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Decolonisation for health: A lifelong process of unlearning for Australian white nurse educators

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Abstract

Indigenous nurse scholars across nations colonised by Europeans articulate the need for accomplices (as opposed to mere performative allies) to work alongside them and support their ongoing struggle for health equity and respect and to prioritise and promote culturally safe healthcare. Although cultural safety is now being mandated in nursing codes of practice as a strategy to address racism in healthcare, it is important that white nurse educators have a comprehensive understanding about cultural safety and the pedagogical skills needed to teach it to undergraduate nurses. We open this article with stories of our journeys as two white nurses in becoming accomplices and working alongside Indigenous Peoples, as patients and colleagues. Our lived experience of the inertia of healthcare and education organisations to address systemic and institutional resistance to the practice of cultural safety underpins the intention of this article. We understand that delivering this challenging and complex topic effectively and respectfully is best achieved when Indigenous and white educators work together at the cultural interface. Doing so requires commitment from white nurses and power holders within universities and healthcare institutions. A decolonising approach to nurse education at individual and institutional levels is fundamental to support and grow the work that needs to be done to reduce health inequity and increase cultural safety. White nurse accomplices can play an important role in teaching future nurses the importance of critical reflection and aiming to reduce power imbalances and racism within healthcare environments. Reducing power imbalances in healthcare environments and decolonising nursing practice is the strength of a cultural safety framework.

KEYWORDS

accomplices, cultural safety, decolonising practice, Indigenous Peoples, nurse education

We acknowledge the People of the Bundjalung Nation and the Gumbaynggirr Nation as the Traditional Custodians of the unceded land on which we all live and work. We pay our respects to Ancestors and Elders, Past, present and emerging.

OPENING STORIES

To open our article, we as two white accomplices tell our stories of our journeys in attempting to decolonise

ourselves, developing our own culturally safe practice and relationships with our Indigenous co-authors. Our collaborations, as two Indigenous and two white healthcare workers and educators, have built close relationships based on respect, shared goals and deep two-way understanding. These collaborations have been primarily through teaching and research in the cultural safety space over the past decade. This is evidenced by publications of our research collaborations, for example, in decolonising research and nursing education practice. We acknowledge relationality as imperative to decolonisation; however, we also acknowledge the burden of racism and the damaging consequences of culturally unsafe practice impacting Indigenous Peoples. All this influences our conscious decision to speak as white nurses to address these issues, in line with the mandating of cultural safety within our Australian National Nurses Registration Body. The voices in this article are those of white nurse/educators, given that our topic is around becoming genuine accomplices in teaching the skills required for culturally safe care and practical strategies in decolonising nursing practice. However, our two Indigenous co-authors have reviewed all that we have written and contributed their knowledge, wisdom and expertise, confirming our position in this paper, that it is our responsibility as white nurse educators to decolonise nursing practice (Fredericks et al., 2020).

LIZ

Working as a registered nurse in an Australian regional hospital, I was shocked by the daily overt and covert racism and frequent micro-aggressions experienced by Indigenous patients. The abject failure of that hospital to acknowledge, let alone tackle unsafe care environments for Indigenous People was confronting. This inherent normalisation of overt and covert racism and disrespect in my workplace caused me to reflect deeply on what I was witnessing. This began my journey into research and academia. My motivation to do research exploring racism and the lack of cultural safety in healthcare for Indigenous Peoples was not driven by a need to climb the career ladder. I was urged to do so by several Indigenous patients and Elders whom I had developed relationships with over a number of years of yarning with them about the systemic racism that was rampant in my workplace and beyond. Yarning is a word used across Australia by many Indigenous People and is a conversational style involving sharing of stories and the development of knowledge. It prioritises Indigenous ways of communicating, in that it is culturally responsive and respectful (Walker et al., 2014). *Working with a community reference group (a group of Indigenous community members formed to provide cultural and practical input to me as an 'outsider' white researcher) of patients, Elders and Aboriginal health workers to guide me culturally in my research was such a gift. My own early experience of working with Indigenous Peoples in research helped me to understand that until more white nurses begin to examine and challenge their own biases, negative assumptions and attitudes towards Indigenous People and reflect on the 'hidden history' of brutality and colonisation in this nation, racism and disrespect within mainstream health services and institutions will remain endemic. How can health institutions be expected to examine and reflect on their culturally unsafe policy and practice unless urged to do so by their nurses and other staff? Being an effective accomplice requires nurses to make a conscious, life-long commitment to forming positive therapeutic relationships and working in a culturally safe way with Indigenous People, aiming for reciprocal learning and understanding within relationship. I have had the privilege of sharing a long-term relationship with Darlene (one of our Indigenous co-authors) since we both worked in mainstream health several decades ago. Over these years, we have developed respect and deep two-way understanding from our shared experiences as health professionals, researchers and teachers. We now teach Indigenous health together at the cultural interface, using our relationship to showcase what we teach our students. I often ask Darlene for her cultural knowledges and advice when working with her People and feel privileged to have access to her expertise and guidance, which she gives freely and with respect. Darlene and I have published together in this and related topic areas and continue to learn from each other.*

FRANCES

I am a nurse educator and a social scientist. For many years, I have had the privilege of working with an Australian Indigenous colleague facilitating teaching and learning of cultural safety within undergraduate nursing education. From my Indigenous friend and colleague, I have witnessed culturally safe practice in action with theory and practice divisions nonexistent, a sharp contrast to unsafe cultural practices I had experienced within the university setting and classrooms. Our workplace has not reflected an understanding of, and commitment to, cultural safety. The privileged process of working with Beth, my Indigenous colleague, and learning first-hand the principles of culturally safe practice at the individual level has been inspiring. Beth routinely taught in circle and modelled the principles of respectful communication, deep

listening in the classroom to create safe spaces for learning. Student feedback reflected the connections that assisted students to flourish. As I learnt more about culturally safe practice from Beth through personal engagement that created relationship and connection, I was prompted to try new ways of teaching that were initially challenging and uncomfortable as I reflected on my own safe/unsafe practice and assumptions. The value of relationship became forefront to my practice, engagements with students and colleagues and in my personal engagements. While we welcomed the mandating of cultural safety within our Australian nursing code of practice and the subsequent requirement of inclusion of it within the nursing curriculum, we were concerned there was a risk of this becoming yet another box-ticking exercise within university education. Our subsequent research project with nurse educators highlighted the lack of understanding of the principles and practice of cultural safety and led us to conclude that it was time for nurse educators to 'step up'. With this in mind, we developed a further research project with students and nurse educators to explore the use of 'teaching in circle' underpinned by principles of culturally safe practice as a way to enhance understanding of cultural safety, which we published together as a team. My white co-author Liz also joined our 'teaching in circle' research project. We four co-authors all share a continuing commitment to cultural safety within the undergraduate nursing programme. We critically reflected on the racism, unconscious bias and apparent resistance to embracing cultural safety within the university sector. I am personally committed to speaking up as an 'accomplice' about my experiences as a non-Indigenous nurse academic in an attempt to highlight challenges and opportunities for teaching cultural safety, cognisant of the need to prepare the next generation of nurses to ensure culturally safe practice.

1 | INTRODUCTION

For Indigenous Peoples and nations colonised by European/Western settlers, accessing healthcare remains perilous and potentially life threatening. Systemic and individual racism is endemic and embedded within healthcare services and delivery (Gatwiri et al., 2021; Limoges et al., 2019; Mayoum et al., 2022). Healthcare systems need to be accountable for the 'ongoing state of racial violence that takes place within it' (Watego et al., 2022, p. 110).

Despite the emergence of BlackLivesMatter conversations across the globe bringing the antiracism movement back into prominence in 2020 (Rix & Rotumah, 2020a), and recent nationwide outrage and protests after an Indigenous teenager was murdered while walking home from school (Dudgeon, 2022), ongoing injustices and inequities for Indigenous Peoples are usually overlooked:

> Against the quietude of the Australian health system on racism are the powerful voices of Aboriginal and Torres Strait Islander peoples, on television screens, on public streets and in our spreadsheets, speaking the truth about how little Black lives seem to matter. (Bond et al., 2020, p. 248)

In recent years, nursing faculties have stated the imperative of addressing racism within the caring profession. This imperative to promote antiracism and support Indigenous students and staff quotas often lacks genuine will and institutional support (Sweet, 2020). Addressing racism appears to be little more than 'box-ticking tokenism' by the dominant culture of the nursing profession, where 'white-identifying nursing faculty dominate nursing education' (Mayoum et al., 2022, p. 462). The lived experience of Indigenous staff and students indicates that this rhetoric may be more aligned to corporate-style self-promotion as opposed to genuine institutional motivation to address racism and deficient cultural safety/competence for Indigenous Peoples (Radio Canada, 2018; Stuart & Gorman, 2015).

In Australia, conversations are expanding about increasing the knowledge and awareness of non-Indigenous nurses and midwives around reducing institutional and individual racism and increasing cultural safety for Indigenous Peoples when accessing healthcare. For the first time in Australian history, in 2022, the Council of Deans of Nursing and Midwifery in Australia issued a formal apology to Indigenous Peoples for the historical and ongoing hurt and harm caused by non-Indigenous nurses and midwives (Council of Deans of Nursing and Midwifery Australia & New Zealand, 2022).

An increasing number of initiatives are urging nurses and midwives to come together and collaborate with Indigenous nurses and scholars in developing deeper understanding of working in a culturally safe way and collaborating with Indigenous patients and healthcare workers as experts. See, for example, a brief video summary 'Embedding Cultural Safety across Australian Nursing and Midwifery' of a 2022 conference where senior Indigenous and non-Indigenous nurses and educators came together with Indigenous healthcare professionals and experts to explore shared strategies in reducing the barriers to accessing culturally safe and respectful healthcare (Congress of Aboriginal and Torres Strait Islander Nurses and Midwives [CATSINaM], 2022). Despite these efforts, the dominance of white and biomedical perspectives on health and well-being remains a major barrier to accessible and acceptable health services for Indigenous Peoples. According to the International Council of Nurses' (ICN) position statement on Nurses and Human Rights, 'healthcare as a right of individuals that is available, affordable and culturally acceptable' (2011, p. 1). Given that Indigenous Peoples have experienced racism and stigmatisation by colonisers since their land and communities were invaded, this is a clear call to all nurses to address this within their practice (International Council of Nurses, 2011). Article 24 of the United Nations Declaration of the

Rights of Indigenous Peoples states 'Indigenous individuals also have the right to access, without any discrimination, to all social and health services' (United Nations, 2008, p. 9). White nurse accomplices must aim to prioritise and promote the value of the expert knowledge and voices of Indigenous scholars, nurses and Elders. Accomplices walk alongside Indigenous Peoples on their journey towards equity, with respect and recognition of their expertise in the health and well-being of their own People.

The nursing profession's failure to prioritise antiracism and cultural safety has been well described by both Indigenous and accomplice nurse scholars in Canada, the United States, Aotearoa/New Zealand and Australia (Gatwiri et al., 2021; Hantke et al., 2022; Laccos-Barrett et al., 2022; Mayoum et al., 2022; Wilson et al., 2022). In Australia, however, there is historical and ongoing lack of political will towards even recognising Indigenous Peoples in the constitution. Because British colonisers refused any form of treaty with Indigenous peoples In Australia, the fight for health and social equity lags behind other first world colonised nations (Curphey, 2021). Australia, until the 1980s, actively pursued and operationalised the 'white Australia policy' (Barton, 2011), effectively creating a dominant 'whites-only' nation. As a result, racism and white privilege remain inherently embedded in the national consciousness of many white Australians. Struggles for Treaty, truth telling and recognition of Indigenous Peoples in the Australian constitution continue. Australians have just rejected a referendum on finally recognising Indigenous Peoples in its constitution, following an extremely concerning national debate, causing further division and trauma (Strating, 2023). As a result, Indigenous Peoples remain excluded from the constitution, with many mourning the lack of progress.

Indigenous Peoples and scholars have been doing the heavy lifting to be recognised and have their voices heard since the arrival of the colonisers. Finley reminds us, 'As just three per cent of the Australian population, Aboriginal and Torres Strait Islander people need the other 97 percent of Australians to do the heavy lifting if we are ever to see true reconciliation' (2020). Effort to reduce racism and inequities within healthcare in Australia is not the sole work of Indigenous Peoples. Critical self-reflection is required by all white Australian nurses to enable them to 'step up' (Doran et al., 2019). We recognise that Indigenous scholars, including our co-authors on this article, have been working in this space tirelessly for many decades. Additional input from the nursing profession is long overdue and cultural safety is the vehicle to drive this. Until individuals and healthcare systems acknowledge this and act, Australian white society and politics will remain a major barrier to social and health justice.

2 | ACCOMPLICES: STANDING ALONGSIDE INDIGENOUS PEOPLES IN THEIR STRUGGLE TO BE HEARD AND RESPECTED

According to Finlay, an Australian Indigenous scholar, accomplices are those who stand and act with Indigenous Peoples (2020). Accomplices support Indigenous People in defining issues and the required actions, unlike 'performative' allies who walk away when things get tough (Thorne, 2022, p. 1). Accomplices never defend white peoples' bad behaviours towards Indigenous People, whether unconscious or blatantly racist; instead, they call it out. As Watego et al. (2022) point out, unconscious bias focusses on the 'intentions of actors and their innate goodness, rather than the consequences for those who died at their hands' (p. 110). Accomplices seek to arrest all acts of racial violence (Kojo Institute, 2022). Accomplices may not always get it right; however, they are always willing to listen and learn (Finlay, 2020).

As accomplice nurse educators, we are committed to promoting an awareness of cultural safety with undergraduate nursing education, working closely with our Indigenous colleagues. With the aim of reducing health inequities for Indigenous Peoples, cultural safety education of all Australian healthcare professionals is now mandated by the Australian Health Practitioner Regulation Agency (Australian Health Practitioner Regulation Agency & National Boards [AHPRA], 2020). Cultural safety is defined in Australia as 'the ongoing critical reflection of health practitioner knowledge, skills, attitudes, practising behaviours and power differentials in delivering safe, accessible and responsive healthcare free of racism' (AHPRA, 2020, p. 18). Similarly, cultural safety/competence and antiracism education is a core component of nursing curricula across the majority of colonised first world nations (Curtis et al., 2019; Valderama-Wallace & Apesoa-Varano, 2019; Wylie et al., 2021). According to the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM), who worked closely with Australian Health Practitioner Regulation Agency & National Boards (AHPRA) to develop cultural safety as a mandated code of conduct in nursing and midwifery, Indigenous People are more likely to seek healthcare and achieve better outcomes from culturally safe services (CATSINaM, 2020). Cultural safety is also crucial to improving recruitment and retention of Indigenous nursing and midwifery workforce, an essential element in closing the gap in life expectancy for their People (Aboriginal Nurses Association of Canada, 2009; Nursing Council of New Zealand, 2005; CATSINaM, 2020; British Columbia College of Nurses and Midwives, 2023).

Nurses are often the first point of contact for Indigenous Peoples seeking healthcare. Education of nurses is therefore central to transforming healthcare practices, reducing racism in healthcare and 'closing the gap' in disparate health outcomes between Indigenous and non-Indigenous Australians. University lecturers are tasked with raising awareness of colonising histories and facilitating cultural safety learning to undergraduate nurses (Aboriginal Nurses Association of Canada, 2009; AHPRA, 2020; Nursing Council of New Zealand, 2005). Doing so requires white nurse educators and students to critically reflect on power imbalances within healthcare settings, resulting from their privilege as members of the dominant culture and through their education and narrow lens on the biomedical system (Curtis et al., 2019). Nursing accreditation bodies determine standards to be met within nursing programmes. Graduates must enter the healthcare sector with an understanding of cultural safety that encompasses critical self-reflection and an

examination of how their own cultural lens impacts their practice (Dawson et al., 2022).

There is now a strong focus on preparing graduates via an understanding of Indigenous People's history, culture and health, to increase cultural safety/competence in the nursing profession across many colonised nations. For example, Canadian nursing education includes postcolonial understanding as one of the core competencies that sit within their nursing curriculum (Aboriginal Nurses Association of Canada, 2009). In Australia, this is mandated to be delivered via a discrete course that is developed and taught from an Indigenous perspective, by or in partnership with Indigenous scholars (Australian Nursing and Midwifery Accreditation Council [ANMAC], 2019). Despite this, some universities demonstrate strong resistance to the inclusion of an Indigenous-led, discrete Indigenous health unit. This strong resistance can extend to the appointment of Indigenous nursing scholars. We have witnessed a lack of progress in employing Indigenous scholars and nursing academics' inability to authentically engage with the principles of cultural safety professionally (within curriculum) and personally, negating faculty claims that cultural safety can just be taught as an 'add on' by all nurse educators in their courses. The 'add on' of cultural safety to curriculum in our view is, however, merely paying lip service to the mandating of it.

We know that cultural safety is broader than curricula and argue that it needs to be embedded across all educational environments, systems, structures and policies. Australian nursing education systems and structures remain heavily colonised (Curtis et al., 2019). Similarly, in Canada, the United States and New Zealand, this resistance to a genuine understanding of and engagement with the theory and practice of antiracism and cultural safety is well known (Canadian Association of Schools of Nursing, 2020; Coleman, 2020; Limoges et al., 2019; Truong et al., 2014; Wilson et al., 2022). Efforts to address racism in the healthcare system through policy reform are ultimately measurable when inequities in health outcomes for Indigenous Australians are reduced. As suggested by Watego et al. (2022, p. 110), the 'Australian health system, despite its professed aspirational anti-racist claims, has Black blood on its hands.'

Report after report over several decades describe failing all targets in closing inequities. The all too frequent preventable deaths of Indigenous Peoples in Australian healthcare institutions and prisons are indeed a national shame (Bond et al., 2020). It is well known that without genuine and sustained critical reflection by all white healthcare providers and increased inclusion of Indigenous ways of knowing, being and doing health, cultural safety is actually not possible (Sherwood et al., 2021, p. 2).

We contend that the nursing profession's approach, including the documentation that one must wade through to comprehend the descriptors of cultural safety, can be a distractor and barrier to achieving a culturally safer workforce (AHPRA, 2020; ANMAC, 2019). For example, a significant focus of AHPRA's 2020 document on cultural safety is key performance indicators (KPIs) and governance. However, instead of prioritising governance by Indigenous scholars now, their KPI of inclusion of two Indigenous representatives in governance by 2025 is a confusing rhetoric. How can nurse educators be urged to decolonise their teaching in the cultural safety space when the governing body of nurses fails to prioritise the leadership of Indigenous expertise (West et al., 2022), instead making it a KPI box to be ticked sometime in the future?

Anecdotally, we know the nursing profession's preference for a plethora of complex terms and acronyms around the delivery of care (such as person-centred care, cultural awareness, CALD, cultural sensitivity, and cultural competence). As a result, terminology can become the focus for nurse educators, managers and those in positions of power within healthcare institutions. This is another barrier to understanding and teaching cultural safety (Rix & Rotumah, 2020b). Critical reflection and working in a person-centred way with other cultures have been embedded within nursing curricula for decades (Burnard, 1988). The principles of the person-centred care model resonate with cultural safety, particularly the first: 'Treat patients with dignity and respect' (Australian Commission on Safety and Quality Healthcare, 2019).

The Australian Health Practitioner Regulation Agency's definition of cultural safety (above) is concise and clear. A clear description, however, of the specifics and the 'how' to put these goals into everyday nursing practice, including education of nurses, is absent. Decolonisation is an everyday practice that needs to be the main focus of these documents to ensure that practitioners truly understand what is being asked of them. Decolonising nursing practice requires that white accomplices be fully committed to addressing inequities and culturally safe practice, regardless of personal or professional costs (Finlay, 2020). In order to achieve the vision for nursing and midwifery, we are urged by Australian First Nations nurses and midwives that must 'take our blindfolds off' and 'join us to speak into the silence that surrounds the tacit acceptance of culturally unsafe care' (Sherwood et al., 2021, p. 4).

3 | DECOLONISING NURSING EDUCATION

Decolonising seeks to reverse and remedy the aftermath of colonisation through direct action and listening to the voices of First Nations People (Korff, 2021; Yellow Bird, 2008). Decolonisation is a term heard increasingly over the past several decades and should be the default position for working with Indigenous Peoples. It is a concept that white nurses and academics must apply to our everyday practice, as we reflect on addressing our (inevitable) unconscious biases and negative assumptions, also maintained and reinforced by the default negative lens of many journalists and media, government bodies and accreditation organisations (Sweet et al., 2014). It is still, however, infrequently used and understood in mainstream nursing conversations. Decolonising practice and addressing power imbalances is what sets cultural safety apart from other frameworks for working with diverse cultural and ethnic groups (Taylor & Thompson Guerin, 2019).

There remains a 'cultural chasm' between Indigenous Peoples and the majority of white nurses, with lack of dignity and respect

often the norm (Jennings et al., 2018). As members of the dominant culture in healthcare, the majority of white nurses remain complicit in preserving the individual and institutional racism that is at the core of the 'gap' that cannot be closed if this continues (Geia et al., 2020; Sherwood, 2013). We, however, ask: how can nurse education embrace cultural safety without a clear understanding of what it is, why it is so important and how to understand the pragmatics of owning safe practice? The majority of white nurse educators have a limited concept of what cultural safety really is, or the harm that their lack of knowledge, ongoing systemic bias and inherent power imbalances inflict on Indigenous students, patients and communities (Doran et al., 2019; Rix & Rotumah, 2020b). Mandating cultural safety/competence into undergraduate nursing and midwifery curricula is futile without ensuring the commitment of all non-Indigenous academics to decolonise their own lenses and teaching (CATSINaM, 2020). Without a decolonising approach, teaching scholars cannot understand or teach students translation of theory into practice, that is, how cultural safety principles influence and shape nursing practice beyond mere theory (Doran et al., 2019; Durey, 2010).

3.1 | Challenges of working with tokenists and performative allies

'Tokenists are those who know on a superficial level that they need to be "seen" to be engaged in Indigenous issues and celebrate our cultures' (Finlay, 2020). The recent emergence of the term 'performative allyship' describes white people positioning themselves as partners in the cause without committing to walk alongside Indigenous and/or nonwhite people in the hard work required for broad societal change (Thorne, 2022).

We work with these people, who pay lip service to including the content but are not committed to understanding what it means, viewing it as a box-ticking exercise (Fredericks et al., 2020). In our experience, ongoing curriculum challenges remain stuck on cultural awareness (Limoges et al., 2019), understanding other cultures, but not on critical self-reflective practice or examining racism at personal, structural and institutional levels (Doran et al., 2019; Geia et al., 2020; Rix et al., 2014). Within this critique, we acknowledge and honour the work and commitment to reducing health inequities and cultural safety that many nurses have done and continue to do. There are numerous nursing codes of practice acknowledging that we need to learn from Indigenous People's expertise in their people's health and well-being, and work 'together'. While some nurse educators are hearing this message, more need to adopt this stance.

A paper titled 'Can a white nurse get it?' cited critical reflection as key to culturally safe practice (Rix et al., 2014). It is confronting to realise that a decade on, the majority still do not 'get it'. The 'cultural interface', a term coined by an Indigenous Australian scholar, refers to the space where Western and Indigenous domains, Indigenous and non-Indigenous knowledges intersect (Nakata, 2007). In this context, we therefore ask: How can nurse educators teach cultural safety without an Indigenous scholar leading the conversation? The Indigenous artwork representing AHPRA's cultural safety strategy highlights partnerships and collaboration as a way to 'building culturally safe healthcare together and empowering the community to have access to equitable, culturally safe healthcare that is free from racism' (Keisha Thomason in AHPRA, 2020, p. 2). Non-Indigenous nurse/academics working alongside Indigenous scholars in delivering culturally safe curriculum innovations can reduce tokenism within nursing education (Durey et al., 2016; West et al., 2022). This is the role of an accomplice. Despite this being the most effective way to teach cultural safety, via showcasing positive relationships between Indigenous and non-Indigenous nurse/academics, this is yet to be embedded as standard practice. While some nursing programmes have Indigenous faculty and present an Indigenised curriculum, there remains an urgent need for further decolonisation of nursing education at individual and institutional levels within Australia.

3.2 | Capacity building for change

Delivery of cultural safety and antiracism curricula requires institutional shifts to support individual capacity building (Yaphe et al., 2019). A recent survey of Australian universities (Universities Australia, 2021) noted that the majority of universities offer cross-cultural or professional development opportunities for executive and senior staff only. We argue for more interactive professional development to support true capacity building of *all* staff. The majority of cultural safety capacity-building education is delivered online, with no opportunity for learning from and developing relationship with Indigenous People (Mills et al., 2022). This seemingly cost-effective, 'tick-the-box' method would be more effectively operationalised with opportunities for face-to-face workshops led by Indigenous community members and experts (Gatwiri et al., 2021; Wylie et al., 2021). This, however, requires greater commitment and prioritisation from education and healthcare institutions.

Positive rhetoric in policies and guidelines in no way guarantees a shift in practice. Only 14 out of 39 Australian universities reported having an Indigenous research strategy in place despite the target for all universities to have one by 2018, and just 17 from 39 universities reported having an Indigenous-specific graduate attribute (Universities Australia, 2021). This needs to be prioritised by universities and healthcare institutions globally. Curtis et al. (2019) reviewed international literature on cultural safety and competency across a range of organisations and proposed that establishing cultural safety within organisations begins with a self-review of the extent to which organisations meet expectations of cultural safety at a systemic and organisational level and identify an action plan for development. They argue that a comprehensive approach is needed, with mandated evidence of engagement and transformation in cultural safety activities as a part of professional development—evidence of cultural safety (of organisations and practitioners) as a requirement for accreditation and cultural safety training and

performance monitoring for staff (Curtis et al., 2019). We argue that until institutions critically examine their own historical and contemporary policies and practice, systemic racism will remain within those relationships (Rix & Rotumah, 2020b).

Organisational change is an essential companion to individual practitioner development (Willis et al., 2010). 'The barriers thrown up by institutional resistance, manifesting as gatekeeping, marginalisation or underfunding, may require organisational change mandated by standards' (Laverty et al., 2017, p. 16). Unless consumer-led evaluation of cultural safety becomes a KPI for nursing and all healthcare professions, it may be impossible to move beyond mere rhetoric and box-ticking attitudes by management and institutions.

4 | SOLUTIONS LIE AT THE CULTURAL INTERFACE AND DECOLONISING NURSING PRACTICE

Some nursing faculties are making progress in addressing the 'cultural chasm', with their prioritisation of the voices of Indigenous nurse/scholars (Mills et al., 2022; Wylie et al., 2021; Yaphe et al., 2019). Canadian nursing schools are being urged to increase the employment of First Nations nurse educators to enable curricula that prepare all nurses as culturally safer practitioners (Aboriginal Nurses Association of Canada, 2009; Canadian Association of Schools of Nursing, 2020). We argue that without Indigenous and non-Indigenous academics working in partnership in fostering an understanding of cultural safety, as well as the 'hidden histories' of colonisation and how this translates into practice, nursing education will inevitably continue to contribute to racism within our profession (Laccos-Barrett et al., 2022; Rix & Rotumah, 2020b; West et al., 2022). Research reiterates and expands on this, citing collaborative Indigenous-led approaches at the cultural interface (Durey et al., 2016), with a strengths-based and decolonising approach as the way forward (West et al., 2022).

Universities must do more to combat racism, starting with universities themselves (Henry et al., 2017; Miller-Kleinhenz et al., 2021; Universities Australia, 2021). Until nursing education uses critical self-reflection to address the deficit lens and discourse that compounds systemic racism in health and education systems, the cultural chasm will remain. Non-Indigenous academics need to 'unlearn' their Western deficit attitudes (West et al., 2022), which compound racism and unconscious bias. One strategy is compulsory: interactive face-to-face professional development activities—not box-ticking online exercises that are too easy to flick through as a minimum requirement. The focus needs to be taking steps to ensure that all nurse academics 'get it'. Cultural safety is a journey (Best, 2018) that requires critical self-reflection, essential for moving beyond mere cultural awareness. Working together in classrooms, at the cultural interface with respect and sharing ways of 'knowing, being and doing', is the way to learn and teach cultural safety that embodies a genuine decolonised practice. 'We stand together Indigenous and non-Indigenous nurses and midwives in this call out for justice and equity in dismantling systems of oppression in health' (Geia et al., 2020, p. 15).

There are now many examples of decolonising practice in health and education, and these are making progress in delivering culturally safe care (Fleming et al., 2020; Freeman et al., 2019; Hendrick & Young, 2017).

Specific examples of decolonising nursing practice may include strategies such as:

- Practicing critical self-reflection to expose nurses' unconscious biases and assumptions
- Developing nonjudgemental, deep active listening skills
- Finding common ground when developing rapport and building relationship
- Using self-disclosure and appropriate humour
- Being comfortable with silence in conversations
- Developing informal yarning-style communication skills
- Demonstrating respect for Indigenous health knowledges
- Speaking up against instances of racism, power imbalances, ignorance and bias, generalisations, uninformed opinions
- Providing welcoming and safe care spaces
- Understanding the healing power of extended family, community, Country and culture
- Commitment to a lifelong journey of learning to be a culturally safe practitioner
- Commitment to a lifelong journey of unlearning colonising privilege

(AHPRA, 2020; CATSINaM, 2022; Hendrick & Young, 2017; Lin et al., 2016).

5 | YARNING: DECOLONISED COMMUNICATION

One practical and valuable way by which nurses can decolonise their practice in everyday clinical encounters with Indigenous Peoples is through the use of yarning as a culturally shaped (therefore patient-centred) way of communicating. As defined in Liz's opening story, yarning is an Australian Aboriginal communication style that is an informal and culturally responsive way of developing relationship and decolonising practice when working with Indigenous Peoples. 'Clinical yarning' is a framework now being utilised in some health services, with three interrelated areas. The 'social yarn' builds rapport by finding common ground and developing an interpersonal relationship. The 'diagnostic yarn' then enables the telling of the patient's health story. The management yarn uses stories and metaphors as tools in creating two-way understanding of a health issue, to enable a collaborative approach (Lin et al., 2016).

The power of yarning as an educational strategy for student nurses was shown to be a valuable pedagogical approach to teaching cultural safety in the classroom, providing lived experience. Our own small research project confirmed that teachers as well as students

developed a deeper understanding of the principles and practice of cultural safety (Doran et al., 2019, 2022).

Another decolonising strategy is simply asking People if they are on their own Country and checking if they would like to have a community member or Elder included in discussions about their treatment and care.

6 | CONCLUSION

We have discussed the ongoing lack of efforts by many white-dominated nursing education faculties to prioritise genuine engagement with the principles and practice of culturally safe and competent care as the crucial skill for working with Indigenous Peoples. Nurse educators and universities need to move beyond the tokenistic and box-ticking culture that remains a major barrier in promoting antiracism and culturally safe care by the nursing profession. Universities must prioritise both the facilitation of cultural safety learning from Indigenous scholars for all staff and commit to policy reform that is genuinely translated into pedagogical practice.

Solutions can be found at the cultural interface, where Indigenous and accomplice nurse educators work together in raising nursing students' understanding of brutal colonial histories as the origins of health inequities for Indigenous Peoples. Deep critical reflection coupled with ongoing commitment to decolonise their own nursing practice can enable nurses to work as genuinely committed accomplices. We assert that decolonisation for health requires a lifelong process of unlearning for Australian white nurse educators and a lifelong commitment to learning to be culturally safe practitioners.

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CONFLICT OF INTEREST STATEMENT

The authors declare no conflict of interest

DATA AVAILABILITY STATEMENT

Data sharing is not applicable to this article as no data sets were generated or analysed during the current study.

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