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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-politico-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

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[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-exiting 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 delegitimating 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 racisms, 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're 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 persuades 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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