion and sense of inferiority that is characteristic of the white possessive logics exercised by the discipline and SON (Moreton-

Robinson, 2015). When asked directly about her perspective on value that her SON demonstrated regarding Indigenous health curricula, she was unsurprisingly pessimistic. She answered,

No, I think it's all very low [in importance] ... I don't think it's seen as important... You're constantly trying to advocate for it to be just as inclusive and as standard as learning about antibiotics or the structure of the heart.

SON and universities seem content with minimal investment to meet accreditation needs, which enables the practice of token tick-box one-off lectures. There should be a sense of dismay about the futility in the stories from Indigenous academics, but they report their commitment, despite the odds. In sharing the frustration of being tokenised, one participant concludes that the curriculum and advocacy work is important enough to justify persevering with the experiences of being devalued by the SON, universities, and colleagues. She shared,

Well should I put up with that? Is that acceptable? Should I be here if my position here working (is) token? ...you do sorta question whether or not that's the right thing to do. But it needs, I feel like some of our work we do is important and that they, that needs to be done.

The National Framework and the Nursing and Midwifery Framework are supposed to make the academic practice of development, and delivery of Indigenous health curricula easier (Department of Health; CATSINaM, 2017). However, they are used instead by SON to determine what is 'feasible', providing neoliberal tools to determine what is implemented, and how academics' performances are measured. This is the risk of the discipline possessing Indigenous health curriculum.

CATSINaM's (2017) initiative to develop the Nursing and Midwifery Framework was a strategy by the nursing and midwifery disciplines to stake their claim of the intellectual territory

of Indigenous health for nursing and midwifery. As a member of the steering group that oversaw and contributed to the development of the Nursing and Midwifery Framework, I confess a prevailing sense of distrust in having non-nurses and non-midwives involved in determining what is best practice for Australian nurses and midwives. This compliance with the white possessive logic of my discipline was exercised to ensure that I and other nursing colleagues who are well read and experienced in the clinical and academic practice of Cultural Safety and Indigenous health were the decision-makers on what we endorsed in the National Framework, and what we needed to redesign. The experiences of Indigenous academics tell of a sophisticated practice of white possessive logics of SON, that will continue to mutate in order to maintain power and control of its intellectual territory, and broader discipline scope of practice.

Prioritising biomedical knowledge and skills, like the chemical composition, actions, adverse reactions etc. of antibiotics and pathophysiology of the heart, divulges what the discipline and SON believe to be foundational knowledge and skills for Australian nursing, i.e., the novice nurse scope of practice. One participant acknowledged the value afforded biomedical curricula, and as shared earlier she hoped for the SON to value Indigenous health curricula *as standard as learning about antibiotics or the structure of the heart*.

This situation suggests that although the discipline has included Indigenous health curricula within the undergraduate accreditation standards, it does not necessarily translate to a priority for the SON. The endorsement of the biomedical dominance of nursing's scope of practice is evident in the way some participants described clinical units including clinical placements as a priority for their SON; these units traditionally provide supervised practice of clinical tasks with the aim for students to be deemed competent. This situation can limit the focus on the potential role of the nurse, which encompasses diversity in the context of practice (including legal and health service policy regulation) and patients' needs (White et al., 2008).

Consider the simplistic characteristics of the chocolate-colour mannequin testimony I shared earlier. In possessing Indigenous health curricula, the discipline and SON are granted power to determine the parameters in which Indigenous health curricula is included. One participant shared,

I feel like a lot of it is driven, well it's sorta about timing and scaffolding... So, it's sorta the informal hidden curriculum like, "We've got a space here and a space there" [for Indigenous health curriculum]. We've got clinical skills too...so sometimes things that I wanna do gets limited by resourcing and timetabling. I'm sorta compromising where I put things to fit with the system.

This participant labels Indigenous health curriculum as '*informal hidden curriculum*', reflecting the low levels of legitimacy afforded Indigenous health education compared to clinical education. However, Indigenous health curriculum is not hidden, as it is an ANMAC accreditation requirement that SON must demonstrate it is included in their undergraduate nursing programs. Even so, the tautologised framing of the curriculum being both informal and hidden is striking, emphasising discursively its perceived illegitimacy within the SON.

Moreton-Robinson (2015) described the operations of white possessive logic in nursing workforce context, where some white nurses emphasise the inferiority of Indigenous nurses and patients and actively exclude Indigenous peoples as a way of exerting their dominance. Such practices are condoned in a context where the majority white nursing staff have been socialised to holding power in white domains of healthcare services and accept such behaviours as normal (Moreton-Robinson, 2015). Applying these ideas to this participant's account suggests that the SONs assert inferiority over Indigenous health curricula and the staff that teach it through the possessive power they maintain over Indigenous health education. This dynamic is evident in the title quote, where the participant explains that SONs are content with superficially achieving the Indigenous health curricula accreditation requirement, which limits

the investment required in this area of the Bachelor of Nursing program. Such situations are but a (re)production of the colonial violence that also suppress Indigenous approaches to health and wellbeing, privileging Eurocentric approaches, i.e., biomedically dominated approaches to health (Nielsen et al., 2014, p. 193).

However, some participants spoke of benefits of being ‘hidden,’ referring to being hidden from the interests of SON leadership, stating that being hidden enabled them to make incremental changes within the curriculum and SON without too much attention and pushback from colleagues and senior leaders. One participant shared,

I’ll be blunt. I sometimes feel like my role here is just a token, tokenistic, and I’ve had other people say it is a tokenistic role, and I try and keep in my head, you know, they may think it’s token, but I can sorta work slowly behind and try and change things without them realising.

The comfort found in being hidden from the interest and gaze of SON leaders is likely short-lived. The SON patrols its intellectual territory methodically, seeking opportunities for ‘innovations’ and ‘efficiencies’ in line with neoliberal tendencies. The ANMAC standards, National Framework, and Nursing and Midwifery Framework provide the tools for SON leaders to do this work.

What may be worrisome for the discipline and SON is the influence of outsiders on the foundational scope of practice of Australian nurses. Earlier I discussed how the discipline has a history of rejecting Indigenous health education as part of pre-registration training and undergraduate education ([Chapter 2](#)). I have also just spoken about my involvement in the development of the Nursing and Midwifery Framework, specifically my compliance in the claiming of the intellectual territory of Indigenous health curricula for nursing and midwifery

undergraduate education. However, it is not just other health professionals that the discipline and SONs may be worried about, but non-nursing community members as well.

SONs are required to include Indigenous peoples in the “design and ongoing management” of undergraduate nursing programs as part of governance accreditation requirement (ANMAC, 2019, p. 15). Some participants report that these relationships would not be invested in and nurtured without their active support, highlighting the apathy evident in SON and faculty leadership. This raises questions about the ability of the current ANMAC’s accreditation standards to enforce legitimate and meaningful accountability from SONs to Indigenous peoples that are engaged to oversee undergraduate nursing education.

One participant insisted that the lack of accountability beyond the minimum standards set by ANMAC may be associated with the lack of confidence of senior SON and university leaders, as one participant suggested, *‘I feel that everybody’s on board (in the faculty leadership team), they just need the leadership around [Indigenous health education] because there’s still a lot of people not feeling confident in the space.’*

This lack of confidence in leadership amongst academics reflects the perceived illegitimacy of Indigenous health curriculum, as discussed earlier. One participant shared the seriousness of this lack of confident leadership in a ‘student academic dishonesty case’ relating to the Indigenous health unit. This participant had to lobby harder than they usually do for other units for this case to be taken seriously by the student academic dishonesty committee, suggesting that academic dishonesty in the Indigenous health unit was not as important, compared to academic dishonesty in other units. She shared, *‘I had to push that, so I feel like potentially without people there, constantly going, you know, “It’s not too hard, and no you can’t just ignore it!”’*

The lack of taking matters seriously extends to how SONs perceive the value of engagement with Indigenous peoples from outside the SON and university to support the Indigenous health education. Participants shared that processes for paying Indigenous guests are not standardised in SON and university policy. This suggests a lack of interest in prioritising the partnership. One participant explained,

so, we advocate for remuneration... yep, as a lecturer... and the school's been really good about that. So far, um, but there's no policy, I don't think, around that. So, while there's directives and guides about involving people [in the curriculum standards], I'm not sure if there's such strong accountability mechanisms yet [for adequate remuneration].

This advocacy is extended to support the implementation of the National Framework and the Nursing and Midwifery Framework, which also insist on ensuring adequate remuneration for Indigenous peoples who are invited into the SON to contribute to Indigenous health education. The participant continued,

I feel like sometimes it comes down to the individual, who is working in the space, and their ways of working, because the [National Framework and Nursing and Midwifery Framework is] there, but whether or not you're held accountable is another thing. So, if you're not sorta on board with, you know... you've gotta serve community coming in, really advocating that they get, that they get paid for their time, um as, they're not qualified in medical terms, but they're qualified in Aboriginal terms.

This participant is advocating for improved accountability regarding Indigenous community engagement, highlighting the imperative nature of working with Indigenous peoples, as well as the lack of current capabilities of ANMAC to enable reporting on and holding SON to account for quality Indigenous engagement. Further, this participant reasons that this devaluing may be associated with the assumption that the lack of nursing qualifications

of Indigenous community members may be the reason why academic colleagues may devalue the partnership for Indigenous community members. The territorialism of the SON, as described by Andersen (2016), is evident here, specifically in how they demonstrate a lack of value for Indigenous community engagement.

The participants spoke about the need to formalise accountability mechanisms with local Indigenous community members as a potential counterbalance to the discipline's and SON's white possessiveness. However, accountability requires strategising regarding negotiating power (Ramsden, 2002) which requires white people imagining and realising relinquishing power (Moreton-Robinson, 2020). One participant shared,

I feel like there needs to be some oversight of everything that's done by Indigenous representatives so that their, they've got a good understanding of how things fit and how things feed in, and then they can choose where they feel like content needs to be delivered by particular people. And where they feel it's left to academic staff. But that requires a lot of resourcing and time and effort, which I don't think we're quite set up for at the moment.

These proposals call for a repositioning of Indigenous community members into positions of legitimate power. This suggests that the current arrangement prescribed by the ANMAC (2019) accreditation requirements, where Indigenous individuals are invited onto the governance committee, enables white possession of SON, realised in treating these Indigenous individuals as token. The research participants were consistent in advocating for the need for SON to be held to account for the decisions around Indigenous health curriculum, by Indigenous peoples. One participant shared,

I really feel strongly about community being part of the university system around, because uh, we need to teach, being informed by what's happening in the community. So, we need that strong partnership with community. Community being part of maybe, the teaching staff.

One non-Indigenous participant believed that the curriculum framework and her own knowledge, skills and experience makes her quite useful in the context of Indigenous peoples' health. However, she believed in being led by Indigenous peoples was imperative to accurately responding to our needs. Using the analogy of a fire service she shared,

if we're in our town and there's fire in the next town or the town over or another area, and we've got fire trucks that could be usefully used, then why would we just sit at home, sitting with our fire trucks? Why wouldn't we go in and ask people how we could best use our fire trucks in their patch? ... they'll tell us how to, you know, which truck to take and what to do and, you know, and be guided by the people who knew the local topography best... well if we've got the skills and abilities and we've got the need coz, if we think about where people are placed because of history and colonisation, then why wouldn't we go in and help?

This analogy enabled this participant to express her concern in the lack of accountability of SON to ensure Indigenous leadership in the development and delivery of Indigenous health curriculum (i.e., Indigenous peoples advising on which fires trucks to take and how best to consider the topography), which would limit the responsiveness of the Indigenous health curricula to the everyday experience of Indigenous people. This right is denied/inhibited by the discipline and SON in claiming the intellectual territory of Indigenous health curricula (that is, through the prescribing of Indigenous health curriculum in discipline accreditation standards, which assumes that nurses can lead this work independent of non-nurses).

An assumption on the part of this participant relates to the 'skills and abilities' of non-Indigenous nurse academics to adequately respond to the needs of Indigenous peoples. This assumption aligns with Marmot's (2016) assertion that Australia has the resourcing and knowledges to address the needs of Indigenous peoples, however, lack the will. Marmot (2016) makes a convincing case for the lack of will, however his assumption that non-Indigenous

people have sufficient knowledge and resources discounts the interest of ongoing neocolonialism, including racism, that maintains Indigenous peoples' disempowerment (Moreton-Robinson, 2015). Marmot (2016) insists that we continue to hold onto hope, that if the will of non-Indigenous Australians improves, then this will have a positive impact on the health and well-being of Indigenous peoples. The research participant demonstrates similar white ignorance.

To return to and add to the fire service analogy, what is not acknowledged by the research participant is that her imagined benevolent town also occupies Indigenous peoples' land. Historically, Indigenous peoples from the surrounding region would have been placed into one community that was considered least valuable (perhaps more susceptible to bushfires?), and so less desirable to non-Indigenous peoples.⁶³ The lack of resourcing of the Indigenous community is by design. Indigenous leadership thus offers insights into the causes, the causes of the causes, the causes of the causes of the causes etc. Thus, it is not enough to advocate for Indigenous leadership, but non-Indigenous peoples must also be prepared to learn and to change, especially to relinquish power (Moreton-Robinson, 2020). This also relates to sharing and relinquishing power to Indigenous peoples within SON and universities.

The call for better resourcing Indigenous academics and the Indigenous health curricula was resounding. This would shift power to Indigenous nurse academics or non-Indigenous academics leading the Indigenous health curriculum, who are best placed to establish and care for relationships. This may counter the current assertion of this role being tokenistic and

⁶³ There are many examples of governments relocating Indigenous peoples to enable financial gains from selling land and exploiting raw material. One that is associated with some of my *Wuthathi* family is the Mapoon Presbyterian Mission (Old Mission), located north of Weipa in Cape York Peninsula. *Tjugundji* people, sovereign people of the land occupied by Old Mission, as well as Aboriginal peoples from surrounding sovereign nations, including some of my *Wuthathi* family, were relocated to Old Mission to vacate their lands. In 1963, Old Mission was closed, and most of the Aboriginal residents were relocated to the communities in the Northern Peninsula Area (Queensland Government, n.d.). This was against the wishes of the Aboriginal leaders of Old Mission; however, the Queensland Government and the Presbyterian Church were more interested in the financial gains associated with selling the land to mining companies (Wharton, 1996).

promote a new knowing of this role as a respected, trusted, and better resourced leader. One Indigenous participant shared her aspiration

to have a team of my own to work in and a, and a budget to work with, and um, you know, the opportunity to bring people in and having some money to pay them, become part of, you know, what we're building here.

Conclusion

It is well understood that colonisation has and continues to dispossess Indigenous peoples of their land, however it also continues to dispossess us of our bodies (consider the biomedical dominance of health) and our souls (consider the spiritual dominance of Western religion) (Drummond et al., 2021a). Supporting the white possessiveness of Indigenous health curriculum perpetuates these dynamics, and is evident in SON and the discipline, including ANMAC, AHPRA, and CATSINaM⁶⁴ claiming to be the knowers of Indigenous health education. This has been claimed from Indigenous communities whose lands are occupied by SONs and universities, Indigenous peoples who are considered by their community as the best to speak on behalf regarding health and wellbeing, or Indigenous patients etc.

The white possession of Indigenous health curriculum has essentially commodified Indigenous health education, and any Indigenous perspectives within the curricula or pedagogical approach. This practice implicitly involves the bastardisation of Indigenous knowledges and perspectives to produce palatable education products. The discipline's

⁶⁴ I have included CATSINaM alongside other discipline organisation as it is a membership organisation primarily for Indigenous nurses, midwives, and respective students, but they also welcome other non-Indigenous or non-nursing and non-midwifery people to be members (Although, not all Indigenous nurses, midwives, and respective students are CATSINaM members). As discussed earlier, some of the standardising work that CATSINaM has led has been complicit in the white possession of the discipline. This does not discount the valuable work the organisation has led since its establishment, nor the tensions between compliance and resistance that CATSINaM as an organisation must navigate. This strategy is likely the best for that moment. However, in working towards decolonisation even CATSINaM will have to eventually relinquish its power to Indigenous communities and their nominated health leader.

regulation frameworks, namely ANMAC's (2019) accreditation framework and the Nursing and Midwifery framework (CATSINaM, 2017) is supposed to provide guidance for academics tasked with developing and delivering Indigenous health curricula. However, the growing neoliberal agenda of universities has influenced how these frameworks are used, particularly in informing minimal approaches to their application and measuring the performance of academics working in Indigenous health education.

This situation creates ideal conditions for the manifestations of performative benevolence by academics. So, of course, this endeavour would be less complicated if the academic staff who teach this content were more compliant. Most research participants yarned about their resistance to dynamics that I have called performative benevolence, despite the lack of value extended to them and the Indigenous health curricula they wish to develop and deliver. Partnerships with local Indigenous peoples are imperative to their approach to limit the (re)production of colonial domination and Indigenous peoples' disempowerment. I propose that more power should be afforded Indigenous peoples who work with academics developing and delivering Indigenous health curricula.

Returning to Freire (1972, pp. 28-29) who asserts that only the oppressed can liberate the oppressed and the oppressor, reviving the humanity of all, warning that "any attempt to 'soften' the power of the oppressor in deference to the weaknesses of the oppressed almost always manifests itself in the form of false generosity." This effect is certainly what I have learned from the research participants and my own experience regarding the possessiveness of the discipline, SONs, and universities, of the intellectual territory of Indigenous health curricula. A false generosity perpetuates perceptions of the Indigenous health curriculum and its academics as token and of Indigenous community members, who are central to the enterprise, as unworthy of adequate recognition. The remedy appears to be strategising towards renegotiating and relinquishing power to Indigenous peoples. However, this approach is the

antithesis to the white possessive logics that drive the institutions of the discipline, SON and universities. It is an approach that leverages off the neoliberal and neocolonial tendencies of these institutions, an incommensurable features of Indigenous health education. But, like the participants of my study, we must persist.

Chapter 6: Relational pedagogy – emplaced knowledge and discipline regulation

This chapter continues my analysis of the research yarns with participants and builds upon Chapter 5 in considering the current experiences of relationships and partnerships as described by the research participants. As established, ANMAC (2019, p. 15) prescribes the inclusion of Indigenous peoples in the governance of undergraduate nursing within their accreditation requirements for SON. And as argued earlier, this standard is insufficient to achieve a form of relationship between Indigenous communities and SON that shares/shifts sufficient power with/to Indigenous communities to effect meaningful and long-term change to undergraduate nursing education that would better serve Indigenous peoples.

Earlier I wrote about how Indigenous academics leverage their relational connections with other Indigenous peoples to support quality and safety in Indigenous health education (Drummond et al., 2021). Unfortunately, the systems and processes of institutions of the SON and universities prove to be inflexible to enable adequate resourcing to make relational work easier for Indigenous academics, which leads to them having to become very resourceful (Drummond et al., 2021). This also requires them to invest their time and energy on preparing their SON colleagues to be more knowledgeable and confident with Indigenous health curricula, which is quite time and energy intensive (Drummond et al., 2021).

The analysis below builds on my analysis of the experiences of Indigenous academics (Drummond et al., 2021). Both Indigenous and non-Indigenous voiced the benefits of relationships with Indigenous staff members, and other Indigenous community members. Such relationships enabled academics to contend with the incommensurabilities within the Indigenous health education context, including knowing what they can teach regarding Indigenous perspectives, and protocols regarding engagement. Such relationships were

important to supporting students' learning, to consolidate learning with real life stories, which also helped address fear and racialised stereotypes held by students. Partnerships with local Indigenous peoples were also good for the wellbeing of Indigenous academics, enabling mentoring, support, and resilience building.

These relationships seemed transformational and protective, juxtaposed with the white possessive nature of the discipline, SON and universities (as discussed in [Chapter 5](#)). This highlights potential for a rethink in how the discipline and university regulate Indigenous health curriculum.

“Sailing along together” – Transformational partnership

Partnerships between Indigenous and non-Indigenous peoples were described as essential by all participants. The nature of these partnerships varied from existing relationships with colleagues and community members who non-Indigenous participants once worked with and for, to family and community members to whom the Indigenous academics have mutual relational obligations with. These relationships were important to enabling quality and safety of the learning material and experience. One non-Indigenous participant shared,

there's a real strength in working in partnership, which is why I'm so glad [Indigenous academic colleague] is there [in the faculty], because I've been working with [her] for years. Working in partnership is so important, because there were times when I'd go, "Yeah, I know I'm not getting something. There's something really important going on, and I might not need to know, or I might need to know." And that's really useful [to yarn about this with someone that can decipher the situation]. And other times when stuff is happening and there's six funerals this week, and the other person just needs to step back, and then we can keep the, keep the ship sailing while the other person's recovering and then we sail along together.

Using the metaphors walking together and sailing together, this participant identifies numerous benefits of working in partnership with her Indigenous academic colleagues. She describes the back-up that is available should a colleague need to take time off work, highlighting the value of working with a team and not in isolation. The relationships also provide support to decipher unwritten/unspoken regulations or protocols, that her Indigenous academic colleague may be privy to, given their more sophisticated grasp of the dynamic relational obligations. This factor does not mean that all Indigenous academics have the privilege to claim/use all Indigenous knowledges, but that they may have a better understanding of who can use what knowledge, and when.

One Indigenous participant shared her common practice of working with non-academic Indigenous community members from the local community in her teaching of Indigenous peoples' health. She explained that

[Indigenous community members] come in and watch some of the things that I do... just to make sure it's ok from a community perspective. But often the things that I teach aren't Indigenous knowledges, I think they're more Indigenous perspectives in a medical context. And anything that goes beyond that, I stand back and let them do [what they need to do].

This participant makes an important distinction between the 'Indigenous perspectives in the medical context' that she brings and the complementary 'Indigenous knowledges' that only the local Indigenous community member can teach. She highlights that it is Indigenous community members who are the source of authority when it comes to teaching Indigenous peoples' knowledges; knowledge that is place-based, belonging to the local Country and its people. This is emplaced knowledge, a practice that recognises and employs relational obligations and privileges accountability to local Indigenous peoples (Tynan, 2020).

As argued earlier ([Chapter 1](#)) ANMAC's (2019, p. 16) accreditation standards that prescribe the inclusion of Indigenous peoples' 'history, culture and health' is problematic. While SONs, with the guidance of the CATSINaM curriculum framework, can lead the partnership work regarding history and health curriculum, it is Indigenous community members who should lead the cultural content, if they deem it appropriate, which is enabled by Indigenous academics' emplaced knowledges.

One Indigenous participant explained this matter in how she worked with non-academic Indigenous community members from the local community. She shared,

... what do we need to include [in the Indigenous health curricula]? And what don't we need to include? So, for [health professionals] do you need to know specifics about cultural tradition to provide good care? Is that going too far? Is that something you just don't need to know about? Is it more about how to communicate with patients and find out what you do need to know for them? And then leave the other stuff because it's none of your business.

This participant later shared,

... there [are] Aboriginal Elders who are [local] Elders who come in and share what they feel is necessary and important. So, that's not [knowledge and perspectives] I can, I can dictate, or I can do. But I can provide a space for that.

In these yarns, this Indigenous participant provides examples of how she navigates the incorporation of Indigenous perspectives into the Indigenous health curriculum. This participant demonstrates ethical practice that resists extraction and exploitation of knowledge to privilege benefits to the SON and discipline. This way of doing business demonstrates her emplaced knowledge. In the era where Universities Australia is pushing to Indigenise the university sector, these questions become more important, because not all Indigenous

knowledges and perspectives are the business of SON and discipline (Nakata, 2007). Her questions about including Indigenous knowledges and perspectives in the Indigenous health curriculum are intriguing “*what do we need to include? And what don't we need to include?*” They prompt fundamental questions: what is the business of the discipline and SONs when it comes to Indigenous knowledges and perspectives regarding health? What is the business of Indigenous peoples when it comes to Indigenous health education? How does current discipline and university sector regulations enable SON to interrogate these questions in partnership with Indigenous peoples?

One participant shared her understanding of her individual business, particularly in developing and delivering Indigenous health curriculum,

I'm really lucky that I've, um, worked here for a long time clinically. And so, I have peoples' voices in my head, and because I worked in women's health, a lot of the [Indigenous] Aunties' voices are in my head. And, um, some of these Aunties aren't with us now, but, mm, but you know, like I hear them and... they guide me still through their messages and the stories and there were some, some of the things they've said to me, and some of, yeah some of them, you know, I could share, like because they never told me any cultural business, because that's not my business, but they shared things with me about ways of working and ways of being together that, you know, that I can share with others

This participant reiterates the point made earlier that ‘cultural business’ is not her business. The Indigenous Aunties taught this participant about ways of working with Indigenous peoples, “*ways of being together*”, and protocols around what she could share with others. These lessons stay with her, evident by the supportive “*voices in [her] head*” that continue to guide her. Her description of her learning experience tells of the imperative of relationships to Indigenous ways of knowing (Moreton-Robinson, 2017). In particular, her articulation of the resonance of the lessons from Indigenous Aunties who she learnt from, as

voices in her heads, reveal a comfort in describing a feature of Indigenous ways of knowing and being, as interconnected with our spirits and ancestors (Martin, 2008), that could be described as poor mental health via a white biomedical logic. Her framing suggests a relational connection was established with the Indigenous Aunties that she learnt from, which benefited her understanding of and continuing practice of her business in Indigenous health education.

Of course, relational connections are also imperative to nursing clinical care, thus an important component of the Indigenous health curriculum. One participant shared his understanding of how relationality is important to nursing care,

how can [students] then relate to Indigenous people that they're looking after on the ward, not being scared to say hello? Not being scared to introduce themselves... not trying to be perfect, but being honest and saying, 'look, I'm not understanding your culture. What can you tell me that I need to do for you?' Particularly when they're dealing with traditional men who've come from the APY lands, who don't speak a lot. Traditional women, how do they, how do you deal with that... how do you manage them in a way that is safe in a sense, safe?

This participant highlights the apparent fear associated with caring for Indigenous peoples, a fear that students require support in confronting as part of their educational preparation. This fear was mentioned earlier, when students' sense of identity, values, beliefs, and knowledge about Indigenous peoples are being challenged (Mills & Creedy, 2019). The informal and formal socialisation that nursing students endure, as members of the Australian public (discussed in [Chapter 3](#)), reinforces stereotypes about the apparent violence of Indigenous peoples. According to this participant, this factor may inhibit student nurses greeting patients and introducing themselves. Thus, the fear of misunderstanding cultural norms, and communication barriers between them and Indigenous people seeking care, inhibits negotiating what may be safe, and can further exacerbate students' fear. These dynamics

suggest prematurity of this participant's (and his colleagues') understanding and confidence in developing student nurses' knowledge and skills regarding relational engagement with Indigenous peoples.

Some participants, however, spoke about how they were incorporating the significance of relationships into their pedagogical approach, by role modelling being a good relation with local Indigenous Elders and community members who agreed to work with them. One non-Indigenous participant shared,

... when they [nursing students] listen to the stories of our Elders, and I find them really powerful as well, just things about, you know, ah, they tell about their perspectives of being part of the Stolen Generation and what that means for them and what that means for their family, so when we're coming in and going, "Alright, social determinants of health, family responsibilities, family commitments and obligations", they can sort of understand.

This non-Indigenous participant yarned about teaching about social determinants of health in partnership with local Elders who share their stories about 'being part of the Stolen Generation'. The degree of Cultural Safety that enables this collaboration must be sufficient for Elders to feel safe to share such stories and experiences. Some participants shared a similar story, of partnerships with older Indigenous peoples that enabled a better quality and safer learning experience for nursing students.

Another participant wished to develop more regarding working with Indigenous peoples to consolidate a relational approach. She shared,

[What] I'd like to develop more is... working with Aboriginal, you know, colleagues and community members. So, at the moment what happens is that [Indigenous clinical nurse colleague] comes in for the face-to-face workshop... [She] comes in and she shares her story as an Aboriginal woman, as someone who tried to go into nursing at first and found it was really racist when she was younger, and then came back as a

mature-aged person and as someone who was Stolen Generation. And so, for an hour she does this most amazing discussion.

This participant describes how her partnership enables the inclusion of her Indigenous clinical nurse colleague's testimonies as Indigenous perspectives into the Indigenous health curriculum. In this example, her colleague shared her lived experience from her social position as an Aboriginal woman who as a child was stolen from her family, and who as an adult eventually became a nurse, despite the racism experienced during her first attempt to become a nurse. Teaching from this social position and drawing on these experiences, is something that this research participant cannot do, hence the importance of her partnership with her Indigenous clinical nurse colleague.

Working in partnerships must be implicitly supportive and is important when working with a curriculum that can be challenging for academics and students. One participant shared, *"working in partnership, I think, for me is really around resilience. Yeah, very much, I'm not a sole operator; very much working with others."*

The emphasis on resilience reflects the demanding nature of the Indigenous health curriculum for students, staff and invited guests. Resilience is required to address manifestations of racialisation, such as racist or ignorant comments and questions in the lecture theatre, tutorial rooms, online learning spaces, assessment pieces and student satisfaction surveys. Supportive partnerships are thus essential to and realised through a coordinated and consistent approach to student educational development. A supportive relationship is evident by whether Indigenous peoples are interested and supported to participate in the development and delivery of Indigenous health curriculum. Such characteristics of a supportive relationship resonate with a cultural safety approach.

Partnerships between Indigenous and non-Indigenous academics were identified as pivotal by several participants. However, not all reported effective working partnerships, which impacted on the wellbeing of the Indigenous academics involved in the development and delivery of Indigenous health curriculum. One Indigenous participant stated, *“Yeah, I feel like, and you probably know this, sometimes as the Aboriginal academic your fellow colleagues may need some guidance around how to do things. So, sometimes you’re not educating students, you might be educating the staff.”*

This issue resonates with the notion of never turning off. Supporting the development of fellow non-Indigenous academics can be mutually beneficial, as this participant later pointed out. She shared,

I’m lucky I’ve got, there’s people in the degree who really get it in the school, and I’ve got colleagues in other schools of nursing who get it as well. So, if I need some advice, “I’m not sure like, I think this is an issue, but people are saying it’s not, what do you think? Can you help me out? How do I address this?” And [they] never get sorta annoyed or upset, coz I don’t feel people are ever, usually acting out of, you know, malice or being nasty or anything. It’s just, people might just see things differently.

This participant describes her colleagues who “get it”. They are knowledgeable and experienced enough to provide peer support, including offering advice and guidance; they have presumably overcome any fear of working with Indigenous people or in Indigenous health; they are not overtly or covertly malicious towards her; and they may have different perspectives and are open to engage in knowledge sharing. From her description, this Indigenous participant appears to trust her non-Indigenous colleagues to seek support from and engage in knowledge sharing with them. Her emphasis on her colleagues’ non-malicious intentions suggests that she still must contend with manifestations of racism from them, however it may be safe for her to address such limitations in her colleagues. ‘Getting it’ appears to require mutual trust, and the

ability to negotiate differences. Such relational characteristics align with Cultural Safety. At an interpersonal level, Cultural Safety requires a shift in the power balance to privilege the powerless to enable the negotiations of an approach that would better serve them (Ramsden, 2002; Cox et al., 2020).

Cultural Safety emphasises the need for institutional change however, not just individual practice change (Ramsden, 2002; Cox et al., 2020). This participant's framing of having culturally safe colleagues as 'lucky' tells of her experience and expectations of lack of cultural safety of the institutions she works within, and perhaps tells of the broader sector. Reflecting the earlier invocation by an Indigenous participant of being 'lucky' to be healthy, this assertion of being 'lucky' highlights the problematic reality of SON and universities being innately culturally unsafe for Indigenous academics. The social position of Indigenous academics is unsafe, where having trustworthy, knowledgeable colleagues who can share power and negotiate differences is rare.

Making changes within the institution of a SON requires knowledge of the discipline and is possible with partnerships between Indigenous and non-Indigenous academics. A non-Indigenous participant explained that such partnerships require a collective understanding of Indigenous and discipline contexts. She explained,

I really, really appreciated [Indigenous academic colleague], and [another Indigenous academic colleague] and I, um, have a lot of shared experiences of both working within the faculty and working on this floor and trying to implement things around Aboriginal health care. Although, I know we're coming, you know, of course we have different life experiences you know, but we, we work together on those. But there's something about another nursing colleague, there's something about nursing... There's something about knowing nursing schools, and, and the way nurses think and operate. Like there's something specifically about nursing.

This participant highlights the value of the social positions of Indigenous nurse academics, as their intersecting professional and personal experiences, including Indigenous lived experience and a nursing one, can nurture a critical understanding of “*nursing schools and the way nurses think and operate*”, which presumably includes the neocolonial and neoliberal logics and operations. Such knowledge would be essential to strategising change within the discipline and SONs, as well as strategising against the counterstrategies of these institutions that seek to maintain dominance in power relations, including the possession of being known as innocent and benevolent.

This situation reiterates the vantage point benefits that Watego speaks about, of the subjugated social positions that Indigenous peoples are allocated (Daley, 2021). This point also resonates with Ramsden’s (2002) insistence that only the powerless (the patient) can determine the Cultural Safety of the service they experience. From their vantage points, patients can advise on the operations of disempowerment that they experience, and how such operations could be addressed.

A pedagogical approach that enhances relational engagement between Indigenous and non-Indigenous academics and other Indigenous peoples appears to have more potential to be receptive to the needs of academics, students, and other Indigenous peoples. Such an approach can enable the cultural safety of all involved, especially Indigenous peoples, and our testimonies and perspective within Indigenous health curricula. A relational approach that reflects Cultural Safety demonstrates ‘ways of working and ways of being together’, that could limit the racialised violence of this work on Indigenous peoples, address the fear experienced and misunderstandings of nursing students and staff, whilst attending to the principal purpose of developing complex, holistic, and historically informed knowledge and skills in relation to Indigenous peoples’ health.

However, such partnerships take time to develop, as the other Indigenous participant shared,

I've been here for 18 years, that's kind of been groundwork, this is the time now where things... you've built up enough knowledge... and skills... Like digging the hole now and pouring in the concrete, the foundations of all that stuff you gathered, you know, over the years.

It is an incredibly generous feat, to patiently work over 18 years, supporting one's colleagues to be ready; supporting their knowledge and skills development. This work reflects her belief of the essential nature of relationships amongst Indigenous and non-Indigenous nurse academics in laying strong 'foundations' for the Indigenous agenda (including Indigenous health curriculum and research, as well as student and staff support). The long-term need for her work highlights the limitations in knowledge and skills of her colleagues, as well as their resistance or fear to being proximal to this work. A pedagogical approach must be founded in relationality amongst academics, which takes time to develop. So, as flippant as 'getting it' may sound, it may actually reflect years of dedication to building the right relationships to support knowledge and skills in Indigenous health.

The 18-year span that this participant used to develop relationships coincides with significant development within the Australian nursing discipline's scope of practice regarding the inclusion of Indigenous health skills and knowledge. These events include the establishment of the Indigenous Nursing Education Working Group (INEWG, 2002) and its report *Gettin' Em n Keepin' Em* ; related changes to registered nursing accreditation standards to include Indigenous health curriculum (ANMAC, 2009), which evolved over two updates (ANMAC 2014; 2019); and the explicit inclusion of 'Aboriginal and/or Torres Strait Islander peoples' health' within Australian nursing's code of conduct, a discipline regulatory standard which sets the 'legal requirements, professional behaviour and conduct expectations for all

nurses' (NMBA, 2018, p. 9; 5). These political and social factors of course cannot be discounted as the ultimate influential factors that have led to the SON developing and delivering Indigenous health education to undergraduate nursing students. However, this Indigenous research participant's articulation of the depth of her relational work with her non-Indigenous academic colleagues to develop their skills and knowledge, raises questions about the limitations of the potential of ANMAC's accreditation standards to create the change it desired (i.e., to better educationally prepare undergraduate nurses). Furthermore, it also raises questions about the educational preparation of academics entrusted with Indigenous health education.

Another significant feature of the yarns of most Indigenous and non-Indigenous participants who engage in a relational approach with Indigenous peoples in their work developing and delivering Indigenous health education, is that most did not explicitly teach about their ongoing work in terms of being good relations. Participants suggested that role modelling for students may be sufficient and that somehow students are able to grasp partnerships that are driven by Indigenous peoples' logic of relationality.

The neoliberal logic of the discipline, SONs and universities sees relationships as enablers to the institutions achieving its goal, and as discussed earlier, this includes the (re)production of colonial power relationships that maintain the status quo of Indigenous disadvantage. However, relationships as determined by Indigenous peoples' understanding and exercise of relationality, appear conducive to the development and delivery of Indigenous health curricula that better serves Indigenous peoples. Relationships can assist with working through the incommensurabilities of Indigenous peoples' health and in doing so create clarity regarding what knowledge and skills are the business of the discipline, and what are not. Relationships with Indigenous knowledge holders are imperative to the latter and Indigenous academics exercise their emplaced knowledge to navigate these matters. Partnerships are a

tactic of resilience, reflecting the complex nature of Indigenous health education. However, building such partnerships is significant labour for Indigenous academics, and takes a lot of time. A relational pedagogy that aligns with Cultural Safety may consolidate a strategy for Indigenous health curricula, one that could transform organisational and discipline regulation standards to better serve Indigenous peoples.

A relational pedagogy builds upon the practice of individuals being good relations. It requires a sharing and relinquishing of dominant power positions by the institutions of discipline, SONs, and universities by negotiating power and knowledge with Indigenous peoples. This is not a small ask of these institutions. To explore some of the necessary incommensurabilities towards a relational pedagogy, I turn now to one of my learning experiences with my colleague, Cherokee Native American Nursing Professor John Lowe, specifically his work with the Keetoowah Cherokee Band. I learnt a lot about the generosity of the Keetoowah Cherokee Band and their partnership with Professor Lowe that supports an immersion placement for nursing students in the Keetoowah Cherokee Band community. I also learnt about the regulations that the Keetoowah Cherokee Band puts in place to protect their ways of knowing, being, and doing from outsiders.

Personal testimony: Protocols that protect against white possession

A year before my PhD confirmation, I had the privilege of participating in one of Professor John Lowe's (Cherokee Native American) Indigenous health immersion programs. He hosted approximately 30 nursing students and me on the sovereign lands of the Keetoowah Cherokee Band of the Cherokee tribe. The students had to present public health education to Keetoowah Cherokee children and parents, and we were all invited to several community events, including a sacred Stomp that celebrated the anniversary of the late Chief Red Bird, who is acknowledged for his legacy regarding the reclamation and teaching of the Cherokee language.

This Stomp took place after dinner one night, in a community gathering place in the forest. Family shelters formed a big circle around a mostly cleared area with exception to several old pine trees. In the middle of this area was an established firepit that was ablaze. When we arrived, the Stomp had already begun.

As guests, we were orientated to some protocol. This was a new experience for me and all the students; an experience that was certainly not considered in the discipline's, SON's or university's policies and procedures. We were advised that we should only join the Stomp if invited, and that we are not allowed to stomp in the inner circle, closest to the fire. The spiritual significance of the Stomp to the Cherokee people was lost on us visitors, as this was not for us to know. Singers from different families would come forward to start a song, simultaneously their kin then other family members encircled the fire. Some Keetoowah Cherokee Band members had small tortoise shells tied to their legs, one on each leg. As they stomped around the fire, they clapped the shells together, providing the beat for the song and the Stomp.

By the second or third song, the Keetoowah Cherokee families started to invite us to their fire to celebrate with them. It was an honour. As I stomped with others in a vortex formation around the inner circle and the fire, I recall feeling excited about the experience, as well as anxious about me or my fellow guests (the students) breaching protocol. I caught myself several times wondering about the meaning of songs, of different pieces of attire, of other things I saw that I didn't understand.

The experience had me thinking about traditional Meriam dancing that I learnt as a young man. The many lessons embedded in songs, in choreography, and in dance attire. I also thought about the regulation of this knowledge, how I have been privy to some of this knowledge, while others remained a secret, until I am ready for that knowledge. The experience as a guest of the Keetoowah Cherokee Band was a different feeling, as I will not inherit their

knowledge, sacred or otherwise, as I do my own peoples. It was a strange realisation, to be content as a guest, concentrating on containing my curiosity and heightening my awareness of my words and actions to avoid breaching any protocols.

Unfortunately, our night ended abruptly. As we retreated to one of the family shelters following a song, Professor Lowe gathered us to say that it was time to leave. As we walked out towards our fleet of cars that we arrived in, we thanked individuals we passed. It wasn't until the following morning during check-in that Professor Lowe advised us that we were asked to leave, because one of the students was seen in the inner circle of the Stomp. No one confessed. This clearly concerned Professor Lowe as we were guests that he brought in, so this had implications on his relationships with and reputation amongst the community.

In imagining the potential for better relationships between Indigenous communities and SON, it is imperative to acknowledge the unsettling that is requisite in shifting/relinquishing power from institutions of discipline, SON, and universities to Indigenous communities. The experience of being asked to leave the Stomp was a real shock. A humbling experience of acknowledging that our group had breached protocol. The swiftness of the community leaders' decision, and Professor Lowe's compliance was also surprising, as this demonstrated a legitimacy that was afforded the regulations and sovereignty of the *Keetoowah* Cherokee Band. From that experience I realised that at any moment the *Keetoowah* Cherokee Band could have asked Professor Lowe to cancel the immersion learning experience and leave their town. No discipline, SON, or university regulation framework could have overturned such a decision. Thus, there appears to be inherent risk to institutions in sharing/relinquishing power to Indigenous peoples. Such risk includes the loss of complete control over the institution

activities that require working with Indigenous peoples. This could include the work of developing and delivering Indigenous health education.

In the context of Indigenous health education, empowering Indigenous peoples for this work requires more than just enlisting a single Indigenous academic to lead this work (as discussed in [Chapter 3](#)). Indigenous health education work requires partnerships with local Indigenous communities to address the incommensurable factors regarding Indigenous peoples' health, including the pursuit of articulating the operations of racism within health and nursing service, as well as determining what is culturally safe. The experience with Professor Lowe demonstrates that Indigenous workforce participation is clearly an insufficient measure of the capacity of SON and universities to ensure quality and safe Indigenous health education. While the immersive learning experience has been realised because of Professor Lowe's work, which his SON and university benefited from, the multiple expectations Professor Lowe is burdened with regarding the relational responsibility on behalf of his SON and university is quite significant.

Engaging with "locally based curriculum" that address colonial relations and our relational connection to Country and human and non-human entities unsettles colonial norms, including the white possessive logics that operate within institutions (Andersen, 2016, pp. 64). In this learning experience, the nursing students and I were unsettled because such Indigenous community power in the context of nursing education was very new. Considering the white possessiveness of the discipline exercises over their intellectual territory and scope of practice, it was a refreshing surprise. This example is not reflective of all partnerships, as evident in the tokenistic partnerships that I have discussed earlier. The difference with token partnerships and partnerships that unsettle, and better service Indigenous peoples seems to be the power that is afforded Indigenous communities that SON and universities partner with.

Bond et al. (2016) found that reciprocal partnerships between the local Inala Community Jury for Aboriginal and Torres Strait Islander Health Research (Inala Community Jury)⁶⁵ and researchers requesting and conducting research in the Inala community empowered community leaders to enhance their engagement with and guidance of research to benefit the community. A shift in the power dynamics and ownership of projects or initiatives to the advantage of the Indigenous community (from objects/subjects to governing enablers within their own community) demonstrates the potential of privileging Indigenous peoples (Bond et al., 2016).

Such situations are unsettling for researchers and academics wanting to work with Indigenous peoples, since the Indigenous community-determined processes and protocols may be unfamiliar to them; however, affording time and resources to establishing and maintaining relations can ease the discomfort (Bond et al., 2016). Such relationships that redesign the power dynamics with Indigenous communities can enable meaningful community development and normalise processes to negotiate the diverse priorities (Pulver Jackson & Fitzpatrick, 2004). They also enable the development and use of local community protocols, which assists researchers/academics, but importantly reflects the effectiveness of those Indigenous peoples engaged to work with researchers/academics. That is, if researchers/academics follow local protocol, this would demonstrate to the broader Indigenous community that the Indigenous peoples who are working with these researchers/academics are fulfilling their professional role and their relational duty to their community (Bond et al., 2016). The Inala Community Jury demonstrates the potential for investing in Indigenous community empowerment, resetting the

⁶⁵ The Inala Community Jury is a committee of local Indigenous community members, non-researchers, who provide ethical clearance for research that intends to include their community as a research site. Consisting of Indigenous Elders, and people who work in local community-controlled services, the Inala Community Jury provides advice and guidance on research that is not quite ready for their community, and approval for research projects that prove their worth. The Inala Community Jury is an entity of the local government health service and is afforded power to determine what research activity takes place in their community, with the backing of the Aboriginal Clinical Director of the health service (Bond et al., 2016).

power dynamics that may unsettle the institutions of discipline and university, but inevitably be of better service to Indigenous peoples (Bond et al., 2016).

Iwama et al. (2009, p. 3) describe the concept of *Two-Eyed Seeing* as “an Indigenous pedagogy, research, practice, and way of living that incorporates Western and Indigenous knowledges” that enables mutually beneficial partnerships between Indigenous peoples and disciplines. Two-Eyed-Seeing originated from the teachings of Charles Labrador, who was a spiritual leader, healer and chief of Acadia First Nations, Nova Scotia, who used the analogy of the different trees in the forest, whose roots are intertwined, holding hands to represent his vision of Western and Indigenous knowledges complementing each other for the betterment of all (Iwama et al., 2009, p. 3).⁶⁶ Iwama et al. (2009) proposes that the divergence between Indigenous peoples and non-Indigenous peoples is at the level of epistemology and ontology, that is, a divergence in ways of knowing and being in this world. Nakata’s (2007) cultural interface resonates with Iwama et al. (2009) theorising about this divergence. Inspired by his work, I recently described the divergence in the specific context of nursing curriculum engaging Indigenous knowledges as a space of contention (Drummond, 2020). Using the analogy of pearl diving, this is a space where Indigenous academics are lowered into the depths of the ocean/space of contention between Indigenous and Western knowledge systems as part of their academic practice, full of tension and incommensurabilities (Drummond, 2020). This is my way of describing the feeling of ‘never turning off’ and immersion in the incommensurabilities associated with teaching Indigenous health.

Charles Labrador’s alternative analogy of two different trees, holding hands (intertwined roots), is realised in the work of Integrative Science/Toqwa’tu’kl Kijijitaqnn and Health (ISSH),

⁶⁶ This work has further developed with Institute for Integrative Science/Toqwa’tu’kl Kijijitaqnn and Health (ISSH) at Cape Breton University, under the guidance of and in partnership with Mi’kmaq Elders Albert Marshall and Murdena Marshall; Elder Murdena is also a Eskasoni spiritual leader (Iwama et al., 2009).

where Mi'kmaq Elders collaborate with ISSH academics to develop learning experiences for applied science students (Iwama et al., 2009). Mi'kmaq Elders are actively consolidating their ways of knowing, being and doing to support their contribution to this partnership. They assert the importance of maintaining the integrity of Mi'kmaq ways of knowing, being and doing in this partnership, stressing that the collaboration is about 'interweaving epistemologies and methodologies', and not integrating or blending them with non-Indigenous approaches (Iwama et al., 2009). Integration or blending suggests fragmenting and extracting Mi'kmaq knowledges to privilege non-Indigenous agendas, while weaving asserts the maintenance of the strand of Indigenous knowledge, complementing the project at hand and bounding it to the Indigenous knowledge holders (Iwama et al., 2009).

The experiences of the Inala Community Jury and the ISSH demonstrate the potential implications of shifting responsibilities of relational engagements from individual Indigenous academics to institutional and Indigenous community leaders. Such approaches would alleviate some of the burden shouldered by Indigenous and non-Indigenous academics, like Professor Lowe, particularly being the sole responsible person for enabling quality and safe educational experiences for student nurses learning about Indigenous health.

Conclusion

The insights from the research participants highlight the current operations of relationships between Indigenous peoples (academics, students, other community members) and all academics who develop and deliver Indigenous health curriculum. They demonstrate that despite the manifestations of white possessive logics within the SON and university, they remain persistent in their work towards better informing the next generation of nurses.

Many participants shared their relational engagement with Indigenous peoples. For non-Indigenous participants, they spoke about learning from Indigenous peoples about how to work together. For Indigenous participants, they described their exercise of emplaced knowledge. These relationships are key to their work within the contentious space of developing and delivering Indigenous health curriculum. It is from these relationships that participants are drawing their strength, clarity, and learnings about how best to be of service to Indigenous peoples.

A proposed relational pedagogy demands an institutional approach by the discipline, SON, and universities, to being good relations to Indigenous peoples. Sharing and relinquishing power would be perceived as risky for institutions who are used to possessing power, as they must share control with Indigenous peoples. The experience of the Inala Community Jury and the ISSH demonstrate that such an approach is more than possible in the context of research and teaching and learning in universities. These are lessons that the nursing discipline, SON, and universities could apply more broadly, if they were indeed intent upon improving their service to Indigenous peoples.

Chapter 7: Conclusion

My thesis investigated the experiences of Indigenous and non-Indigenous academics tasked with developing and delivering Indigenous health curriculum in Australian undergraduate nursing programs. Their experience provided insight into the interests and preparedness of the institutions of the nursing discipline, and their Schools of Nursing and universities to support them to do this work. Their yarns also highlighted the importance for them of being good relations to Indigenous academics, students, and community members, as essential to developing and delivering Indigenous health curricula.

To be a good relation requires a consideration of relationality to Country and entities beyond the anthropocentric understanding of relationships. Being a good relation to the land and sea Country and to their metaphysical entities (including spirits and ancestors) is an extension of being a good relation to traditional owners. The following testimony elaborates on this broader understanding of relationality.

Personal testimony: Non-possessive practice:

Months into the PhD journey I found myself amongst friends on a catamaran, anchored on one of the sandbars between the islands of Minjerribah of the Quandamooka people (North Stradbroke Island) and Moorgumpin of the Nughi people (Moreton Island). It was a welcomed break from work and the PhD; the latter especially, as I had spent days trying to get my head around several Indigenous methodologies and methods.

Having spent the most of 10 years living away from Weibene, where my siblings/cousins and I went fishing with our grandparents, mums/aunts, and crayfishing and hunting with our dads/uncles every week, being back on the ocean was healing. The familiarity of the hypnotic swaying side-to-side with the boat as it gently rolled over the small waves, the heat of the sun

of a clear day on my exposed skin, and the breeze that swept over my body, cool from its journey across the sea towards me. The pristine water glistened, the golden sand occasionally interrupted with fish, starfish, and a couple of turtles. The latter, my kin connected through my maternal grandfather. I wasted little time in not joining them.

Life on the sandbar was more teeming than assumed from the deck, and much more colourful; the starfishes formed marine constellations of red and yellow. As I let the current carry me along the sandbar, a familiar shape caught my attention. A single squared-shape pearl shell sat mouth-close and facing upwards towards the sun. My paternal grandfather was a pearl diver, and as a child he filled my memory with many of his stories of being lowered into the depths of the oceans of Zenadh Kes to collect pearl shells. Seeing this pearl shell reminded me of him, so I became curious to take a closer look at the pearl shell that stood proud on the sandbar below.

I thought that it would be easy to pluck it from the sandbar, after all it was only holding onto sand. I clasped my hands around the lip of the pearl shell, as if my hand was another shell trying to consume it. I pulled at it a few times and was shocked by the stoicism of the pearl shell; it remained unmoved. I returned a second time, after a brief visit to the water's surface to refill my lungs. But, despite my efforts, it remained unperturbed. In a final attempt before I had to resurface my fingers grabbed at the tip of the shell and accidentally broke off a couple of small pieces of the lip. I was hoping to avoid this, as I knew this would compromise the natural protection of the pearl oyster. I returned to the surface and to the boat feeling a little disappointed and bad for preparing the pearl-oyster for certain consumption by fish.

Reflecting on this interaction soon after it happened, I realised that I had just had an engagement with the Quampie, the central being of Martin's Quampie Story about

Quandamooka epistemology of relatedness, in her book, 'Please knock before you enter: Aboriginal regulation of Outsiders and the implications for researchers' (Martin, 2008). A lightbulb moment, a teachable moment, as I was taught as a child by my grandparents, parents, aunts, and uncles. It was no coincidence that this interaction related to my PhD work learning about Indigenous methodologies as the Quandamooka Quampie story was one that I had started to weave into my theoretical framework. This was one of the many timely engagements with Mother Earth and entities', that I have experienced during the PhD journey, expressions of relationality (Drummond, 2020). Instinctively, I tried to decipher what the lessons were.

The principal lesson from the Quampie Story at that time was a reminder of the regulations associated with Indigenous knowledges, and further, that these regulations are maintained relationally within Indigenous communities (Martin, 2008). Institutions of disciplines, SON and universities have a history of engaging in colonial extraction and appropriation of Indigenous knowledges for their benefit, with little regard for whom they are stealing from (Nakata, 2007). So, for me to just extract this knowledge without investing in being a good relation to Quandamooka people would be a (re)production of colonial extraction. This would also break one of the laws of my mother's people which forbids the taking of that of another. This lesson was a reminder of Indigenous sovereignty and our ways of regulating access to our Country and knowledge. It was also a reminder of who I was, a sovereign *Meriam-Dauareb Le* and *Wuthathi* man, who does know better.

Rhizomatically reflecting on my interaction with the Quampie now, near completion of my thesis, new teachings emerge, particularly regarding the harmful operations of white possession over Indigenous peoples and knowledges. I liken the harmful operations of white possession to the way in which I tried to remove the pearl shell from the sandbar, intending to satisfy my curiosity. Its interconnectedness with its environment made extraction impossible, and

eventually resulted in me compromising the integrity of the pearl shell. I propose that in trying to claim possession of Indigenous peoples and knowledges, disciplines cause harm to both.

The research participants shared insights into the ongoing operations of white possession within these institutions, manifesting as apathy, white ignorance, and institutional racism. These manifestations are reproductions of historical operations within the discipline, evident in the historical governmental and discipline reports that shows how the discipline kept Indigenous health curriculum out of pre-registration training and undergraduate education. Now that Indigenous health curriculum is embedded within ANMAC's (2019) accreditation standards, SONs now possess power to determine the parameters of investment and academic practice in Indigenous health education.

Andersen (2016) warns of disciplines claiming possession of intellectual and physical (on campus) territory regarding Indigenous studies from dedicated Indigenous studies departments, and by extension Indigenous communities that the latter works with. Moreton-Robinson (2004) asserts that white possession is an aprior for Western ways of knowing, and thus, as Nakata (2002) suggests regarding disciplines' 'engagement with Indigenous knowledges, it is innate of disciplines to claim possession of knowledge as part of legitimising knowledge.

However, in the nursing context, it is not just the claiming of possession of knowledge, skills, and attributes that is prescribed by the ANMAC (2019) registered nurse accreditation requirements, or the National and Nursing and Midwifery frameworks (Department of Health, 2014; CATSINaM, 2017), but more broadly the claim over the care of Indigenous peoples. Institutions of hospital, health services and health workforce have discursively claimed possession of the social position of the solution to poor health experienced by Indigenous peoples (simultaneously ignorant to their claim of the causes and causes of the causes of our

poor health). For Indigenous peoples, knowledges, and perspectives to be employed to benefit Indigenous peoples' health and wellbeing, they must be indoctrinated. These are extremely violent manifestations of colonial racism that endure, highlighting the problematic fact that such manifestations are perpetual with the current colonial power-relates. This is the promise of the Indigenising and cultural competency agenda in the university and School of Nursing context regarding Indigenous health education.

Tuck and Yang (2012) insist that decolonisation is not a metaphor, however we can work towards decolonisation with a commitment to the ethic of incommensurability. An ethic of incommensurability supports unsettling the status quo of white dominant culture and white institutions. Cultural Safety is a theoretical and practical framework that aligns with these requirements. Manifestations of cultural competency on the other hand supports an Indigenising agenda that supports a neoliberal agenda that reproduces colonial power relations and insist that Indigenous peoples rely on 'hope' that eventually white peoples will know enough to see us and treat us as humans. Watego (2021) calls this white hope.

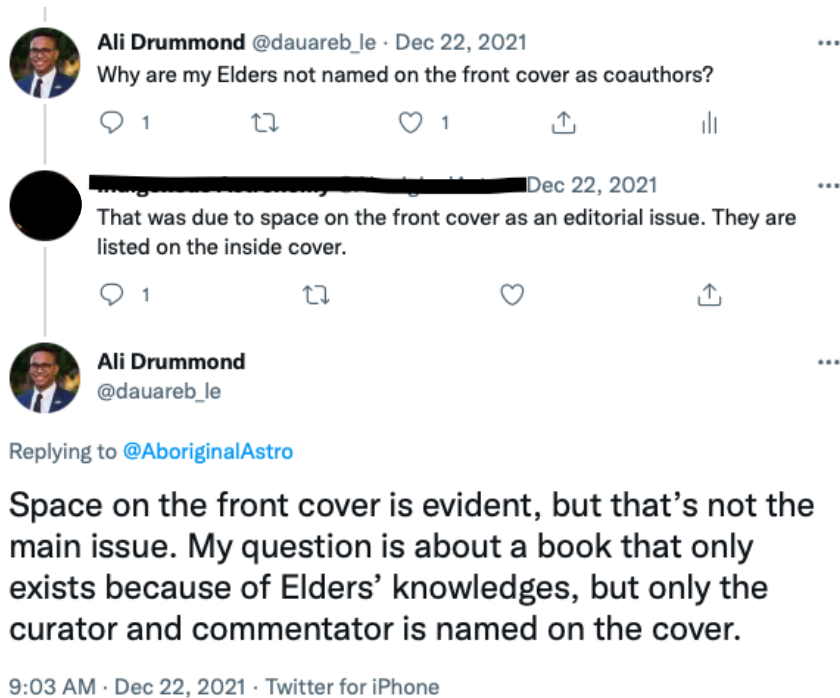
Watego, in her theorising about 'hope', warns us about the futility and fatality of relying upon hope. Holding onto hope in white institutions and their agents, in them being educated enough to be convinced of us being humans, is constructed to distract us (Watego, 2021). Toni Morrison (1975, p. 7) warned us about racism manifesting as distractions as the "real enemy... [as] it keeps you from doing your work." She reminds us that "there will always be one more thing" for us to prove to demonstrate that we are not an inferior race of people (Morrison, 1975, p. 7). This never-ending pursuit is fuelled by hope, that one day they will finally be convinced of our humanness, or that we will transcend race, or that they may even leave. However, we are reminded by Aunty Lilla Watson (via Watego) that "we were never to see justice, in that we will never have returned to us what they have taken" (2021, p. 211).

There was a fleeting sense of hopelessness in writing that last citation, the teaching from Aunty Lilla and Chelsea, an overwhelming sense of uncertainty and doubt. In fact, it took me days to reflect and strategise about how to weave in Chelsea's theorising about retiring hope, particularly on where her theorising takes me. But I had to go beyond just writing about it, I had to embody it; I had to feel myself letting go of hope in white performative benevolence. This brought a sense of liberation and clarity, a blue-sky moment (Watego, 2021), that has helped me attend to the end of this thesis. Watego (2021, p. 198) states that hope is "the psychological tool of the coloniser to insist that we accept things the way they are, forevermore... [it] sedates the logical response of anger and outrage that fuels Black insistence." Hope is another manifestation of false generosity that Freire (1972) warned us about, a quite successful one at that. Thus, Watego (2021, p. 218) asserts "fuck hope. be sovereign".

Being sovereign means being a good relation. In the context of developing and delivering Indigenous health curriculum, this requires reimagining the status quo and contending with the incommensurabilities associated with shifting power towards Indigenous peoples. Being sovereign, for Indigenous academics, also means remembering that we are of this place, and our relational connections are deep and complex.

Appendices

Appendix A: Tweet



Bond University



Volume 8

Issue 1

2020

Indigenous academics teaching Indigenous health: 'it's part of who we are, our spirit, our soul, our knowledge... that goes into our teaching'

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Indigenous academics teaching Indigenous health: 'it's part of who we are, our spirit, our soul, our knowledge... that goes into our teaching'

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Abstract

Aim: Explore the experiences of Indigenous academics teaching Indigenous peoples' history, health and culture in Australian Bachelor of Nursing programs.

Methodology: Theoretical framework comprises of Indigenous methodologies including Indigenous women's standpoint theory and Indigenist research principles.

Methods: One-on-one research yarns that were voice-recorded, transcribed verbatim, and analysed through an assemblage approach.

Findings: Participants of this study shared their doubts about the legitimacy afforded to them and Indigenous health curriculum by some of their colleagues and their school and faculty leaders. They highlighted that strategic and careful disruption of the status quo is a quality imperative. Participants identified the paradox of revisiting personal trauma as pedagogy and curriculum, suggesting a lack of preparedness of their schools to adequately support them. Relational engagement with other Indigenous peoples was emphasised, however, the implicit expectation for them to capitalise on personal relationships involved risking their reputation for their schools, who seemingly demand their resourcefulness as substitute for resources.

Conclusion: Indigenous academics care for quality learning and teaching of Indigenous peoples' history, health, and culture. This care extends to nursing students, fellow academics, as well as school and faculty leadership, despite the lack of care afforded to them. Realising relational and reciprocal care, through providing appropriate support and resources, would benefit them and their academic practice.

I INTRODUCTION

The nursing profession has a long history of interest in the health and well-being of Aboriginal and Torres Strait Islander (Indigenous) peoples. Florence Nightingale's 1863 report on the sanitation of native colonial schools found that Western Australian schools reported the highest child death rates of 143 schools in British colonial states (Nightingale, n.d., pp. 4-5). Nightingale (1865, pp. 7-8) also spoke out against certain colonial practices of 'civilising' Australia's Indigenous peoples. She did not advocate against the colonisation of Australia and its sovereign people who own and belong to their country, instead she asserted that colonisation should be more humane (Nightingale, 1865). Parallels exist between Nightingale's legacy and contemporary practice. We must learn from her legacy and go beyond just reporting on the disadvantage of Indigenous peoples or advocating for more humane ways of diminishing, demeaning or disempowering Indigenous peoples, to reflecting on our professional roles in maintaining the status quo and transforming nursing practice (Barber, 1999).

The current practice of teaching and learning about Indigenous peoples' history, health and culture (Indigenous health curriculum) in undergraduate nursing education aims to better develop the knowledge and skills of future generations of nurses. In 2009, the Australian Nursing and Midwifery Accreditation Council (ANMAC), enshrined the requirement of 'Aboriginal and Torres Strait Islander Peoples history, health and culture and incorporates the principles of cultural safety' into Australian undergraduate nursing accreditation standards (ANMAC, 2009, p. 12). This requirement is instilled in the 2019 ANMAC accreditation requirements (ANMAC, 2019, pp. 15-16).

The accreditation guidelines are vulnerable to loose interpretations ranging from acknowledgment to silence in regard to colonisation, racism and genocide. The principles of cultural safety, referenced earlier, require such historical literacy. These principles are also susceptible to loose interpretations, and often considered only relevant to Indigenous peoples' health. While cultural safety is an ideal theoretical and practice framework for Indigenous health, it has potential to benefit broader contemporary nursing practice (Cox et al., 2021). Cultural safety was borne out of the Aotearoa New Zealand colonial context, coined by a Māori nursing student and theorised by Māori nurse Irihapeti Ramsden as the Māori concept *Kawa Whakaruruhau* (Ramsden, 2002). It is a philosophy and practice built upon critical theory and social constructionism that aims to make the power dynamics conspicuous of the broader context of health and social determinants of health (Ramsden, 2002; Cox et al., 2021). In the context of Indigenous health, cultural safety enables the interrogation of the socio-political-historical context that has and continues to demean, diminish and disempower Indigenous peoples', including the perpetual racialisation of Indigenous peoples.

A noteworthy omission in the 2019 ANMAC accreditation requirements is the need for Schools of Nursing (SON) to invest in Indigenous nurse academics within their workforce. In 2012, ANMAC highlighted the need for SON to increase the number of Indigenous nurse academics as part of their staff recruitment strategy, requiring them to, 'take affirmative action to encourage participation from Aboriginal and Torres Strait Islander peoples' (ANMAC, 2012, p. 16). The current Bachelor of Nursing accreditation standards show a retreat in ANMAC's earlier expectations of SON, from 'encouraging participation' to undertaking consultation with 'external representatives of the nursing profession, including Aboriginal and/or Torres Strait Islander peoples, consumers, students, carers and other relevant stakeholders' (ANMAC, 2019, p. 15).

Trepidation about increasing Indigenous participation is not unique to the nursing discipline. Reflecting the problems of the society in which they are embedded, Australian universities consistently fail to meet parity (per percentage of population) of employment of Indigenous academics, a fact that is emblematic of institutionalised racism in the form of lack of action and apathy towards Indigenous peoples' needs and issues (Behrendt, et al., 2012; Universities Australia [UA], 2020). For SON, the ANMAC measures provoke questions about the preparedness, interest and capacity of SON and academics to fulfil ANMAC's requirements. Concerns such as these inspired the program of doctoral research on which this paper is based.

II BACKGROUND

A Indigenous nurses' advocacy for accreditation requirement

The development of the ANMAC accreditation requirements regarding the inclusion of Indigenous health curriculum is largely the result of the labour of Indigenous women, specifically Indigenous nurses and midwives. In 1997, the Council of Aboriginal and Torres Strait Islander Nurses (CATSIN)¹ was established as a network 'to formally represent Indigenous nurses', committing also to implement the recommendations developed at their initial workshop predominantly aimed at supporting the increase of Indigenous peoples within the nursing profession (National Aboriginal and Torres Strait Islander Nursing Forum [National Forum], 1998, p. 28).

The National Forum declared that better Indigenous health education for all future nurses was pivotal to increasing Indigenous peoples' participation within the nursing profession, and both were essential to addressing the health and well-being needs of Indigenous peoples (National Forum, 1998). These recommendations echoed those made in the *Royal Commission into Aboriginal Deaths in Custody* (Office of the Aboriginal and Torres Strait Islander Social Justice Commission, 1996) and the Stolen Generation report titled, *Bringing them Home: National Inquiry into the separation of Aboriginal and Torres Strait Islander children from their families* (Commonwealth of Australia, 1997). The National Forum insisted that this education must include the teaching of the:

'nature and effects of past and present government policies of colonisation, assimilation, forced removal of peoples from their traditional lands, forced removal of children from their families and their traditional land and forced urbanisation... and the current appalling health status of Indigenous peoples' (Indigenous Nursing Education Working Group [INEWG], 2002, pp. 29-30).

The National Forum advocated for 'the utilisation of Indigenous nurses as consultants to faculties of nursing as a practical means of ensuring cultural education and mentoring' (1998, p. 30). This recommendation was absent in the follow-up report developed by INEWG (2002). The reasoning for this is not explicitly reported, however, a coinciding national nursing review, the *National Review of Nursing Education 2002: Our Duty of Care* and the Federal Senate Report on the *Inquiry into Nursing – The Patient Profession: Time for Action*, focused more on increasing the number of Indigenous nurses and improving nursing care provided by all nurses to Indigenous peoples (Heath, 2002; Commonwealth of Australia, 2002). This suggests a consensus by discipline leaders to delay investment in Indigenous academics, which eventually appeared in the 2012 ANMAC accreditation requirements (ANMAC, 2012).

B Current Indigenous nurse academic workforce

According to Australian Health Practitioner Regulation Agency's (Ahpra) 2018/2019 annual report, the Nursing and Midwifery Board of Australia (NMBA) registered 416,943 nurses and midwives. Indigenous nurses and midwives comprised 1.2% of this workforce, or 5,037 people in total (Ahpra, 2020; Commonwealth of Australia, 2019, p. 2). Ahpra's *National Scheme's Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020-2025* aims to inform structural change to enable, amongst a number of outcomes, increased participation of Indigenous peoples across all health professional groups (Ahpra, 2020a).

Similarly, the *Universities Australia Indigenous Strategy 2017-2020* identifies Indigenous peoples' employment participation as a strategic aim for their sector. Like Ahpra, they also aspire to achieve Indigenous workforce participation of 3% which would reflect the total proportion of Indigenous peoples in the population (UA, 2017). In 2018, 1.2% of Australian academic and professional university staff identified as Indigenous, with a majority being professional or administration staff (UA, 2020, p. 36). In 2019, 58 Indigenous nurses and midwives identified

¹ This group became the Congress of Aboriginal and Torres Strait Islander Nurses and now the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM)

tertiary education facilities as their principal work setting (Commonwealth of Australia, 2019, p. 8). However, not all are necessarily working in SON.

C Experience of Indigenous nurse academics

The role of Indigenous nurse academics within SON is quite broad. Their role consists of supporting Indigenous nursing students (West, Usher, Foster & Stewart 2014; Gorman, 2017), leading the development and delivery of Indigenous health curricula (Sherwood & Edward, 2006; Jackson et al., 2013), including the incorporation of Indigenous perspectives (Drummond, 2020), and supporting relationships with relevant stakeholders (Best & Stuart, 2014).

The presence of Indigenous nurse academics and the relationships they develop with Indigenous nursing students is an important student success factor. These relationships establish a sense of safety which is critical to support relationships between Indigenous students and non-Indigenous academics, the school and university (Best & Stuart, 2014; West et al., 2014). Indigenous academics have a role in protecting Indigenous students from being forced to be experts in Indigenous health, who can be called upon to answer any questions about Indigenous peoples, which can be unsafe for Indigenous nursing students (Gorman, 2017, p. 695).

Indigenous nurse academics develop and maintain relationships with key stakeholders outside of the SON and university. This practice is central to ensuring a strategic approach to developing and delivering quality Indigenous health education, and developing research partnerships (Best & Stuart, 2014).

Indigenous nurse academics are also enablers for Indigenising nursing curriculum (Sherwood & Edwards, 2006; Jackson et al., 2013; Drummond, 2020). Approaches such as the use of yarning circles support the teaching and learning context of Indigenous health curriculum. However, they require clear instructions for teaching staff to ensure that learning is optimised and safe for all students, especially Indigenous nursing students (Drummond, 2020).

The success of these approaches requires significant effort from Indigenous nurse academics, work that is often invisible to their colleagues and supervisors. In 1999, CATSIN (as cited in Sherwood and Edwards, 2006, p. 182) stated that 'Aboriginal and Torres Strait Islander nurses are forced to live a 'double life'. This living in two worlds and two cultures causes internal conflict.' The narrative of being positioned between two worlds is a common one for Indigenous peoples, an expression that draws attention to the contrasting socio-political realities of Indigenous and non-Indigenous peoples' lifeworlds (Styres et al., 2010; Stewart & Warn 2016).

Our task here is to sophisticate the current understanding of living and working within two worlds for Indigenous academics. This paper draws on research that investigates the experiences of Indigenous and non-Indigenous nurses and other academics engaged in clinical and theoretical teaching of Indigenous health curriculum. This initial publication from the first author's program of doctoral research, privileges the experiences of Indigenous academics, making conspicuous their roles in supporting their schools to fulfil ANMAC accreditation standards.

III METHODOLOGY AND METHOD

This paper draws from the experiences of two Indigenous academics who participated in a broader qualitative study of both Indigenous and non-Indigenous academic experiences in teaching Indigenous health curriculum in Australian SON. Participant numbers are small because this is the reality of the context of Indigenous staffing in Australian universities generally including in nursing.

The theoretical framework informing the research study draws on a number of Indigenous research approaches including relationality, Indigenist research principles, Indigenous women's standpoint, research yarning and dadirri. Relationality refers to the interconnectedness amongst humans, such as amongst family, community, colleagues and other humans. It also exists between human and non-human entities (e.g., animals, plants and spirits). Implicit in these

relational connections are potential for responsibilities and reciprocity, that is the potential to develop and realise terms of relational engagement between beings. Relationality is embedded in the way Indigenous peoples understand the world, ascribe value to different things and determine the ways to be in this world. Thus, relationality precedes and informs research methodology and methods (Moreton-Robinson, 2016; Tynan, 2020).

This research project was interested in the relational engagement of Australian nurse academics, specifically in their operations of responsibility and reciprocity with stakeholders such as nurse academic colleagues, senior school, faculty and university leadership and other Indigenous peoples. These stakeholders enable and enhance the development and delivery of Indigenous health curricula within undergraduate nursing programs. The social, historical and political context of the nursing discipline highlight the general disempowerment of Indigenous peoples and their knowledges and perspectives (Power et al., 2021). Thus, methodologies and methods engaged in this research project had to be able to elucidate relevant social, historical and political operations of disempowerment (including racial and gender discrimination) and make explicit the nature of responsibilities and reciprocity afforded to Indigenous people and Indigenous peoples' knowledges and perspectives. The Indigenous research methodologies engaged for this work include Rigney's (1999, 2001) Indigenist research principles and Moreton-Robinson's (2013) Indigenous women's standpoint theory.

Research participants were invited to engage in a one-on-one research yarning session about their experiences. This method was informed by Bessarab and N'gandu's (2010) research yarning and Ungunmerr-Baumann's (n.d.) *dadirri*. Research yarning is intentional in enabling the sharing of yarns, i.e., information through stories, in the co-creation of knowledge between research participants (Bessarab & Ng'andu, 2010). Complementarily, *dadirri* asserts the importance of 'watching, listening, waiting and then acting', inclusive in this is quiet contemplation on what is shared (Ungunmerr-Baumann, n.d., para. 11).

All research yarns were voice-recorded and transcribed verbatim. The first author wrote brief memos following each research yarn to capture initial thoughts, stories and ideas that aligned with and contrasted from the preceding research yarns. The research team reflected on these initial insights and made connections to other sources that provided different perspectives on stories and ideas, nurturing deeper thinking about the relationship between stories and ideas shared. These sources included journal articles, textbook chapters, grey literature, podcasts, art pieces including music and movies, and relational engagement with human and non-human entities. This process guided the researcher memo process, but also extended to the analysis process.

The continued engagement with research yarning and *dadirri* throughout the analysis process complements the French concept *agencement*, translated to *assemblage* in English. In the research context, *assemblage* describes the ability 'to create new concepts, rather than merely fit things into pre-existing forms' (Adkins, 2015, p. 22). Using the analogy of a rhizome, philosophers Deleuze and Guattari propose a different approach to knowledge creation, one that challenges the dominance of stable and hierarchical approaches to knowing which recreates what is already known and how it is known (Adkins, 2015, pp. 22-23). The rhizome analogy encourages researchers to investigate relations between 'wildly diverse things', for example 'with a plant, with a feeling, with a song, with a mathematical formula' (Askin, 2015, p. 24). These relations are dynamic, thus meanings are not absolute, and researchers are encouraged to make meaning of the connections/relations (Askin, 2015).

Assemblage reflects the significance of relationality in Indigenous ways of knowing, which at times may seem unorthodox to the hegemony of Western ways of knowing. In this study Bessarab and N'gandu's (2010) research yarning and Ungunmerr-Baumann's (n.d.) *dadirri*, grounded in relationality (Moreton-Robinson, 2016), enables a practice of assemblage that is founded in Indigenous ontology and an episteme that is of this place. This conscientious privileging of Indigenous research approaches resonates with Tynan's (2020, p. 163) project to 'challenge the hierarchy of knowledge implicit in research as (she) attempt(s) to promote Indigenous-led

scholarship and increase relatedness across many Indigenous knowledge communities.' Further, it is also a reflection of how the first author has been taught to think, to value and to be in this world.

This analytic approach was immersive, it required constant revisiting of the research yarning transcripts, overlapping note-taking and multiple attempts at articulating the first author's interpretation of each transcript. The first author wrote out stories of his own personal and professional experiences that related to key ideas/concepts interpreted from the stories in the transcripts. These stories were transcribed as well so that they could be engaged through ongoing assemblage with the other transcripts, and collectively they highlighted the significant and mundane lessons that required articulation through further interrogation of and assemblage with the literature and other sources.

IV FINDINGS AND DISCUSSION

Our study found that the participating Indigenous academics contend with multiple tensions, some of them unique to their daily academic practice. Their experiences cannot be generalised, however the common challenges that they endure reflect the first author's experiences and those of Indigenous academics in other disciplines. These findings should be considered by Australian SON to support further research as well as associated system and process changes.

A 'I feel like it's just a token tick-box': Legitimacy within the discipline's scope of practice

The participants shared their concerns about the perceived legitimacy of the Indigenous health curriculum within their Bachelor of Nursing program. They reported a lack of accountability and a general undervaluing of Indigenous health curriculum, which is considered subsidiary to clinical education.

Lack of accountability is evident in the notable inconsistency in the quality of Indigenous health education, as one participant shared:

'there's expectations set that you need to deliver Aboriginal health and depending on who's driving the agenda, is to how that's delivered and whether or not it's just a tick-box.'

This lack of accountability of the teaching team, relates to the lack of confidence of senior school and faculty leaders, as one participant disclosed:

'I feel that everybody's on board [in the faculty leadership team], they just need the leadership around that issue [of Indigenous health teaching and learning] because there's still a lot of people not feeling confident in the space, you know. I get that.'

When asked about her perspective on how important Indigenous health curriculum was to discipline education, one participant shared her pessimistic perspective.

'No, I think it's all very low [in importance] ... But I don't think it's seen as important... You're constantly trying to advocate for it to be just as inclusive and as standard as learning about antibiotics or the structure of the heart.'

Indigenous health curriculum is labelled '*informal hidden curriculum*' by one participant, reflecting a low level of legitimacy afforded Indigenous health curriculum compared to clinical education.

'I feel like a lot of it is driven, well it's sorta about timing and scaffolding... So, it's sorta the informal hidden curriculum like, "We've got a space here and a space there" [for Indigenous health curriculum]. We've got clinical skills too in year one, but not in year three, so sometimes things that I wanna do gets limited by resourcing and timetabling. I'm sorta compromising where I put things to fit with the system.'

The 'informal' and 'hidden' status relays a general sense of insignificance normalised by the discipline. But the participants declared their opportunistic approach despite this, and persevere

with navigating the systemic and interpersonal obstacles, because the risk of enabling unsafe clinicians and practice is too great.

'once they're [health students] in that clinical scenario, we know... that you have unconscious tendencies that influence decision-making and interactions. So, some of that [unconscious bias] is in preparation for them going into clinical practice... because unconscious bias is talking about racism.'

Bond (2014, para. 9) argues that this systemic assertion of delegitimizing Indigenous curricula and academics also extends to the student body, evident in how some of her students 'try to decipher whether (she is) an "authentic Aborigine" or a "legitimate academic"'. She states that such questions are a reflection of the 'pervasive racialised imaginings of us (Indigenous academics)' within universities (Bond, 2014, para. 18).

The daily need to contend with the racialisation of their bodies, and of Indigenous health curricula is part of contemporary Indigenous academic practice (Mukandi & Bond, 2019). While disciplines are interested in claiming the intellectual space to teach Indigenous curricula, often claiming this teaching from dedicated Indigenous studies spaces (Andersen, 2016), the status of legitimacy within contemporary discipline institutions and scope of practice remains elusive. Bond (2014, para. 22) reminds Indigenous academics, '(o)ur presence is more than a parity project of "black window dressing" ... (it) is disruptive, confrontational, and confusing, and a necessary part of transformative "warrior scholarship"'. This declaration suggests that disruption of the status quo is perhaps a better measure of legitimacy, rather than merely fitting in.

B *'It never turns off': Teaching Indigenous health within this cultural interface, a space of tension between Western and Indigenous knowing and being (Drummond, 2020, p. 129)*

The participants highlighted that teaching Indigenous health curriculum in undergraduate nursing programs had significant social and emotional costs and labour. One participant shared her reflection on this argument:

'one of the key things for us as academics, Black academics, is that we just don't turn off at home, you know. Our work within the Indigenous health space is carried over from professional to personal. Because, in most cases, we're actually living some of the experiences we teach about, you know, within our family and our community. So that's really quite another burden to carry, particularly when you're in, you know, an academic position in university and you're asked to teach this and read that. Um, and then you go home, and you have to deal with this and that at home. That just impacts, and yeah, it's like it, it never turns off. It never turns off.'

Indigenous academics are faced with the paradox of teaching current and past trauma experienced by Indigenous peoples within the curriculum (Bond, 2014). This may include personal individual trauma, experiences of their family and community, and historical trauma. The Indigenous academics in our research study are no different, expressing the potential positive outcomes and the real worry they simultaneously carry for themselves and their family when teaching about such traumas. While this is indeed Indigenous perspectives, not as a synonym but as the intention and result of colonisation, the situation is obviously highly problematic. This perspective is also not to say that non-Indigenous academics do not experience trauma or health issues in their lives that reflect the content being taught such as diabetes or heart disease, but these are not anchored to ethnicity, everyday racism, histories of invasion and colonisation and living through the next neo-colonial wave of dispossession.

One participant yarned about potentially positive outcomes of supporting Indigenous Elders to share their stories of oppression and agency.

'When they (students) listen to the stories of, of our Elders, and I find them really powerful as well, just things about, you know ah, they tell about their perspectives of being part of the Stolen Generation and what that means for them and what that means for their family, so when we're coming in and going, "Alright, social determinants of health, family responsibilities, family commitments and obligation...", [the students] can sort of understand. And they're building on their experiences to bring that in, and then we can say, "Well that matters for you managing patients because maybe you need to think about X, Y and

Z and support here before you can do this." So, it's kind of, they do link, and we're trying to get them to understand that the social, cultural determinants, how that directly influences their medical practice'.

One participant disclosed her worry for her family and the role she has as a mother and the daughter of community leaders to enable better lives for her family and community. These worries and aspirations are not separate from her nursing practice.

'But you know, talking for myself, I know my, my community is, is, the work that I do, is paramount in building my community so that they're able to, to, to go forward, you know, with, particularly, the younger generation. We don't want to lose them, we don't want... you know..., I'm a mother of three boys, three adult men, and my concern is always for them to be able to walk in both worlds properly and not feel, you know, to be able to deal with the racism out there but still hold their head up strong. You know, [saying what she hopes her sons will say] "I'm a married man, I'm a black man, I can do, you know. I come from, you know, this community, or my mother's from, from this country and, yeah." It's a whole identity thing, um, but, but for me the commitment up here is because I, you know, my, my parents were leaders in that community'.

This sense of intergenerational duty to family and community is not uncommon. Huggins's (1998, p. xi-x) shares something similar about her mother and son saying, 'she left me a lingering legacy – to carry the struggle. I believe my son will do this for me someday... As a mother of a son, John, my wish is to see him develop into a good human being incredibly proud of his Aboriginality despite the pressures that arise because of his race.'

Both participants spoke of legacies bestowed upon them by parents and nursing and midwifery mentors. These statements emphasise the commitments to family, community and to the nursing profession. When asked about these legacies, one participant imparted:

'Yeah, from professional point of view, from mum and dad, from my individual personal point of view, so the two blend nicely together, you know... I have a, I guess, a really strong loyalty to both, yeah'.

The nursing profession's legacy is a tension that one participant highlights as a reason for her commitment to improving the teaching of Indigenous health to the next generation.

'[Nursing has] been part of government policy and practice enacted upon Aboriginal people, removing children, um really, um punitive, almost military style, um supervision of families and their households'.

She reflected on the lived experience of her family being subjected to strict inspections by the local nurse in their community.

'[The nurse] would come and check the houses, she'd put on a white glove and run their fingers along shelves and things like that, you know, that's, that's still in my generation. And if it wasn't, if there was dirt on their gloves, then you know the woman was told to clean her house again. I mean, and this is when we lived with fibro wall houses, um, cement floors, um, you know, poor. Well, there's running water in the house, but really poor for sanitation and all that. You know, and they expect you to live the way white people live'.

Historical accounts like this participant's experiences in and with the nursing profession can be found in the literature (Cox 2007; Forsyth 2007; Cox et al., 2021). Here the problems surround the assumptions made by nurse academics and clinical nurses in health and educational systems about the lifeworlds of Indigenous people. Indigenous academics live these lifeworlds and struggle with and succeed in protecting family and community from the penetrating gaze of white domains which can be (re)produced in curricula and academic practice dominated by white ideals and norms which cannot serve the educational or health needs of Indigenous people (Drummond, 2020).

In discussing her legacy and concerns regarding the politics of Indigenous health one participant declared that:

'Indigenous health is not going to go away. I mean, I think I do have a concern, whether you call it a fear or not, but I do have a concern that with successive governments that Indigenous issues and Indigenous health issues get watered down and get assimilated... our First Nations people are really central to, I mean, to the freedom of this country really'.

Indigenous health is a well-worn content 'football' more susceptible to the vagaries of governmental and organisational politics than other content within the nursing curriculum. This situation is due to the intense focus on government and institutional 'performance' in relation to improving health and educational outcomes amongst Indigenous Australians. This is evident in the Prime Minister's yearly review and reporting of the so called 'Closing the Gap' targets, ANMAC's mandating Indigenous content in nursing curricula, universities', health departments' and services' Reconciliation Action Plans, mandatory cultural (other) awareness training or various visions and mission statements, plans and policies. This situation directly impacts Indigenous academics. As Indigenous peoples within white cultural spaces, they are constantly witness to the running commentary and associated reactions and outcomes of many non-Indigenous staff towards these institutional agendas.

The participants of our study listed a number of tensions they endure which constantly evolve, so too the innovation and approach of the participants in responding. Such experiences elaborate the concept of 'living in two worlds' demonstrating how complicated and laborious it can be for Indigenous academics and suggesting a lack of preparedness of SON to adequately support Indigenous academics.

C 'If we don't address racism, we're doing our community a disservice': Preparedness of SON

Our research participants expressed their concerns about their schools' preparedness to adequately engage with Indigenous peoples as 'external representatives of the nursing profession' who are required to be consulted regarding the 'design and ongoing management of the (undergraduate nursing) program' (ANMAC, 2019, p. 15). Like Indigenous academics, these external representatives also offer their Indigenous perspectives and knowledges as part of their engagement.

One participant was asked about her school's preparedness to engage with Indigenous peoples and develop and deliver Indigenous health curriculum. She responded with questions asking:

'What do we need to include? And what we don't need to include? So, for, for doctors, do you need to know specifics about cultural tradition to provide good care? Is that going too far? Is that something you just don't need to know about? Is it more about how to communicate with patients and find out what you need to know from them? And then leave the other stuff, because it's none of your business'.

These incisive questions on the part of this participant go to the heart of culturally safe practice (NMBA 2018; Cox et al., 2021) by pointing out that it is not esoteric knowledge about Indigenous 'culture' that is needed. One's own culture is of more importance, as are the power dynamics within institutions like hospital, health services, universities and the nursing profession and how associated cultural norms perpetuate hierarchies (e.g., racial, gendered, ableist) that continue to diminish, demean and disempower those on the lower rungs of these hierarchies (Cox et al., 2021).

One of the participants pointed to the need to engage with both Indigenous and Western knowledges and perspectives. She declared:

'racism is a Western construct... It's something that didn't exist, I would say, in [Indigenous peoples'] society before colonisation. So, it's like, it's an effect of colonisation... Racism isn't Indigenous knowledge, but it's so fundamental to health and to how we practice as good practitioners. That needs to be addressed. If we don't address racism, we are doing our community a disservice.'

Other Western knowledges and perspectives are barriers to Indigenous health curriculum. For example, both participants spoke about how the discipline privileges clinical education and describe that as a structural barrier to their work of carefully scaffolded learning about Indigenous peoples' health and well-being. This matter reflects a biomedically-dominated understanding of health, thus health professional scope of practice. This argument aligns with Bond, Singh and

Tyson's (2021) assertion that contemporary health disciplines value Indigenous peoples' body parts that need fixing more than the humanness of Indigenous peoples.

One participant stated:

'anything that sorta sits outside of your predominant biomedical Western science tradition, that is not readily accepted, needs somebody to champion it'.

It thus seems imperative for the Indigenous academics to be this champion, to disrupt, confront and confuse (Bond, 2014).

The participants listed a number of helpful resources that they access as part of their practice as champions. These included the National Indigenous Health Curriculum Framework, discipline-specific curriculum frameworks, the Leaders in Medical Education (LIME), the Leaders in Nursing and Midwifery Education Network (LINMEN), faculty-based Indigenous health teams, Indigenous Education Units, discipline mentors as well as Indigenous Elder mentors.

One participant elaborated on the significance of the latter:

'We're quite, I feel, quite lucky here... because we've got cultural advisors sitting in the [Indigenous Education Unit] ... So, there's two Elders that sit there and they've been involved in our curriculum in [health], and I often go to sorta talk to them about a few things, get them to come watch a few things, just to make sure it's all ok. Get their advice on who we should bring in. So, they've been a very helpful resource for us here.'

D 'How things fit and how they feed in': Relationality

The study participants spoke about the requirement for them to utilise their relationships and reputation with other Indigenous peoples and organisations to enable curricula development and delivery, highlighting the challenge of maintaining the integrity of these relationships and their reputation. One participant shared that they are not a local Aboriginal person, and therefore must be respectful of working with local Aboriginal people with relevant teaching and learning activities. She stated:

'(s)o when we do some of our learnings in Aboriginal health in the [health] program, things we advise for um, the broader faculty, there is Aboriginal Elders who are [local] Elders who come in and share what they feel is necessary and important. So that's not things I can, I can dictate or I can do. But, I can provide a space for that'.

The other participant shared some of the challenges of being from the local Indigenous community, whose land the SON occupies. She shared:

'(f)amily's family, you know, family reciprocity, family responsibility that can over, be over-whelming sometimes. You go to, I know we don't like saying 'no' to our families, but sometimes you gotta say, "No, I can't do that right now. I can't do this for you, I need to rest", you know. Otherwise, we just burn out, and the people that really need you around don't have, you know. That's it and, and the work doesn't get done.'

Reflecting the notion of *never turning off*, the relational responsibilities and reciprocity for Indigenous academics to their family and the local Indigenous community are omnipresent. This invisible work is not well recognised or understood by many colleagues and discipline leaders. The dedication of the Indigenous academics to their relational responsibilities and reciprocity to their family, community and local Indigenous community highlights sources of authority that could determine legitimacy for Indigenous health curriculum and teaching practice.

Tynan (2020) explains how relationality enables accountability for her PhD thesis through relating to her thesis as kin, as a sister. She explains, '(t)hesis as kin pivots around a form of relational accountability that is emplaced; moving towards different modes of accountability dependent on where I write, who I am researching with, and how I listen to and am able to translate the message of Country' (Tynan, 2020, p. 168). Howes (2005, p. 7) defines emplacement as the 'sensuous interrelationship of body-mind-environment', where environment refers to both the physical and social (Howes, 2005, p. 7). Tynan (2020) takes this concept further

by asserting that emplacement is not just about sensing the environment but engaging with the physical and social environment relationally. She demonstrates how her exercise of responsibility and reciprocity with family (including her sister, her thesis), community and country engaged in her research work has enabled accountability and trustworthiness of her research (Tynan, 2020, p. 168).

The research participants of our study demonstrate how emplacement is achieved in their teaching practice and enables accountability and trustworthiness. This practice involves observing and realising relational responsibility to and reciprocity with their family, the local community and the country on which they work. This process requires balancing personal and professional responsibilities, which may sometimes mean that their family does not get the support they require, due to their commitments to their school and university.

E 'So, in a perfect world it would be, this is what I want': Resourcing relational engagement

Ensuring informed and meaningful engagement with local Indigenous people also faces systemic challenges. One participant explained:

'I feel like there needs to be some oversight of everything that's done by Indigenous representatives, so that their, they've got a good understanding of how things fit and how things feed in, and then they can choose where they feel like content needs to be delivered by particular people [from the local Indigenous community], and where they feel it's left to academic staff. Um, but that requires a lot of resourcing and time and effort, which I don't think we're quite set up for at the moment'.

This sentiment is echoed by the other participant who shared:

'I'd love to have a team of my own to work in and a, and a budget to work with, and um, you know, the opportunity to bring people in and having some money to pay them, become part of, you know, what we're building here... I really feel strongly about community being part of the university system around, because uh, we need to teach, being informed by what's happening in the community. So, we need that strong partnership with community. Community being part of maybe, the teaching staff, you know, um, rather than adjuncts or guest lecturing and stuff like that. And for us to be able to be resourced to pay community members for their knowledge... we're bringing their knowledge in to teach students and to teach the staff'.

This participant continued by proposing a process, whereby community representatives meet with school representatives throughout the year to discuss the progress of the nursing students' educational development regarding Indigenous health. This way, Indigenous community members can be actively engaged and properly remunerated for their work and knowledge in the development of students.

The lack of resources available for such an engagement suggests a reliance on the resourcefulness of the Indigenous academics to utilise their relationships and reputation to develop and deliver Indigenous health curriculum. These circumstances also suggest a lack of trust that the SON have in Indigenous academics, to have access to resources and decision-making power. Distrust of Indigenous peoples within the nursing profession is historically evident in the systemic exclusion of Indigenous peoples from becoming nurses (Best, 2015; Best & Gorman, 2016) and remains evident in the testimony of Indigenous nurses who continue to endure systemic and interpersonal racism (Moreton-Robinson, 2015; Power et al., 2021).

Indigenous academics access support from their nursing colleagues. One participant explained:

'You got to bring people around. But, having supporters in the, in the program is key. If there weren't sorta, higher up supporters as well as other supporters, then it would be very difficult'.

However, given the lack of confidence of colleagues and accountability measures discussed, it falls upon Indigenous academics to provide support and professional development to colleagues. One participant stated:

'yeah, I feel like, and you probably know this, sometimes as the Aboriginal academic your fellow colleagues may need some guidance around how to do things. So, sometimes you're not educating students, you might be educating the staff'.

One participant described the long-term investment and challenges needed to create change. She declared:

'I've been here for 18 years, that's kind of been groundwork, this is the time now where things... you've built up enough knowledge... and skills... Like digging the hole now and pouring in the concrete, the foundations of all that stuff you gathered, you know, over the years.'

The evident frustration in these accounts suggests a normalisation of apathy from white domains and people, despite the overwhelming evidence of Indigenous peoples' health needs. These experiences are made more acute as the Indigenous participants were bound to observe this enduring process from their isolated position, similar experiences to Sherwood and Edwards (2006). We argue that the dimensions of these processes arise from white dominance, a form of institutionalised structural racism that corrodes the well-being of the academics. Even though one of the participants works closely with a non-Indigenous colleague and the other reports supportive colleagues, neither have access to adequate resources and do a lot of the heavy lifting in the Indigenous health curriculum space. They are expected to rely on their resourcefulness to persuade others of the importance of Indigenous health. This expectation is innately violent, as they are not recognised as legitimate fellow academics but as evidence of an organisation's tokenistic efforts to fulfil the requirements to be part of the solution in addressing social disadvantage. These challenges persist notwithstanding supportive accomplices with whom partnerships are formed.

V CONCLUSION

In the age of Indigenising universities, the role of Indigenous academics must be disruptive. Engaging their emplaced knowledge, our research participants exercise relationality in optimising their academic practice. This process maintains their work in supporting students and staff development and in addressing ANMAC's accreditation requirements regarding Indigenous health curricula. This labour is intellectual, social and emotional; however, it is largely invisible to and undervalued by many non-Indigenous colleagues due to its unintelligibility to many nursing colleagues and senior leadership within schools, faculties and universities. Indigenous academics are at the forefront of creating profound and complex change that may not be universally supported by colleagues and so engender violent responses and resistance. Future strategising and investing in the Indigenous academic workforce must consider the violence of the work and workplace through the lived experiences of current Indigenous academics and prioritise reciprocal care to them.

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Appendix C: Publication List

Below is a list of publications that I wrote while completing my PhD that are relevant.

Drummond, A., Brough, M., & Cox, L. (2021). Indigenous academics teaching Indigenous health: 'It's part of who we are, our spirit, our soul, our knowledge... that goes into our teaching'. *Australian Journal of Clinical Education*, 8(1). doi: 10.53300/001c.30070

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