

**Dancing With Power:
Aboriginal Health,
Cultural Safety and
Medical Education**

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ABSTRACT

This thesis is a study of the relationships between Aboriginal and Torres Strait Islander health scholars and the medical schools within which they work. It is an empirical study, and a story, not only of the inclusion of Indigenous health into medical curricula in Australia, but an analysis of the relationships that underpin the way Aboriginal health in Australia is conceptualised, defined and translated into policy and practice.

Theory, literature, field notes, case studies and Indigenous autoethnography are synthesised into a rich analysis of the pedagogy of place, power and power relations, structural violence and whiteness. The notion of ‘inclusion’ is revealed as problematic in Australian health, higher education, state and social institutions, in that these institutions tend to include Aboriginal peoples on terms which appear altruistic, but which actually reify white power and racism. In this way, medicine and medical education is practiced upon and for Aboriginal peoples, rather than with, using paradigms that render Aboriginal individuals as the problem. Medical schools and state institutions have difficulty in understanding Aboriginal paradigms of health care, and in particular, difficulty in implementing and applying these paradigms in action. Medical schools, while sustaining Indigenous health programs, can exhibit differing and covert values and motivations, a reticence to share economic control and governance, and poor adherence to, or understanding of, accountability and quality as it relates to Aboriginal health.

The thesis proposes clearer definitions of what constitutes ‘Aboriginal health’ and ‘cultural safety’, a clearer model of applied cultural safety, and an implementation framework for making institutions culturally safe as a pretext for the practice of Aboriginal health using Aboriginal health paradigms.

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I dedicate this work to The Elders' wisdom, and the love and power of the next generations, in all their colours, to make change. This is what will save the world.

CHAPTER ONE – INTRODUCING CHANGE

I will start with a story, as most good Aboriginal teaching and learning does (Stiffarm 1998, McNally 2004, Yunkaporta 2009, Yunkaporta and Kirby 2011).

When I was younger, I spent a lot of time in a remote far north Queensland Aboriginal community, while undertaking my master's degree. I spent a year going back and forth to the community to learn, to watch, and to tell a story about addictions and healing in Aboriginal country – a story that belonged to that community (Phillips 2003). The wet season that year was a particularly long and rainy one, with frequent flooding of the creeks and rivers. There were two main roads into this community – one that was mostly dirt and more vulnerable to flooding, and another, much longer road, which was partly paved with bitumen and partly unpaved, with lots of potholes in the unpaved sections.

On one visit to the community during the wet season, it rained very hard in the morning, and then seemed to slow down from lunchtime onwards. In the late afternoon, I was due to drive back to my home, and catch a plane early next morning to Brisbane for a conference. I asked some locals if they thought I could safely drive home on the dirt road. A couple of locals said it should be OK, and that the water in the main two creeks that had been flooding lately should have started to subside from lunchtime that day, but they also said they couldn't be sure, and to perhaps ask an Elder. So I asked an Aunty, a very wise Elder, who happened to be walking by, what she thought of the roads. She thought for some time and said, "No, I think it's better to take the long road. It's been raining in the hills for a few days, so I think it will take a long time for the water to come down at that main creek on the short road."

I thought about the advice she had given, but decided that because the other two locals had said the short road should be okay, I would take a chance and try to get home earlier. I reasoned that it was such a long drive home, it was getting late, and I had a very early morning start the next day. I thought, 'I know the Elder is wise, but maybe she's wrong this time?' So I took the short road, and drove across the first few creeks easily. I came to the main creek I had been worried about, and while the water was high, my four wheel drive got me across safely. Only fifteen minutes later, however, at the next major crossing, it was just too unsafe; the water was deep and raging. Cars were lined up on the other side waiting for the water to subside. It could take hours or even days for that water to come down in level.

So, reluctantly, I turned around, drove an hour and a half back to the community, hurried through with my head bowed in shame, hoping no one would see me, and drove the next seven hours, in the rain, on a road full of potholes. I got home at 3.30am, barely in time to make a 7.00am plane.

I start this thesis with this story, because it speaks of many of the themes that have emerged in this study. It is a story about place, wisdom, knowledge, respect and relationships. At first, I was cocky, even as an Aboriginal person myself, thinking I could ignore the Elder's guidance and rely on others' advice, and that my needs to get home were more important. Then when I had to turn around and drive home while my neck and back got jolted every fifty metres or so from the potholes, I was angry, resentful and ashamed that the Elder dared tell me the truth. I was still arrogant. It was only days later that I could admit my shame and foolishness, and thank the Elder for teaching me a valuable lesson about who knows the country more. She taught me about Aboriginal knowledge. I had learned my lesson.

This thesis is a study of the relationships between Aboriginal and Torres Strait Islander scholars and the medical schools within which they work. It is an empirical study, and a story, not only of the inclusion of Indigenous health into medical curricula in Australia, but an analysis of the relationships that underpin the way Aboriginal health in Australia is conceptualised, defined and translated into policy and practice. It is a story about who owns medical curricula, who owns decision-making, who owns the country the medical school is situated on, and whose knowledge is privileged in the operations and business of educating the medical workforce. I seek here to make clearer the nature of change. If Australia is to improve Aboriginal health outcomes, and if the state and Aboriginal peoples have attempted this for so long with only minimal improvements, then what else needs to occur? What is missing from analysis and understanding? Perhaps, like I learned that day in the rain, the shorter road is not always the wisest route.

THE HISTORY OF ABORIGINAL HEALTH

Aboriginal and Torres Strait Islander healers and medicine people, along with healthy diets and lifestyles, kept us alive and thriving for millennia. That we could do so on some of the harshest country on Earth for so long, and to be the oldest living cultures in the world right now, our peoples had to be doing something right. When James Cook invaded, he acknowledged the nature of the Eora peoples at the place that he named Sydney Cove:

... in no way inclined to cruelty, as appeared from their treatment of one of our people ... they may appear to some to be the most wretched People on Earth; but in reality they are far happier than we Europeans They live in a tranquility which is not disturbed by the Inequality of Condition. The Earth and sea of their own accord furnished them with all the things necessary for life ... (Gilbert 1988: 2)

Bill Gammage (2011) has acknowledged that Aboriginal peoples successfully managed the greatest estate on earth for thousands of years, and has made the point that our science and

wisdom is of equal value to any other cultures'. From these early observations, and from the weight of material (Watson 2007), social (Ganesharajah 2009) and historical (Reynolds 2000) evidence, we know that Aboriginal health and the land are intimately connected. Yet how is this wisdom and knowledge translated in Aboriginal health today?

The Modern Aboriginal Health Movement

In July 1971, well before the Alma Ata Declaration on Primary Health Care (World Health Organization 1978), Dr Fred Hollows and two Aboriginal nurses, Marjorie Baldwin-Jones (later, Jilpia Nappaljari Jones) and Sally Goold, established a clinic for Aboriginal people in the lounge room of an old rented terrace house in Redfern (Goold and Liddle 2005):

It was established principally to address the discrimination experienced by Aboriginal people in mainstream services; the ill health and premature deaths of Aboriginal people; and the need for culturally appropriate and accessible health services. Since then the number of ACCHSs have expanded in order to address Aboriginal health needs throughout the country (Aboriginal Health and Medical Research Council of NSW 2013: 1).

At around the same time, in 1972, a group of Aboriginal people in Gippsland, Victoria set up a health and community services organisation, which included the services of a part-time doctor, and some Aunties and Uncles who wanted better health for their people (Gippsland and East Gippsland Aboriginal Co-operative 2013).

The establishment of Aboriginal medical and health services did not occur in isolation. Rather, this was part of a broader political and social movement striving for equality – events like the 1960s freedom ride of Charles Perkins and his university student friends (Perkins 1975), the success of the 1967 referendum after a long campaign by Uncle Joe McGinness and Aunty Faith Bandler as leaders in the Federal Council for the Advancement of Aboriginal and Torres Strait Islanders (Australian Institute for Aboriginal and Torres Strait Islander

Studies 2007), and the burgeoning Aboriginal land rights movement (Stephenson and Ratnapala 1993). These movements were further inspired and strengthened by the poems of Kath Walker (later Oodgeroo Noonuccal) (Walker 1966, Walker 1970), and Kevin Gilbert's underground political theatre play *The Cherry Pickers* (1978), as well as by the civil rights movement in the United States (Clark 2008).

In Alice Springs in 1973, the Central Australian Aboriginal Congress (CAAC), a health organisation, was established by Aboriginal people:

Our struggle for the Aboriginal control of our organisation is a fundamental human right. The only proper way is the Aboriginal way. And yet to achieve fully-fledged Aboriginal control we desperately need financial and economic and political independence. White people in government health departments do not know our ways and never will. They are not our people... Why is it they continue to receive the massive funds for hospitals, doctors, aeroplanes and training? Why is it our people here are mostly sick and homeless with no tucker, no water, no roof over their heads, no work and finally no recognition? This sad tale goes on day by day and year by year... Where and when will it end? In spite of this we retain our Aboriginality and our struggle; it is all we have. We appeal to the funding bodies and the Australian public to read our story and help us implement recommendations which have been voiced by our people in Central Australia. In this way we will take the degradation, sickness and poverty out of being Aboriginal, and remove *lelentye etja* (empty promises) from our vocabulary. Aboriginality will once more, as it was forty thousand years ago, be synonymous with pride, health and autonomy (Leo Williams, President, cited in (Nathan and Leichleitner Japanangka 1983: vii).

The establishment of Aboriginal community health services implicitly included several important concepts. First, the people who established the services were strongly of the view that a cultural model of health care was critical. This cultural model included notions of holistic health – that spirit, culture and physical health were interconnected:

“Aboriginal health” means not just the physical well-being of an individual but refers to the social, emotional and cultural well-being of the whole Community 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. It is a whole-of-life view and includes the cyclical concept of life-death-life. Health care services should strive to achieve the state where every individual is able to achieve their full potential as a

human being and this bring about the total well-being of their community (Aboriginal Health and Medical Research Council of NSW 2013: 1).

Second, the CAAC's statement implied that mainstream health services were somehow ineffective or culturally unsafe in terms of the services they delivered to Aboriginal peoples. Government health clinics of the time were mainly geared towards white peoples' needs, and many Aboriginal people reported that it was not safe to go to hospital unless they really needed to, as Rose Gilby, an Aboriginal registered nurse academic, told me while I was visiting medical schools:

“I still have a hard time getting Aboriginal people to believe the hospital is for them, and I used to work in it! It's hard not to see why when my own Mother wasn't allowed to have me in the main ward of the Griffith hospital. She had to be on the verandah, where all the other Aboriginal women were allowed to stay. And this is only forty or so years ago, so Aboriginal people still remember that” (2012).

The third element of the statement from Congress is that community development, or 'grass roots' approaches, were the types of services which Aboriginal people most needed (Anderson 2007), and to which they would most likely respond and utilise (Campbell, McCarthy et al. 2007).

CAAC's statement also suggested a sophisticated understanding of the social determinants of health (Marmot 2011) – that housing, education, employment and poverty were affecting the health outcomes of Aboriginal people (Tsey 2008). This understanding was being proffered at a time when the broader social factors in health care were not well understood or accepted by the mainstream medical community (Henderson, Robson et al. 2007). Another element is that of a strength-based approaches to health care, with the local community seen as part of the solution to delivering good health care, rather than as less powerful patients, passive individual recipients of health care (Abbott, Dave et al. 2014). Another element of CAAC's

call for better health was to question the effectiveness and accountability of government health service delivery, summed up in the question: “Why is it they continue to receive the massive funds for hospitals, doctors, aeroplanes and training?” (Nathan and Leichleitner Japanangka 1983: vii). This accords with other calls for more clarity and accountability of government in terms of the amount of money being spent on Indigenous health, particularly the quality and effectiveness of care (Calma 2005, O'Donnell 2014).

A critical aspect of the CAAC's call for better health was notions of control and autonomy. More than simply stating that Aboriginal people wanted control of planning and implementing their own health care, and that this would result in improved health outcomes (Chandler and Lalonde 1998, Hunter New England Health Aboriginal and Torres Strait Islander Strategic Leadership Committee 2012), CAAC spokespeople were arguing their independence in planning and delivering health care, reflecting broader notions of self-determination and empowerment (Frank, Smith-Lloyd et al. 2001, Councillor 2003).

These related concepts – cultural holism in health, the need for non-racist and culturally safe health services, community development, accounting and planning for the social determinants of health, a strengths-based approach, accountability of mainstream services and funding, and control (autonomy and sovereignty) – can be seen to form a *paradigm* for Aboriginal health. Even in the mid to late 20th century, therefore, to Aboriginal people, Aboriginal health was not merely concerned with the biomedical, individualising and deficit approach common in mainstream health planning (Ivanitz 1999).

The strategic and practical imperatives implicit in these community visionaries' work meant that people were envisioning and seeking to implement something akin to what today we

would call comprehensive primary health care. Aboriginal community leaders with limited or no formal health training were planning and delivering a world class model of health care, well before analysts of the Australian public health system recognised that not everything could be delivered through hospitals or general practice clinics. This insight and organisational initiative in relation to Aboriginal health has never been formally recognised by the Australian public health system. Public health planners and academics often fail to acknowledge Aboriginal innovation and intellectual property as valid or ‘scientific’, and recognising Aboriginal knowledges as world-class science is often hard for those in white academia (Rigney 2001). To do so would make it clear that Aboriginal people are not the objects of charity or ‘the problem’ in need of white experts to fix them (Farmer 2005), but in fact, have quite often been leaders in public health strategy. Today, the movement to GP super clinics, medicare locals and comprehensive primary health care in Australia seems to be about co-ordination, better access and more local community control (Australian Medicare Local Alliance 2014). These principles sound very familiar to what CAAC and other Aboriginal communities were establishing in the 1970s (Nathan and Leichleitner Japanangka 1983, Aboriginal Health and Medical Research Council of NSW 2013).

This paradigm and its notions of self-determination are intrinsically concerned with redefining power and redistributing power relations between the state and Aboriginal communities. Aboriginal communities are expressing their desire for equal power relations in governance, by virtue of their notions of being sovereign people (Walter 2007). At the heart of this thesis is the notion that Aboriginal health and community control for Aboriginal people includes a declaration of sovereignty, but this is not understood in versions of community-control understood by white governments and bureaucrats. This is illustrated by examining the measures taken to include Indigenous health in medical curricula.

Aboriginal Health Outcomes

Aboriginal and Torres Strait Islander peoples experience a higher burden of disease than their non-Indigenous counterparts (Australian Institute of Health and Welfare 2012). This includes a life expectancy gap of 9.5 years for Indigenous females compared to their non-Indigenous counterparts, and a 10.6 year life expectancy gap for Indigenous males compared to non-Indigenous males (Australian Institute of Health and Welfare 2013), although this gap may be as high as seventeen years due to data unreliability and differing formulae for estimation (Phillips, Morrell et al. 2014). This life expectancy gap is, in part, due to significantly higher rates of cardiovascular diseases (Brown, Carrington et al. 2013), diabetes (Eades, Gubhaju et al. 2012), cancer (Kirk 1993, Australian Institute of Health and Welfare & Cancer Australia 2013) and mental illness (Purdie, Dudgeon et al. 2010). Aboriginal peoples' use of tobacco (Thomas 2012, Briggs, Lindorff et al. 2013), alcohol (Breen, Shakeshaft et al. 2014) and other drugs is high (Perkins, Sanson-Fisher et al. 1994), although the way this is reported is often highly contested and politicised (Sutton 2005). For example, a recent crisis of alcohol-fuelled violence in the broad Australian community sparked calls for a national inquiry and taskforce to address it. After days of lobbying from the liquor industry, the federal government decided instead to limit the scope of the national inquiry to alcohol use by Aboriginal people only (ABC News 2014).

While reliable data are limited, what are available tells us that for some diseases, there is a high degree of geographic variation, while for other diseases, rates are similar for cohorts in remote, regional areas and urban areas (Eades, Taylor et al. 2010). Understanding the local variability of contributing and confounding factors for disease prevalence is necessary (Walter 2008), particularly given an Aboriginal health paradigm which requires cognisance

of local attributes (Ware 2013). For example, in remote areas, the homelands movement has been found to be beneficial for Aboriginal health outcomes:

Aboriginal people who live in homelands communities appear to have more favourable health outcomes with respect to mortality, hospitalisation, hypertension, diabetes and injury, than those living in more centralised settlements in Central Australia. These effects are most marked among younger adults (McDermott, O'Dea et al. 1998: 653).

In urban areas where access to traditional lands is problematic, programs that strengthen cultural identity are seen as even more crucial (Dudgeon, Wright et al. 2010, Kilcullen 2011).

Reporting Aboriginal Health Outcomes

A pervasive aspect of discussing, reporting and planning Aboriginal health is the use of a deficit lens (Bond 2009, Bourke, Humphreys et al. 2010). As a corrective to this, and as a way of demonstrating the challenges in Aboriginal health, it critical to start this thesis with a description of the strengths of Aboriginal health as a paradigm (Van Uchelen, Florence Davidson et al. 1997, Foley and Schubert 2013). I outline here several aspects of Aboriginal health that are critical to conceptualising the strengths inherent in Aboriginal health, but which enjoy less attention and currency in public discourse than the deficit discourse (Sweet 2013). This is not to deny the burden of disease experienced by Aboriginal and Torres Strait Islander people, but to shift the paradigm of health reporting (Nguyen and Cairney 2013). While statistics are used to report health outcomes, they can also be problematic, in that they are often interpreted falsely. Correlations between identified cohorts and health outcomes can become confused where the intrinsic nature of individuals is identified as the cause of sickness, particularly in public discourse and the writing of policy (Mader 2011).

Closing the Gap

In 2005, given the appalling state of Aboriginal health outcomes over decades (Australian Medical Association 2011, Australian Institute of Health and Welfare 2013), the Aboriginal and Torres Strait Islander Social Justice Commissioner called for a national campaign to close the gap in life expectancy between Aboriginal and non-Aboriginal Australians “within a generation” (Calma 2005: 21). This led to a national campaign of health organisations and advocates (National Aboriginal Community Controlled Health Organisation 2012). The campaign has garnered national bipartisan political support, with national partnership agreements ensuring multi-billion dollar investments in the key target areas of infant mortality, literacy and numeracy, and housing, and the government of the day reporting on its progress in meeting these goals (Australian Human Rights Commission 2014). However, all government literature and communications refer to ‘closing the gap’, not ‘close the gap’, as the original campaign preferred (National Aboriginal Community Controlled Health Organisation 2012). Further, the current conservative federal government has not re-negotiated or re-signed a new national partnership agreement (Council of Australian Governments 2014), despite a commissioned report pointing to the economic benefits of Aboriginal community approaches to health care (National Aboriginal Community Controlled Health Organisation 2014).

Small improvements in Aboriginal health outcomes have been seen in key areas like infant mortality rates and birth weights, yet the Prime Minister’s annual report to parliament (Department of Prime Minister and Cabinet 2014) suggests progress is very slow:

1. Close the life expectancy gap within a generation (by 2031): there has been a small improvement, but progress will need to accelerate for the gap to close by 2031.

2. Halve the gap in mortality rates for Indigenous children under five years within a decade (by 2018): on track to be met.
3. Ensure all Indigenous four-year-olds in remote communities have access to early childhood education within five years (by 2013): data not available until April on whether the 2013 target was met.
4. Halve the gap for Indigenous children in reading, writing and numeracy within a decade (by 2018): progress has been made but only two of the eight areas have improved since 2008. This target is not on track.
5. Halve the gap for Indigenous people aged 20-24 years in Year 12 or equivalent attainment rates (by 2020): on track to be met.
6. Halve the gap in employment outcomes between Indigenous and non-Indigenous Australians within a decade (by 2018): no progress has been made.
(Australian Indigenous Health InfoNet 2014)

The Close the Gap Campaign Steering Committee (CTGCSC), which has taken a human rights-based approach, and which makes its own reports on progress, has in the same year suggested the following are priorities:

1. Multiparty resolve and commitment to close the Aboriginal and Torres Strait Islander health and life expectancy equality gap by 2030 to continue, and for policy continuity during the term of the new Australian Government.
2. For the completion of the implementation of the National Aboriginal and Torres Strait Islander Health Plan 2013–23 in genuine partnership with Aboriginal and Torres Strait Islander peoples and their representatives at the national level
3. For the Australian Government to forge an agreement through the COAG process on a new National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes
4. National Partnership Agreement on Indigenous Early Childhood Development.
5. For the Australian Government to strengthen the national effort to close the gap by... [a range of systemic, funding and legislative reforms].
(Holland 2014: 3)

By comparing the reports on progress of the Department of Prime Minister and Cabinet (DPM&C), and the CTGCSC, it is clear that the DPM&C considers progress to be measured individually and epidemiologically; for example, by measuring infant mortality and childhood literacy and numeracy, while the CTGSCS is concerned with systemic and structural arrangements to enable progress.

In terms of the representation and reporting of Aboriginal health outcomes, it has been suggested that the closing the gap targets used by DPM&C may do more to consolidate the deficit model of thinking and planning, rather than promote the desired strengths-based approaches (Pholi, Black et al. 2009), and that this suits the surveillance model of epidemiology (O'Neil, Reading et al. 1998), where Aboriginal people become 'the problem' by virtue of being counted (Briscoe 2003) and construed statistical identities (Walter 2010). This means, for example, that the association between Aboriginal people's alcohol drinking and their identity as Aboriginal people is construed as causal rather than correlative (Lewis 1992, Langton 1993, Siggers and Gray 1998).

The Social Determinants of Aboriginal Health

The 'social determinants of health' is a term used to account for the effects of factors like housing, education and employment on health care outcomes (Marmot and Wilkinson 2005). The related and complex effects of the social determinants of health on Aboriginal health, such as housing, education and legal matters, have more recently been quantified (Henderson, Robson et al. 2007, Marmot 2011). The poor quality of housing and the limited availability of hot water, for example – a commodity taken for granted in white rural and urban communities – affects environmental health outcomes deleteriously (Rainow 2004). As noted above, however, the establishment of the Central Australian Aboriginal Congress in 1973 said the same thing (Nathan and Leichleitner Japanangka 1983). The continuing effects of past-government policies on health outcomes have also been quantified (Zubrick, Silburn et al. 2005).

Further, as I elaborate below, the health system itself – the artefacts of public health surveillance and government, along with the pervasive barriers to access to health services

and poor preparation of the health workforce – are major contributing factors to the poor health outcomes of Aboriginal and Torres Strait Islander people. Racism (Larson, Gillies et al. 2007), systemic and structural barriers such as the availability, affordability and acceptability of services, have been identified as factors in producing poor health outcomes for Aboriginal people (Australian Medical Association 2011). Yet identifying the Australian public health system itself as a contributing factor to the production of sickness is hinted at, but rarely publicly measured or identified, as in other countries (Manderson 1996, Mooney and McIntyre 2008, Harrisa, Goudgea et al. 2011). I contend that the Australian public health care system can contribute to the production of sickness by using individualizing and epidemiological measurement, planning and governance techniques, and the ensuing chapters offer evidence on how and when this occurs.

Health Services for Aboriginal and Torres Strait Islander People

There are significant barriers for Aboriginal and Torres Strait Islander people in accessing health services, including significant limitations on the availability of health services (Australian Institute of Health and Welfare 2012), particularly in rural remote areas, where issues of language, trust, and lack of public transport and telecommunications are critical (Australian Bureau of Statistics 2010). Additionally, major barriers to health services in urban areas exist, given the racism and inappropriate communications in health services reported and documented (Henry, Houston et al. 2004, Hunter New England Health Aboriginal and Torres Strait Islander Strategic Leadership Committee 2012); and poor patient referral and follow-up pathways, particularly for cancer (Kirk, Hoban et al. 1998, Kirk, McMichael et al. 2000, Australian Institute of Health and Welfare & Cancer Australia 2013) and other chronic diseases:

Constraints included practitioners' lack of awareness of item numbers, staffing, poor state of clinical information systems, billing against non-Indigenous-specific items or more general follow-up items, emphasis on health assessments with less attention to requirements for follow-up, limited capacity to arrange and facilitate follow-up, and communication and transport challenges for patients (Baillie, Schierhout et al. 2014: 653).

Further, for reasons of burn-out and poor preparation for communities experiencing significantly higher than average rates of traumatic stress syndromes, albeit unacknowledged (Phillips 2003), a significantly higher turnover of staff working in Aboriginal health settings is evident (Muecke, Lenthall et al. 2011). Limitations in the health workforce include poor education and training (National Indigenous Health Equality Council 2010), racism and discrimination in both individual health care professionals and the professions they represent (Fredericks 2009a), and only relatively recent systemic changes to attempt to ensure effectiveness and quality in the accreditation of health and medical professional courses (Australian Medical Council 2007).

Aboriginal Health Workforce

If the nation is to close the gap in life expectancy outcomes between Aboriginal and non-Aboriginal Australians, a health workforce cognisant of the needs, cultures and particularities of delivering health care in Aboriginal Australia will be required (Mackean, Mokak et al. 2007, Kickett, Hoffman et al. 2014). Health workforce trainers will need clearer definitions and models to ensure continuous quality improvement (Johnstone and Kanitsaki 2007).

Until 2002, efforts to improve the health workforce for Aboriginal Australians were primarily focussed on the role of Aboriginal Health Workers (AHWs), working mainly in Aboriginal Community Controlled Health Organisations (ACCHOs), of which there are 180 nation-wide (National Indigenous Health Equality Council 2010). Some diploma and bachelors level

courses were offered in the 1970s and 1980s (Bin Sallik 2003), including the Aboriginal Taskforce at the then South Australian Institute of Technology (Lane 2009). The first known Aboriginal nursing graduate was Lowitja O'Donoghue in 1954 (Goold and Liddle 2005), and the first Aboriginal medical graduate was not until 1983: Professor Helen Milroy at the University of Western Australia (Australian Indigenous Doctors' Association 2009).

The first National Aboriginal Health Strategy called for a more responsive workforce for Aboriginal and Torres Strait Islander health (National Aboriginal Health Strategy Working Party 1989), although it was not until 2002 that a specific workforce policy was developed which paid stronger attention to the role of mainstream professions in delivering services to Aboriginal Australians (Standing Committee on Aboriginal and Torres Strait Islander Health 2002). In the same year, the Commonwealth developed a strategy specifically for the role of medical schools (Office of Aboriginal and Torres Strait Islander Health 2002).

The then Committee of Deans of Australian Medical Schools (CDAMS) - now known as Medical Deans Australia and New Zealand (MDANZ) – was successful in partnering with the Commonwealth Department of Health and Ageing and the Onemda VicHealth Koori Health Unit at The University of Melbourne to conceive of and deliver a nationally-agreed Indigenous health curriculum framework for medical schools in Australia (Phillips 2004a).

I was employed between 2003 and 2007 as a project manager on the curriculum project to work with the deans of medicine, Aboriginal health academics in medical schools, the Australian Indigenous Doctor's Association (AIDA), medical student representatives, Aboriginal community representatives and interested medical colleges. The objectives of the project were first, to audit medical school curricula for Aboriginal health content, second,

write a curriculum framework, third, submit the framework for accreditation by the Australian Medical Council, and finally, establish a network of medical educators who could carry the work of implementation and quality improvement forward (Phillips 2004a, Phillips 2004b). We were successful in all four objectives (Phillips 2004a). A parallel project – to identify the support and retention needs of Aboriginal and Torres Strait Islander medical students – was developed in a partnership between AIDA and CDAMS (Minniecon and Kong 2005).

Together, these two initiatives, along with a similar project in nursing (Indigenous Nurses Education Working Group 2002), created a seismic shift in the Australian medical education landscape – never before had the deans agreed to a nationally consistent curriculum framework in any area of health care (Medical Deans Australia and New Zealand 2012). Never before had the accreditation body laid down explicit requirements for medical schools in relation to Aboriginal health (Australian Medical Council 2007). The curriculum framework and Indigenous medical student support and retention projects were evaluated by MDANZ in 2012. The major finding was that while medical schools were teaching more Aboriginal health curriculum content than they were in 2003, and that Indigenous medical student enrolments had increased significantly, there was no apparent increase in resources or mechanisms to assess curricula quality and graduate learning outcomes. Additionally, the rate of Aboriginal medical student graduations had not increased (Medical Deans Australia and New Zealand and Australian Indigenous Doctors' Association 2012).

Indigenous Higher Education

The first Aboriginal person known to graduate from a university in Australia was Margaret Williams in 1959 (Reconciliation Australia 2011), although until 1973, when Charles Perkins

graduated (Perkins 1975), success in Aboriginal higher education was relatively unknown. That public discourse did not acknowledge these achievements, in itself was revelatory of the Australian imagination and the significant barriers to participation in education over many relatively recent decades. After many years of advocacy and leadership by Aboriginal scholars (Bucksin 2013), and investments by some universities and governments (Andersen, Bunda et al. 2008, Pechenkina and Anderson 2013), the rate of graduation of Aboriginal scholars has markedly improved (Behrendt, Larkin et al. 2012). In the years between 2008 and 2012, 143 PhDs were awarded to Aboriginal and Torres Strait Islander people (Bock 2014).

The Behrendt Review into Higher Education Access and Outcomes for Aboriginal and Torres Strait Islander People found that, currently:

1. Aboriginal and Torres Strait Islander students made up 1.4% of all enrolments in university in 2010;
2. Aboriginal and Torres Strait Islander people are less likely to participate in university compared to non-Indigenous people;
3. Aboriginal and Torres Strait Islander students are less likely to be admitted to university on the basis of their prior educational attainment compared to non-Indigenous students;
4. Aboriginal and Torres Strait Islander students are more likely to be female compared to non-Indigenous students;
5. Aboriginal and Torres Strait Islander students are more likely to be mature-age students (aged 25 years and over) compared to non-Indigenous students;
6. Aboriginal and Torres Strait Islander students are more likely to use an external mode of attendance compared to non-Indigenous students;
7. Aboriginal and Torres Strait Islander student retention rates are lower compared to non-Indigenous students;
8. Aboriginal and Torres Strait Islander students have lower completion rates over a five-year period compared to non-Indigenous students (Behrendt, Larkin et al. 2012: 7).

Fundamental issues remain in Indigenous higher education, including the need for better transitions from secondary to tertiary education (Henderson-Yates, Dodson et al. 2014), and the need to address systemic barriers in access and admissions (Argy 2007, Behrendt, Larkin

et al. 2012), financial barriers (National Aboriginal and Torres Strait Islander Health Council 2009), racism (Gunstone 2009, Fredericks 2009d), epistemic violence (Fredericks 2009b), academic staff perceptions of Indigenous students' ability to succeed (West, Usher et al. 2014), and structural barriers to Aboriginal participation in decision-making (Sonn, Bishop et al. 2000).

These broader issues of Aboriginal participation in higher education are relevant to this study, since some of the deans of medicine I met in 2003 had never met an Aboriginal person, and the lack of familiarity with Aboriginal people applied more broadly among staff in medical schools and among their students. I will assert that the CDAMS Indigenous Health Curriculum Project and AIDA's project to improve recruitment and support of Indigenous medical students, referred to above, can be seen as a microcosm of broader Aboriginal and non-Aboriginal relationships and race relations – two distinctly differing cultures – Aboriginal and medical – coming together for the first time to achieve a goal, and perhaps in the process, learn a little from each other.

This study then is concerned with exploring the dynamics of implementing curricula change – what are the factors that will improve the content, resourcing and quality of curricula for Indigenous health? Are there other factors and dynamics present internal and external to medical schools that affect the resourcing and quality of medical curricula? What is meant by 'Aboriginal health' in a medical school context? How do the notions of 'cultural awareness' and 'cultural safety' impact on Aboriginal health in workforce training, given the terms were regularly used by academics in medical schools? What is meant by these terms?

RESEARCH QUESTIONS, THEORY AND METHOD

This is a theoretical analysis and retrospective study of an Aboriginal health and medical education curriculum project. It examines the experience of writing and implementing Aboriginal health in medical school curricula in Australia. In doing so, I form a thesis relating to power and power relations in Aboriginal health, and between Aboriginal and non-Aboriginal peoples more generally. The study aims to identify the nature and dynamics of the terms of participation and power in Aboriginal health, by using the example of the inclusion of Indigenous health in medical curricula.

Given the outline and rationale proffered above, the research questions I seek to answer are:

1. What was the experience of including Aboriginal health and cultural safety into medical school curricula?
2. What does this reveal about Aboriginal health in Australian society?'

I draw on the theories of Foucault (1982, Foucault, Rabinow et al. 1997), Farmer (2005), Fredericks (2009c) and Ramsden (2002) to interrogate concepts of inclusion, cultural safety, power, place and whiteness in relation to both higher education and Aboriginal health more generally. I will demonstrate that the theories of Foucault (1982) in relation to the subject and power are particularly critical to understanding the individual and organisational dynamics that arose in the course of efforts to include Indigenous health in medical curricula, in Aboriginal health policy more generally, and in Aboriginal-non-Aboriginal race relations. Additional theories of whiteness (Moreton-Robinson 2000, Fredericks 2009a), post-colonial theory (Anderson, Perry et al. 2003, Bleakley, Brice et al. 2008), pedagogy of place (Callejo Perez, Fain et al. 2003) and structural violence (Farmer 2004, Farmer 2005) have also emerged as critical to this analysis.

Methodologically, as I explain in detail in Chapter 2, I use field notes and project and policy documents from my time working nationally in the CDAMS Indigenous health curriculum project; case studies of the experiences of curriculum planning and implementation in medical schools; accreditation reports of medical schools; auto-ethnography as an Aboriginal medical anthropologist working in the culture of medical schools as organisations; and theoretical analysis of related policy and strategic documentation. I do so using the principles of Indigenous research methodologies (Denzin, Lincoln et al. 2008, Wilson 2008), where motivations, method and ethics are intricately tied to the story at hand.

In this thesis, I use the terms ‘Aboriginal’, ‘Aboriginal and Torres Strait Islander’ and ‘Indigenous Australian’ interchangeably. Where I am referring to the health of Indigenous people in other countries, I explicitly state so.

ABORIGINAL HEALTH AND CULTURAL SAFETY

It is important to interrogate what is meant by the terms ‘Aboriginal health’ and ‘cultural safety’ before any relationship between the two can be considered.

What is ‘Aboriginal health’?

The first National Aboriginal Health Strategy (1989) defined health as:

Not just the physical well-being of the individual but the social, emotional and cultural wellbeing of the whole community. This is a whole-of-life view and it also includes the cyclical concept of life-death-life.

This definition incorporates concepts of holistic care, where various human realms other than the physical are embodied, and it also alludes to community rather than individual care alone as being important. However, ‘Aboriginal health’ as a term is used in Australia in many

different ways – part inspiration, part practical and part manifesto (Boddington and Räisänen 2009). The term is frequently used to describe the experience of merely increasing access for Aboriginal peoples to health care services (Australian Institute of Health and Welfare 2012), or ‘fitting Aboriginal people into a western health paradigm and system of health care delivery’, rather than coherently articulating and translating Aboriginal definitions of health into effective practice (Lutschini 2005). Implicit in this usage are five notions.

The first notion is that ‘Aboriginal health’ is simply the health of a given population, in this case, Aboriginal and Torres Strait Islander peoples. In the western health paradigm, this means Aboriginal people are often treated as a ‘population health’ problem or issue – that is, any differences in health care outcomes in this group can be resolved by using the principles and practices of population and public health employed in other populations. This is problematic in that it does not account for: the power relations integral to the use and interpretation of statistics as state measures of control (Foucault 1982, Mader 2011), the assumption that epidemiology and other public health measures and practices are not culturally bound or can be used without regard to cultural difference (O’Neil, Reading et al. 1998), that the discourses of public health based on epidemiological measures are often inadvertently racist (Paradies 2006, Reid and Robson 2006) and that Aboriginal health is often problematised and politicised rather than evidenced (Phillips 2003, Behrendt 2010).

Second, the contemporary use of the term ‘Aboriginal health’ implies that Aboriginal health cannot be conceptualised by western health paradigms and systems unless it is done so using western theoretical stances and paradigms (Fredericks 2009b). That is, while western health paradigms can conceive of the health of Aboriginal people as ‘population health’ or ‘public health’ or ‘Aboriginal health’, and count, describe, make policy and fund service delivery for

Aboriginal and Torres Strait Islander peoples (and sometimes even include them in policy making), they are unable to see the limitations of their paradigmatic and ontological conceptions of Aboriginal health. Thus, what is referred to rather loosely as ‘Aboriginal health’ really is allopathic medicine’s conception of Aboriginal peoples and their health (Wilson 2008). In an effort to improve Aboriginal people’s health outcomes, Aboriginal community groups, advocates and health professionals have long argued for the inclusion of cultural values, customs, histories and languages in policy-making, service delivery and research. Yet I argue here that any ‘inclusion’ of Aboriginal worldviews and ways of doing things into health planning or programs have been at the service delivery, policy and sometimes funding levels, but rarely at the ontological, paradigmatic, diagnostic or decision-making and governance levels (Fredericks 2009c).

Third, western health paradigms, research methodologies, surveillance and service delivery systems implicitly posit themselves as more powerful, knowing, valid and efficacious than any Aboriginal health paradigms (and make this assessment using their own western assessment techniques); Aboriginal medicinal paradigms or understandings of illness and wellness are seen as inferior and ‘unscientific’ (Durie 2004). If the whitestream (Andersen 2009) planners of medicine truly conceptualised ‘Aboriginal health’ as Aboriginal and Torres Strait Islander peoples do, they would understand our health care paradigm to be holistic (including physical, mental, emotional, and spiritual realms), community-based, related to the health of the land and water, solutions-focussed, epistemologically and ontologically flexible, and axiomatically respectful (Lutschini 2005, Wilson 2008). This is apparently different to western research paradigms, which are concerned with a Cartesian mind-body nexus, individually-focussed, environmentally distinct, problem-focussed (epidemiology),

epistemologically and ontologically rigid (science, bio-medicine and biopower), and axiomatically detached (Denzin and Lincoln 2011).

Fourth, for the purposes of epidemiology, Aboriginal and Torres Strait Islander peoples are often construed as an homogenous grouping, and always compared to the ‘west’ for ‘statistical validity’ (Hoy 2011). In other words, the power relations implicit in social epidemiology (Foucault 1982), mean that the diverse, heterogeneous and complex nature of contemporary Aboriginal and Torres Strait Islander identities and cultures are essentialised, glossed-over and discounted (O’Neil, Reading et al. 1998). This means that the state plans health care programs and services for a homogenous group and tries to apply them locally, as opposed to conceiving, planning and designing health care plans from an Aboriginal paradigmatic and ontological worldview, which would locate interventions in a theoretical, contextual and spatial specificity (Cameron, Andersson et al. 2010).

Last, ‘Aboriginal health’ is often conceptualised by the west as charity – that western health paradigms, knowing, services and systems should be mobilised and politicised to ‘help’ Aboriginal and Torres Strait Islander peoples (Phillips 2003). In this power dynamic, Aboriginal peoples should be passive recipients of the all-knowing, all-powerful and benevolent outside white helpers and saviours (Goold and Liddle 2005). This is similar to the power dynamics Paul Farmer (2005) has described, in differentiating charity, development and social justice, where the former two trends seek to reinforce power imbalances and “manage social inequality to keep the problem under control” (2005: 140). He argues instead for deeper changes to the relations of power, whereby doctors, epidemiologists, health policy-makers and researchers understand that:

If these individuals are privileged like me, they understand that they have been implicated, whether directly or indirectly, in the creation and maintenance of this structural violence. Making an option for the poor inevitably implies working for social justice, working with poor people as they struggle to change their situations. In a world riven by inequity, medicine could be viewed as social justice work (2005: 157).

While one must be careful not to tie Indigenous identity to discourses of poverty as causal, rather than correlative (Reid and Robson 2006), Farmer (2005) here illuminates a pervasive dynamic of Aboriginal-state power relations in terms of the construction of 'Aboriginal health' and public health policy making in Australia.

The view of Aboriginal health as charity or development without a social justice framework that is historically deep, geographically broad and economically cognisant (Farmer 2005), assumes Aboriginal people had no medicine of their own, or no knowledge, beliefs or values relevant to health and wellbeing or social structures. Most critically, this view also assumes that those in allopathic medicine have no values in 'helping' – individuals are apparently 'scientific', value-free and non-culturally-bound in the relations and implementation of 'their' health care system onto others (Ramsden 2002). Thus, the term 'Aboriginal health' could be more correctly construed by those in allopathic medicine as the belief that non-Aboriginal people do not have any culture, values or power in the relations and operation of their health care system, or that their beliefs are 'normal'. Imposing these sets of beliefs onto Aboriginal people then becomes an apparently implicit act of doing health care to Aboriginal peoples, rather than with or together, for their own good. Even in those instances where Aboriginal people are successful in ensuring some cultural values are included in health planning and programs, such as in the case of Aboriginal social and emotional wellbeing programs (*vis-a-vis*, mental health), only the actual workforce and Aboriginal conceptual understanding of the

causes of illness are referenced, but not the paradigmatic, ontological and diagnostic bases for planning and service delivery (Timpson, McKay et al. 1998, Phillips 2003).

A truly Aboriginal conception of ‘Aboriginal health’ would mean that Aboriginal paradigms of health care are given primacy, and that Aboriginal people conceive of their own health care interventions – using the best of their own health care understanding and that of the west, and east for that matter, and then plan, implement, deliver and evaluate those programs based on Aboriginal terms, with biomedical conceptions adding some assistance (Timpson, McKay et al. 1998). This is different to trying to fit Indigenous intellectual property and cultural values into the mainstream’s ways of doing things (Durie 2004). Further, Aboriginal conceptions of health care are fast being used by the whitestream without any reference to Aboriginal intellectual property – because in the public imagination and discourse of those in the whitestream, it cannot be valid unless they think of it first (Moreton-Robinson and Walter 2009, Fredericks 2009b).

What is ‘cultural safety’?

The term ‘cultural safety’ was reported to have been used first by a young Maori nursing student, Hinerangi Mohi, in a meeting that was discussing the failure rates of Maori nursing students (Wepa 2003). The student said: “You talk about legal safety and you talk about ethical safety. But what about cultural safety?” (Pere 1997: 45)

Implicit in her statement was an understanding that the cultures of the recipient, health professional and institution are critical to any clinical or service delivery interaction.

Thus, the term’s usage in New Zealand became a strategic focus for Maori nurses and their communities to decolonise the nursing profession (Dyck and Kearns 1995), bringing into

play post-colonial discourse, theory and practice (Ramsden 2002, Richardson and Carryer 2005), This is based on the Treaty of Waitangi and the rights enshrined in it (Te Kaunihera Tapuhi o Aotearoa Nursing Council of New Zealand 2002), and cognisant of the social determinants of health (Lynam and Young 2000) and the importance of bi-culturalism in a modern Maori and pakeha society (Ellison-Loschmann 2001, Richardson 2004, Johnstone and Kanitsaki 2007).

The Nursing Council of New Zealand (2005) make the distinction between cultural awareness as a first step to understand that there are cultural differences; cultural sensitivity as an alert to the legitimacy of difference and the implications of cultural differences; and cultural safety as a safe service as defined by the Maori or other non-white users of mainstream services. At the heart of ideas of cultural safety were notions of: strengthening and validating Maori cultural identity in an essentially western, biomedical and alienating health care system (Te Kaunihera Tapuhi o Aotearoa Nursing Council of New Zealand 2005); identifying how otherness and white privilege worked in a systemic way (Moreton-Robinson 2000, Ramsden 2002); promoting understanding of reflexivity such that the myth of mono-culturalism as ‘normal’ was exposed (Richardson 2004), and empowering and giving voice to Maori worldviews, beliefs and customs (Ramsden 2000).

Cultural Awareness and Cultural Safety in Australia

In this section, I discuss an insider’s perspective on the development of cultural awareness in Australia in keeping with the principles of auto-ethnography (Ellis and Boschner 2000) and Indigenous research methodologies (Denzin, Lincoln et al. 2008).¹ This account is supported

¹ See Chapter Two for a detailed description of the methodologies used here

by relevant literature and theory. I also interrogate the term cultural safety, and proffer some of the common elements that are evident in the varying usage and meanings of the term.

In Australia, cultural awareness programs have been common since the 1980s – Aboriginal and Torres Strait Islander peoples have held the belief that many non-Aboriginal people were ignorant of our customs, values and beliefs, and if we simply taught them our ways, then they would understand us and our needs better (Downing, Kowal et al. 2011). This strategy and belief is partly based in an extremely culturally strong practice of ‘showing people our country’ – that if we could show people our country, our sacred sites, our language, our values and songs, then they would understand the dreaming, our traditional lore and laws more readily, and that perhaps, on that basis, they might even understand that we are equals as human beings. Perhaps, we thought, they might understand that we are equals in matters of law, tradition, spirit and ‘religion’ – that we were and are from complex, equal and valid cultures.

That we tried to share our deeply held beliefs was admirable, imbued with a deep understanding of ‘passing the culture on’ for all to learn, and an emphatic attempt to help people understand the nature of survival for all human and plant life on this continent we now call Australia. We were trying to teach non-Aboriginal peoples that the inter-relationships between the economy, environment and social relations (immigration, national identity, population policy, for example) were all crucial to sustainability, and ultimately survival – our relational accountability (Wilson 2008). In summary, more than teaching them about us, we were also trying to teach them about themselves and us in relationship.

Yet our strategy was naive.

The very fact that Aboriginal people should have to prove ourselves to anyone is a testament to the after-effects of invasion and colonisation – that white privilege, power and class would be maintained at all costs – and Aboriginal peoples could, by the very nature of our political disempowerment, simply be content to ‘dance at the edges of the fray’ – and teach some fascinating cultural insights about ‘the other’ while always remaining paupers in our own land (McDaniel 2008, Durey 2010). Cultural awareness assumed that the Crown’s sovereignty would never be challenged, that Aboriginal and Torres Strait Islander people would never have equal say in the decision-making of the parliament, the courts, media or corporate Australia, and that at best, all we could do is hope to influence others and perhaps be rewarded with an advisory post on a government committee.

That’s a lot to give away for very little return - to give away our cultural beliefs, values and intellectual property, with no guarantee of change in policy or programs or funding or legislation. How many non-Aboriginal people came out of cultural awareness workshops, despite the best intentions and awesome skills of many facilitators and teachers, with a truly changed understanding of the world? (Coffin 2007) Critically, how many participants changed their own actions or the decisions of their workplaces, families or companies? (Downing, Kowal et al. 2011) Surely some did. Yet this is not enough to engender equity in outcomes and opportunity. The best we can hope to achieve should not be a token and often romantic or stereotyped understanding of Aboriginal and Torres Strait Islander worldviews.

So, cultural awareness was very much about ‘us’ and ‘them’, and while it was often a valiant attempt to leave something better for our children and grandchildren (programs, policies, institutions), we inadvertently played into the hands of colonisers by being cast as ‘the other’ (Moreton-Robinson 2000). By establishing cultural awareness programs, we thought we were

teaching ‘them’ about ‘us’, but westerners just saw these programs, and the Aboriginal peoples referred to in them, as cultural relics, as fascination, while failing to understand that what we really were teaching was survival for all (McDaniel 2008). By recounting the litany of poor statistical outcomes endlessly, we thought we were building a case for reform, but westerners just thought we were asking for help – that ‘we’ needed ‘them’ to be the experts, the bearers of intelligence that we could never hope to possess, or worse, that we were saying we would always remain passive recipients of their favour (Phillips 2003). Very few non-Aboriginal people got the implicit message that we were really teaching a more respectful and sustainable way to survive and thrive on the planet for all (Gammage 2011).

What is the Relationship Between Aboriginal Health and Cultural Safety in Australia?

Cultural awareness programs have reduced in popularity in recent years, and the terminology used in programs has changed markedly (Downing, Kowal et al. 2011). In Australia, there are now many, widely variant terms and meanings in circulation, and the terms ‘Aboriginal health’, ‘cultural awareness’ and ‘cultural safety’ are used interchangeably and with confusion. Here I analyse the use of the terms ‘Aboriginal health’ and ‘cultural safety’, elicit their underlying meanings and assumptions, and analyse any relationship between them. I begin by summarising the literature and giving examples of how various terms and their meanings are used in relation to health professional training.

Culture and Individuals

‘Cultural awareness’ refers to teaching about Aboriginal and Torres Strait Islander cultures, values, societies and the historical, social and political influences that have impacted on them (Gondarra 1994), usually from the perspective of ‘the other’ (Downing, Kowal et al. 2011).

‘Cultural reflexivity’ builds on cultural awareness and also refers to the knowledge and awareness of an individual health care worker’s *own cultural values* and beliefs, and how they impact on perceptions of others and how one may treat or engage with the other (Phillips 2003, Hill, Lee et al. 2010).

‘Cultural competence’ builds on awareness and reflexivity to refer to a set of knowledge, skills and attitudes that individual workers are expected to possess and *apply* safely and respectfully in health or other settings (Nash, Meiklejohn et al. 2006).

‘Cultural capabilities’ similarly refers to relevant skills and actions of individual health care workers (Stratton and Ang 1994), such as responsiveness, communication, advocacy, reflexivity and respect (Aboriginal and Torres Strait Islander Health Curriculum Framework Project 2014).

While acknowledging there is no clear pedagogical framework regarding cultural competency, Universities Australia have published a matrix “for students and staff to become skilled to function effectively in inter-cultural contexts and develop a culturally competent system”, and they refer to ‘cultural proficiency’ as building on individual knowledge, awareness, sensitivity and competencies in relation to Indigenous curricula (2011: 6).

What all of the terms listed above seem to have in common is that they are concerned with the awareness, knowledge, skills, attitudes, reflexivity, competencies, practices and actions of *individual* health care workers, students or educators.

	Cultural incompetence	Cultural knowledge	Cultural awareness	Cultural sensitivity	Cultural competence	Cultural proficiency
Professionally specific skills						
Cross-cultural skills						
Critically examining the profession						
Reflexivity of values and attitudes						
Understanding Indigenous cultures and histories						
Generic understanding of culture						

Figure 1: A Developmental Model for Indigenous Cultural Proficiency in a University Course or Unit (Universities Australia 2011)

Culture and Institutions

By contrast, the following terms seem to be concerned with both individual *and institutional* factors, processes and systems.

‘Cultural respect’ is defined by the Australian Health Ministers’ Advisory Council (AHMAC) as: “recognition, protection and continued advancement of the inherent rights, cultures and traditions of Aboriginal and Torres Strait Islander Peoples”, leading to improved outcomes and quality; more efficient and effective services; expenditure reduction; and improved customer satisfaction. AHMAC refers to the health system environment as needing to be culturally safe for Aboriginal and Torres Strait Islander peoples. Critically, AHMAC implies here that both individual and institutional systems, policies and enabling environments are important factors in improving health outcomes (2004: 7-8).

Similarly, in terms of nursing education, the term ‘cultural congruence’ has been used to refer to the systemic and contextual factors contributing to the success of Indigenous students, such as relevant curriculum, staff training in teaching Indigenous curricula, and recognition of extra cultural and familial factors at play for Indigenous students (Omeri and Ahern 1999). Again, this implies an understanding of institutional factors influencing Indigenous outcomes, rather than only the individual agency or capacities of Aboriginal or Torres Strait Islander peoples.

‘Cultural safety’ in Australia has been used to refer to structural and systemic reform to better enable Indigenous participation in education, professions and health care (Dowd and Eckermann 1992, Bin Sallik 2003, Milera 2014). The Australian Indigenous Doctors’ Association (2013) refers to cultural safety as “the accumulation and application of knowledge of Aboriginal and Torres Strait Islander values, principles and norms” in relation to leadership, “genuine partnerships” and accountability mechanisms (2013: 1-2). In a slightly different use of terminology, Coffin (2007) defines cultural safety as consisting of “small actions and gestures [by individual workers], usually not standardised as policy and procedures”, and ‘cultural security’ as direct links between understanding and actions, systematised by policy and procedures (2007: 23). While using different terminology, Coffin is making a similar point to the original definitions of cultural safety proffered in New Zealand (Te Kaunihera Tapuhi o Aotearoa Nursing Council of New Zealand 2005), and by others in Australia (Phillips 2005, Australian Indigenous Doctors' Association 2013), that the knowledge, skills, attitudes of individual health care workers are critical, but so too is the respectful *application* of these principles in institutional practices, policies and systems.

In the broader socio-political context, cultural awareness programs have been replaced by Reconciliation Action Plans (Reconciliation Australia 2012) and social inclusion programs, all implying some institutional responsibility in improving Indigenous participation, although their efficacy and philosophical underpinnings have been questioned (Fredericks 2009c, Phillips 2014).

What is also common among the terms cultural respect, congruence, safety and security is an implicit understanding of the nature of partnerships between Aboriginal and Torres Strait Islander individuals and communities, and the white institutions with which they engage (Fredericks 2009b, Rochecouste, Oliver et al. 2014). That is, scholars are acknowledging an inherent power imbalance in the terms of engagement with white institutions given colonisation and continuing marginalisation in society (Bin Sallik 2003, Behrendt, Larkin et al. 2012, Rochecouste, Oliver et al. 2014). This is why Ramsden (2002) argued strongly for cultural safety in nursing education and the New Zealand health care system as a decolonising task; concerned with values and beliefs as much as individual actions or institutional practices and policies.

Ramsden also refers to the need to address and share power on the basis of commonly agreed values, motivations and worldviews (2002). Similarly, Karen Horney's (1942) work in social psychology has enunciated the need for values; given that values are one of the basic motivating factors for human endeavour, she argues they should form the basis of social programs and change-making (Paris 2000).

In Australia, we have moved to using terms like 'cultural security', 'cultural safety' and 'cultural respect', and also use terms like 'real partnerships' or 'genuine partnerships' to try

to address this power imbalance. We refer to and acknowledge factors such as power imbalances, values and the need for ‘real partnerships’, and we have correctly diagnosed the need to move from the ‘othering’ and fascination of cultural awareness programs and individual health care worker knowledge towards changing both the actions of individuals and also institutional processes, policies and strategies. Yet we still have not properly developed the architecture or language to address these in action; at least not to the point of actually improving Indigenous health outcomes (Ewen, Paul et al. 2012). Thus, something is missing.

In terms of language confusion, for example, Johnson and Kanitsaki (2007) use the term ‘cultural safety’ to refer to the capabilities or competencies of individual health care professionals, and on the basis that cultural safety is not clearly defined in the Australian context, prematurely discount its efficacy and effectiveness in reducing Indigenous health outcomes. In attempting to evaluate the efficacy and effectiveness of cultural safety, they have used a definition which continues to locate responsibility for improving health outcomes with individual health care professionals alone. In doing so, they seem to have ignored the institutional and structural factors at play in Aboriginal health.

This dynamic of confused meanings of terminology is common in Australia. For example, I gave a presentation to one medical school curriculum committee meeting about the CDAMS project and about the differences between cultural awareness and cultural safety. After I had finished explaining that cultural safety was concerned with reforming institutional practices as much as educating individual students and the lecturers who could teach Indigenous health content, one senior faculty member in charge of ‘cultural diversity training’ said, “right, we will change the name of our training to cultural safety!” What she meant was, she would

simply change the name of the training, but not actually undertake any of the reform of curricula, decision-making or institutional practices that posited Aboriginal scholars and students as recipients of white benevolence.

RACE AND RACISM IN AUSTRALIA

Racism has always been a feature of Australian colonisation: it was introduced implicitly in the founding constitution at the time of federation (Behrendt 2001), and formalised explicitly in 1947 in the White Australia Policy (Moreton-Robinson 2004, Department of Immigration 2013), wherein white people and their institutions prevailed (Carey and McLisky 2009).

Racism can be found in many aspects of Australian society (Dunn, Forrest et al. 2004), politics (Koerner 2010), sport (Tatz 1995), health (Anderson 2005, Mansouri, Jenkions et al. 2009), education (Perera and Pugliese 1998) and justice (Cunneen and Rowe 2014). While the extent and source of racism can be highly contested space (Paradies 2006, McAllan 2011, Hollinsworth 2014), its effects are well documented (Paradies, Truong et al. 2014).

Much of the literature focuses on the systemic nature of racism and disadvantage for Aboriginal and Torres Strait Islander peoples (Henry, Houston et al. 2004, de Plevitz 2007, Larson, Gillies et al. 2007, Mansouri, Jenkions et al. 2009, McDermott 2012, Rahman 2013, Chingaipe 2014). In terms of Aboriginal and Torres Strait Islander Australians, the effects of racism in health are clear (Mellor 2003, Paradies 2006, Awofeso 2011), including its physiological (Larson, Gillies et al. 2007), social (Kelada 2008, Priest, Paradies et al. 2011), political (Australian Indigenous Doctors' Association 2008) and economic (National Aboriginal Community Controlled Health Organisation 2014) dimensions. Racism towards Aboriginal and Torres Strait Islander Australians has been found within health professions in terms of recruitment into courses and professions, delivery of health services and the

operations of professional organisations – including in nursing (Goold and Liddle 2005, Milera 2014), social work (Walter, Taylor et al. 2011, Bennett 2013), medicine (Henry, Houston et al. 2004) and psychology (Purdie, Dudgeon et al. 2010). In education, Aboriginal and Torres Strait Islander students have much lower outcomes by virtue of their socio-economic disadvantage (Rigney 1995), and curriculum and institutional processes and strategies that are racist (Fredericks 2009a, Fredericks 2009b, Hollinsworth 2014). In higher education, racism has been documented in terms of epistemic violence (Fredericks 2009c), institutional processes (Gunstone 2009) and structural disadvantage, where Aboriginal people's participation in decision-making and governance in relation to Indigenous student admissions, curricula quality and research ethics are curtailed (Behrendt, Larkin et al. 2012).

Racism underpins Australian policy making, administrative systems and legislation (Bergmann 2003, Dunn, Forrest et al. 2004, Cornell 2006, Giannacopoulos 2006b, Altman and Hinkson 2007, Australian Indigenous Doctors' Association 2008, Carey and McLisky 2009, Armstrong and Murphy 2011). Most recently this is evident in relation to the Northern Territory Emergency Response (Kelada 2008), or 'the Intervention', where the Racial Discrimination Act of 1975 was suspended (Altman and Hinkson 2007) to allow the federal government to send the military to Aboriginal communities to deal with child sexual abuse and alcoholism (Wild and Anderson 2007), despite successive governments' to effect improvements in health outcomes positively (Australian Indigenous Doctors' Association 2008).

Racism and Health Overseas

Other countries with Indigenous populations with similar socio-economic indicators to Australia (Anderson, Crengle et al. 2006) have documented the role of racism in producing

poor health outcomes. This includes the United States for Native Americans (Blaisdell 1993, Belcourt-Dittloff and Stewart 2000, Keawe‘aimoku Kaholokula, Grandinetti et al. 2010), First Nations, Metis and Inuit peoples in Canada (Adelson 2005, King, Smith et al. 2009, Reading and Wien 2009) and the Maori of Aotearoa New Zealand (Bhopal 2006, Curtis, Harwood et al. 2010, Came 2013, Huria, Cuddy et al. 2014). The effects of racism on African Americans’ health care has also been extensively documented (Chambers, Tull et al. 2004, Clayton, Parker Dominguez et al. 2014, Coogan, Yu et al. 2014), and for Latino Americans (Brondolo, Beatty et al. 2009), including in relation to medical trials but also to health outcomes, risks, and services (Washington 2006). Racism has also been well documented in health care systems in the United Kingdom (Moghal 2014, Warshafsky 2014) and South Africa (Harris 2002, Mager 2004, Williams, Gonzalez et al. 2008). These findings are all informed by the institutional nature of systemic racism in health care systems (Arnold, Rebhook et al. 2014, Feagin and Bennefield 2014). This evidence has prompted the editor of Chest medical journal to call for a new medical research paradigm:

We now have evidence that beyond the hurt and social stigma, racism is a public health issue. As such, given the high cost of ... care, we should consider public health/disease prevention interventions. An example would be the incorporation of evidence-based elements of antiracism training programs into early education curricula with an eye toward the long-term attenuation of racism at all ages (Cykert 2014: 442).

Race and Racism Dialogues

Scholars have documented how discussions about race and racism, particularly in colonised countries, leads to a series of identifiable responses – among them denial and disbelief (Wing Sue 2013), minimisation (Nelson 2014), justifications of being ‘color-blind’ (Neville, Awad et al. 2013) or ‘treating everybody the same’ (Nelson 2014), that reverse racism is as prevalent as racism (Rahman 2013), and that racism is over-inflated, meaning any reporter of racism is often disbelieved as a first response (Zuriff 2014).

Dealing with racism in Australia meets with similar responses, wherein denial, guilt, anger and minimisation are prevalent (Mellor 2003, Moreton-Robinson 2004). A particular feature of Australian responses to racism is a narrative of ownership: that is, white people own Australia, and apparently, everybody else is coming to try to take it over (Moreton-Robinson 2004, Kelada 2008, Koerner 2010, Nelson 2014).

Educating Out of Racism

In terms of higher education and medical education in particular, scholars have asked if it is possible at all to educate out racism (McDermott 2012). Given the often hostile and emotional reactions of learners in first year medical school who may not have encountered Indigenous peoples and Indigenous studies in their primary and secondary high school curricula (Rasmussen 2000), it is critical to first address the issues presented by such hostile reactions to Indigenous health – to address the ‘transformative unlearning’ needs of non-Indigenous learners (Ryder, Yarnold et al. 2011). This is similar to calls for learning about cultural difference and reflexivity (Iedema 2011, Gerlach 2012), in general as a necessary pre-cursor to Indigenous cultures and Indigenous health. This was the approach ultimately suggested in the CDAMS curriculum framework (Phillips 2004b).

Others contend that it is best not to address racism and whiteness directly in the early stages of a given course, and that talking about privilege and disadvantage is the best place to start (Taylor and Guerin 2010). Others have found that a ‘stepped’ or vertically integrated approach to curriculum is most effective, where first-year tertiary students’ emotional reactions to Indigenous health are ‘managed’ until, in later years of the course, learning critical clinical skills in practice can be contextualised and the importance of the curricula made more clear (Paul, Carr et al. 2006). The Standing Together Against Racism (STAR)

Project at James Cook University has taken a strong stance in identifying the common responses to Indigenous health education in medical curricula, and then training trainers to deal with those responses (Grant 2013).

In Australian society, anti-racism strategies have been initiated in education (NSW Department of Education and Communities 2013), health (Durey 2010), health professions (Rix, Barclay et al. 2014) and in society in general (Australian Human Rights Commission 2014). However, Australian society's approach to Aboriginal affairs and the politics of Aboriginal representation and place has been characterised and consumed by the reconciliation movement. In this reconciliation movement, a white-polite version of Australian history is told, and the relations of power between Aboriginal and non-Aboriginal Australia is predicated, apparently as a norm, on whiteness and white institutions retaining power (Phillips 2014). While there have been various attempts to respond to racism in society, education and health, the over-arching public discourse in Australia is still one of unease, hostility or minimisation in talking about race and addressing racism (McAllan 2011, Chingaipe 2014), and an illuminating finding of the National Reconciliation Barometer, is that Aboriginal and non-Aboriginal Australians still largely mistrust each other (Reconciliation Australia 2012).

Thus, racism, often unacknowledged and misdiagnosed, continues to seep into the consciousness and unconsciousness of the Australian state. This study is partly concerned with understanding its impacts and effects in terms of both planning and implementing effective Indigenous health curriculum content. If racism is a part of the social, political and institutional enabling (or disabling) environment, how does one effectively design and implement high quality Indigenous health curricula in medicine? Similarly, in dealing with

racism, if we are unclear in educational discourses about whether we are educating about ‘racism’, ‘cultural safety’ or ‘Aboriginal health’, and these terms become blurred and are used interchangeably, then perhaps the most optimal curricula quality is less likely. Further, it is necessary to identify and examine the actors – resources, training, decisions – that are acting upon the quality and effectiveness of anti-racism, Aboriginal health and cultural safety education.

THE LONGER ROAD

In this chapter, I have outlined a paradigm of Aboriginal community health at odds with the individualizing and epidemiological approach to health care planning and governance favoured by the Australian public health system. I have outlined how the social determinants of health impact on Aboriginal health outcomes, including structural and systemic barriers to access and participation in health and higher education. I have outlined the confused usage of various terminology and their meanings Australia with regard to ‘cultural awareness’ and ‘cultural safety’, and highlighted the literature’s distinctions of the individual and institutional nature of reform. I have identified racism in its many forms in the Australian polity, and discussed the task of educating out racism within a prevailing race dialogue of denial, hostility and minimisation.

Extending on the race and racism literature, I contend that the notions of sovereignty and self-determination that Aboriginal people see as intrinsic to an Aboriginal health paradigm, are taken as optional extras, or are misunderstood by a public health and higher education system intent on maintaining and extending their influence through techniques of surveillance, planning and counting. For example, Carey (2013) has highlighted how health planners confuse notions of ‘Indigenous health’ and ‘Indigenous wellbeing’ as being the same thing.

Aboriginal peoples refer to ‘wellbeing’ as representing a broader set of holistic values, factors and influences on wellness, and health care planners refer to these broad principles simplistically as ‘health’. In doing so, they curb Aboriginal worldviews and try to fit them into the western health planning architecture.

Medical schools in Australia have completed the articles of inclusion and equity – a curriculum framework, professional development network, and voluntary curriculum review tools. The accrediting body has completed an accreditation framework (Australian Medical Council 2007), even though the AMC subsequently wound back the nature of its standards and guidelines (2012). Yet questions remain about the quality and extent of investment in curricula implementation (Medical Deans Australia and New Zealand and Australian Indigenous Doctors' Association 2012), and I expand on this discussion in Chapter Five.

Therefore, in conceptualising this study, I have realised that any discussion about Aboriginal health and its place in a ‘western’ medical curricula actually invites exploration of a much broader set of values, ideas, beliefs and customs – differing worldviews. Rather than focus simply on curricula and its place in medical courses, along with its concomitant discussion of cultural safety, what really is at issue here is ‘whose medicine are we using?’ Is Australia seeking to develop and implement Aboriginal cultural views in health care and medicine? Or is Australia simply trying to fit Aborigines and our worldviews about health and medicine into a western medical system, including approaches to curricula, public health and their underlying sets of cultural beliefs (Carey 2013)? One suspects it is the latter rather than the former. At issue are questions such as: who gets to define the terms of knowledge production in medical schools and universities, and the terms of health care in health systems? Who does the planning? Who decides? In other words, who has power (Molloy and Grootjans 2014)?

In this thesis, I seek to clarify the nature and dynamics of power operating in medical schools, higher education and Australia in general in relation to Aboriginal peoples, and propose a clearer model of applied cultural safety as a strengths-based framework for operational and strategic improvements in health workforce education.

This thesis is concerned with change, culture, power and relationships. It is a story of the longer road.

CHAPTER TWO – PLACING THE STORY

To illustrate my motivations and my place, position and power in relation to this study and to Aboriginal health in general, I will start this chapter with a story about country.

STORY ABOUT COUNTRY

The young white tour guide (male, 26, from Adelaide) was interpreting the Aboriginal history and cultures of Kakadu to a group of (mostly white) tourists from Melbourne. Early on in the tour, he stated how much he respected Aboriginal culture, and how he felt white Australians could learn a lot from them. Overlooking beautiful grassy wetlands, he then explained that the wetlands were in danger of being ruined by imported Indonesian water buffaloes, but that if their numbers were carefully managed and planned, the maintenance and health of the country could be maintained. He said that “The local Aboriginal people used to manage the numbers, but now there aren’t enough of them around now, so we have to use science to work out how many buffaloes are OK.”

I was in this tour group, and my incredulousness at this statement was immense; yet I chose to stay silent, to give the young man a chance to redeem himself. I thought, “are we extinct? How many Aborigines are needed?” I saw quite a few in nearby Darwin and in Kakadu National Park. I know them - they’re my cousins and extended relatives and friends. Besides, I thought, is the question really about how many buffaloes are enough to manage the grasses? Or is it about the fact that the buffaloes are Asian, and shouldn’t have been imported in the first place? Who decided when the buffaloes would be imported? Did they ask Aboriginal people, who had managed the wetlands for millennia before whites arrived? Who got to decide if Aboriginal or western scientific traditions were used in the management of the wetlands?

These questions and concerns, and Aboriginal peoples’ thinking and responses to them, are the markers of white privilege (Moreton-Robinson 2004). Aboriginal peoples in Australia,

and in other colonized nations, confront these kinds of statements on a daily basis (Kelada 2008). We respond to these issues through a series of decisions and actions, sometimes muddled, sometimes clear, but often designed to find the path of least resistance. As occupied peoples, we must choose our battles. If we were to respond and confront directly to statements such as these every time they occurred, we would burn ourselves out, and potentially become so embittered and angry that we would be less effective and less able to continue with everyday life and the political encounters that are part of it. In instances like this, we have not only to comprehend the meaning of what the person is saying and assess its factual basis and relevance, but also to make a series of assessments and decisions about where the person is coming from – are they meaning harm, or are they ‘just ignorant’, or both? Is it safe for me to react and say something? Do I have the energy to confront them and correct this right now? Is there a better way to deal with this? Is there a way to teach this person? What other needs do I have to look out for? Often all of these assessments are made in a split second, and decisions about how or what to say or do, if anything, are designed with certain motivations and values in mind.

The primary motivating factor for Aboriginal people in Australia, and many other Indigenous peoples, is survival (Neidjie 1989). We are often not the romanticized peace-makers, or alternatively, the ignorant savages, that anthropologists, historians and social commentators sometimes wish us to be (Killsback 2013). We have a deeply ingrained instinct to survive and to thrive. We know that sometimes peace-making is the best way forward, sometimes confrontation, sometimes simply ignoring and passing by the transgressor is better, in the sense that it produces less conflict at the time (Gondarra 1995). We know that surviving and thriving cannot be guaranteed unless we relate with and respect all of nature, including all animals, and sometimes, all *homo sapiens* in all of their variations (Wilson and Wilson 1998).

We know that our survival and ability to thrive is inter-linked to all peoples, all animals and all lands and waters, the sentiments of which are encapsulated in the statement by Uncle Jacob Nayinggul (Chair of the Board of Management of Kakadu): “We all help each other to look after our land, just as our ancestors did” (Nayinggul 2013: 58). Thus, attacking other human beings must be done with the greatest of reasons – to defend not just our, but their ability to survive. If someone does wrong on our lands, we see it as our responsibility to help that person learn so they don’t do it again (Gondarra 1994).

But often these micro-aggressions (Sue, Capodilupo et al. 2007) leave residual feelings of anger and mistrust, frustration and tension, especially if we have chosen that it was not safe to respond, or that we simply didn’t have the energy at that time and in that place. Sometimes we make less than effective decisions ‘in the heat of the moment’, and often if we choose to say something, however reactive or proactive, we are marked out as ‘radical’, ‘trouble-makers’ or ‘victims’, and are incarcerated in alarming numbers as a result (Cunneen and Rowe 2014). This is the extra emotional labour Aboriginal people must undertake every day in their workplaces, social groups and sporting clubs, but which is often unacknowledged (Williams, Thorpe et al. 2003). Racism is so prevalent, and we are so used to undertaking this work, that it becomes normalised.

Rather than merely analysing this ‘simple’ moment of micro-aggression – a moment of ‘accidental racism’ as it is sometimes called in Australia (Mellor 2003, McAllan 2011) – it is necessary for me to describe the place and lands on which this story took place. This will help me illustrate and analyse the deeper meaning of the moment.

Kakadu

Kakadu National Park is a stunning country of rare natural beauty and meaning. Registered with the World Heritage Commission, the park and its borders demarcate approximately 20 000 square kilometres of lands. This demarcation was determined by white people; the park's borders are a poor approximation of the traditional borders which demarcate the ownership of the traditional lands of the Gun-djeihmi, Kun-winjku and Jawoyn Aboriginal peoples. But looking beyond the park borders, to all of this area, the 'Top End', as it is affectionately known, is to look into the past 60 000 years of human history, and to the present dreaming and creation (Parks Australia 2013).



Figure 2: Kakadu Floodplains from Ubirr Rock. Image by Gregory Phillips.

A revered Aboriginal Elder from Arnhem Land, Uncle David Yirawala, has described the continent now known as Australia as a huge human-like spirit creator being. He has drawn it with its torso and spine running north and south from Darwin to Adelaide; its legs and feet splayed across the western and eastern seaboard; its lungs represented by Purnululu Ranges, in the north west, with its vast desert windy sweepscapes; and its heart at Boodjamulla (Lawn Hill) – my Waanyi people's country – in what is now as North West Queensland. The belly button, or birthplace of the continent, he suggests, is Uluru and Kata Tjuta, in the very centre of the nation; and the head and brain, says the Elder, is Kakadu. Kakadu is, in this dreaming story, the intelligence centre of knowledge production and the command post for thinking,

belief and actions (Le Brun Holmes 1993: 42). It is fitting, therefore, that this story takes place in Kakadu, this place of knowledge.

When you are on the lands in Kakadu, looking across the vast floodplains, soaking in the meaning of 60 000 years of human heritage, admiring the rock art, you sense Creator beings so powerful they still watch you, feel the gush of thunderstorms and lightning pulse through your veins: then you know you are connected to something else. The knowledge in the rocks, the art and the lands predates all of the pyramids, all western scientific traditions, all of Plato and Aristotle (Norris 2014). These people were alive and surviving and thriving on what could only be highly sophisticated knowledge, cultures, governance systems and economic traditions. They managed human existence and interaction with the lands and waterways in a manner that enabled healthy people, healthy land and healthy spirit (Gammage 2011).

The lands, if you listen to your deeper wisdom, are alive with the fullness of the moment. In many Aboriginal ontologies, the dreaming (or creation) of Aboriginal peoples and the lands is not a story that only happened millennia ago, but it is a story that is unfolding now. As Leo Killisback (2013) has enunciated, Aboriginal peoples' conception of time and history means that dreaming stories and creation myths are kept alive by oral tradition; not because they are quaint or fanciful creation myths devoid of science, but precisely because they are scientific, in the sense that the retelling, respecting and re-enacting of these stories ensure humanity's survival.

This giant land-brain, home of human knowledge and deeper meaning, is the home of one of their respected Elders, Uncle Bill Neidjie. He talks about caring for country by saying "you got to have the feeling for the country" (Neidjie 1989: 12). You must feel your way to

respecting the land and each other. These lessons and this knowledge have profound implications for a humanity on the edge of destruction caused by western science and religion (Norris 2014). In many Aboriginal worldviews, science and religion are the same thing, and knowing and understanding this is critical to survival; reading its messages in the land, decoding its deeper feeling of love and respect. This is the deeper meaning of the moment.

Finding My Voice

There I was, an Aboriginal gay man, among my white gay and lesbian swim teammates. We had been to Darwin for a gay swimming competition, and now we were on holidays in Kakadu. As a marginalised group in society, my teammate who booked the tour on our behalf took great care to ensure the tour guides would not be homophobic, and would be respectful of our cultural values as gay and lesbian peoples. The tour company owner took care in selecting the tour guides to ensure the guides were respectful.

Yet my cultural values as an Aboriginal person would soon be challenged. The initial statement about the buffaloes was followed by an action that I thought was very telling. At the entrance to Ubirr, a sacred rock art site where the art has been dated at older than 60 000 years, the tour guide stopped our party at two adjoining signs. One sign showed a map of the area and described some of the plants and fauna in scientific and Aboriginal terminology (Figure 3). The other sign showed pictures of Aboriginal senior custodians and Elders, including Uncle Bill Neidjie and his family (Figure 4). The tour guide ignored the sign with the pictures of Uncle Bill and his family, pointed to the first sign with the map on it, and explained the topology of the surrounding country, before moving on with the group to view the rock art.



Figure 3: First sign at entrance to Ubirr Rock, Kakadu National Park.
Image by Gregory Phillips.



Figure 4: Second sign at entrance to Ubirr Rock, Kakadu National Park.
Image by Gregory Phillips.

I was now angered by his actions. I had forgiven the first buffalo comment as an act of ignorance, and thought to myself ‘what else would I expect of a young white fulla trying to interpret Aboriginal history and culture?’ But now, I had reason to believe this was not just a random act of ignorance, and actually something far more insulting. Why would he want to show people the maps, but not the people, I thought? Are the people too black for him? Why did no one in the group ask about the other sign and its images?

We moved on to the rocks and I felt as though the rock art was not something I should photograph, but rather something I should sit and ‘feel’. I should sit down and soak in the moment, try to feel the messages the rock art and ancestors, and the place itself, were telling me. This is the instruction Elders like Uncle Bill Neidjie have given me when walking on country. So I tried to sit a little away from my teammates. I witnessed my friends and teammates fervently taking photos, chatting, laughing, pointing, going to the rocks and taking photographs. I felt their actions were disrespectful of the country, but in a millisecond, I justified it in my mind as ‘silly white fullas who don’t know respect; what else should I expect?’

My mind was swirling with thoughts and my heart was swirling with frustration. ‘Why can’t these whitefullas just sit and listen to the country?’ ‘Why do they have to make so much noise?’ ‘Why are they taking photographs like we’re in Disneyland?’ ‘Is it just me thinking they’re disrespectful, or are they actually disrespectful?’ ‘Maybe they didn’t mean to ignore the second sign?’ ‘Maybe it was an honest mistake?’

I was confronted about how to respond because on the one hand, I knew and loved these people as friends, teammates and generally respectful people. On the other hand, their actions

were confronting for me, and essentially racist. I was also very angry for even allowing myself to be shown the country by a whitefulla. I knew some of the local people, and my niece lived in Jabiru. I had asked her for recommendations of culturally respectful tour companies before we travelled to Darwin, but I had asked her too late. I knew it was a risk to my cultural safety to go on a tour of Aboriginal lands with white people, I thought, so I had no one to blame but myself. So, caught between two versions of my teammates and my own self-blame, again, rather than making a scene, I chose to stay quiet.

Just then, one of my teammates, a person I considered enlightened insofar as racism and inequality were concerned, asked me if I was OK. I said, “yes, it’s very frustrating, but I’ve decided to practice patience meditation,” and let out a big laugh. She said she was getting angry about the statements because many of them were so racist. I said, maybe the tour guide was not intentionally racist, but she insisted he still was. That small debrief helped me deal with my frustrations at that point.

I chose to forgive the guide and my teammates, because I thought maybe they hadn’t had anyone to show them how to respect the land – a sure sign of spiritual poverty in Aboriginal cultures. Instead of making a scene, in order to deal with my frustrations, like any good anthropologist, I took out my notebook and started taking copious notes – notes about the buffaloes, the signage, and other little behaviours and instances of ignorance and micro-aggression. These notes form the basis of this story.

I decided a better way to deal with the situation would be to wait until they were ready to hear the lessons of walking on country respectfully, take some notes instead, and have some time to myself. I stayed within earshot of the main group, hung back a little, and went up to

the top of the escarpment by myself. I sat there looking across the country, having *dadirri*, or quiet time, a kind of Aboriginal meditation, where you stay quiet and listen to the deeper messages from within and from the lands where you are; you try to understand the belonging of the people to that country (Baumann and Williams-Browne 2011).

I shook my head and thought about how ignorant some white people could be, but I also thought about my own family, the state of Aboriginal politics, my personal circumstances, world affairs, how I was struggling to find my voice in writing this PhD, when I met Uncle Bill Neidjie years before, when my own Aunty in Darwin had passed away, when my family would meet in a few days in Townsville to bury my young nephew who had just committed suicide. All these things were on my mind, yet the beauty of the escarpment and the views across the plains, the birds, the clouds, the blue sky, the breeze, the deep significance of the rock art I had just taken in. Something about the country and the power of the very rocks I was sitting on, the power of the country, the power of *dadirri*, started to work its magic. I felt the country. I felt at home. In a spiritual process so deep that my thinking mind could not fully comprehend, my mind softened, my breath deepened, my heart opened, my spirit drank full.

The very situation of feeling like an Aboriginal gay outsider within a gay white group on Aboriginal country, which appeared to ignore the Aboriginal principles of respecting country, was precisely the issue I was trying to write about in this thesis – how do Aboriginal peoples get included in white spaces, and on whose terms? There we were on Aboriginal land, and yet somehow, in those moments of interaction, it was still a white space. I decided I would save my frustrations and write them down. Write them down in the notebook, and in this thesis. I had let go of my personal frustrations and decided to transmute them into positive action and

teaching. I thank the escarpment and the country for teaching me that. I thank the rocks for helping me find my voice.

Coming back down the rocks to my waiting teammates, I decided that the tour guide was a good person. He was a young white kid from Adelaide who knew nothing about Aboriginal culture really, who was completely ignorant about many aspects of traditions, but who also was doing his very best to be respectful and honouring of Aboriginal peoples. I also decided that I would just take responsibility for what was missing – knowledge of how to walk on country. Even though this was not the traditional lands of my tribe, I would share my limited knowledge of some general principles for respecting the country.

His intentions were good. Two of my teammates had noticed me hanging back from the group, asked me if I was OK – they had known about my need to go from Kakadu to Townsville for a family funeral, and, knowing I am Aboriginal, probably had also thought there might be something wrong with the tour. I just said I just needed some quiet time.

Walking back to the truck past the signs, however, I stopped the three teammates who were near me, and explained who Uncle Bill Neidjie was, that I had met him and knew him and some of his family, and how powerful and important he was to maintaining the story and the land of Kakadu. They were appreciative that I had shared this knowledge with them, even if they might have been a little bewildered as to its deeper meaning (Figure 5, used with permission). For the rest of the trip, I spoke with the tour guide about my Aboriginal cultural knowledge, listened to him and respected him for some of the things he could teach me, and shared with my teammates bits and pieces of Aboriginal culture and principles for respecting country.



Figure 5: Friends at the entrance to Ubirr Rock, Kakadu National Park.

Image by Gregory Phillips.

I sum up my time in Kakadu here.

Kakadu Love

"You must feel the country"
The wise Old Man said
"You must see the country"
The young white man said
Dreams, snakes, spirit
The red dust and full moon
Shone on my heart
My mind went to deep pools
The green plains, hot air
Infectious
Tourist chatter piercing the silent spirits
Rocks who watch, listen, hear
The truth in my soul
My mind a vast expanse of
Connection, culture, history
I stayed silent
Practiced meditation
White noise around me echoed

I communed with the Old People
They planted secrets in my dreams
My voice bristled, stirred
And my spirit opened
My soul drank of the cool clear depths
The rock pools nourished my bones
I felt the country
Renewed my love
Saw deep truth
Heard ecstasy laugh
Saw beauty reflect
Felt sun infiltrate my darkness
Violate my unease
I relaxed
I opened
I danced
I dreamed
I felt
I prayed...
I stayed.

Refection

In reflecting on this story, I have considered the various factors at play that day. The young white man really wanting to be respectful in interpreting Aboriginal culture yet being, perhaps unintentionally, racist, represents a snapshot of Australia. The actions of my swim teammates were of good people (who I love and respect), who were taught about white cultural values and traditions, and who performed respectfully in those traditions. Yet they had not been taught about Aboriginal cultural values like respecting the country.

In white cultural traditions, it is normal to take photographs of millennia old paintings in an excitedly tourist fashion – in other words, to consume Aboriginal art, to consume Aboriginal country and to consume Aboriginal culture. In consuming, they maintain their whiteness, their power and their ownership of the land and the space in which these events occurred. White Australians have ‘allowed’ Aboriginal people to have a semblance of ownership and

management of their traditional lands (Langton, Mazel et al. 2006) and perhaps this is better than nothing at all, yet through consumerism, white Australian rules of governance, the white cultural space and terms of power prevail (Andrews and Higgins-Desbiolles 2012). If there were no Aboriginal people in the tour group, or others concerned with social justice, then tourists could quite easily travel to an Aboriginal cultural landscape, and through tourism, consume Aboriginal art, culture and country, without ever having to meet an Aboriginal person, and this happens often (Spracklen 2013). This is whiteness, neoliberalism and privilege in action; Australia is still deemed to be a white place, owned by white people (Healy 2008).

It is not that my teammates are bad people, but perhaps, that they are good people taught traditions which do not match the landscape in which they live (Gondarra 1998), and who continue to enjoy privilege as a result. This combination of goodness, ignorance, disconnection from the land in which they live, neo-liberal values, privilege and power can, and does so often, add up to racism – both individually, socially and institutionally, whether intended or not.

MOTIVATIONS

To begin this PhD with any integrity, I had to ask, what is my motivation here? Am I engaged in this work merely to complete a set of study tasks to allow me to gain a PhD? Have I undertaken this to make a serious contribution to an evidence base for public policy and community empowerment regarding Aboriginal health equality? Am I undertaking this work to build my career prospects? Or am I crazy enough to attempt a PhD because I think bio-medically trained doctors would care at all about what an anthropologist might write? The answer is probably an amalgam of them all, but in answering these questions, it has prompted

me to consider where I have come from to get me to this point of wanting to investigate and write about cultural safety and medical education.

In my twenties, I spent a decade working in healing, addictions and leadership programs with other young Aboriginal and Torres Strait Islander peoples, and other Indigenous peoples internationally. I had considered myself very anti-academic for much of that decade, for reasons of wanting to remain practical, and because anthropologists and other social scientists had written some horrendous things (VicHealth Koori Health Research and Community Development Unit 1999) and conducted unethical research with Aboriginal peoples (Smith 2012). As an alcohol and other drug project officer, however, I was trying to chart a way forward in addressing addictions and underlying contributing factors such as unresolved trauma, yet felt very disempowered by the bureaucratic and academic fallacies I felt were inhibiting progress. For example, the state government public health and health promotion teams' approach to alcoholism at that point was to introduce speed bumps into remote communities to reduce the number of alcohol-related road accidents, and to introduce plastic containers into community alcohol canteens, instead of glass; again to reduce alcohol-related injury. While these were worthy injury-prevention and health promotion initiatives, the fact that they were the sum total of the public health response to alcoholism spoke volumes. Mental health, therapeutic or other health-based alcohol prevention programs were extremely limited. Thus, I decided I would reluctantly join academia, if only to try to contribute to some practical outcomes, and at the very least, some clarity. This experience culminated in the publication of my master's thesis (Phillips 2003).

After a brief break from working in health, I was asked to interview for a position working with medical deans, as a project officer, to integrate Aboriginal health curriculum in medical

education, as described in Chapter One. I went into the position with many questions: Was moving my whole life to Melbourne worth it for a one year contract? How would I maintain spiritual and cultural links with my family and community? What really were the motivations of the Deans of Medicine? How serious were they about reforming their curricula to include Aboriginal health? Did they respect Aboriginal views of medicine? Would they see me as merely a soft, wet, lefty whose research in medical anthropology, trauma, healing and feelings be too much for them? Was The University of Melbourne and the other medical faculties far too conservative, white and unwelcoming for a Blackfulla like me? Most critically, I was very concerned that the spiritual integrity and cultural healing worldviews I had might be mocked, ignored, misunderstood or undervalued in a medical teaching context.

THE CDAMS INDIGENOUS HEALTH CURRICULUM PROJECT

At the interview, I was pleasantly surprised after meeting with Professor Richard Larkins, the then President of the Committee of Deans of Australian Medical Schools (CDAMS);² he left me with the impression that if good evidence were presented to him, he would not hold any particular ideological or social views that would prevent or negatively impact on our attempts to include Indigenous health in medical curricula. In fact, he seemed to be openly championing it. Yet, while the Deans had obviously made some strategic commitment to Indigenous health by the mere fact that they proposed to seek funds to begin a project and employ a project officer, I still wondered how far and deeply that commitment went among the other Deans. I was soon to find out.

² CDAMS changed its name to Medical Deans Australia and New Zealand in 2007.

Despite the success of the project in building collaborative relationships, developing accredited curricula, and establishing support networks, it took me some years to answer some of the questions I had at the beginning of the project.

At the outset, the leader of the Project, then Associate Professor Ian Anderson, an Aboriginal doctor, and I, very quickly learned that the project was not so much about medical curriculum – we could have written what we thought white doctors needed to know in two weeks. It was far more important at that point to engage with the business of strategic alliance and relationship building with the Deans, primarily because most of them at that point in 2003 had never met an Aboriginal person, or had very limited interactions with us, particularly in a professional setting. My first priority in the job was to travel to meet them all and reassure them that this was not a radical project aimed at storming the barricades and planting Aboriginal flags and land rights placards on their front lawns. It was a project aimed at doing something about the evidence. The evidence was that in measuring Australia's burden of health care, Aboriginal and Torres Strait Islander peoples were severely over-represented, and that as stewards of the profession, medical deans ought to be concerned and do something about it. The flags came later.

This strategy of building alliances based on common ground, rather than stoking fear and broadening cultural alienation between the two groups was the masterstroke of Associate Professor Ian Anderson, Professor Richard Larkins, Ms Danielle Brown, then Executive Officer of CDAMS, and many Indigenous doctors and advocates who had for years called for reform (Phillips 2004a).

On the third day in my new job, I had to travel to Sydney to meet the then Dean of Medicine at the University of Sydney, Professor Andrew Coates, an Englishman who had only a few weeks before immigrated to Australia to take up his new post. I was very nervous, as this was the first formal interview and meeting conducted for the project, and the first medical Dean I had met other than Professor Larkins. After thanking him for his time, outlining the project and my purpose for the meeting, and sustaining some polite conversation for approximately fifteen minutes, he blurted out that he confessed he knew very little about Aboriginal health, as he had just moved to Australia. He said so with an exhalation of deep breath and a slightly sweaty brow. I breathed a deep sigh of relief and told him, “Well, that’s good you told me that, because I know nothing about medical education!” From that brief moment of candour, I knew that while I would continue to nurse some healthy cynicism regarding the rest of the Deans’ motivations and level of commitment, I would, in fact, have something solid to work with. It was worth giving it a go.

While I was interviewing the Deans and their senior curriculum and administrative staff, two messages were made clear to me from a variety of participants. Firstly, medical school staff in charge of curriculum matters said they were sick of curriculum audits as they received them almost weekly and they required huge amounts of time to fill out. Additionally, they said they frequently received requests from different sectors of the health care industry lobbying for more time in medical school curricula. While they understood and were mostly sympathetic to the requests received, they reported feeling increasingly under pressure to make difficult decisions about priorities in an overly-packed curriculum model. Only once before had the Deans endorsed a national curricula approach in any aspect of health care – they had been previously lobbied by the alcohol and other drugs sector for common curricula. Yet that particular curriculum was reported to have languished, as a result of its very

prescriptive assumptions about the amount of teaching hours and placement of content within medical courses. Participants warned us to ensure the curriculum framework was flexible enough so it could be adapted to each medical school's curriculum, and yet identify a common set of principles and learning objectives.

Participants suggested that the audit had to be user-friendly, and the curriculum framework itself needed to respect each medical school's academic autonomy and approach to teaching medicine. They warned that if the curriculum were not flexible enough to allow for each school's pedagogy and timetable, and if there were not sufficient leadership from the Dean to mandate its implementation, then whatever curriculum was written risked the fate of "sitting on a shelf collecting dust."

Secondly, one Dean candidly stated: "There are only two things that make medical schools jump – accreditation and money." What he meant was that if Aboriginal health curriculum was to be successfully written, and if it was to be taken up and implemented with any rigour or quality, then making it a requirement of medical school accreditation was essential, as was stimulating reform with financial investments.

These two initial very clear messages were rattling around in my head as I completed the interviews, and I tried to diplomatically include them in the audit report. I presented a draft of the audit to a national meeting of Deans, medical school staff from every university in the country, the Australian Indigenous Doctor's Association (AIDA), Aboriginal community-controlled health organisations, rural health academics, medical students and federal department of health representatives. There were sixty people present at that meeting in Victor Harbour, South Australia, in August 2003. Ms Natalie Harkin and her team from The

University of Adelaide, and Dr Tamara McKean, an Aboriginal doctor from Flinders University, helped in terms of local planning and logistics. In our deliberations, we felt it was important for the Deans and other participants to receive a proper Welcome to Country ceremony to acknowledge Aboriginal prior custodianship of the land, but also to teach them something of our cultural values and beliefs about medicine and the land.

Moogy (Major) Sumner gave the Welcome to Country atop a hill overlooking Victor Harbour. He told of the times when Aboriginal people and the great whales would understand each other and live together in a reciprocal relationship. He told of the medicinal beliefs his people hold, and how healing and health must be holistic and rooted in care for country and care for self. Critically, he shared, all good health care was based on love. In sharing these messages, he had us standing around a fire with some gum leaves smouldering, and then invited participants to share in a ceremony. In this ceremony, he asked every person to go around the circle and give every other person a hug. Most participants embraced the activity warmly, even though quite a few of the Deans seemed startled and uncomfortable.

This beginning of the Project was in many ways the first time two very different cultures – Aboriginal and medical – had met at a national level. AIDA had previously presented to the national CDAMS meeting, and others had advocated within individual universities for change in medical school curricula and support for Aboriginal and Torres Strait Islander students, yet never before had Deans and the other participants sat down as equals, at least nominally, united for a common purpose of national importance.

The deliberations were frank and intense, yet cordial and open. Participants voiced their fears that the curriculum guidelines might be too prescriptive or expecting too much too soon, and

of watering down curricula or the facts of colonisation and racism in health care and hospital settings, for example. People highlighted important issues like who would train non-Indigenous lecturers (staff development)? What funding would the Deans commit? Who made academic or political or other decisions about curriculum maps and pedagogical approaches in each medical school?

The very fact that participants attended, actively engaged in robust discussion, and had their fears allayed, meant that by the time the meeting was completed, we had succeeded in building a very strong and strategic relationship base, and identified a core group of champions. We began discussing the components of a curriculum framework, based on the audit's findings, and we resolved that, pending the final product, all medical students in Australia must be taught curricula which was nationally agreed.

These discussions confirmed what audit interview participants had suggested – that curriculum content had to be matched by addressing issues of context, like funding, staffing and decision-making structures. As I continued to travel around Australia, and later, the two medical schools in New Zealand, it became increasingly clear that we were not engaged in merely a discussion and exercise in developing curriculum content, but rather, what we had begun was a process of organisational reform.

These issues will be addressed more fully in the ensuing chapters. Now I turn to broader discussions about articulating and translating worldviews about health and medicine between these two very different cultures.

Tensions

In coming to this work, I have thought long and hard about my own professional and personal experiences, and what this brings to the current work. In doing so, I am engaging in self-reflexive anthropology (Nazaruk 2011), and a form of auto-ethnography (Okely and Callaway 1992), where one's lived experience is documented, analysed and compared against theory, public policy records and academic literature. Paul Whitinui, a Maori scholar, has identified a particularly Indigenous form of auto-ethnography where:

Indigenous autoethnography seeks to resist the more dominant ideologies by deconstructing and reconstructing various historical accounts. It also seeks clarity, socially and culturally, by constructing and materializing a new reality to protect who we are and why we are who we say we are (2013: 10).

In this way, Indigenous autoethnography is not merely a valid method of social inquiry, but an act of resistance to other's definitions of our identity and very being. Our stories are valid method of inquiry not only because it is defensible against the criteria of robustness and rigour, but because we declare them to be. My story is valid not only as a robust method of social inquiry, but because as an Aboriginal person, under the principle and ethics of Indigenous autoethnography outlined in Whitinui's (2013) paper, my truth is my truth.

But how did this translate when working in medical schools framed by western knowledge production traditions?

I had experience in working in medical schools over a ten year period as both a project officer for the deans, and as a Head of School for a newly established School for Indigenous Health within a large and prestigious medical faculty. Sitting at Faculty Executive meetings as a young, Black, gay, medical anthropologist, with no PhD, a man on a spiritual life journey, questions about Aboriginal or western medicine and belief systems often came into sharp

relief for me personally and professionally. The experience forced me to interrogate not only my own belief systems, and belief in self and my skills and worldviews, but also about the legitimacy and balance Aboriginal worldviews, the social sciences, and a young, queer left wing intellectual aesthetic might bring to the table. I was strengthened by the experiences of other scholars who had negotiated the path (Rigney 2001, Fredericks 2009d, Smith 2012).

Far from mechanically establishing a new school for Aboriginal health merely concerned with Aboriginal health curricula and a research agenda that posits Aborigines and their health outcomes as a public health ‘problem’ to be solved, I realised that we are engaged in a much broader organisational and philosophical reform process that would take years to implement. Today Indigenous scholars worldwide are engaged in a decolonising and reforming task that will take us from being passive recipients of western expert scientific health professionalism, to equal, knowledgeable, respected intellectuals, solution-finders and practitioners in our own right (Walter 2007). Aboriginal medicine has more to teach white Australians about wellness, health care, teaching and learning styles and equality than a western medical faculty might often be ready for.

In illustrating the tensions implicit in this process of change, I recount a particular event of Aboriginal and western medicine coming together in a medical faculty.

STORY ABOUT MEDICINE

In 2005, the Australian Indigenous Doctors Association (AIDA) held their annual symposium at Newcastle, New South Wales, in conjunction with the annual meeting of the then Committee of Deans of Australian Medical Schools. The two groups had arranged for a joint meeting given the success of the curriculum framework and student support projects, and to

cement their ties in a collaboration agreement. The occasion also marked the twentieth anniversary of the first Aboriginal medical school graduates from The University of Newcastle. It was the first time Aboriginal and non-Aboriginal medical professionals met on such a large scale to consider professional and workforce development matters, and what each group could do together to contribute to improving Indigenous health outcomes.

What was even more special was the presence of two *nangkaris* – Aboriginal traditional healers from Central Australia (NPY Women's Council 2013). The *nangkaris* were invited by AIDA to share their story about the healing practices they used and their views on improving Aboriginal people's health and wellbeing. This was the first time they had attended an annual symposium. I remember sitting in the audience being in absolute awe of them. Many Aboriginal doctors and symposium participants reported being so excited and awestruck to hear from and meet the healers, particularly given that they held them in such high regard. I felt as if we were being honoured by their mere presence, and that the western training we received at white universities was very small and insignificant compared to the aeons and depth of Aboriginal traditional healing.

Yet one of the first things the *nangkaris* said when they got on stage was, “we are so happy to be here, we respect your [white] medicine too, and we should work together”. So here were these men, imbued with thousands of years of spiritual, physical, emotional and mental health healing techniques, being humble and saying they wanted to learn off white medicine too. It made everyone in the room immediately comfortable and relaxed. The *nangkaris* were teaching us that neither western nor Aboriginal medicine was ascendant or superior over the other, and that both offered positive skills to be utilised in health care.

This is similar to the teaching from Mason Durie (2004), a Maori psychiatrist, who has explained that we should not use western scientific measurement criteria to judge the efficacy of Maori or Indigenous medicine, but nor should we use Maori or Indigenous measurement criteria to judge the efficacy of western medicine. In essence, he says, both are valid and effective, depending on the contexts, and that the challenge for us as contemporary Aboriginal and non-Aboriginal health care workers and professionals is to be practiced integrating the two knowledge systems. This does not mean western medicos should train in Indigenous medicine, nor should Indigenous people *have* to train in western medicine, but rather, that both systems of medicine and measurement are valid and equal, and that practitioners of both persuasions should be respectful and practiced at referring the other as appropriate.

Given the above story of how western and Aboriginal medicine need not be juxtaposed or oppositional, it is important to interrogate why it might be seen as such. It would seem that western medical doctors and biomedical researchers, and their professional groups, might seem to believe that their status and prestige as experts and in control of the national health agenda might be challenged should the system recognise Aboriginal medical beliefs and practices, and indeed, those considered complementary and alternative. Perhaps they think their beliefs and medicine is superior to any others? More likely is that they believe they have no belief – that their medicine is based on a science that is objective, value free and gold standard. This of course is still a belief, and as such, is still culturally bound. It is not that western medical groups see their medicine as superior to all others (although, of course, many of them do); it is that they believe they have no belief (Taylor 2003). Therefore, all others are simply ‘ethnic’, ‘other’, or ‘folk’ medicine beliefs not to be validated or construed as equal or effective.

At the heart of these matters are notions of prestige, personality types and power. Western medical groups seem to think their power to make decisions and money and control agendas and medical economies will be usurped or weakened if others enter the fray. Costa (2012) reports that according to the 'Friends of Medicine' group, chiropractic and naturopathy are "quackery with no scientific evidence," and "dangerous to the public if Medicare sanctions them" (2012: 1).

An example of working with a mainstream medical faculty is presented here. I attended a faculty curriculum committee meeting every two months – this was the committee that approved or recommended changes to all existing or planned courses and subjects in the faculty. On one particular day, a course called 'Complementary and Alternative Medicine' had been presented for consideration and comment. The authors of the proposed subject curricula had not intended to actually teach reiki or meditation, but given that 60% of adult Australians report using complementary and alternative medicines (Manderson, Canaway et al. 2012), they had argued that it was important to teach health professional students how to refer and ensure the safety of their patients who might be using complementary and alternative medicines.

When the Chair announced the proposal and asked for comments, there were sniggers of derision and comments made such as:

We can't give the impression we're teaching this stuff, I don't like the name, we must change it. For heaven's sake, I am a scientist and I teach science in our courses! I mean, what next? We'll be teaching all sorts of quackery!

More comments like this were made and a good five minutes of conversation had passed. The Chair moved to wind up the discussion and move to the next item, when one member of the

Committee said, “but I suppose we should think about the application of this in things like palliative care.” There were quite a few moments of silence. Then someone else nervously offered, “I suppose it might be useful for things like treating patients with cancer,” to which there were tentative nods of approval from two or three others. I suggested, “I think we need some sort of course like this, because in Aboriginal health, we’re going to need to teach students how to work with Aboriginal traditional healers if their patients request it. I mean, it can’t be all quackery,” to which there were furious nods of agreement from many in the room.

This example is revealing in three ways. Firstly, it illuminates that some western scientists and health professionals still hold judgemental and ideological views about complementary and alternative medicines – that their view of medicine is superior to others’. Secondly, it highlights that western biomedicine is limited in its ability to deal with things it can’t control with a diagnostic and treatment formula – like the feelings that cancer and other life-threatening lifestyle diseases might produce in disease treatment or in palliative care. Thirdly, it shows that western medicine may be more willing to respect other forms of medicine if there is a strong evidence base or cultural, social or political meaning attached to it, such as in Aboriginal medicine. Further, these examples show that western medicine often struggles to hold on to prestige, power and ascendancy as the experts in control. Apparently, five thousand years of Chinese medicine or forty thousand years of Aboriginal medicine have nothing to offer five hundred years of western medicine.

Part of the apparent incredible arrogance of western doctors and scientists in assuming ascendancy is that they believe their medicine to be beyond culture or religion. Their belief system is that religion, faith, complementary and alternative medicines are all ‘quackery’

because they are not definable, safe or repeatable. In essence, they are saying these practices are something they cannot reduce to a formula, therefore they cannot *control* them.

Western medicine often attracts students who are uncomfortable with their own feelings, and who wish to reduce their own discomfort by reducing the discomfort in others (Yamey and Wilkes 2001). To reduce the discomfort in others, they need a formula. If there is no formula, students often feel uncomfortable, and feel at a loss to be the expert and stay detached (Paul, Carr et al. 2006). Then they are faced with their own feelings. This is scary, so they sometimes return to control, denial and distance cloaked under the guise of professionalism, science and objectivity, particularly in dealing with the risk of burnout (Bahrych 2011).

Western medicine and science also use hierarchal leadership, control of information, prestige and ascendancy in the profession, certain dress, language and communication skills, and particular forms of membership, ritual and rites of passage (DeVecchio Good, James et al. 2002). In other words, western medicine is a religion (Chattopadhyay 2007, Malerba 2011). It has its own culture. It is not value free. Its beliefs and religion are that it is value free (Taylor 2003).

Whose Medicine?

In conceptualising this study, I realised that any discussion about Aboriginal health and its place in western medical curricula actually invites exploration of a much broader set of values, ideas, beliefs and customs – differing worldviews. Rather than focus simply on curricula and its place in medical courses, along with its concomitant discussion of cultural safety, what really is at issue here is ‘whose medicine are we using?’ Are we nationally seeking to develop and implement Aboriginal cultural views in health care and medicine? Or

are we trying to fit Aborigines and their worldviews about health and medicine into a western medical system, including approaches to curricula, public health and their underlying set of cultural beliefs? One suspects it is the latter rather than the former. This study aims to answer these questions.

AN ABORIGINAL RESEARCH PARADIGM

This work draws on both Aboriginal and western research paradigms and theories of knowledge and knowledge production (research). A research paradigm is defined here as “labels that are used to identify sets of underlying beliefs or assumptions upon which research is based” (Wilson 2008: 33). It would be inappropriate to use only western research paradigms and methods as *a fait accompli* in this study for three reasons.

First, it cannot be assumed that the western ontological and epistemological paradigms and knowledge production processes are necessarily objective, normal or value-free (Phillips 2003, Darlington 2011). Epistemology and ontology is inherently culturally bound; thus, these must be named and analysed in order to produce a fuller and more complete set of methodologies, analyses and conclusions (Kirkham, Smye et al. 2002). While this is commonly acknowledged for positivism and post-positivism paradigms, even post-modern theory and constructivism can be seen as culturally bound, as Wilson (2008) states:

The commonality... [with all of them]... is that knowledge is seen as being *individual* [author’s emphasis] in nature. This is vastly different from the Aboriginal paradigm, where knowledge is seen as belonging to the cosmos of which we are a part and where researchers are only the interpreters of knowledge (38).

Second, the focus of the study is on Aboriginal and Torres Strait Islander Australians and their experiences of Australia’s health care system, through the microcosm of experience of including Aboriginal health curricula in medical education. Aboriginal scholars have

identified major flaws and inherent power imbalances in western research paradigms, and have argued for the decolonization of research methodologies (Sherwood 2010, Smith 2012). They have argued for and articulated more appropriate research methodologies involving Aboriginal peoples in Australia (Jamieson, Paradies et al. 2012), Aotearoa/New Zealand (Smith 2012) and Canada (Cole 2002). Further, Aboriginal scholars have begun the work of identifying a wholly Aboriginal research paradigm, including the theoretical underpinnings of Aboriginal ontology, epistemology and axiology (Wilson 2008). This work is necessarily ground-breaking, for it at once challenges notions of the superiority and objectivity of western intellectual knowledge production practices (research), identifies Aboriginal ways of knowing, and simultaneously argues for an appropriate usage of both paradigms in appropriate contexts (Rigney 2001).

Third, one of the principles of Aboriginal research paradigms is that research is relational, contextual and necessarily subjective. This principle implies that the researcher and his or her story or background is as important to the work as the topic, methodology, findings and participants. In Aboriginal research paradigms, operating similarly to participatory action research or participant observation in western research traditions, if one does not name oneself and position oneself in the landscape of the research and its findings, then potential for bias is more readily at risk (Denzin, Lincoln et al. 2008, Whiting 2013). That is, by naming one's story and background (subjectivity), one is less likely to wrongly or inadvertently attribute findings to the research participants or process, without clarifying the underlying value and cultural assumptions implicit in hermeneutic interpretation and analysis (Wilson 2008).

Given this principle, it is important to identify at the outset that I - the researcher and author of this work - am an Aboriginal Australian man. I have Waanyi and Jaru Aboriginal Australian ancestry, as well as Chinese and western (French, English) ancestry. It is important for me to name this in the first person, thus that the principles of Aboriginal research paradigms are honoured. Identity is of course a complex and intensely personal matter, so I will address why I identify most strongly with my Aboriginal heritage, rather than others, in the sections on positioning and methodology below. However, it is also important at this point that I honour my western heritage and its concomitant theoretical and philosophical traditions in the knowledge production process. That is, western research paradigms will also be used in the course of this work, but they will be interrogated as limited if used alone.

Two Ways of Knowing

As discussed above, Mason Durie (2004) has written about how it is important for both *pakeha* (white New Zealander) and Maori knowledge systems to be employed in the effort to improve Maori health outcomes, and that one method of verification or validity checking cannot be used to judge or assess the other paradigm. This can be said for many Aboriginal peoples – certainly in Australia – where Aboriginal Elders and scholars have called for the recognition of Aboriginal ways of knowing (Martin 2003), Aboriginal Terms of Reference (Watson 1990), and Aboriginal research methodologies (Moreton-Robinson and Walter 2009).

Many Ways of Knowing

There are many ways of knowing other than western and Aboriginal paradigms. Other paradigms relevant in the Australian context include complementary or alternative medicines

– an encompassing phrase referring to a host of modalities such as yoga, massage, reiki, meditation, aromatherapy, naturopathy, ayurveda and homeopathy (Manderson, Canaway et al. 2012). These modalities come from practices and medicinal paradigms that are millenia old, with deep and rich philosophical, ontological and epistemological bases for survival (Di Stefano 2006). Whether or not the efficacy of these paradigms can be ‘proven’ in the western scientific research paradigm, and whether or not they need to be, it is important to include a discussion of these modalities and paradigms for three reasons.

First, Australians are using these modalities in significantly increased numbers and in complex, integrated ways (Manderson, Canaway et al. 2012). Second, there is anecdotal evidence that Aboriginal Australians are using some of these modalities, particularly in care for cancer, palliative and other chronic illness (Kirk 1993, Aboriginal and Torres Strait Islander Committee of the South Australian Cancer Clinical Network 2011). Third, the paradigms that are sometimes labelled ‘hippy’ or ‘new-age healing’ by some commentators are in fact practices similar to Aboriginal healing modalities. For example, an Aboriginal Elder once re-counted a story to me:

You know bub, what them white people call reiki, you know our people used to do that too. We just call it laying of the hands. It’s the same thing – moving energy around the body and feeling where the sickness is (Aunty Hazel Kaur 1996).

Western detractors of what has been called complimentary, alternative, integrative or ‘new-age’ medicine or therapies often state their concerns about efficacy and the burden of proof of effectiveness and clinical and ethical safety (MacLennan, Myers et al. 2006).

It is true that all knowledge systems referred to here have incumbent on them the burden of proof; that is, how does one know if what one sees, feels or thinks is actual or perceived?

How does one know if the modalities are safe? However, this does not automatically mean that other Aboriginal or other paradigms and modalities should be judged by western standards alone (Durie 2004).

THE METHODOLOGIES EMPLOYED HERE

Having placed this story, and having described my place in it, I now turn to the specific methodologies employed in undertaking this work.

In this study I will explore the usage of the terms ‘Aboriginal health’ and ‘cultural safety’, elicited their underlying meanings and assumptions, and analysed any relationship between them. I will do this by describing the experience of including Aboriginal health and cultural safety in medical curricula in Australia and New Zealand. It is important to frame the discussion through the *experience* of writing and implementing Aboriginal health curricula in undergraduate medical and other health courses for two reasons. Primarily, a formal review and evaluation of implementation of the curriculum framework has been completed elsewhere (Medical Deans Australia and New Zealand and Australian Indigenous Doctors’ Association 2012).

In my experience of undertaking the work to develop and implement the curriculum framework, I was very aware that there were both content and context issues at play, and wrote about these in the initial national audit of curricula (Phillips 2004a). The content issues were about which particular learning objectives and teaching tools or foci were used, and about how many hours or case scenarios were included. The contextual issues identified included things like staff capacity to teach the curricula – if the staff had no background or confidence in teaching Indigenous health, how could we expect the highest quality curricula

implementation, for example. Other contextual issues included resourcing for Indigenous health (human and financial), the sorts of supports Indigenous scholars in an otherwise alien white academy might require, decision-making mechanisms so Indigenous scholars and faculty leaders shared responsibility and decisions regarding curricula implementation, and the importance of community partnerships with local Aboriginal groups (Phillips 2004a). These issues represent the so-called hidden curriculum – the hidden agendas and issues impacting on medical curriculum design and implementation, and what is considered important and not important (Hafferty and Franks 1994, Hafferty 1998).

These were the ‘grey areas’ that so deeply impacted on not only Indigenous health curriculum, but Aboriginal people’s participation, health needs and agendas. This is important, because it initially appeared that some medical schools were interested in the development of Indigenous health curriculum, but not the social justice needs of the Aboriginal community – scholars, individuals, organisations – including to have a say and participate fully in decision-making, curriculum design, resource allocation and overall goals of the medical school in creating a workforce to respond to local needs.

Further, the Aboriginal and non-Aboriginal scholars and students I engaged with when collecting data for the national audit often revealed very different narratives about their inclusion and participation in the life of the medical school than did those told by the Deans and curriculum committee Chairs. Aboriginal and non-Aboriginal scholars and students were deeply concerned with issues of political representation and participation in the life of the medical school, rather than merely curriculum content issues. The conversations with Deans and curriculum committee chairs seemed focussed on issues like ‘where will we find time to commit to this’, ‘how do I form a relationship with the local Aboriginal community’ (despite

there being Aboriginal staff in their own school who could guide them), and statements like ‘I confess don’t know about Aboriginal people and their health’. In short, Aboriginal scholars were concerned with full participation in the life of the medical school, and most white scholars were concerned about their own place, fears and issues regarding development and change.

The Project team and I considered this very real narrative mismatch during development of the curriculum project. On the one hand, we wanted to validate and give voice to the Aboriginal scholars and students’ concerns, yet on the other, not directly offend or interrogate the Deans and their curriculum committees about perceived racism or hidden curriculum agendas. We were concerned about maintaining their overall support in order to get a curriculum framework developed and accredited. To balance these competing interests, we resolved to include curriculum content issues as ‘content’, and hidden curriculum issues as ‘context’ (Phillips 2004b). It is telling that after ten years of the curriculum framework being published, and medical schools being accredited on its contents, medical schools appear to have advanced in terms of the amount of Indigenous health curriculum taught – the ‘content’, but there is less evidence of advance in terms of the structural, resourcing and hidden curriculum issues so profoundly impacting on quality – the ‘context’ (Medical Deans Australia and New Zealand and Australian Indigenous Doctors’ Association 2012). Seemingly, the Deans and medical schools have have broadly concentrated on curriculum content issues, but not so much on the curriculum *implementation* issues.

For these reasons, I needed to utilise data collection and analysis techniques that allowed me to ‘get under the skin’ of the professed and surface conversations and interactions – to

address the hidden curriculum issues at play. There are three data sources and corresponding analysis techniques that I have used, and I outline them here.

Describing the inclusion of Aboriginal health and cultural safety in medical curricula

In this chapter, I have described the CDAMS Indigenous Health Curriculum Development Project in terms of its inception, rationale and outcomes, and this has been supported by academic literature, my story and recall of this experience, government documents including workforce plans and policy statements (National Aboriginal and Torres Strait Islander Health Council 2009, National Indigenous Health Equality Council 2010). I have drawn too on Project documents and materials (Phillips 2004a, Phillips 2004b, The Leaders in Indigenous Medical Education (LIME) Network 2012, Haynes, Collins et al. 2013), and the outcomes of the Project through the Medical Deans' Review (Medical Deans Australia and New Zealand and Australian Indigenous Doctors' Association 2012). Another major source of this baseline data has been my field notes from my time working on the Project. I have drawn on field notes and a series of PowerPoint presentations used in public speeches during the development of the curriculum framework and the ensuing period of curriculum implementation, and they served to prompt my memory about key insights and recollections as a Project staff member.

These baseline data sources were analysed and synthesised using two techniques: thematic analysis (Howitt and Cramer 2010), and Indigenous research methodologies (Denzin, Lincoln et al. 2008, Wilson 2008, Chilisa 2011). One particular aspect of Indigenous research methodologies employed here is the use of story and narratives to illustrate environmental, social and contextual matters impacting on events – the place of the story – to elicit deeper meaning. This is similar to self-reflexive anthropology (Nazaruk 2011),

Indigenous auto-ethnography (Whitinui 2013) and auto-ethnography (Okely and Callaway 1992, Ellis and Boschner 2000, Doty 2010) where, rather than relying on memory or conjecture to elicit meaning, the story and narratives of the self as valid inquiry tool are further juxtaposed against field notes, PowerPoint presentations and commonalities in narratives related to me by other people during the course of my working experience on the Project (Ragin 1994, Ragin and Amoroso 2010). This analysis technique has helped to identify particular teachable moments (Reuben 1997) that resonated in the lived experience (Hsieh and Shannon 2005) of the actors at the time.

The experience of developing and implementing curricula: using case studies

In an effort to capture the ‘grey areas’ and the hidden curriculum issues voiced by Aboriginal scholars and students during the initial audit period (Phillips 2004a), I use a further major data source: case studies (Denzin and Lincoln 2011, Flyvbjerg 2011).

In the chapters that follow, I present seven case studies of curriculum implementation in medical schools and faculties. The intention in presenting case studies is to further illuminate the various usages and meanings of the terms ‘Aboriginal health’ and ‘cultural safety’ in medical schools and faculties, and in Aboriginal health discourses more generally, and to further explore hidden curriculum issues. This provides a richer contextual analysis in which to interrogate the dynamics at play, given that much of the academic literature and public policy documents reveal concerns with improving access to services for Aboriginal peoples, but not necessarily any of the structural or power relations implicit in working with the same (Grenfell, Wade et al. 2012).

The case studies were reviewed by the major participants in them to ask for permission to include their story in the thesis, to check for accuracy, and to ensure that there were no misrepresentations. They have been written so as to ensure de-identification of the particular medical school in which it took place, and pseudonyms have been used to further protect confidentiality for individual participants or groups.

The technique used for the analysing the case studies is qualitative content analysis (Kohlbacher 2006) in order “to provide an analysis of the context and processes which illuminate the theoretical issues being studied” (Hartley 1994: 323). The case studies were analysed by first presenting a reflection using reflective analysis (Evans and Maloney 1998), situating myself as both the author of this study and interpreter of the case study’s possible meanings. Indigenous auto-ethnography was particularly useful here:

Grounded within a resistance-based discourse, Indigenous autoethnography aims to address issues of social justice and to develop social change by engaging Indigenous researchers in rediscovering their own voices as “culturally liberated human beings” (Whitinui 2013: 1).

The sampling used for the case studies was purposive sampling (Oliver 2006) in that the examples used simultaneously provided the most immediate and lived experience of the case study participants, while also illuminating many of the dynamics and issues reported in other institutions of similar size, as in theoretical sampling (Coyne 1997).

Organisation of the Chapters

After analysing the baseline data (academic literature, health policy and accreditation documents, Project materials, my recollections, meanings and stories, and field notes) and the case studies, I came up with the following themes:

1. Ownership
2. Place
3. Isolation
4. Structural organisation (the place of Indigenous health in medical faculty organisational structures)
5. Enabling environments
6. Power
7. Decision-making
8. Partnerships
9. Strategic priority placed on Indigenous health as optional or core
10. Quality
11. Accreditation
12. Motivation
13. Values
14. Politics
15. Symbols
16. Problematism
17. Definitions of and paradigms for 'cultural safety' and 'Aboriginal health'

From these themes, and thinking about major discourses in the literature, four major groupings of themes emerged:

PLACE

1. Ownership
2. Place
3. Isolation
4. Structural organisation (the place of Indigenous health in medical faculty organisational structures)
5. Enabling environments

POWER

6. Power
7. Decision-making
8. Partnerships

STRUCTURAL VIOLENCE

9. Strategic priority placed on Indigenous health as optional or core
10. Quality
11. Accreditation

WHITENESS

12. Motivation
13. Values
14. Politics
15. Symbols
16. Problematism
17. Definitions of and paradigms for 'cultural safety' and 'Aboriginal health'

These major domains became central organising tools around which the data chapters emerged. To further analyse the themes and domains emerging from the baseline data and case studies in each chapter, I then present an exegesis (Krauth 2011), or ‘a story of the story’ to highlight major events, occurrences and dynamics at play (Hamilton and Jaaniste 2009). This is a particular form of ‘practice-led’ research, where the creation of the text as an artefact helps to inform analysis (Hamilton and Jaaniste 2010).

Overall, a grounded theory (Strauss and Corbin 1997) approach was taken here, whereby the academic literature, public policy documents and lived experiences are analysed for themes both by induction, deduction and continual refinement to elicit reliable meanings and interpretation (Ellingson 2011). Personal recollections and diary notes have added richness and texture to the accounts (Okely and Callaway 1992).

In summary, the baseline data and case studies were analysed using thematic analysis, content analysis, Indigenous research methodologies (including Indigenous auto-ethnography), reflective analysis and grounded theory to produce themes and domains. These were all synthesised using exegeses to produce a rich analysis and conclusion of findings for each chapter (Krauth 2011).

Conceptual Framework

The conceptual framework for this study is summarised in Figure 6 below. As illustrated, of the data chapters, Chapter Three is concerned with describing the pedagogy of place as related to the CDAMS Indigenous Health Curriculum Framework. Chapter Four is surveys power and biopower as they relate to medical schools and faculties. Chapter Five is an account of structural violence as it relates to Aboriginal health and medicine in general, and

Chapter Six discusses the phenomenon of whiteness in relation to Australia as a nation and society. Cutting across these four domains and chapters are the theories and lived realities of power relations and the notion of cultural safety.

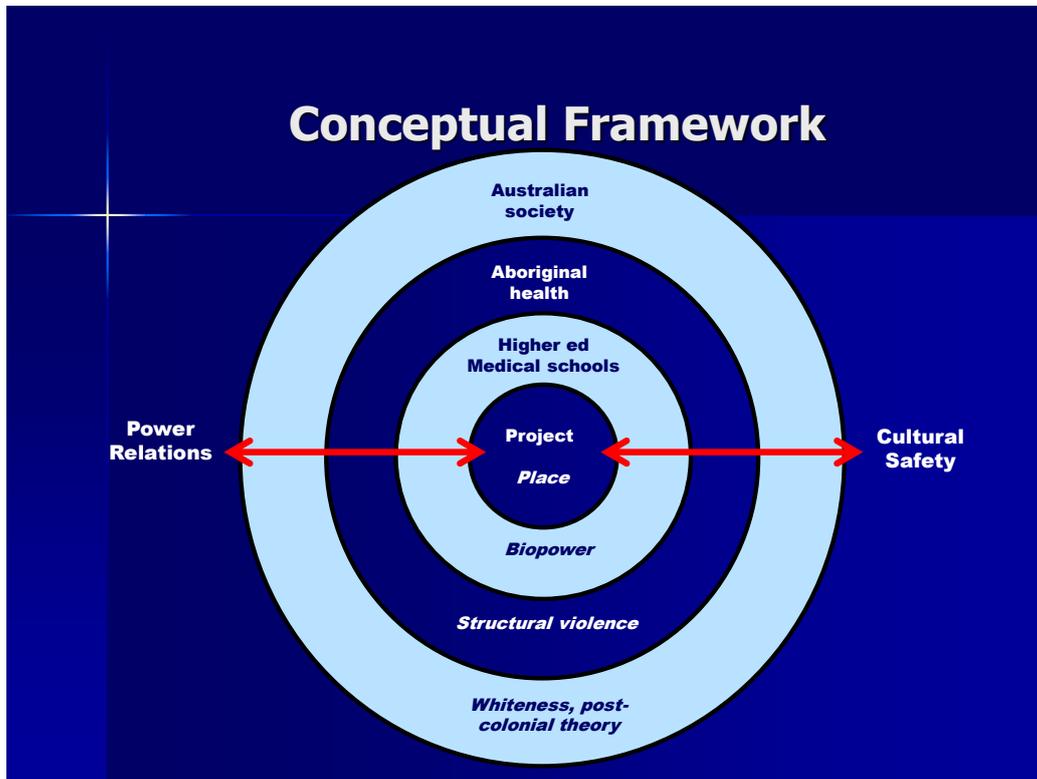


Figure 6: Conceptual Framework for This Thesis

Potential for Bias

The methodologies I have outlined here, in particular the fact that I am the author and was one of the actors within the events that took place (project officer, employee), potentially leaves me open to charges of bias or misinterpretation of the events and issues. I have controlled for this potential bias in three ways. First, the baseline data produced consistent and repetitive themes that required attention and further investigation, particularly given the national review of curriculum conducted by the Deans themselves (Medical Deans Australia and New Zealand and Australian Indigenous Doctors' Association 2012). Second, I have

asked for feedback and comment from case study participants to ensure accuracy of both the events that took place, and my reflections and interpretations of them. Third, in terms of synthesising the exegeses and theoretical literatures into conclusions, I have always noted and discussed the ‘null hypothesis’, meaning, taken as far as possible, other issues and factors into consideration. I present them here so as to assist in controlling for bias.

ETHICS

This study adheres to the National Health and Medical Research Council’s *National Statement on Ethical Conduct in Human Research* (2007) and *Values and Ethics: Guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander Health Research* (2003).

This study was primarily theoretical in nature, and no original interviews or primary data were collected for this study. Where quotation marks are used, they represent stories related to me directly, without prompting, or are quotes related to me by other staff while working within medical schools. These comments were all made in the context of public discussions and fora.

I specifically engaged with Aboriginal and Torres Strait Island peoples in the design, conduct and dissemination of this research by establishing a community reference group of Aboriginal and Torres Strait Islander and non-Indigenous health academics and community members who have guided and advised the author. This group included Aunty Joan Vickery (Victorian Aboriginal community elder), Ms Angela Clarke and Ms Nicole Shanahan (The University of Melbourne), Professor Helen Milroy (The University of Western Australia, and Commissioner, Royal Commission Into Institutional Responses to Child Sexual Abuse), Dr Norrita Morseu-Diop (Malu Mai Consultancy, social worker and academic), Mrs Leonie

West-Taylor (Project Manager, Royal Commission Into Institutional Responses to Child Sexual Abuse).

Further, discussions were held with both the Australian Indigenous Doctor's Association and Medical Deans Australia and New Zealand regarding this study. It was important to me to make sure they were informed of the study, for them to receive a brief description of the study (questions, methodology, theoretical framework, supervisors, ethics, attached here as Appendix 1), and for them to be asked to provide a letter of support. Both organisations provided written letters of support for this project (Appendix 2), and expressed a strong desire to consider its outcomes in the content of continual improvement in implementing Indigenous health curriculum in medical curricula. On the basis of this support, I submitted an ethics application to Monash University's Human Research Ethics Committee, and gained ethics approval on 12 April, 2013 (See Appendix 3).

Conclusion

In this chapter, I presented two stories to illustrate my motivations, positioning and methodologies in undertaking this study. In the same way that the story of my positioning as an Aboriginal gay man's struggle to find appropriate voice in a white gay swim team tourist party takes on deeper meaning when considering the place and context in which it occurred – Kakadu, the positioning and place of Aboriginal health curriculum in medical education takes on a deeper meaning when read as an Aboriginal medical anthropologist in a white medical school, and as Aboriginal health in a higher education system born of a white Australian biopolitical state. I turn to issues of place in medical education in the next chapter. It is a story of positioning, belonging, and power.

CHAPTER THREE – PLACING EDUCATION

In the following four chapters, I present and discuss case studies related to the inclusion of Indigenous health curricula in medical courses. The case studies highlight curricula content issues such as definitions of Aboriginal health and how it is taught, and draw attention to contextual matters such as who teaches Aboriginal health and what financial, political and cultural factors influence its implementation.

The first case study presented here concerns the issue of place – geographic and physical, and contextual, social and historical – as it relates to Indigenous health curricula. As foreshadowed in chapter two, the pedagogy of place is crucial to understanding and enacting the best learning outcomes possible. I extrapolate this concept of the pedagogy of place beyond the education context in which this case study occurs, to a broader survey of the social and political context of Australian society. The case study highlights issues of ownership and possession, the isolation of Aboriginal and non-Aboriginal peoples both geographically and structurally, and the over-arching socio-political reality of post-colonial and neo-colonial power relations. That is, questions of who owns Indigenous health curricula and who decides how it is delivered may well be representative of broader social issues of who owns Australia and who decides the terms of its functioning. The enabling environment, and the place of Indigenous health in medical curricula, become both a source of tension and a potential source of understanding. In this case study, it can be seen that the place of Aboriginal and Torres Strait Islander people in Australia – physical, political, social, economic, psychological, cultural – impacts on the decisions taken in relation to Aboriginal and Torres Strait Islander health curricula.

I draw on three theories in this chapter to contextualise place as it relates to Indigenous health and medical education: the pedagogy of place, post-colonial/neo-colonial theory, and actor-network theory. When read together, these theories provide a description of the location of Aboriginal people and their health in both medical education and broader Australian society.

PEDAGOGY OF PLACE

Pedagogy of place is a concept that comes from outdoor education, whereby the geographic location of the education lesson is critical to the pedagogy of what is being taught (Diden 2009). Proponents of this theory argue, for example, that it is far less effective to teach team-building or trust relationships as effectively indoors as one might outdoors, and argue that teaching on a beach will be a different learning experience than in an outdoor lawn bowls club (Wattchow and Brown 2011). The pedagogy of place assumes that the physical location of teaching interacts with and influences the effectiveness of learning (Somerville, Davies et al. 2011).

Others take this concept further, arguing that physical location is important to pedagogy in both cultural (Callejo Perez, Fain et al. 2003) and social ways, such that a critical pedagogy of place “seeks the twin objectives of decolonization and re-inhabitation through synthesizing critical and place-based approaches” (Gruenewald 2003). Central to these arguments is the concept that the physical place of teaching and learning is critical to personal and human liberation; that it is essential for humans to take an approach to education that locates them in interaction with their ecological environment, rather than as masters who laude power over nature (Somerville, Davies et al. 2011, del Carmen Salazar 2013).

Indigenous researchers have documented human learning relationships with land and its implications for Indigenous education models in Canada (Wilson and Sarson 2008) and

Australia (Wilson and Battiste 2012), and have noted the centrality of this concept to Indigenous cultures for millennia (Yunkaporta 2009).

Pedagogy of place and critical pedagogy of place are concepts important to Indigenous health and medical education in two ways. First, Aboriginal medical educators have argued for medical schools to recognise traditional owners on whose land the medical school and university operates, and to form relationships with local Indigenous communities which honour this recognition (Phillips 2005, Ewen, Paul et al. 2012). The rationale for this has been articulated both in terms of recognising social and historical context of dispossession and its effects on current social determinants of health, and also to inform better teaching and learning. In this way, 'place' is defined as the social, cultural, historical and contextual realities of the country of those to who one is teaching.

The second way in which this is relevant is in relationship to romanticized notions of Aboriginal identity and location. In my ten years working in medical schools, it was quite common for medical educators at various universities to tell me they had sent their students to the Northern Territory or the remote Kimberley region for "an Indigenous health placement." When I inquired as to why they didn't see fit to immerse their students in the reality of Aboriginal health in urban Indigenous communities, for example, Inala (Brisbane), Redfern (Sydney) or Dandenong (Melbourne), they most often looked shocked or disappointed. I was never sure if they regarded Aboriginal health as being synonymous only with rural locations, or if they thought Aboriginal people's identity was determined by their physical living location. When auditing medical schools for Indigenous health content, the Dean of an established urban medical school in the south of the country proudly told me:

We have two initiatives for Indigenous health; a lecture in the first year, and the other is a case study where we pay for people from the Tiwi Islands [remote Northern Territory] to come and give a guest lecture about smoking and respiratory diseases.

This statement was made in a context where those two “initiatives” were the only Indigenous health curriculum content students of that particular medical school received (in 2003), where there was no strategic approach to Indigenous health curriculum development across the medical school (despite that the neighbouring school of public health one hundred metres away had a sophisticated Indigenous health teaching and research program), and where there was relatively high concentration of Indigenous people living within a fifty kilometre radius.

If critical pedagogy of place was a concept engaged with or understood by the medical schools in question, it would be hard to understand why local Aboriginal communities were not engaged in the design and delivery of locally appropriate Indigenous health content.

Similarly, Fredericks (2009a) has identified how hospitals are physically alien environments for Aboriginal women, and therefore women refuse to attend unless very ill. Thus, in relation to Aboriginal people’s access to institutions such as medical schools and hospitals, a critical pedagogy of place would require cognisance of relationships between lands and humans as essential for ecological learning, that historical and socio-cultural contexts should correctly inform learning, that the social determinants of health are important factors, and that these determinants and contexts collectively require the redressing of socio-political power imbalances, at the very least, in terms of curricula content, design, delivery and evaluation.

Post-colonial Theory and Whiteness

Educators have theorised that instead of discussing the oppressed person or community's 'disadvantage', the academy should 'return the gaze' and focus on the oppressor's privilege as a technique to better analyse power relations inherent in colonisation and patriarchy (Morrison 1992, Moreton-Robinson 2000, Friere 2007, Hartmann, Gerteis et al. 2009). Post-colonial theory assumes that euro-centric power and paradigms have allowed colonisation to occur, yet a more egalitarian geopolitical order has evolved, in the sense that intellectual dialogue on the effects and basis of this power has been forthcoming (Gandhi 1998). Others (Said 1978, Spivak 1988, Deloria 1997, Spivak 1999, Chakrabarty 2000, Mbembe 2000, Briggs and Sharp 2004, Moreton-Robinson 2004) have developed a more critical postcolonial theory, wherein the intersections of gender, class and race are discussed from a self-centric critical view rather than those who are not white being positioned as 'the other' in the West's imagined and real power dynamic.

These theories are important to this work given the necessary imperative to challenge both the medical academy and the state to interrogate their own concealed ontological 'normality' – read 'power' and 'biopower' – and expression of this in white privilege. Further, the whitestream (Wilson 2008) must be challenged to accept its responsibility to identify and change its racist behaviour as a result of this white privilege, instead of always focussing on, in this case, Aboriginal people as 'problems'.

This discussion is elaborated upon more fully in Chapter Seven below, but insofar as it relates to theories of place, it is important in two ways. First, the powerful biomedical establishment gets to posit itself as powerful, benevolent, normal and scientific, while Aboriginal peoples and other political minorities are constructed as powerless, passive, victims, sick, criminal,

unscientific, unintelligent, and ‘other’. Epidemiology is sometimes used sparingly to create this imagined social construction (O’Neil, Reading et al. 1998), such that medical researchers and practitioners can fall into the trap of thinking that it is only their science and medicine that can save Aborigines problematized as being responsible for their health status – deficit thinking, as opposed to constructing Aboriginal individuals and communities as intelligent constructive, and as having some ideas or suggestions as to how to solve their own health situations. Here, we can recall the Cartesian separation of mind-body upon which modern bio-medicine rests (Hart 1996), and highlight that Indigenous and other scholars are calling for a more ecological (Anyinam 1995) and socially accountable medicine (Strasser, Lanphear et al. 2009) as critical to progress.

Second, post- and neo-colonial theory is important in that it calls into question ownership of the land upon which activities are carried out. Who owns the medical school? Who owns the medical school curriculum? Who owns the country on which the medical school is situated? Who owns the nation-state in which we live? In the western bio-political state (Moreton-Robinson 2006), using western norms of bio-medicine and bio-power (Foucault 1983), such questions are considered immaterial. That is, western biomedicine is concerned with a scientific power regime that has created a health system made up of problematised individual sickness (Krause 1977) and epidemiological identity ‘normality’ (Mader 2011).

In this regime, the social and cultural contexts for Indigenous health outcomes can become easily conceptualised as merely epidemiological, rather than paradigmatic – that the reason for ‘contributing to’ Indigenous health is simply to ‘help’ Aboriginal individuals out of their individual biomedical sickness (with all the benevolence and disempowerment that implies), rather than address the upstream socio-political and economic factors that produce such

inequality (Qureshi 2013), or rather than consider the lessons Aboriginal worldviews and systems of health care might teach western medicine about more effective disease control or treatment (Phillips 2003).

The possessive patriarchal logic that imbues the Australian bio-political state (Moreton-Robinson 2004) is the enabling environment in which medical schools operate. The logic underpinning this is that white people and white science own medicine and medical schools and control the organisation of biomedical knowledge, and that participation in this white system is doled out benevolently to 'let' Aboriginal people participate in it. cursory or paternalistic reference may be made to Aboriginal peoples during welcome to country ceremonies or acknowledgements of the traditional owners where medical schools are situated, but only if the white masters allow it, and only if white rules of science and ownership of the institution and its curriculum are guaranteed (Fredericks 2009c).

Actor-Network Theory

Bruno Latour's work (2005) is relevant to the theory of place in that he asserts that the social is an assemblage of 'actors' within a 'network', where the actors are individual components working together in a system or network. Actors can include groups of people, values, customs, languages, economic or economic factors, physical locations, and behaviours, for example. This re-imagining of the social or contextual is important to the theory of place and Indigenous health and medical education in that it encourages us to see the physical location of a medical school as related to both its political, historical, economic, philosophical ownership, and also to its relevance to the knowledge the school should teach by virtue of that physical location. That is, educators in a medical school in Dandenong (an urban context) may teach Indigenous health slightly differently to those in a medical school operating in

remote Western Australia. While the key student outcomes for Indigenous health may remain similar across the country (Phillips 2004b), how the medical school applies and teaches them in differing local physical contexts is, in part, most correctly determined by relationships between the medical school staff and local Indigenous communities and organisations (Edwards and Sherwood 2006, McCubbin 2006).

CASE STUDY 1 – THE ELDER

Rural clinical schools are funded by the Commonwealth Department of Health as investments in the quality of medical curricula for rural health service delivery. The over-arching rationale for this program is that training medical and other health science students in the bush is more likely to produce better clinical services when those graduates start practicing in rural areas. Medical schools across Australia are funded to deliver training for all their students as compulsory curricula. Rural clinical schools are consequently funded for academic and administrative staff, student accommodation, buildings and infrastructure and teaching resources. They are often co-located with rural hospitals or health clinic outposts.

In 2010, a rural clinical school (Site A) at John Flynn University (pseudonym) taught a wide variety of teaching programs in medicine and other health sciences, enabling rural health rotations and core teaching modules to be delivered by the rural clinical school to medicine, nursing, dentistry and other allied health science students. An Aboriginal academic named Jane (pseudonym) was employed by a section of the medical faculty, Department X, to teach Aboriginal health curricula across the Faculty's various schools, although she was physically located at the rural clinical school site (Site A). This meant that her official supervisor was the head of Department X, but she was also expected to answer to the Director of the Rural Clinical School, creating a confusing line management structure. To make matters more

confusing, Department X was also structurally located within the overall School for Rural Health. This meant that within the School for Rural Health, there were competing interests regarding Aboriginal health – Department X, and the rural clinical school (See Figure 7).

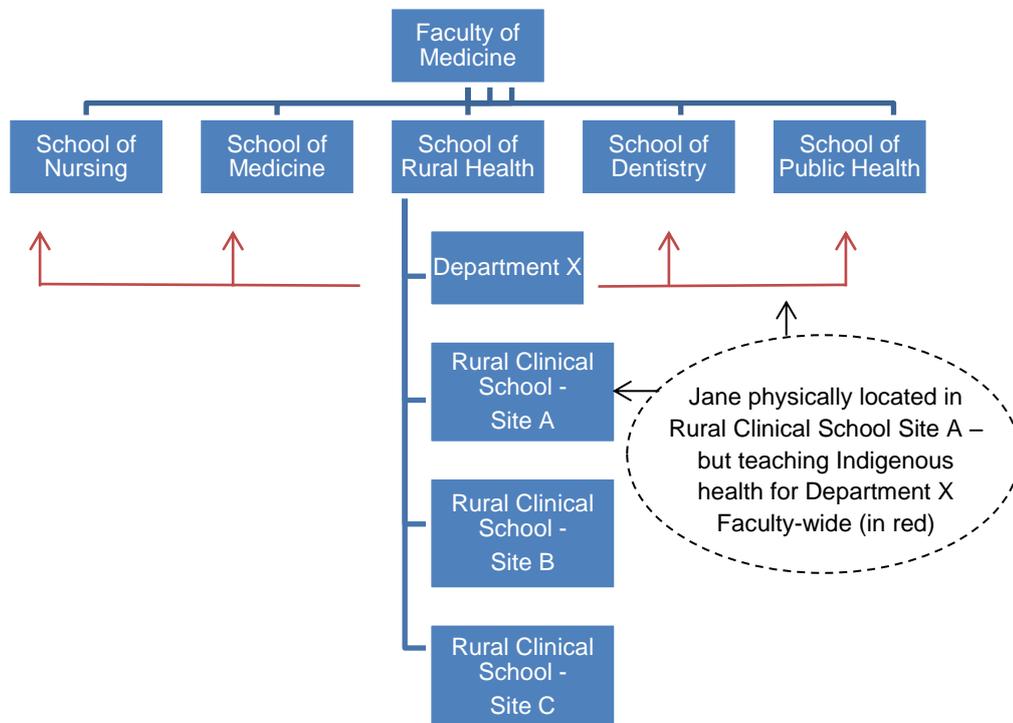


Figure 7: Organisational Structure of Department X

Department X was expected by the Dean to provide ‘advice and teaching support’ to other schools and departments in the Faculty regarding Aboriginal health, but its staff were not empowered as the course co-ordinators or owners of any particular course. For example, the School of Nursing had some Aboriginal health curricula (two one hour lectures) as a part of a semester-long subject called ‘The Health of Disadvantaged Populations’. The staff of Department X were often asked to teach as guest lecturers in this subject, but were asked to do so free of charge, or without teaching income accruing to Department X. Further, if the School of Nursing chose to restructure or change the curricula, they could do so with no formal requirement for Department X to have a say in how the Aboriginal health curricula

might be organised or taught. Further, Department X was not resourced with enough lecturers to deliver a comprehensive approach to Aboriginal health across the Faculty's eight health science disciplines/degrees. Other schools and departments either asked Department X to deliver their Aboriginal health teaching as unpaid guest lecturers, or would ask them for advice about which Aboriginal or Torres Strait Islander community member they could ask to give guest lectures (often without offer of payment). Department X did own and co-ordinate a semester-long introductory elective course entitled 'Aboriginal Health and Wellbeing', but timetable and scheduling logistics meant many students in health science degrees could not take advantage of the subject. Moreover, the Aboriginal health curricula content within other degrees was often not co-ordinated with the subject 'Aboriginal Health and Well-being' – students did not have the advantage of an overall Aboriginal health curriculum that was horizontally integrated, meaning a stepped and co-ordinated approach to learning as students advanced through their degree courses.

Department X staff also reported that researchers within the School for Rural Health and within other schools in the Faculty would often ask for last-minute advice regarding their research proposals, such as "could you please find me a community to collaborate with? The proposal is due next week", or "this grant is due tomorrow and I had no idea I had to have Aboriginal input into it", even though the proposal was about Indigenous adolescent health. Department X was rarely approached by course co-ordinators or researchers seeking Aboriginal input into curricula development or research proposals in a pro-active manner.

Jane was a registered nurse by training, employed to teach Aboriginal health components of curricula to medical and other health science students. Jane took a community development approach to her work, understanding that having strong relationships and partnerships with

local Elders, traditional owners and the local Aboriginal community-controlled health organisation (ACCHO) were critical to her work. This was particularly important because it enabled Jane to take students to visit the ACCHO and experience ‘real-life’ health service delivery to Aboriginal and Torres Strait Islander clients in an Aboriginal community setting. Further, Jane saw the visits as important in educating the students regarding how local Aboriginal customs and approaches would be critical to understanding their clinical roles.

Jane was often isolated within the Rural Clinical School by her peers, whereby she was not invited to attend academic staff meetings, reported being ridiculed by a particularly vindictive administrative officer (for example, having crass jokes made about her at a staff Christmas party), and where her views about curricula matters other than ‘Aboriginal health’ matters were ignored or not sought. This pattern of treatment had continued for a couple of years. Jane complained about this to her supervisor, the head of Department X. He in turn made various representations to the Director of the Rural Clinical School and the Director’s superiors about the inappropriate treatment of Jane, and the fact that the Aboriginal health curriculum seemed isolated and not integrated into the overall teaching and learning experience of students when they were on rural rotation. Jane reported feeling ridiculed, ignored and misrepresented. In an effort to sustain her professional and personal resilience, she stayed in close contact with Aboriginal community Elders, community members and staff of the local ACCHO. She made particular effort not to denigrate the Rural Clinical School in her dealings with Aboriginal community members, for fear it would keep Aboriginal people from associating with the Rural Clinical School. She tried to maintain a professional linkage role between Aboriginal community members and the Rural Clinical School where she worked, yet her experiences seemed to fit the pattern that the local Aboriginal community

had come to experience from mainstream health services in the town – poor treatment, racism and indifference.

In an effort to build partnerships between the Rural Clinical School and the local Aboriginal community, Jane requested that NAIDOC Week (National Aboriginal and Islander Day Observance Committee) activities be run at the Rural Clinical School as a learning experience for students. After a couple of years of trying to convince the Director of the Rural Clinical School as to why NAIDOC Week was important, Jane was granted permission to run a morning tea during NAIDOC Week for students and staff, to which local Aboriginal health workers and Elders were invited as guest speakers. After a couple of years of this activity, the Jane was granted permission to host a more formal flag raising ceremony and morning tea at the clinical school, at which the Australian flag, the Aboriginal flag and the Torres Strait Islander flag would be raised. After a whole year of meetings with Elders and the health service convincing them to put aside their distrust of mainstream health service, and arguing that it was worth trying to build partnerships with the Rural Clinical School, the Aboriginal health academic succeeded in gaining the agreement of a senior Elder and traditional owner to give a welcome to country at the flag raising ceremony.

At the ceremony, the Elder gave her welcome to country, including telling the audience of local customs, traditions and cultural matters. The Elder also recounted the massacres and food poisonings that had taken place in the local area, and about the forced removal of children and relocation of whole tribes and families to new missions and reserves. The Elder recounted that many local Aboriginal families had only left the missions in the last ten to twenty years to move into towns and cities, because prior to that, they were not really welcomed or could not find work or housing. The Elder tried to draw a link with the present-

day health care status of Aboriginal peoples, and explained that much of it was due to racist and unacknowledged history, the resulting mistrust of mainstream health services, and that local Aboriginal people regularly experienced racism in the current health care system. The Elder went on to say how the flag raising ceremony was an important step in building bridges and beginning to break down some of the barriers between Aboriginal and non-Aboriginal people.

After the ceremony, the Director of the Rural Clinical School said to Jane and other staff: ‘I do not want *that* woman back in my clinical school!’ [emphasis reported] When asked the reason for his statement, the Director said:

“That’s all in the past, we know that. I do not want that negative stuff being brought up. I’ve been to Alice Springs where real Aboriginal people are, and they do not tell the same old tired history when they welcome people.”

The Director’s emphatic statement made its way back to the Elder, who felt shocked and disrespected. The Elder reported that she felt the Director’s statements were a direct attack on her Aboriginality, and given that she was a stolen generation survivor herself, she felt particularly hurt and maligned. Jane was also upset and dismayed that an Elder had been hurt, and that her efforts to help the parties build bridges seemed to be going backwards. Jane spent weeks convincing the Elder to make a formal complaint, which they finally agreed to do. A formal complaint was made to the Director, the Director’s immediate superior, the head of Department X, and the Dean of the Faculty of Medicine.

The Dean of the Faculty of Medicine referred the matter to a newly appointed Associate Dean of Indigenous health, who had been in the position for one month. The Associate Dean travelled to the Rural Clinical School to meet with the Director. The Director started the

meeting by saying how dismayed they were that they never saw anyone from 'head office' in the rural areas, and that he felt upset and distraught when decisions were taken regarding medical curriculum 'by those in head office without talking to us'. After a while of letting the Director of the Rural Clinical School complain, the Associate Dean raised the matters of the treatment of Jane in terms of not being invited to academic staff meetings, and of being ridiculed and isolated. The Director stated he was upset with the news because 'she is made to feel welcome here just like everyone else, but yes, I do have to speak to the administration officer about their behaviour'. When pushed as to why the Aboriginal health academic was not invited to academic staff meetings, the Director replied, 'because they are for the academic staff who teach medicine.'

When asked about the fact that a local community Elder had made a formal complaint about the statements made after the flag-raising ceremony, the Director re-stated the view that 'that negative stuff is all in the past, we have to get past that. I went to Alice Springs and saw a really good positive welcome to country.' The Associate Dean suggested that for some communities, it was critical to re-tell the history so it would never be forgotten, that respectfully listening to and understanding the stories was a critical part of building trust and partnership, and that access to health services today would not be improved unless some of that mistrust was broken down. The Director said they thought his school was being unfairly represented, and that they were only interested in solutions.

The Associate Dean also was told during the trip to the rural location that the Director of the Rural Clinical School and the administration officer had been involved in an extra-marital affair, that all the staff of the Rural Clinical School were aware of it, and that the relationship had since broken down. It was understood that the administrative officer was very recalcitrant

to direction from the Director on regular work matters because their personal relationship had ended badly.

The Associate Dean reported back to the Dean, and recommended that the Dean travel to the Rural Clinical School to address feelings of isolation from head office in general, to deal with the apparent intransigence of the Director to deal with treatment of Jane, and to meet with the local Elders and traditional owners to apologise and assure them that steps were being taken to ensure that such disrespect would never happened again.

The Dean and Associate Dean travelled to meet with the Director, during which professional human resources support was offered to the Director to deal with his staffing issues with the administration officer. The Director stated he would not make public statements like the one he made about the Elder again, and that he would ensure Jane was invited to academic meetings.

The Dean and Associate Dean met with the Elder, who was still visibly upset and shaken.

The Elder listened to the explanations given by the Dean, and appreciated that her Aboriginality itself was not in question, but that the negative attitudes of one particular person were – the Director. The Dean stated that the Director’s statements were not a university or faculty position, and that steps were being taken to address the Director’s negativity. The Dean stated cultural safety training would be implemented for all staff at the rural clinical school. The Dean asked the Elder for forgiveness, and re-stated how thankful they were that the Jane had developed such good relationships with the local Aboriginal community.

Subsequently, Jane was invited to academic staff meetings, a one day cultural safety training program was run for all staff (the Director did not attend, apparently due to conflicting schedules, despite six weeks' notice), and the Elder maintained a good working relationship with Jane, but maintained it would take a long time for them to trust the rural clinical school again.

Two years after the above events, Jane reported that the new Director of the Rural Clinical School was much better in attitude to Aboriginal people and Aboriginal health, but that other academic staff regularly made decisions about Aboriginal health education without her input. Jane also reported that community relationships between the Rural Clinical School and the Elder and local Aboriginal community had been slowly rebuilding, yet this was made difficult because the new Director sought other local Aboriginal people's opinions if he did not like Jane's advice regarding the best way to engage with Aboriginal communities.

Reflection

This case study raises important questions on the nature of Aboriginal-white race relations in Australia, particularly in, but not exclusive to, rural communities. Aboriginal and non-Aboriginal Australians do not trust each other – Reconciliation Australia, a national not-for-profit organisation, commissioned research which found that only thirteen percent of non-Aboriginal Australians and fifteen percent of Aboriginal Australians trust each other, and that seventy and seventy-two percent, respectively, believed they were prejudiced against the other (2012). This means that much more work must be done for Aboriginal and non-Aboriginal Australians to trust and understand each other:

Australians believe the relationship is important but they do not think it is very good. They would like to know more about Aboriginal and Torres Strait Islander peoples, histories and cultures. It will take a generation to see significant change in the

perceptions and attitudes of Aboriginal and Torres Strait Islander and non-Indigenous Australians towards one another. Improving levels of trust and reducing levels of prejudice will happen slowly as we understand each other better and communicate more (Reconciliation Australia 2012: 3).

Yet building such communication and understanding is still debatable when it comes to primary and secondary school curriculum, let alone in tertiary environments. Investment in Aboriginal studies as part of the national primary and secondary school curricula is a hotly debated political issue – the Labor governments of 2007 to 2013 introduced the concept of a nationally consistent curriculum, with Indigenous, environmental and Asian studies as ‘breadth’ themes across all subjects and courses. The current conservative government has questioned the validity of that, and the Minister for Education has suggested there is not enough emphasis on ‘western civilisation’ in the curriculum (Cullen 2014).

Thus, if the prevailing social and political enabling environment is one of mistrust and misunderstanding between Aboriginal and non-Aboriginal Australians, and education and curriculum is politicised (Marshall and Preiss 2014), it should come as no surprise that whiteness, romanticisation of Aboriginal identity, and colonial attitudes of ownership of place still exist.

EXEGESIS

This case study illustrates and enables me to reflect on a number of issues, which I now discuss.

Representation of Aboriginal health in organisational structures

This case study is an example of how varying definitions of ‘Aboriginal health’ influence its structural representation in university organisational charts. Aboriginal health units or

programs in universities across Australia are often structurally located in schools or departments that often have competing interests, and that might not be the most logical fit (Phillips 2004b). For example, structurally aligning Aboriginal health programs with rural health departments or units, as seen in this case study, represents poor strategic thinking and planning in three ways.

First, it unwittingly conveys a message that Aboriginal and Torres Strait Islander people only live in rural areas. Approximately sixty percent of Aboriginal and Torres Strait Islander people live in cities and major regional towns, with the largest concentrations being in western Sydney, South-East Queensland and metropolitan Perth – according to the Australian Bureau of Statistics:

At 30 June 2011, around one-third of all Aboriginal and Torres Strait Islander people lived in Major Cities of Australia (233,100 people). A further 147,700 people lived in Inner Regional Australia and 146,100 people in Outer Regional Australia. The remainder lived in Remote Australia (51,300 people) or Very Remote Australia (91,600 people). (2011)

Table 1: Estimated Resident Aboriginal and Torres Strait Islander Population, Remoteness Areas, 30 June 2011

(<http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/3238.0.55.001Main+Features1June%202011>)

	Aboriginal & Torres Strait Islander	Non-Indigenous	Total
Remoteness Areas	%	%	%
Major City Areas	34.8	71.3	70.2
Inner Regional	22.0	18.3	18.4
Outer Regional	21.8	8.7	9.1
Remote	7.7	1.2	1.4
Very Remote	13.7	0.5	0.9

(Australian Bureau of Statistics 2011)

Yet in the imagination of the uninformed in Australia, ‘the real Aborigines live in the Northern Territory’ or ‘the bush’:

Too many Australian government policies are about Aboriginal people who live in remote areas, almost as though if that's not where you live you can't be a real Aboriginal person (Hayward 2009: 18).

Urban Aboriginal and Torres Strait Islander communities have long been poorly considered in national health planning (Eades, Taylor et al. 2010), and some communities have responded by developing organisations like the Institute for Urban Indigenous Health in Brisbane (Institute for Urban Indigenous Health 2014).

Second, this structural alignment of Aboriginal health only within rural health departments represents the thinking of governments and planners about who has the most need, who is at higher risk, what the dimensions of need or risk are, and what measures one uses to assess this risk or need (Eades, Taylor et al. 2010, Hoy 2011). In the last days of the Howard government, urban Indigenous health and education programs were significantly reduced because governments considered that urban communities had less need than people in the Northern Territory (Hoy 2011). The Labor governments from 2007-2013 introduced a minister and ministry of Indigenous health and continued the Northern Territory Emergency Response, thus focussing much of the government’s attention in the Northern Territory. This trend of a focus on rural and remote Aboriginal and Torres Strait Islander communities at the expense of urban Indigenous communities has been revived by the new Abbott government, where overall federal Aboriginal health policy and services will remain within the health department, but the Department of Prime Minister and Cabinet will take over Aboriginal rural programs and Aboriginal mental health (National Aboriginal Community Controlled Health Organisation 2013).

While improving health outcomes for Aboriginal communities in the Northern Territory is sometimes more complex, by virtue of geographic distance to health services, marked language and cultural barriers (English as second or third language), and colonial racist attitudes (Eades, Taylor et al. 2010). However, it is incorrect to assume that urban Aboriginal and Torres Strait Islander communities do not also have cultural and social alienation factors to contend with (Rowley and Anderson, 2007). Being such a small percentage of the population in a city and thus more ‘invisible’, language barriers between Aboriginal English and communication styles and common English, higher transport costs, whether one feels as if they ‘fit in’, are dressed ‘correctly’, and that urban health systems are very hard to navigate, are all examples of barriers to access experienced by Aboriginal and Torres Strait Islander people in urban communities (King et al 2009).

It would seem the mistake health and Indigenous affairs planners often make is in comparing remote and urban communities, and making assumptions that geographic distance alone is the reason why remote communities ‘need services more’ than urban communities (Hayward 2009). Thus, the mistake is two-fold – that communities should be compared at all – that one set of needs is more or less important than the other, and also that geographic distance or proximity to health services could be considered a deciding factor in assessing risk or need.

This is reminiscent of the state playing a marked role in defining the norm of identity for its citizens through use of statistics and epidemiology (Foucault 1983), and how deviation from this statistical norm can have dire consequences when interpreted incorrectly for social planning (Mader 2011). This may be because for the public health system, assessing needs based on remoteness is a well-established health planning tool (AIHW 2013). Yet in Aboriginal and Torres Strait Islander communities, with all their diversity across urban, rural

and remote Australia, issues of racism, language and cultural and social alienation exist in equal measure and in diverse and complex ways (Paradies 2006).

Third, a more insidious and concerning element seems to be taken into account in planning Aboriginal and Torres Strait Islander health services, policy and planning. This issue is identity. There is false assumption if you come from rural or remote Australia, then you must have darker skin, live a more traditional lifestyle, and speak more Indigenous language than your city cousins. That is, you must be more 'real' if you come from the bush (Hayward 2011). This romanticised and racist thinking strongly pervades policy-making and health planning in Australia (Rowley and Anderson 2007). Thus, the implication of structurally aligning Aboriginal health programs in rural health schools and departments without clear organisation-wide ambit, is not only to disseminate and reify factually incorrect demographic data, it is in fact to define Aboriginal identity as inextricably linked to the bush. While Aboriginal people clearly have an affinity with the land and sea, this does not preclude land now taken up by urban cities and communities as no longer Aboriginal or belonging to an Aboriginal traditional owner group.

Who is responsible for Aboriginal health?

From the case study presented here, it can be inferred that structurally aligning Aboriginal health academic programs within a school of rural health or population health highlights three further important features of the organisational dynamics of medical schools.

First, there seemed to be confusion over who was responsible for Aboriginal health. At the local level, while the Aboriginal health academic had a clear official reporting relationship with her supervisor, and that supervisor was nominally responsible for leading Aboriginal

health across the whole Faculty, problems with the realities of everyday decision-making and action occurred. The Aboriginal health academic was forced to answer to two supervisors – an official head of Indigenous health, and an informal yet no less real locational supervisor in the Director of the Rural Clinical School. This confusion, coupled with competing vested interests in the same faculty, would appear problematic.

Further, at the Faculty level, there seems to be confusion over whose responsibility it was to broker solutions to the problems between the Director of the Rural Clinical School and the Aboriginal community. The responsibility to fix the problem seemed unclear – it was not clear if the head of the school for rural health, the human resources department, the Dean, the Associate Dean for Indigenous health, or everybody shared responsibility.

The Medical Deans Review (2012) and Indigenous Health Curriculum Audit highlighted a tension between ‘Indigenous leadership and faculty responsibility’ (Phillips 2003). This is a dynamic where in some cases, some medical schools leave ‘everything Indigenous’ in the hands of one or two individuals charged with Aboriginal health. In other cases, people not charged with leadership responsibility for Aboriginal health even so deem it appropriate to undertake Aboriginal health related teaching, curriculum development or research without consulting, including, collaborating with or engaging Aboriginal health staff and leadership.

This dynamic would seem to be at play in the case study presented here. Jane was not invited to take part in Aboriginal health curriculum decisions, nor was she invited to take part in more general curriculum discussions and meetings. The implication of this is that Jane was being viewed, in effect, as only worthy of Aboriginal health work, not for example, as a lecturer in general rural health nursing by virtue of her professional qualification. Others

appeared to be taking a lead for Aboriginal health and placing the sole Aboriginal health academic into a thematic and racialised box. Yet when there was a problem with the delivery of the teaching of Aboriginal health - the Elder's Welcome to Country as a community development and teaching opportunity – it suddenly was not everybody's issue, but the Associate Dean of Indigenous Health's responsibility to broker a solution. To his credit, in this case the Associate Dean had the skill to bring the whole Faculty into play – the Head of School, the Director, the Dean and other relevant parties, and in this case, the Dean took his responsibility in this area very seriously.

Who pays for Aboriginal health?

The case study reveals the economic and competitive nature of vested competing interests within the same medical faculty. The head of Department X was officially supposed to be leading Aboriginal health teaching and research across the Faculty, and was funded to do so by the Dean, yet there were no economic incentives for other departments and schools to buy in to Department X's lead on Aboriginal health matters. That is, if other schools or departments wanted Department X to help develop curriculum or give a lecture or collaborate on a research project, that school or department would have to pay Department X for it. Given the nature of ever constricting funding streams, most schools reported being reluctant to buy in teaching from another Department, even when, in this case, there was apparently a moral case to do so. Thus, the everyday economic reality was that other schools asked Department X for free lectures or contacts for free guest lecturers from Aboriginal community members.

The Director of the Rural Clinical School also had a vested and competing interest in Aboriginal health – university departments of rural health have reporting requirements for

funding relating to Aboriginal health, and concomitantly, rural health academic leaders are expected to produce and deliver Aboriginal health teaching and research outcomes.

The only federal health department program that funds Indigenous health education in universities is delivered through the rural health section of the government (Urbis 2008, National Indigenous Health Equality Council 2010). This systemically strengthens the false belief that Aboriginal health is synonymous with rural health, and thus, gives important economic power to rural health academics programs as competitors rather than collaborators with Aboriginal health academics in medical faculties.

It would seem that a strategic and coherent Faculty wide co-ordination of Indigenous health would be more advantageous than leaving the leadership, funding and participation in Aboriginal health teaching, research and education as unclear and morally directed. This concurs with the findings of the Medical Deans Review (2012).

Attitudes

The attitudes of the Director of the Clinical School are interesting in that he seemed to exhibit anger at someone 'bringing up the past' and 'not being like other more positive and more real Aborigines'. Attitudes of denial and racism have been found to be a common assumption among medical students in relation to Indigenous health (Rasmussen 2000) and are likely to persist among students unless a vertically integrated and strategic approach to curriculum is implemented (Paul, Carr et al. 2006). Thus, the role of educator in Indigenous health is not only one of educating about Indigenous peoples and their health care, but also to play a counsellor role in helping students overcome their emotional reactions - often negative or racist responses, or reactions of utter disbelief and shock. This is not surprising, given that the

current and past cohort of medical students in Australia have not grown up with Aboriginal studies as a core part of primary or high school curricula. Thus, the formation of medical and all higher education students' views and perspectives on Aboriginal and Torres Strait Islander people in general is skewed to towards media representations and reporting (Rasmussen 2000).

The attitudes and beliefs of staff in medical schools has also been shown to be a contributing factor to the implementation of Indigenous health curricula (Phillips 2004b, Medical Deans Australia and New Zealand and Australian Indigenous Doctors' Association 2012). When completing the original audit of Indigenous health content in medical schools in Australia (Phillips 2004a), a senior medical educator told me:

It's not only the students whose attitudes have to change, it's also the staff, especially in teaching hospitals. I mean, what's going to happen to all the stuff we teach them in the pre-clinical years if they get to do ward rounds with senior doctors who tell them 'Aboriginal people don't experience pain as much as other peoples'?

If medical students have not had access to balanced and factually correct curriculum at primary and high school years, then their medical educators who were educated in the 1960s and 1970s would have had even less access to balanced and fair Aboriginal studies. Their attitudes and beliefs about Aboriginal people would be even more prone to racism by virtue of the time when they grew up and were educated, and that the prevailing social and political views of Aboriginal people were at the time characterised by a mixture of pity, anger, denial and guilt.

Further, senior medical educators are considered to be above reproach by many medical students, in that the apprenticeship model popular in most medical school teaching until the 1990s was one of never questioning your senior consultant. This gives rise to major

difficulties in asking students to correct or disagree with any balanced or positive information they may receive about Aboriginal people in pre-clinical years. More broadly, this has to do with the culture of medicine and of medical schools, whereby the medics who are employed at medical schools believe medicine has no culture (Taylor 2003).

What is implicit here then, is that for Indigenous health to be taught well, or 'included' in the curriculum, there is something about the enabling environment of the medical school, the university, and indeed, society, that is critical to this enterprise. That is, Aboriginal health cannot be taught in a vacuum, devoid of being cognisant of the attitudes, beliefs and preceding information the subjects in any given interaction have received.

Australia as a country has a particular history of denying the truth of mistreatment of Aboriginal people, with notable exceptions such as then Prime Minister Paul Keating's famous Redfern park speech where he acknowledged massacres and the stealing of children (Keating 1992). Former Prime Minister John Howard, on the other hand, refused to acknowledge and apologise for the forced removal of Aboriginal children, although he presented a motion of reconciliation to the national parliament (Hansard, 26 August 1999). When Kevin Rudd was Prime Minister, he made an impassioned national apology that was welcomed widely and helped seal his arrival on the international stage of diplomacy (Hansard, 13 February 2008). Yet at the same time the apology was made, the then Labor government was supporting a Northern Territory Emergency Response, where the Racial Discrimination Act was repealed to allow racist legislation to pass the parliament, supposedly in the interests of Aboriginal children and women (Altman and Hinkson 2007).

By contrast, other countries have held formal inquiries or commissions concerned with truth and reconciliation, where the facts of colonisation and/or genocide have been presently openly and honestly, public memorials and museums have been established, and national legislation and curricula has been written to acknowledge and never forget the problems of the past (Manderson 2008). In Australia, we have a national monument to reconciliation, that is literally underground, and a reconciliation movement concerned with moving forward rather than talking about and acknowledging genocide. I recently asked the Co-Chair of Reconciliation Australia if the organisation was interested in lobbying for a Truth and Reconciliation Commission. She replied that it was not on their agenda (Cilento 2012).

I have dealt with Australia's political and cultural position in relation to Aboriginal and Torres Strait Islanders more closely in previous chapters, yet for the purposes of this case study, it is clear that the tumultuous diversity of views on Aboriginal-white relations does impact on Aboriginal health in medical education, insofar as the enabling environment for education is, at best, tenuous.

In this particular case study, the enabling environment was one where 'negative' views of Aboriginal history – that is, massacres and poisonings – were considered less important on current Aboriginal health outcomes than, say, whether or not an Aboriginal patient took his or her diabetes medications. Further, the enabling environment here was one that placed medicine as a culture of no medicine, above all else, and one where the apprenticeship model of medical education produced a less optimal learning environment, particularly when outdated social and political beliefs were bought into play. The Director of this Clinical School may have been ignorant to the weight of evidence about the social determinants of Aboriginal health which clearly outlines the link between 'history' and present-day health

outcomes (Zubrick, Silburn et al. 2005, King, Smith et al. 2009), and also the growing weight of evidence of racism and its impacts in health (Paradies 2006, Durey 2010). It could also have to do with a person's attitudes and beliefs, and where they get them from, regardless of their formal education or scientific prowess.

The enabling environment on display in this particular case study is also one that reveals a discourse of discontent, by virtue of the Director of the Clinical School reporting a feeling of being isolated in the bush with limited attention or support from head office regarding curriculum and other matters. The Director also intimated that he owned the rural clinical school – “I will not let that woman back into my school.” He considered the school to be his space, as opposed to being jointly shared with, for example, anyone from the local community including from the local Aboriginal community. This is interesting in that the Director of the Rural Clinical School reported a discourse of isolation and marginalisation by virtue of distance from the head office, and by extension, isolation in decision-making, yet seemed unable to appreciate or empathise with the isolation and marginalisation experienced by Jane from decision-making. It was almost as if in his mind, the Director was judging rural isolation and marginalisation to be more valid and remarkable than that of the Aboriginal health academic by virtue of race – he apparently was a victim too!

Similarly, the sense of ownership and gendered language the Director used in his emphatic statement “I do not want *that* woman back in *my* school!” would suggest that Aboriginal peoples, despite having more than forty thousand years of connection with the country around this particular rural clinical site (a significant world heritage cultural site is located nearby), are not welcome or should be invited into ‘his’ space, presumably unless the Elder is ‘more positive’ and ‘more real’, ‘like those Aboriginal people from Alice Springs’.

In this case study, then, the attitudes of leading and powerful staff can be characterised as contributing to an enabling environment that is racialised, gendered, victimist, racist and geographically and spiritually detached from acknowledgment of local Aboriginal peoples and their sense of place.

Pedagogical Approach

The case study presented here reveals a difference in approach to health education, a different pedagogy, between that of a traditionally educated medico Director and the Aboriginal health academic. The Director's approach, while attempting to steward a new paradigm of health care based on the realities of rural medical practice and teaching, relies on certain traditional biomedical theoretical and cultural philosophies of care. These include focus on an individual patient's symptoms, a belief that intervention in only the physical aspect of health is required to fix a physical symptom – allopathic care, and that science, and by extension, medicine, is necessarily value free. Further, this regime of biomedicine assumes that to teach biomedicine, it must be re-iterated and taught in a clinical setting, with the only difference being that the setting is a metropolitan hospital or in this case, rural hospital. While the emerging paradigm of rural health is concerned with adapting these underpinning philosophies and approaches to care to a different geographic and social reality – the bush – it is not often concerned with changing the dimension of power or bio-power between a clinician and 'their' patients, for example, or with reflecting on the apparent 'value-free' practice of scientific medicine.

By contrast, Jane could be said to be operating within a holistic health paradigm, where focus is directed towards community intervention, underlying causes of illness, re-balancing power imbalances between the clinician and their patients by giving communities a say in their

health care, and the belief that any intervention must acknowledge place, history and context in a community development and health promoting way.

If the values, beliefs and underlying assumptions in approaches to health care and health care education are not agreed, understood or at least discussed, it seems inevitable then, that clashes of approach will result in the party with most structural and social power to prevail. In this case, it appears the Director of the Rural Clinical School was not even aware that the work Jane was undertaking was academic at all, but rather, saw her role as one of community liaison or engagement. That is, if one conceptualises ‘real medicine’ or ‘real academic work’ as only belonging to a certain set of assumptions, beliefs, philosophies and approaches - in this case, biomedical, and associates these subconsciously with being white – then this perhaps explains why Jane was not invited to academic meetings. The Director was unable to see an Aboriginal person as an academic as well, despite her (or his) professional qualifications, and he was unable to see engagement in community development as a ‘real academic’ enterprise.

The CDAMS Indigenous Health Curriculum Framework (Phillips, 2004) noted the difference for a different set of pedagogical approaches than traditional biomedical education. It is interesting that in this case study, however, the Director, who identified similar themes of isolation and marginalisation as a rural health medic, could not understand the dynamics and effects of marginalisation and categorising of the Aboriginal health academic’s approach as ‘other’ as problematic.

Professional Isolation and Burnout

Perhaps the most glaring question for the medical school and higher education institution in this case study was who was looking after the interests of the Aboriginal health academic.

Not only was Jane geographically isolated from her direct supervisor in Department X, but she was racially, culturally and professionally isolated, and socially ridiculed.

Far from Jane burning out or leaving the position, she persisted in her role, and further, encouraged the local Aboriginal community to become involved in the work of Rural Clinical School. Jane reported that she believed if she could 'hang in there' and break down some barriers between the Aboriginal community and the Rural Clinical School, then eventually there might be finding of some common ground on pedagogical approaches and therefore effectiveness in health and medical education.

This presents a plethora of human resources and occupational health and safety issues, as well as a number of moral leadership issues for the medical school and the university. Jane's supervisor, the head of Department X, had made representations to the head of the overall School for Rural Health, about the Director of the Rural Clinical School, yet the isolating and ridiculing behaviour appears to have continued. The change in pattern seemed to be that when an Associate Dean for Indigenous Health was available, Jane and her supervisor saw an opportunity to raise the matter further up the management structure. Organisationally, why wasn't an anti-racism or human resources workplace safety policy brought into play? How is it that an Aboriginal, or any staff member, could be subjected to such intimidating behaviour for so many months without organisational intervention? It is true that, initially, Jane had not taken the matter directly to human resources, but to her supervisors. Why did they not referred the matter to more senior staff in human resources? What is it about the culture of

this medical school, and the fact that the players seemed to have difficulty in identifying the racist nature of the behaviour, and enacting a clear strategy to intervene?

The LIME Network and the Medical Deans Review (2012) have identified the needs of Aboriginal health academics, and the national review into Indigenous higher education (Behrendt, Larkin et al. 2012) found a similar pattern of burnout or poor retention because of mistreatment or the stress associated with trying to enact an Aboriginal pedagogical approach to Aboriginal health education in an essentially biomedical and alienating environment.

Definition of Cultural Safety

When action was taken, the Dean, not the Director of the Rural Clinical School, apologised to the Elder on behalf of the Faculty, and the action implemented was ‘cultural safety training for all staff’, rather than anti-racism training. This reticence to name and identify racism and for human resources to intervene in a tricky but serious occupational health and safety issue is very revealing. It speaks to an enabling environment not used to identifying or resolving racism, and an enabling culture unable to deal with differences of pedagogical approach.

Cultural safety training was deemed to be synonymous with anti-racism training; yet the definitions and implications of this were unclear. Cultural safety training should correctly include not only the facts of history and cultural difference – the story of ‘the other’ – but the facts of institutional barriers, systemic racism and the need for decolonization of the organisation (Dyck and Kearns 1995, Ramsden 2002). Anti-racism training for individuals would be one aspect of overall cultural safety approaches, yet it is unclear why in this case, specific anti-racism training, or other redress, was not offered by the human resources department or the Faculty. It could be inferred that it was an issue that was ‘too difficult to

deal with'. Perhaps the Faculty and university in question were not used to dealing with such issues. Despite having formal anti-racism strategies and policies, perhaps the officers responsible were not really used to activating or implementing the policies – perhaps the enabling environment was not really that culturally safe after all. It is my contention that if one calls something 'cultural safety training', but does not address racism as part of its overall decolonisation pedagogy, then it may be the institution is merely implementing 'cultural awareness training', that is, the focus of change and problematisation continues to rest on 'the [marginalised] other'.

Partnerships

This case study also reveals differences in approaches to partnership. The Director's approach to partnership seemed to be one of benevolence and 'letting' an Elder speak in 'his' Rural Clinical School, as long as she spoke on what he preferred she speak about. Jane and Elder's approach seemed to be one of building and maintaining trusted relationships, and then with time, beginning to work on concrete activities like educating staff and students about local history in the context of National Aborigines and Islanders Week. It is revealing that this difference was not formally documented or acknowledged – the motivations and values underlying the terms of any partnership were unstated, and as such, remained undifferentiated.

Conclusion

This case study represents a snapshot of what is taking place in rural health clinical schools, departments and units across Australia – a workshop of the Indigenous Staff Network of the University Departments of Rural Health (2012) listed a range of concerns about decision-making, community partnerships and lack of staff support. Workshop participants stated that Aboriginal health was being confused with rural health because of an invalid belief that if

rural health is addressed, then Aboriginal health needs would also be covered. Small towns and remote locations, where ‘rural health’ occurs, are often still racist and unwelcoming to Aboriginal organisations or claims for rights, they reported. Hospital and health system access for Aboriginal and Torres Strait Islander people in rural and remote areas is still very poor (Australian Institute of Health and Welfare 2012). Rather than this being representative of some mythic Aboriginal unwillingness to seek wellness, it is more likely to be the case that the often culturally inappropriate and racist health professionals, systems and institutions on offer in rural and remote locations mean that potential Indigenous patients simply stay away from health providers until their illness is far more advanced (Anderson, Crengle et al. 2006).

The issues presented here reveal the need to be far clearer about the definitions of Aboriginal health, cultural safety, ownership and place. If Aboriginal health is defined as being synonymous with rural health, with deficit thinking, or as being different to ‘real medicine’ or mainstream pedagogy, then the implications of that definition are problematic. Further, the issue of who is responsible for Aboriginal health, who pays for Aboriginal health and who owns Aboriginal health, reveal not only issues of power and the structural dissonance of being problematically located in often competitive organisational structures, but also reveal issues of motivation, values and attitudes. Rather than Aboriginal health and its place in medical education being seen as a positive contributor to the decolonisation of institutions and redistribution of power and resources – its pedagogy of place – it was seen by some senior non-Aboriginal academics in this case study as an opportunity to compete for Aboriginal health resources and influence, and as an opportunity to define Aboriginality and recast history in terms more preferable to some senior white decision-makers. Whiteness prevailed.

In effect, it is clear that the medical school hierarchy's understanding of how physical location, socio-cultural context and history influences current health trends will, in turn, influence the ability of its staff to understand Aboriginal health, and by extension, their ability to teach it effectively to students.

Medical school curricula for Indigenous health cannot be culturally safe if it does not account for and observe local cultural practise, histories and customs, including the decolonising practices of ensuring Indigenous leadership, and shared decision-making and resourcing in partnering with other academics and stakeholders. The pedagogy of place, with shared ownership, is critical to Aboriginal health and medical education.

CHAPTER FOUR – POWER AND PRETENCE

In this chapter, I address theories of power as they relate to decision-making and partnerships in Aboriginal health and medical education. Three case studies are presented that illuminate the nature and application of power and decision-making in medical faculties in relation to Aboriginal health. In the exegesis of these case studies, I highlight underlying issues and draws out the critical assumptions and dynamics that define and constrain Aboriginal peoples' inclusion in medical and higher education, and frame the Australian state's handling of Aboriginal health more generally.

POWER AND POWER RELATIONS

While Foucault acknowledges the cultural limitations to his theories (Foucault 1982, Foucault, Rabinow et al. 1997), his work on the subject and power reveals four concepts illuminating for and relevant to this work. First, Foucault argues that state power acts upon the actions of others (1982: 789). The panoptic control whereby the state “structures the possible field of actions of others” (1982: 790) sets the parameters for the individual's or the subject's actions. This “possible field of actions” are pre-determined and agreed by a set of social networks (1982: 793), norms and rules of the dominant culture's making. Within that, individual difference is tolerated to encourage a sense of personal freedom, even if that freedom is not total (1982: 783).

This theory of state power is relevant to Aboriginal-state relations in Australia given that Aboriginal people regularly argue that they have not ceded their sovereignty in a treaty (Brennan, Behrendt et al. 2005) or some other formal agreement (Langton, Mazel et al. 2006), thereby meaning that we retain our stake in sovereignty in and of the land, and therefore are

operating within Australia as quasi-citizens, exercising some of the privileges and responsibilities of citizenship, but not acceding to a state power that remains foreign to us. Native Title has mediated this relationship, but not replaced the reality that sovereignty of Aboriginal tribes remains largely intact (Stephenson and Ratnapala 1993).

This is relevant in health policy-making today, because the state declares its power over Aboriginal people's lives in governmental, military and policy senses, as demonstrated in the Northern Territory Emergency Response (NTER) (Altman and Hinkson 2007). However, Aboriginal people assert and demand equality in partnerships, community-control in Aboriginal health care (National Aboriginal Community Controlled Health Organisation 2014), and for self-determination in arrange of policy areas (Cornell 2006). They are essentially saying they know governments have control over their lands and lives now, but are asking politely for some measure of control in their own lives (Altman and Hinkson 2007). The issue here is that self-determination and partnerships still are articulated within the overall legal, military and political parameters of power set by the state:

These apparent successes have resulted in an incorporation of indigenous communities and their politics into mainstream institutions in ways which can actually increase state supervision and threaten cultural independence (Hollinsworth 1996: 114).

Further, the federal Attorney-General Department's webpage states "(s)elf-determination is widely understood to be exercised in a manner that preserves the territorial integrity, political unity and sovereignty of a country" (2014). Thus, one could argue that even self-determination and partnerships cannot lead to true expression of sovereignty unless Indigenous sovereignty is first accepted.

In contrast, Aotearoa New Zealand's Treaty of Waitangi is written into the national public health legislation and national founding documents (Durie 2004). While there is considerable debate over the application of the Treaty and its principles to health service delivery, the critical factor is that it guarantees some measure of Maori decision-making for Maori; articulated as a requirement for Maori representation on District Health Boards, and that all board members understand the principles of the Treaty (Kingi 2007). Similarly, in Canada and the United States, researchers have found Indigenous cultural practices and control of decision-making is critical to the likelihood of better service delivery, uptake of services and health outcomes (Chandler and Lalonde 1998, Cornell 2006).

Second, Foucault (Foucault 1982: 782) argues that state power is individualizing and (Foucault 1982: 782), totalizing and that it defines one's identity. In Aboriginal Australia, while we have argued for community control of the definition and control of our identities and their expression, state control of identity was most clearly illustrated in the practice of forcibly removing children from their families and homes through the twentieth century (Wilson 1997). Currently, identity wars have erupted between the imaginary culturally imperial 'real Aborigines' of the north, and the 'less-than' urban identities of the south (Phillips 2009), and the tensions that have emerged from this are played out in Aboriginal politics (Behrendt 1995, Jamieson 2011). The state has delivered a national apology (Rudd 2008) and yet treats the 'real Aborigines' of the north as both culturally superior to those of the south and simultaneously as problematic, addicted and abusive (Bell, McNaughton et al. 2009, Howard-Wagner 2012). Aboriginal communities themselves have played into this power dynamic, such that the state no longer needs to define who is more Aboriginal than others; we do it ourselves (Hollinsworth 1992, Phillips 2009). Further, this state practice of defining identity for its citizens exacerbates any internal community debates by favouring

those it deems more ‘real’, ‘deserving’ and ‘needy’ (Herald Sun 2010), despite evidence suggesting approximately sixty percent of the overall health gap is attributable to urban and rural regions (Vos, Barker et al. 2009, Eades, Taylor et al. 2010).

Foucault’s theories are relevant to Aboriginal Australia also, in a third way, through the concept of pastoral power (1982); this is similar to what Farmer (2005) calls a ‘charity’ or ‘development’ framework for conceptualising working with or for the underserved. In this form of power, the state is charged with the responsibility of benevolent parent (Friere 2007), assisting the salvation of individuals, sacrificing itself for salvation, and being concerned with “knowing the inside of people’s mind ... it implies a knowledge of the conscience and the ability to direct it ... it is coextensive and continuous with life; it is linked with a production of truth – the truth of the individual himself” (Foucault 1982: 783). Again, this state omnipresence which ‘concerns itself with helping the underserved’ is simply state power presented as charity, as if communities themselves have no power, theory, paradigms, strategy or agency.

Pastoral power plays out in Aboriginal-state relations regularly, through the formal pastoral power delivered by the work of church missions, and state benevolence, whereby, for example, ‘Closing the Gap’ means the ‘regular’, ‘normal’ apparatus of epidemiology and western primary and public health (with its culturally bound ontology and epistemology) is applied to Aboriginal people uncritically (Cooper 2011). Any argument to change this power imbalance is seen as challenging the state’s benevolence rather than its exercise of power or its rights to do so (Kunoth-Monks 2014).

This totalizing and self-directed state power can only operate successfully if there is a power relationship, where ‘the other’ resists the dominant, and insists on their freedom (Foucault 1982: 789).

There is no face to face confrontation of power and freedom, which are mutually exclusive (freedom disappears everywhere power is exercised), but a more complicated interplay. In this game freedom may well appear as the condition for the exercise of power... The relationship between power and freedom’s refusal to submit cannot...be separated... a relationship which is at the same time reciprocal indication and struggle, less a face to face confrontation which paralyses both sides than a permanent provocation (Foucault 1982: 790).

This is relevant to Aboriginal-state relations in that Aboriginal people are in a dependent and victimised relationship with the state, where the state wields power and control over Aboriginal people. There is a dance between the two, an interplay, whereby government constantly blames Aboriginal people for their bad health outcomes and thinks it is necessary to do things *for* or *to* Aboriginal people (eg income management, NTER) to ‘help’ them, and Aboriginal people constantly blame government for bad health outcomes while arguing for equal relationships to design and implement programs by themselves (e.g. community-controlled health organisations, self-determination) or *with* the government.

Biopower

Foucault’s concept of biopower helps explain how the state regulates knowledge and power to control its subjects (Danaher, Schirato et al. 2000). This plays out in institutions like prisons, barracks, workshops, hospitals and clinics (Dreyfus and Rabinow 1983). Foucault says: “Bio-power brought life and its mechanisms into the realm of explicit calculations and made knowledge/power an agent of transformation of human life” (1978: 143). Bio-power plays out in the medical profession particularly through the control of docile bodies (Foucault 1975) and in higher education through the control of disciplinary knowledge (Rabinow 1991).

A feature of bio-power is that institutional arrangements, including buildings, professionalization, systems and structures all reinforce the power of the state (Rabinow 1991).

The concepts of the docile body and control of disciplinary knowledge are especially relevant to an analysis and understanding of Aboriginal health, cultural safety and medical education, in that Aboriginal people are expected to submit to western paradigms and knowledge regarding health care, such as diagnosis, prevention, and treatment, and through ideas that our bodies are ‘wrong’, in ways reminiscent of Sullivan’s work (2008) with other marginalised groups like transsexuals (2008). Health and medicine can be delivered to passive recipients of western knowledge and benevolence. Further, Aboriginal participation in higher education, the medical profession or Aboriginal policy in general, is translated and applied in program settings as ‘inclusion’ as passive state subjects (Fredericks 2009c). Rarely is a strengths-based approach utilised, where Aboriginal paradigms of education and medical practices representing thousands of years of knowledge get meaningfully incorporated (Nakata 2007). The CDAMS Project, for instance, attempted to include Aboriginal health in medical education, but the Project was limited by the acceptance, as *a fait accompli*, that western bio-medical education paradigms and structures were taken as ‘normal’. There was limited room for the Project to challenge the belief systems of western bio-medicine itself, rather, it simply focussed on the normalization of Aboriginal health within the parameters of existing biomedical, public health and state relations of power. Last, western medical education is largely concerned not only with the health of individuals and populations as individualised and pathologised bodies, but also with the re-production of the power of the discipline and professions of medicine (Farmer 2005). This is often to the exclusion of other medical or health beliefs or practices.

Bio-power plays out in Aboriginal health and medical education in particular ways: “power is tolerable only on condition that it mask a substantial part of itself. Its success is proportional to its ability to hide its own mechanisms” (Foucault 1978: 86). Thus, bio-power and power in Aboriginal health policy and programs exists, and is transmitted under, the cloak of secrecy of notions such as inclusion, altruism, and serving the needs of those in greatest need.

GOVERNMENTALITY

Foucault (2003b) defined governmentality as separate to sovereignty; that is, power is derived not from ownership by a sovereign ruler of particular lands, but from the control of the population itself. Where power was derived from sovereignty, such as in feudal societies, the exercise of that power relied on the sovereign’s control of the land through military might, and through employing values such as wisdom, salvation and pastoral benevolence to maintain the common good of its citizens. This maintained control and ownership of the land. By contrast, Foucault argues that between the sixteenth and eighteenth centuries, there were changes worldwide, including colonisation, changes in economic ownership and production, shifts in the role of religious orders as a field of government, and population growth. With these changes, power had to be exercised in different ways, leading to the development of the ‘art of government’ (Foucault 2003b). This led to a ‘governmentality’ whereby a ruler drew not on notions like wisdom to ensure the common good of the people and his or her ownership or control of the territory, but rather, governmentality derived from power separated from land and focussed on control of the population to maintain power for the state. I have summarised this change in techniques of power, according to Foucault (2003b), in Table 2 below.

Table 2: Techniques of Power (Foucault 2003b)

	Sovereignty	Governmentality
Values	Wisdom, morality	Rationality
Economy	Family as the model	Family as the instrument
Concerned with	Common good	Spread of resources for some
Techniques	Military power, religion	Laws, statistics, tactics
Maintains control and ownership of	Land	People
Power for	Sovereign ruler	State

Foucault (Foucault 2003b) asserts that this apparent binary of techniques of power were again changed during the seventeenth and eighteenth centuries to include the discipline of populations through policing and organisational units such as factories, schools and armies, and that:

the transition that takes place in the eighteenth century from an art of government to a political science, from a regime dominated by structures of sovereignty to one ruled by techniques of government, turns on the theme of population, hence also the birth of the political economy (242-243).

Mitchell Dean extends Foucault’s thesis of governmentality by clarifying that in contemporary forms of state power “the relation of the arts of government and sovereignty is not the replacement of one by the other but each acting as a condition of the other” (1999: 106). That is, sovereign states rely on a physical territory in which to practice their form of government; conversely, individuals and populations under government rely on forms of state territorial power for their citizenship, or a place to call home in an increasingly globalized world (Dean 1999). Thus, the notion of government becomes concerned with control of the lands, control of the economy, and control of the people.

Governmentality and Aboriginal Health

These theories of power in relation to Aboriginal health expose three ways in which the triumvirate of governmentality, discipline and sovereignty misconstrue or negate Aboriginal conceptions of health and well-being.

First, the changes from techniques of sovereignty to techniques of governmentality are based on a separation of populations from land and territory as the basis for power. In the logic of governmentality, regardless of the territory which people inhabit, the state's primary goal is the control and management of people through discipline and the economy (Foucault 2003b). This contrasts with Aboriginal territorial notions of power. In Aboriginal law, it is impossible to separate a person's power from the land; people derive their personal power from the land, and oral histories and creation stories reinforce that relationship. Western forms of government, which see control of the people as separate to control or governance of the land, make it easier to separate people from their land. No acknowledgement of the intrinsic connection of Aboriginal people and governance is apparently necessary. Individuals are separated from the personal codes of conduct, which form part of their systems of governance and law-making, and are simply incorporated into the neoliberal project under the guise of 'Indigenous governance':

Government and resistance articulate, mingle and hybridize, so that resistance cannot readily be thought of as external to rule. In this way, liberalism's governmental relations with resistance are characterized by incorporation of resistant, 'indigenous', governances. In turn, this is a source of its innovativeness and flexibility, becoming part of its strategy of government at a distance. However, this incorporation creates tensions and contradictions within the liberal project itself, instabilities which cannot be reduced to the status of external sources of programme failure (O'Malley 1996: 310).

According to Dean, in "this way of thinking about power, appropriation is a condition of precisely those Lockean notions of a political community and rights; ideas of justice and legitimacy, as much as territory and security, presuppose it" (2011: 8).

If this logic is employed in developing policies and programs to address poor Aboriginal health – a logic that Aboriginal people are construed as are any other citizen – to be controlled and planned for, devoid of territorial place, environment and context; then it becomes easy to see why Aboriginal health programs in one particular physical location are not easily transferred to other settings. Transferring an Aboriginal person to another territory is to take away their laws of governance. It is culturally and philosophically inconceivable to Aboriginal peoples that the same techniques of cultural control and power, accorded to them by birthright as sovereign traditional owners, can simply be transferred to another physical location.

Second, a contemporary logic of power where governmentality, sovereignty and discipline intersect and transform the family as the *model* of economic distribution, as opposed to being the *instrument* of distribution (Foucault 2003b), is problematic. It is problematic in relation to Aboriginal individuals and families because it treats such families as if they are simply an epidemiological instrument, a planning unit that statisticians and government administrators can control in recognisable categories and identities (Walter 2010, Mader 2011, Harris, Cormack et al. 2013). However, ‘Aboriginal health’ is a paradigm; it does not merely refer to the health of a series of individual epidemiological units or bodies. Aboriginal people are construed by the modern state as separated from land/territory and so context and place (as discussed in the previous chapter), and seen instead as epidemiological units and instruments, to be controlled in ways that maintain white state power. However, Aboriginal health requires the individual, family and community, along with their land, to be regarded as the philosophical and conceptual basis for health and wellness. High quality health care interventions, drawing on an Aboriginal explanatory model (Kleinman 1976) of care, would

take into account personal and relational perspectives and values in health planning, rather than take account of the epidemiological basis of poor health alone (Phillips, 2003).

Third, the change in motivation and concern from common good to state control of resources (Foucault 2003), and the use of tactics and techniques to distribute those resources according to the values or priorities of the day, are the basis for the state sponsored production of inequality (Qureshi 2013). Thus, if the state were concerned exclusively with the ‘common good’ of Aboriginal peoples and their health, they would potentially allow Aboriginal control of decision-making and resources regarding their health care more freely. Instead, the Australian state employs techniques that are primarily concerned with reproducing their power, sponsoring inequality through the rubric of the free-market, and feigning concern about ‘closing the gap’ through ultimately benevolent rather than social justice means.

Liberalism, the Social Economy and Inequality

Extending notions of governmentality, the development of liberalism in the eighteenth century “present[ed] itself as a critique of the excessive disciplinary power in the name of the rights and liberty of the individual... [yet]... the generalization of discipline is a condition of liberal government and necessary to processes of the democratization of sovereignty” (Dean 1999:113). This gave rise to the idea of society and the social welfare state, where the social became necessary “not in opposition to the state but as a consequence of a form of citizenship that in principle regards all as equal under the law. This necessity applies to all law-governed states characterized by the inequality-generating domain of the economy” (Dean 2010: 681). In other words, sovereign states concerned with equality, yet influenced by an unequal economy, developed the idea of the social whereby “society is formed from a relation to and between state and economy, not in opposition to them” (Dean, 2010: 686). Neo-liberalism

extended these ideas, however, by attempting to limit the potential counter-balance of ‘the social’ as community civil society, and to concern itself primarily with market forces and the maintenance of power for the few (Dean 2010).

Dean traces the history of the social economy in relation to health by citing the example of British labourers, where:

The attempt to include poverty as a normal status in the liberal economy led to a view of ‘pauperism’ as condensing a range of moral attributes that are inimical to the form of the life of the labourer and *his* family; imprudence, dependence on relief, licentiousness, idleness and even criminality... Rather than poverty being attacked as a moral deficiency, it started to become visible as a ‘social’ problem, which encompassed morality within a wider bundle of causes. (2010: 688)

This means that individuals themselves came to be blamed for their poverty by virtue of moral judgements of their character – imprudence, dependence and so on.

O’Malley (2000) extends this thesis by suggesting a difference between the economic rationalities of risk and uncertainty as notions of good government, where risk is defined as the calculable statistical modelling of possible threats to good governance (using technologies such as insurance), and uncertainty is represented as individual self-governance (using technologies such as entrepreneurialism). In the risk concept, liberalism removes moral or personal characteristics from the science of planning, and relies on generic or presumed statistical and economic characteristics to predict the future:

This capacity for calculative ‘rationality’ renders these liberal subjects free, that is, able to govern themselves, while ‘irrationality’ (whether in the insane, children, women or the feckless) vitiates freedom in proportion to its sway... the process of rationality, while assumed to be ‘logical’ and ‘coherent’ is invisible: its operation is known by its effects – the fact that the behaviours of the rational subjects are predictable, while those of the irrational are not. (O’Malley 2000: 467)

While Nikolas Rose suggests that “the psy sciences have a key role in the rationalities and techniques of government... on the basis of the forms of authority they have produced and the kinds of legitimacy they have accorded to those who want to exercise authority over human conduct” (Rose 1999: xxii), in O’Malley’s account, there will always be an expert science of the prediction of risk able to be used by technocrats and planners; this will always be counter-balanced by the “uncertainty...mode of self-government required of the liberal, rational, free and calculating subject” (2000: 480).

In this context, the generic and presumed characteristics of who is deemed to be rational and good managers of risk include everyone who does not enjoy political power. Thus, women, the insane, children, people with disabilities, and potentially, non-white peoples, are considered liberal subjects but not good governors of risk; they are considered to be irrational or incompetent. Further, inequality is built into modern states, not by employing risk or uncertainty, or sovereignty, liberalism or neo-liberalism, but by virtue of statehood being reliant and built upon economic and political governance systems that are regarded the preserve of those considered ‘rational’ – white males. This is reminiscent of Petersen’s and Lupton’s account of public health, “where the new public health is used as a source of moral regulation and for distinguishing between self and the other” (1997: back cover). I turn now to a discussion of the role of the state in producing inequality in health.

POWER AND PRETENCE

Qureshi (2013) has shown how the English parliamentary and health systems corrupted a public discussion about health inequalities, such that policy became focussed on measuring the health outcomes of certain groups of individuals, rather than on the upstream factors which cause inequality, such as socio-economic differentials. In 2005 then Prime Minister

Tony Blair commissioned an Equalities Review “to inform Cabinet Ministers on the cause of persistent inequalities and discrimination in British society” (Qureshi, 2013:5), as reflected in six ‘streams’ of inequality in Britain - race, disability, gender, religion, sexuality and age. The Review Panel was asked to examine inequalities in a health context. It commissioned a conceptual paper which utilised Amartya Sen’s (1985) capabilities framework, rather than separating society into arbitrary ‘streams’ of disadvantage. The paper also argued that social class was an essential factor to assess inequalities. The Review Panel chose to ignore this, as the senior civil servant servicing the Panel said:

The Panel want to re-state the case for action – I mean the moral imperative, the social justice argument about how the state should be looking after the most vulnerable and of course, the economic case. We’re not going to suggest redistribution. I know there’s Richard Wilkinson’s work, the examples of Cuba, the monkeys and all that. But this government is not about that. The tax and benefits system is out of our scope – that’s being reviewed separately as part of the budget and comprehensive spending reviews. (Qureshi 2013:6)

Qureshi elaborated that “[the senior civil servant] further explained that whilst the recommendations were supposed to be independent, they had to be first approved by the cabinet ministers who would be responsible for acting on the review” (2013:6).

This example suggests that there was a major conflict of interest between the Review Panel and its independence, and the political motivations of Cabinet Ministers. The evidence that social class was a major determining factor in health inequality was systematically ignored by the Review Panel and the responsible Cabinet Ministers. Further, one might expect that Ministers would make decisions on the basis of political pragmatism, and Review Panels, regardless of apparent independence, might be influenced by these same political considerations, or, minimally, work only within the terms of the review as set in the appointment of the Panel.

However, Qureshi's example is illuminating in a second way: it is very significant that the senior civil servant for the Review appeared to be interpreting or reiterating the Panel's views. Whether the civil servant directly reported the Panel's views, or interpreted the Panel's views and added his own gloss to the positions presented, his role in influencing policy was based on political imperatives rather than the evidence alone. Civil servants in the Westminster tradition are commonly understood to be 'above politics' and 'to give fearless and frank advice', yet this senior civil servant seemed to relay and agree with the political considerations and motives of the Review Panel. Qureshi summarises:

[The civil servant's] cautious recognition of the political constraints acting on the Review demonstrates that, contrary to the 'two communities' view of researchers and policymakers, it does not seem to be for want of dissemination or lack of engagement that research evidence on health inequalities has failed to be translated into policy. Rather, 'independent' advice is shaped or constrained according to policymakers' perceptions of what politicians conceive as practicable and for which there would be an electoral appetite. The selection and operationalisation of the evidence-base is therefore a political process holding a strong grip over the policies adopted to tackle health inequalities, and limiting the discussions of alternatives. (2013:6)

Other scholars (Naughton 2005, Smith 2007, Smith et al 2009) have also documented the appropriation of evidence of health inequalities for political ends, with evidence-based policy becomes policy-based evidence (Marmot 2004).

This case exemplifies Foucault's claim that the state rarely enacts direct power over citizen subjects, but instead sets out the parameters within which the subject must act. The government "is destined to act upon the possibilities of action of other people... to govern, in this sense, is to structure the possible field of action in others" (1982:777). The state apparatus – in this case, the Cabinet – has both defined the terms of the review of the 'independent' panel, and maintained veto rights over its recommendations, thereby defining the parameters of action of others. Further, the bureaucracy (as represented by the senior civil

servant) has interpreted, defended and reified the parameters set by the state, using it as an excuse to actively deny the examination of significant causes of health inequality (social class) because “the tax and benefits system is out of our scope” (Qureshi 2013:6).

The apparent political operationalisation of the terms of the review to actively deny evidence is not isolated, but representative of a pattern of governmental processes,³ calls into question the role and purpose of government itself, and so, in this case, the role of the Westminster system. Is the apparatus of state control, the government, concerned with the provision of services and equality for all (as the ideal of social and neo-liberal democracies, the welfare state), or with the maintenance and extension of power for a few?

The State and the Production of Inequality

The Westminster system of government in this example seems to focus on individual downstream factors rather than major upstream societal causes of health inequality (Marmot and Wilkinson 2005, World Health Organization 2013). Technical aids such as targets and performance measures of individuals and groups are used to ‘prove’ the scientific basis for progress (Hull 2008, Qureshi 2013), and statistics and data tell convincing ‘policy stories’ which obfuscate complexity and context (Stevens 2011:243). Powerful actors in the state – politicians, Cabinet ministers, senior bureaucrats – use data and ‘scientific’ evidence to support their own political agendas, and focus on measuring downstream factors such as health outcomes, rather than the upstream factors of inequality such as social class and privilege and how these factors heavily influence and personal agency.

3 As famously detailed in the television series ‘Yes, Minister’, BBC.

This suggests a powerful cultural and political belief that the free market, capitalism, is immutable and unchangeable – that there will always be ‘the haves and have nots’, and that this cannot or will not change. For instance, the current Treasurer characterises Australia as a nation of “lifters, not leaners” (Hockey 2014: 5), while simultaneously declaring the “poorest people either don't have cars or actually don't drive very far in many cases” (Massola and Ireland 2014: 3). If this belief that inequality is presupposed is central in the ideology and policies of powerful state actors, then their role in responding to unequal health outcomes is to minimise the *effects* of unequal wealth distribution, rather than to minimise unequal wealth distribution itself. Hockey states this outright: “striving to achieve equality is not the role of the government” (GetUp 2014).

Three conclusions can be drawn here. First, the Westminster system of government is an incapable, inefficient and inflexible way of translating health evidence into health policy. Second, the system of government itself reinforces power differentials, and therefore health (and other) inequalities, by accepting class difference as *a fait accompli*, and it uses the same system of disempowerment to try to empower individuals and groups. Third, it could be argued those with state power *do not want* the system to translate evidence into policy or practice, lest addressing social class inequality through redistribution of wealth might diminish the basis of their power and privilege, and/or at least prove electorally unpopular.

It could be argued that the state’s powerful actors and health researchers have different motivations and values. Many researchers continue to argue that class inequality produces health inequality, and that the role of the state should be to reduce inequality (and redistribute wealth) as a moral and social justice imperative; notably that inequality should be reduced by focussing on individuals capabilities, rather than deficiencies (Sen 1985, Nussbaum 2005).

Yet, in the present, powerful state actors (such as cabinet ministers and senior bureaucrats) seem motivated to ‘honour efficiency at all costs’ and to keep the status quo of the capitalist system – class inequity and privilege for the upper classes – while maintaining the pretence of dealing with the moral imperatives of inequity through focussing on *individual* health outcomes rather than systemic power differentials.

State Delivery of Health in Cuba

Cuba’s health system, by contrast, may offer lessons for the Westminster system. In Cuba, most primary health care and community health education is concentrated in easily accessible family doctor clinics, while secondary care hospitals provide services for the vast majority of patient events. These hospitals include, under the one roof, small accident and emergency rooms, options to see a family doctor for consultations, medical imaging, physiotherapy, orthopaedic care, social work, dentistry and mental health services). The co-ordination of service delivery lessens the loss of patient compliance and follow-up, increases efficiencies and reduces duplication. The patients who need tertiary care (e.g. for major surgery) are a very small percentage of health event cases.

In addition, the entry requirements for studying medicine are markedly different than in the West. In countries such as Australia, high scores in maths/science exams and a range of personal suitability tests increases individual chances of entry to medicine courses. I interviewed the Director of the International Medical School, which trains doctors from elsewhere in Latin America and the USA for free.

Gregory: So what are the entry requirements for medicine here?

Director: As long as they are willing to go home and serve the underserved.

Gregory: Yes, but there must be some exam marks or levels that you consider as cut off scores?

- Director: No, it is different here. As long as the student wants to serve the underserved when they go home, we will support them.
- Gregory: But how do you assess basic readiness to study medicine?
- Director: In this international medical school, all students do a basic six month course to help them settle in, learn Spanish if required, build a good network with the other students and lecturers. If they pass the exam at the end, they go on. If they do not, they can repeat the six month course.
- Gregory: Oh OK. What if they don't pass a second time?
- Director: They can continue to repeat the course as many times as they like. The most we've had someone do it is three times.

Thus, the motivation and entry requirement to study medicine in Cuba is simply that students “want to go home and serve the underserved.” Doctors are not paid at the exorbitant levels they are in many other countries, where motivations include prestige, benevolence, power and influence. Thus, the Director was arguing, they have a very different approach to studying and delivering medical care.

The example of Cuba's health system occurs in a socialist enabling environment – one which enables simultaneous state co-ordination and control of the education, training, workforce and service delivery systems. Rather than suggesting Western countries abandon capitalism in search of the holy grail of equality, there might be a cautionary middle-ground, where the principles from its successes could be married with the successes of the Westminster approach to individual freedom, liberty and agency. This ‘middle ground’ could see the principles of co-ordination and motivation to serve the vulnerable (rather than fulfil individual ambition alone) from Cuba, coupled with strategies to address upstream ‘inputs’ in an equitable (redistributed), not equal (same) way. The works of Amartya Sen (1985) and Martha Nussbaum (2005) are particularly relevant here, in that they propose an approach to societal wellbeing that identifies and measures an individuals’ capabilities, rather than their

‘deficiencies’, and one which does not define individual worth based on their situation in comparison to a statistical and societal norm (Rawls 1971, Mader 2011).

I turn now to two case studies that illuminate the nature and application of power and decision-making in medical faculties in relation to Aboriginal health.

CASE STUDY 2 – PHYSIOTHERAPY STUDENT

An Indigenous high school student had his heart set on studying physiotherapy, and applied to do so to a metropolitan medical faculty. His maths and science results in high school were between 60 and 70 percent, and his chosen physiotherapy course entry requirements were above 90 percent. He applied to physiotherapy anyway, but was not successful. Rather than do another course or apply to another university, he chose to work for a year and volunteer at a physiotherapy clinic to gain some experience. The next year, he applied to the same university where his friends were studying, through special entry for Indigenous students. He was again rejected. A senior Aboriginal academic staff member noticed the case, and brought it to the attention the Dean of Medicine and the Deputy Vice-Chancellor, both of whom recommended the student be allocated a special place in the course, with extra tutoring support. The Head of the School of Physiotherapy would not accept the student, arguing that the special entry application process was not specified clearly enough in the course admissions handbook, and so it could leave the School open to court challenges from aggrieved students who did not get in, and who might claim unfair advantage for Aboriginal students. The senior Aboriginal academic met with the head of school to ask what some of the issues were for them in making their decisions, with a view to addressing them. The head of school stated:

Medicine gets all this money for administration, and physiotherapy gets nothing. If I do one special entry assessment, I have to do it for every application I receive and I just don't have the staff to do it. Our course is so popular and it's as hard as medicine to get through it, if not harder. I don't want to set this student up to fail.

The case highlighted the university's approach to Indigenous special entry. A strong case was made within the university that unless Indigenous students were from low socio-economic status or disability backgrounds, then their case for special entry was weak. Indigenous staff at the same time advocated for Indigenous education, research and student matters to be taken from the equity portfolio and made into a university-wide, pro-active and strength-based strategic approach. Dejected but unperturbed, the student applied for entry and was successfully admitted into a Bachelor of Health Sciences, and the next year, taking advantage again of the special entry requirements of Physiotherapy, was accepted. Two years after, the student had passed his exams, had sought and enjoyed extra tutoring, completed many extra-curricula activities, and was considered an exemplary student by his lecturers in terms of drive, enthusiasm and achievement.

CASE STUDY 3 – NURSING CURRICULA

In 2009, the School of Nursing Studies was buying Indigenous health curricula and staff teaching time from another school within the faculty. One first-year subject, called 'Aboriginal Health and Wellness', had been written for all nursing, medicine and allied health science students, although only the nursing and rural health schools made this a compulsory subject. In addition, a subject called 'Cultural Awareness and Nursing' was offered to nursing students, with one lecture out of ten dedicated to 'Indigenous Cultural Awareness'. The Aboriginal academic co-ordinator of the subject and the lecturer who were responsible for the whole course made two written and verbal representations to the school,

arguing that it was inappropriate for Indigenous health to be included within general cultural awareness training, but this was ignored.

The head of school reviewed the student evaluations of 'Aboriginal Health and Wellness' and noted that students had rated the teaching of the subject poorly, with comments such as 'Why should we have to learn this rubbish?!' and 'The lecturers are being racist to whites'. The head of another school suggested that the style of teaching by the Aboriginal health academic co-ordinator was 'a bit aggressive. They come in and tell the students that white people are to blame for everything.'

The Head of School of Nursing Studies tried to have the Aboriginal health subject cancelled by applying for this change to the education and curriculum committee of the faculty. The chair of the committee mentioned the application in passing to the Aboriginal health academic, who was very disheartened that the only guaranteed teaching for the nursing students was about to be cut. The academic made representations to the Dean, and in an extraordinary move, the Dean directed the head of the School of Nursing to keep the subject.

The following year at subject review time, the head of nursing again applied to the education and curriculum committee to make significant changes and to remove the subject. The Aboriginal health academic was not informed, and found out about the application only in an informal manner. The committee supported the application; again the Dean overturned the decision.

The next year, in order to be proactive, the Aboriginal health academic approached the School of Nursing to ask if there were any proposed changes, and asked to be kept informed

of their intentions for the subject. The head and director of curriculum of the School of Nursing stated that there would be no application for changes to the subject's place in the curriculum.

That same year, the school made major revisions to the whole curriculum in anticipation of a visit from the accreditation agency. There were also changes to the process of applying for curriculum changes, a new Dean was appointed, and the Aboriginal health academic left the university. The nursing school applied to the curriculum committee to cancel the 'Aboriginal Health and Wellness' subject, and instead to teach Aboriginal health as a part of a course called 'The Social Determinants of Health'. Twenty-five percent of the total teaching time of this subject was dedicated to 'Indigenous Health'. This equated to four lectures – one each on 'Aboriginal Health and History', 'Aboriginal Cultural Awareness', 'Social and Cultural Determinants of Aboriginal Health' and 'Communications and Working With Indigenous Communities'. The committee approved the application for change.

The nursing accreditation framework at that time had standards to ensure nursing schools taught specific or discrete Indigenous health teaching (rather than being rolled into general multi-cultural awareness'), and requirements for consultation with Aboriginal health academics, Elders and community members in the development of curricula. Although neither of these accreditation standards seem to have been met, the nursing school gained accreditation.

The nursing school had established an external advisory committee with representatives from policy, academic, community and professional groups, and an Aboriginal person was included on this committee. However, the committee was not asked about curriculum matters,

and the Aboriginal person was not informed about approaches to Aboriginal health within the school, nor asked for their input. The representative reported feeling like a token representative, and so stopped attending the meetings.

When the new academic in charge of Aboriginal health curriculum across the faculty questioned the decision, the head of school of nursing said:

I apologise for not letting you know, it accept it was an oversight. But we have thought long and hard about how to do this better, and we've decided this is the best way to go. The accreditation council accepted our approach. We're happy for you to come and do some teaching in our new approach though.

The Dean said he did not feel comfortable raising the issue given his newness in the position, and given that the accreditation council had approved it. The new Aboriginal health academic was told “just accept it this time,” and that a Faculty-wide approach to Aboriginal health was required.

Reflection

What stands out to me about both of these case studies is that despite the rhetoric of medical faculties and other allied health science schools to diversity policy, including to ‘include’ Aboriginal health, there still appears to be considerable obstacles to Aboriginal peoples to advance their scholastic goals. This was justified here as ‘following the rules’, in the case of the physiotherapy student, and as ‘a mere mistake of process’, in the case of the nursing curricula, yet it would seem that other motivations and techniques of power, governance and decision-making were at play. In this context, the sheer determination of Aboriginal students and scholars to find their way through this minefield of power is remarkable. I turn now to examine the techniques of power used here.

EXEGESIS

These case studies demonstrate that power is not necessarily conducted by those at the apex of the hierarchy (e.g. the deputy vice-chancellor or dean), reason, or notions of common good and managing uncertainty, but rather, by indirect techniques whereby the agents of power (the head of physiotherapy and the head of nursing) utilised several ‘unseen’ yet potent methods to undermine or limit the actions of Aboriginal scholars and students as subjects.

These techniques include the power to define the other as irrational, counted as individual epidemiological units, and subjects devoid of territory, context or place (and therefore cultural formulations of governance or authority); the redeployment of narratives of inequality in terms of power and resources as ‘normal’; and subtle and overt techniques of inclusion based on prevailing ideas of neo-liberal rationalism and whiteness (see also Chapter Six).

‘Illegitimate’ Power

The techniques of power evident above can be considered against Clegg’s (1989) reading of power in organisations, in which he draws a distinction between the deployment of Weberian power through explicit hierarchical structural decision-making, and what Thompson (1956) called ‘illegitimate power’: “such exercises are premised on an illegitimate or informal use of resource control, access to which is given by members’ place in the organisational division of labour” (Clegg 1989: 189). Further, “a concern with the exercise of power from within a given structure of dominance is not the same thing as concern with mechanisms of dominance, strategies of power and regimes of control” (Clegg 1989: 190). That is, power is rarely exercised directly in organisations, but rather, is administered indirectly, in ways reminiscent of Foucault’s discussion of disciplinary power and surveillance (1975). The state

draws on ways by which ‘power acts upon power’ – the state controls subjects and individuals, not by physical force but by surveillance, defining the parameters of power and statistical definition, often through discursive idea of ‘the norm’. Yet specific ‘illegitimate’ techniques of power are used by actors, as above.

The case study of the physiotherapy student presents three examples of ‘illegitimate’ or indirect power: authorisation, resources and identification. In terms of authorisation, the reason why the student did not gain entry was not because the established entry criteria rules and weighting system was so inflexible as to disallow special cases, nor was there a problem with hierarchical authority in having the flexible to make a decision – the deputy vice-chancellor, acting as vice-chancellor that week, had given authority. The decision not to let the student study in the first two years was based, instead, on the head of physiotherapy’s reliance on the rules of entry as static, and presumed inflexibility to consider special cases. This was reported as a fear of backlash or retribution should the decision be challenged legally. This concern would seem less relevant had hierarchical authority figures agreed and directed entry for the student.

Further, there appears an attitude of competitive jealousy between the disciplines of medicine and physiotherapy, in terms of both entry criteria and resources. The head of physiotherapy made a series of statements about the difficulty of studying physiotherapy, and suggested that no-one who did not reach the entry criteria could ever succeed in the course, despite a similar university establishing that high school results and entry scores were not the best predictor of success in terms of income and job satisfaction five years after graduation (Willis 2011). The head of physiotherapy seemed concerned about assessing the student’s readiness to study because of resources. The reason for not letting the student in, on this count, had nothing to

do with the student's abilities, but the resources to assess entry suitability beyond formal entry criteria. Thus, authorisation and power to decide entry was not exercised here on the basis of hierarchical authority, but on individual attitudinal authority and concerns about finances and resources at the level of the school.

This resonates with Clegg's thesis:

The central concern of organization theories of power has been in a restricted conception of 'politics' which is premised on discretionary control of strategic contingencies or resource dependencies (Pfeffer 1981). Regarded in this way, power is a 'capacity' premised on resource control. It is also tautological. How is power to be recognized independently of resource dependency? Resource dependency of X upon Y is the function of Y's power. Equally, Y's independence is the function of X's dependence upon Y, given the previous X-Y relationship. The cause of power is resource dependency. At the same time, the consequence of resource dependence is equivalent to its cause. Hence notions of cause and consequence are meaningless in such formulae. Part of the problem is the pervasive tendency to think of power as a thing without considering that it must also be a property of relations (1989: 190).

A further example of 'illegitimate' power was by challenging questions of identity and deviation from the statistical norm, with the student identified as Aboriginal but not economically disadvantaged. The implication of this was that Aboriginal students cannot be deemed to be disadvantaged if they are not economically poor. The rules operating in relation to entry therefore were used to define Aboriginality: Aboriginality was only a valid criteria for special entry if the person in question was poor (however defined). This presumes that Aboriginal people whose parents were middle class did not face structural or social inequity or racism. Further, it presumes that Aboriginality and economic disadvantage should be tied. In other words, one apparently cannot be 'the right kind of Aborigine' if not also poor.

Disciplinary Practices of Surveillance

In the case study of nursing curricula, elements of illegitimate power emerge in the withholding of information by the head of nursing with the Aboriginal academic about intentions concerning the Aboriginal health course. However, the theory of the disciplinary practice is especially helpful in analysing the techniques of power employed here.

Foucault's (1975, 2003) disciplinary practice theory is:

meant to render those micro-techniques of power which inscribe and normalize not only individuals but also collective, organized bodies... Surveillance, whether personal, technical, bureaucratic or legal, is the central issue. Its types may range through forms of, for instance, supervision, routinization, formalization, mechanization, legislation, which seek to effect increasing control of employees' behaviour, dispositions and embodiment, precisely because they are organisation members (Clegg 1989: 191).

Thus, Foucault suggests that disciplinary practice is a kind of 'micro-technique' of power, where surveillance is used to maintain conformity.

This disciplinary practice can be seen in the nursing curricula case study where the justification for attempts to cancel or change Aboriginal health curricula came from student evaluations – a technique of surveillance. The head of nursing appeared only too quick to use this justification, over several years, without regard for evidence in terms of assessing Aboriginal health curricula quality; medical educators have found that student feedback from years one and two of medical courses, in relation to Aboriginal health curriculum content, routinely report negative and dismissive attitudes. Accordingly, they illustrate the challenges in the transformative unlearning of racism and privilege (Ryder, Yarnold et al. 2011) and the need to make up for a secondary education system lacking standard Aboriginal studies curricula (Rasmussen 2000, Paul, Carr et al. 2006). Yet in later years, after a carefully

planned and vertically integrated Aboriginal health curriculum, student feedback becomes routinely more positive given the transformative effects not only of the curriculum, but because students learn about reflexivity, systemic bias and privilege (Paul, Allen et al. 2011). Further, a concerted effort over three years was made to change or cancel the course, without direct discussion with the Aboriginal health unit course convenors about the content and quality of the curricula, or the interpretation of the student feedback.

This disciplinary ‘micro-technique’ of surveillance served to justify and codify the value of Aboriginal health curricula: it could not be important or valued if student feedback was poor. Assessment of value in this case did not appear to include Aboriginal health being central to nursing curricula, as the accreditation body had suggested, nor to consider the chronic health disparities experienced by Aboriginal and Torres Strait Islander Australians, nor the potential learning value that questions of Aboriginal health might offer nursing students.

This notion of value linked only to student evaluations reveals another dynamic at play here – the definition of Aboriginal health as synonymous with notions of ‘equity’, ‘diversity’ and ‘cross-cultural awareness’. Aboriginal health was synonymous, in the head of nursing’s mind, with cross-cultural studies and the social determinants of health. Aboriginal health curriculum, and consequently, Aboriginal people, were only deemed to be valuable for their ‘disadvantaged’, ‘cross-cultural’ or ‘other’ status. Aboriginal health was construed as made up of ‘other’ (not white) bodies, easily substitutable for discourses of the social determinants of health, and any cultural or ethnic ‘other’.

Sarah Ahmed’s (2007) phenomenology of whiteness is useful here, in explaining the dynamics of whiteness as it relates to power and decision-making in universities:

In actual terms, this involves a desire to hear about ‘happy stories of diversity’ rather than unhappy stories of racism. We write a report about how good practice and anti-racist tool kits are being used as technologies of concealment, displacing racism from public view (Ahmed 2007: 164).

The value of non-white scholars in higher education institutions, inscribed by and made up of white bodies and whiteness, reflects what white bodies want to hear – happy stories of diversity. In this way, Aboriginal health curriculum was deemed to lose its value if white students were offended by Aboriginal health teaching, even if issues of vertical integration and assessment of the quality of curriculum were not discussed openly. The terms of the ‘inclusion’ of Aboriginal health curriculum, and the inclusion of Aboriginal scholars in decision-making, was deemed valuable only if it were synonymous with and reflecting of white values and beliefs about Aboriginal health, taught as a part of the social determinants of health (discursive discourse of ‘disadvantage’). Any discussion of problems with the system, or as Aboriginal people as paradigmatically rich or as not ‘disadvantaged’, was deemed to be too challenging, and so subject to efforts to control and cancel the course: the stranger has a place by being ‘out of place’ at home” (Ahmed 2007: 162). The word inclusion then, covered thinly veiled epistemic violence (Fredericks 2009c). Aboriginal peoples and their health were only deemed valuable if the inclusion was conducted on white terms of benevolence, rather than equal terms of justice (Farmer 2005).

These techniques, among others, give rise to a kind of plasticity of white power in maintaining privilege. Where formal techniques of power such as direct authority or formal sovereignty (decision-making by the dean or deputy vice-chancellor, or accreditation requirements) do not hold sway, or where agents of power do not wish to adhere to them, then other techniques are employed in relation to Aboriginal health. These techniques – illegitimate power, disciplinary surveillance, whiteness masquerading as ‘diversity’ or

‘inclusion’ – form a kind of plasticity in governmentality where individuals can be separated from context and place or territory. Their identity, and what is expected and ‘normal’ insofar as their statistical representations (income, skin colour, ethnicity, gender), can be used indirectly to deny resources, access and legitimate representation in decision-making. An individual’s value to an organization becomes dependent on his or her sameness as an epidemiological and statistical unit, and economic value as a neo-liberal subject. Any challenge to this ‘norm’ is excluded, or worse, is ‘included’ as ‘a problem’.

POWER AND CONTROL IN ABORIGINAL HEALTH AND INEQUALITY

Farmer (2005) has shown us how benevolence in medicine informs structural violence in health (Farmer, Nizeye et al. 2006), Fredericks (2009c) has discussed epistemic violence in relation to Aboriginal ‘inclusion’ in higher education in Australia, and Fanon (1961) has discussed the roots of colonial power. Friere (2007) has examined the ways in which power is exercised over colonial subjects in terms of dominant society’s thinking, belief and values. Foucault (1982) has shown how power acts upon power, and how states use the conduct of conduct (1975) and other disciplinary surveillance mechanisms (2003b) to maintain techniques of power. I have illustrated how other techniques of power can form a plasticity of governmentality, whereby techniques of power and control are used interchangeably or concurrently to form a malleable and unstructured set of power and control techniques of Aboriginal subjects in white higher education institutions.

In extending this thesis, I discuss here the nature of partnerships and decision-making – on what and whose terms power is deployed. If the criteria used for ‘inclusion’ and decision-making regarding Aboriginal health in medical and health faculties comprises adherence to discursive notions of Aboriginal identity, and inclusion is based on Aboriginal people as

epidemiological and economic units, rather than paradigmatic collective entities, whose interests are served in maintaining this form of ‘inclusion’?

It is my contention that the plasticity of techniques of power and control serves to maintain white power in higher education institutions, and these techniques have, as their basis, the maintenance of white power over economic control of resources. Universities appear to have diversity, equity and inclusion programs *de rigueur*, but there are rarely mutually agreed terms of power, governance and decision-making over curriculum, resources and identity (Ahmed 2007). Similarly, health systems appear to extoll the virtues of equality, yet do nothing to change the systemic basis of inequality, instead seeing the systemic roots of inequality and relative disadvantage as ‘normal’ (Qureshi 2013). Thus, while appearing to be altruistic and inclusive, universities and health systems only ‘include’ on terms that suit their own values – whiteness, economic control, and paradigmatic dominance, which in this case is both bio-medical and bio-political.

In using this idea of plasticity in power, higher education institutions seemingly ignore or fail to comprehend issues such as the ethics of viewing capabilities and social justice as a primary planning tool (Nussbaum 2003), or Levinas’ ethics of alterity and reciprocity (1999).

Reciprocity has been clearly enunciated in the relations of power between Indigenous peoples and higher education institutions (Phillips 2005, Fredericks 2009b), as has the need for reflexivity of the clinician (Iedema 2011), educators (Ramsden 2002) and curriculum planners and administrators (West, Usher et al. 2014), where awareness of one’s own power, privilege and values and their implications on actions are necessary. Lilla Watson (1990), an Aboriginal Elder and philosopher, has pointed out the exclusion of Aboriginal Terms of Reference in Aboriginal-white relations in Australia, particularly in higher education.

Power in Aboriginal health is set up by the state to define Aboriginal people as irrational, individualized, counted as epidemiological units, and separated from context, land and cultural systems of governance and authority; inequity is accepted as normal. Aboriginal people are included, but their paradigms are not. Aboriginal people as passive bodies are counted as epidemiological units, and only included on benevolent terms under the goals of equity, diversity and inclusion. Yet, Aboriginal paradigms of governance, such as power-sharing, social justice, ethics and reciprocity, and of well-being (interconnectedness, community, holism, and the family as a model), do not match the motivations of universities in maintaining the status quo as far as power and control of resources are concerned. A pretence is maintained, where universities will only include Aboriginal peoples on white terms. In effect then, the conduct in medical faculties, universities and health systems seek to 'close the gap' in health inequity, while simultaneously maintaining white power and control of Aboriginal peoples and their health through the plasticity of techniques of power and governmentality. The maintenance of white power and control, in itself a primary contributing factor to inequity, is conveniently ignored.

CHAPTER FIVE - STRUCTURAL VIOLENCE AND ABORIGINAL HEALTH

In this chapter, I am concerned with the intersections between Aboriginal and Torres Strait Islander health policy and higher education policy. I examine the terms of participation of Aboriginal and Torres Strait Islander peoples in higher education through the use of two case studies of Aboriginal health curricula and accreditation in Australian medical schools. Is Aboriginal health curriculum and research an optional extra for medical and other health science students? Is Aboriginal health a core priority for universities and governments, an optional extra, or, in more sinister terms, a strategic priority in symbolic but not material terms? I suggest that if Aboriginal and Torres Strait Islander peoples are expected to participate on terms established by the white bio-political state (Moreton-Robinson 2004) as normal and unquestioned, then this participation is marked by institutional structural violence and inequity. Farmer's anthropology of structural violence (2004) is particularly helpful here, in that it illuminates the irony of expecting the 'disadvantaged' to gain equal access to an unequal system, where the system's rules are apparently immutable. In this chapter, I raise questions not only of justice, fairness and substantive equality, but also issues of priority, expectation and quality in curricula development, teaching and research.

THE ORIGINS OF SCHOLARSHIP ON STRUCTURAL VIOLENCE

Johan Galtung (1969) first used the term structural violence to refer to institutions and structures in society which systematically and consistently failed to meet the basic needs of certain groups, most often those who were poor or politically underrepresented. He subsequently updated his discussions of social justice to include the term cultural violence, defined as "any aspect of a culture that can be used to legitimize violence in its direct or structural form" (Galtung 1990: 291). Thus, Galtung suggested that cultural violence and

structural violence, and the inequities they entail, can be made to ‘look right’ or, at the least, be legitimized as normal. More recently, Scheper-Hughes and Bourgois (2004) have focussed on the macro-social factors at play in social inequity in relation to health, and Bourgois and Jeff have enunciated the particular intersections between individual actions and broader social forces (Bourgois and Jeff 2007). Similarly, other scholars have focussed on the structural violence and power relations implicit in individual actions and mitigation of HIV risk (Shannon, Kerr et al. 2008). Kathleen Ho (2007) has discussed structural violence as a form of human rights abuse, where:

The unequal share of power to decide over the distribution of resources [is] the pivotal causal factor of these avoidable structural inequalities. Recognizing that structural causes are responsible for constrained agency is pivotal in making the transition from structural violence to structural violations of human rights. It is the effect of structures on individual agency that results in this gap between potential and actual fulfilment of rights... when agency is constrained to the extent that fundamental human needs cannot be attained, structural violence becomes a structural violation of human rights (2007:1).

Inequity, as discussed in the previous chapter, and the link between structural violence and human rights abuses referred to here, are important for both medicine and health in general, and for Aboriginal health. I discuss the implications here.

Structural Violence in Health and Medicine

Paul Farmer (2004, 2005) defines three approaches used by medical professionals toward public health problems caused by poverty – charity, development and social justice (or liberation theology). In the charity approach, as mentioned above, medicine as an agent of the state seeks to do *for* people: “Charity underpins the often laudable goal of addressing the needs of “underserved populations,” while retaining power and benevolent self-gratification (Farmer 2005: 154). He gives examples from the USA and South Africa, where kindness and a decline in justice are linked, and where medicine may be able to treat malnutrition and its

complications, but not address the system that produced the poverty in the first place (Farmer 2005:154). In the development approach,

Liberal views place the problem with the poor themselves: these people are backward and reject the technological fruits of modernity. With assistance from others, they too will, after a while, reach a higher level of development. (Farmer 2005: 155)

Here it is clear that liberal and neoliberal ideas locate the problem of poverty and sickness within the individual themselves (Isquith 2014), rather than also acknowledging the system which gave rise to it (Navarro and Muntaner 2014). Further, notions of poverty alleviation and development are linked with modernity and consumption – one cannot ‘be modern’ without consuming in the economic marketplace (Navarro 2007, Sircar and Jain 2013).

Thus, in attempting to address health outcomes, the formulation of the nature of the problem is critical to the formulation of the solution (Bacchi 2009); problematisation is inherently political, and taken for granted ‘truths’ are revealed as myths (Bacchi 2012).

In contrast, Farmer argues for a social justice or liberation theology approach to medicine, where “we must understand that whatever happens to poor people is never divorced from the actions of the powerful” (2005: 158), and where historically deep, geographically broad and economically cognisant interventions need to be arrived at by the people themselves. In a structural sense, this means that the people whose health is being planned for should be more ethically and morally included in the design, delivery and implementation of health programs, including the power to decide and control decisions regarding resources and planning. The role of medicine becomes simply to provide technical assistance where requested: “In declaring health and health care to be a human right, we join forces with those who have long laboured to protect the rights and dignity of the poor” (Farmer 2005: 159). This does require

that participation does not become defined by medicine or the state as a series of platitudes, rather, that participation is committed social action as defined by the people.

STRUCTURAL VIOLENCE AND ABORIGINAL HEALTH

Farmer's conceptualisation of charity and development approaches in medicine as a feature of structural violence is directly relevant to Aboriginal and Torres Strait Islander health policy in Australia. Structural inequities underlying poor health outcomes are often dismissed, and the political focus remains on perceived individual or community shortfalls in responsibility, agency and intelligence (Eckermann and Dowd 1988). Similarly, the epidemiological discourses and methods regarding Aboriginal health have been shown to be detrimental if structural and social factors are discounted (O'Neil, Reading et al. 1998). Kirmayer and colleagues, (2003) writing about Canadian Aboriginal communities and the impact of structural violence, have concluded that "the social origins of mental health problems in Aboriginal communities demand social and political solutions" (2003: 15). This implies that, in this case, the mental health problems of an individual cannot be attributed to the individual's agency or actions alone, particularly when that individual is from an economically, socially or structurally disadvantaged community.⁴ This is particularly the case for Aboriginal and Torres Strait Islander health, where Aboriginal voices and abilities to define and solve problems is hindered or silenced (Kurtz, Nyberg et al. 2008).

If one construes Aboriginal health as being the fault of individual agency and actions alone, or one situates the locus of control for change within the individual, then it is reasonable to assume the locus for control to change the situation is also located within that same

⁴ See Chapter Four for a discussion on the normalisation of inequality.

individual (Bacchi 2012). Alternatively, if one locates Aboriginal individuals within an overarching social and political enabling environment, both individual actions and agency, along with structural agency and factors must also be accounted for (Moran 2008, McMullen 2013). This is exemplified by a recent national debate about alcoholism, violence and a spate of one-punch killings:

The Federal government has backed away from a proposed wide-ranging national inquiry into alcohol and violence programs. It appears the Federal Indigenous Affairs Minister Nigel Scullion has been over-ruled and a parliamentary inquiry will now only consider the effects of alcohol on Indigenous people (ABC News 2014: 1).

Here, not only is alcoholism and violence considered the precinct of the individual subject alone, but the problematisation of alcoholism and violence as individual in the general community becomes conveniently transformed into the problematisation of individual Aboriginal drinkers. The nation's denial about societal alcoholism and violence becomes constructed as individual Aboriginal shame.

Development approaches in Indigenous affairs may be detrimental if they are applied using an uncritical neoliberal frame:

Craig and Porter (2006) link neoliberalism, community development and the rise of NGOs with their term 'inclusive neoliberalism'. They argue that, under the neoliberal idea of community development, empowerment is conceptualised as participation in local and global markets; institutional capacity building becomes preoccupied with commercialisation; human capital is built through services rather than education; vulnerability is aided by formal legal rights rather than welfare; and citizen responsibilities are cast as moral obligations to community and work (Moran 2008: 2).

Consequently, for Aboriginal and Torres Strait Islander peoples, the terms of participation and inclusion in the neoliberal and bio-political state is cast in moralistic and paternalistic terms, where Aborigines and their individual agency are constructed as the problem, and charity or development is presented as the answer.

Structural Violence and the Social Determinants of Aboriginal Health

The Australian state has attempted to address the underlying structural inequity of poor Aboriginal health outcomes by using the broad public health concept of the social determinants of Aboriginal health (Marmot and Wilkinson 2005, Baum 2007). This can be seen in terms of the ‘Closing the Gap’ campaigns to reduce the difference in life expectancy between Indigenous and non-Indigenous Australians:

There has been increasing recognition of the significance of more intangible determinants such as control over life circumstances (Tsey 2008), social exclusion and factors associated with cultural difference (Anderson et al. 2007, Halloran 2004). Evidence shows that these determinants – falling broadly in the domains of control and culture – are directly relevant to the issues targeted by Closing the Gap, yet ... have been neglected or negatively impacted in the development and implementation of its policies (Cooper 2011: 2).

Thus, Aboriginal health policy, as it is constructed by the state, seeks to ‘close the gap’ or meet the needs of the underserved by increasing equity through the rubric of the social determinants of Aboriginal health, yet fails to address or recognise contributing factors to the sources of inequity, such as unequal power relations and control or input into decision-making. Further, the state chooses which social determinants of health it wishes to address; in the example above, the tangible over the ‘intangible’ domains of culture and control. This is telling – it suggests the state prefers to focus on the provision of housing and education, rather than to consider who decides about what housing gets built and what education gets taught, and the appropriate governance structures might be needed for this kind of consideration. The state wants to focus on the ‘what’, not the ‘how’. Evidence shows that where Indigenous governance systems (Chandler and Lalonde 1998) and Indigenous participation in non-Indigenous governance systems is assured (Cornell 2006), then Indigenous health outcomes improve.

While the social determinants of Aboriginal health as a conceptual tool recognises upstream factors, its translation into practice is problematic in two ways. First, this planning tool means it relies on the same system (and its public health parameters) that produces inequity to try to solve it. The public health system recognises that education and housing are critical upstream factors in producing health inequity, but does not know how to translate this evidence into practice because of policy silos (Chamber of Commerce and Industry Western Australia 2007) and a skewed focus on funding treatment rather than prevention (Harris and Mortimer 2009). Second, while the conceptualisation of the social determinants of health explains and accounts for upstream factors, it does not necessarily empower those most affected; in this case, Aboriginal peoples – with the capacity, tools or governance mechanisms to share decision-making and power in their resolution. This does not mean the social determinants of health as a conceptual tool and evidence base should be dismissed; rather, that the underlying structural violence and power relations implicit in the system used to apply this evidence should be more fully revealed and addressed.

Consequences of Ignoring Structural Violence and Power in Aboriginal Health

The CDAMS medical curriculum project in which I was involved argued for self-determination and sovereignty as one of its critical guiding principles for Aboriginal health (Phillips 2004b, Australian Medical Council 2007). We knew that an important feature of the project's development would be that the Deans take ownership of the project, but that the project would be led on a day to day basis by Aboriginal scholars and staff. We were attempting to share leadership on the issue, and coined the term 'Indigenous leadership and faculty responsibility' to denote a sharing of responsibility for implementation of the curriculum framework, where Indigenous scholars would be empowered to lead intellectually and on a program basis, but that the responsibility for the implementation of a medical faculty's

Indigenous health strategy would be shared across various departments and areas of responsibility. For example, Indigenous student recruitment would require the benefit of Indigenous scholar leadership with community engagement, identifying potential students, and reforming admissions and selection criteria to be more equitable. Concurrently, the associate dean for student affairs, or his or her equivalent, would also be responsible for working with their Indigenous colleagues to reform admissions and selection criteria, train their staff in the new guidelines, and invest in the potential of capable Indigenous students.

Yet we were not aware enough of the epistemic violence that sometimes hides behind the word ‘inclusion’ (Fredericks 2009c). That is, while we were arguing for Aboriginal sovereignty and self-determination as a philosophical basis for Aboriginal participation in higher education, the implications of this for decision-making regarding curriculum design and implementation or Indigenous student recruitment were not fully articulated, discussed or agreed upon at the beginning of the Project. The terms of ‘inclusion’ that the Deans were signing up to – in this case, were in retrospect, different to the terms of ‘inclusion’ that Aboriginal scholars, including me, were agreeing to. Aboriginal scholars thought that when they articulated Aboriginal sovereignty and self-determination in the curriculum framework (Phillips 2004b) and the accreditation guidelines (Australian Medical Council 2007), this would naturally flow through to operational matters such as Aboriginal ownership of teaching units and the derived income, Aboriginal decision-making, and consultation on matters of Aboriginal curriculum design and implementation (e.g. who should or could teach Aboriginal health curricula content), shared decision-making regarding Indigenous student recruitment selection criteria, and Aboriginal community input into the quality and continuous quality control processes. This was not the case; senior non-Indigenous medical school staff had

differing ideas about what self-determination and sovereignty meant in the context of medical education, at times did not accept the relevance of it, or had no idea what it meant at all.

In retrospect, this confusion regarding the meaning of the terms of sovereignty and self-determination in relation to medical education, and a focus on the product (the curriculum framework), and leadership at the Deans' level, was naïve. Instead, discussion of the values and motivations of each party may have elicited clearer meanings of sovereignty and self-determination and how these were critical to Indigenous participation in health and medical education. Timeframes for the project impacted on this oversight, as contractual pressures stipulated the development and delivery of the curriculum framework, a network and accreditation within one year. Yet herein lies an important learning – moving to develop a product too quickly, without considering the values on which a partnership are based, may impact on the overall performance, uptake or implementation of the final product. Further, more detailed discussions about the nature of partnership, decision-making and governance mechanisms between lead Indigenous scholars and Deans, and at day to day operational level within a given medical school (e.g. subject curriculum design or Indigenous student admission policies), would have been beneficial.

The focus therefore was on the product, without detailed discussions of values and motivations, nor discussions on governance and the terms of participation and decision-making at a project and individual medical school level. In consequence, the project was unintentionally operating from a charity or development approach. In this approach, a purely biomedical and epidemiological approach to Aboriginal health was taken for granted, decision-making power rested in the hands of non-Indigenous Deans and senior staff, curriculum committee chairs and heads of student recruitment. Power was not shared.

Indigenous lead scholars attempted to address this by instigating ‘Deans’ Indigenous health leadership forums’ to discuss values and motivations, and some medical schools appointed senior Indigenous staff as associate Deans or equivalent to attempt to ensure Indigenous leadership. Yet the nexus of power encapsulated in the term ‘Indigenous leadership, faculty responsibility’, was not fully clarified or understood in a mutually agreeable way. The terms of inclusion and sharing of power were not fully enunciated. The unintended result was that structural violence and the continuing production of inequity occurred, under the banner of ‘inclusion’. I turn here to specific cases of the application of structural violence and the social determinants of Aboriginal health.

CASE STUDY 4 – A FIVE MINUTE CHAT

In 2010, a senior Aboriginal health academic named Roberta (pseudonym) was at an overseas conference with a number of medical school colleagues, and was casually asked for “a five minute chat or coffee” by the head of the medical degree. Roberta agreed to meet. The colleagues grabbed a coffee at afternoon tea break of the conference, and the head of medicine said to her: “I just wanted to run our AMC report past you. As you know, the accreditation team is again coming in three months, and I wanted to make sure our response to them on Indigenous health is OK. What do you think?”

Roberta pointed out that it was a large program, and that this required a bit more of a discussion than ‘a five-minute chat’. The head of medicine was embarrassed, but agreed. Instead of a five-minute chat, at Roberta’s suggestion, a half hour meeting was convened during the conference, attended by very senior education, research and administrative staff from their university. Roberta made the point that the review, assessment and reporting of Indigenous health curriculum in medicine was a complex task that should be completed

systematically. All in attendance agreed. The head of medicine proposed to convene such a meeting when everyone returned to Australia. The meeting was not convened. Six months later, just before the AMC team visited, the head of medicine apologised profusely for not arranging the meeting, and asked Roberta to review the draft two-page section of the report regarding Aboriginal health, which was to be submitted to the AMC. Roberta reiterated that it was inappropriate to not have had the more systematic and strategic discussions beforehand, and that she had not been involved in drafting the summary document. However, she reluctantly agreed, asking the head of medicine to ensure it never happened again.

Two years later, Roberta was no longer employed by the university, but she was still a professional associate of the university. The head of medicine contacted her, and explained that the AMC was again coming the following week for a review meeting. Could she please attend, he asked, “to discuss our community engagement initiatives with the AMC?” Roberta reported feeling used, and again made the point that it was not appropriate for these last minute approaches to make things look good for the university, with seemingly no serious strategic planning or resources. Roberta told the head of medicine she wasn’t available. The head of medicine then contacted an Aboriginal community organisation with which the faculty had a partnership, and asked it to nominate members to attend. The organisation, believing that the approach from the medical school was well-intentioned, sent a non-Aboriginal worker to the meeting, who cheerfully reported that the organisation and the university were working towards a stronger partnership. The AMC accreditation team was not aware of the terms of the partnership, nor what questions they should ask in determining if there was a quality approach to curricula design or implementation. Further, no information was sought about the partnership, or about process or structures. Aboriginal participation in decision-making was not discussed or clarified.

Reflection

Three issues come to mind in reviewing this case. First, such stories were regularly recounted to me during my travels with the CDAMS Indigenous Health Curriculum Project. As National Program Manager, I visited all medical schools in Australia and New Zealand, and met with the Deans, the chairs of their curriculum committees, their Indigenous health academic staff, and sometimes, with students with a particular interest in Indigenous health, such as members of rural student health clubs (Phillips 2004a). Indigenous health staff would often tell me that where Indigenous health content was integrated into other areas of medical curricula, such as say, pathology or diseases of the heart, they were not consulted in decisions regarding how Aboriginal health should be taught in that course. On the other hand, some medical schools only had discrete Aboriginal health content in medicine, with, for example, one or two lectures or cases across the whole medical curricula that were tagged as ‘Aboriginal health’, most often on stereotypical topics, such as ‘Aborigines and alcoholism’ or, in one case, a subject entitled ‘Psychological Problems: the Health of Disadvantaged Minorities’. Some Indigenous health staff reported that they were not regularly included on curriculum committees, that the terms of their membership were vague if they were asked or consulted on isolated matters, and that they had no idea of the frequency or schedule of meetings. These staff reported that when they were asked to participate, it was usually only when the AMC accreditation teams visited, and even then, they were not privy to the submissions and claims of the medical school in relation to the rest of the curriculum.

Second, I am struck by how frustrating this must have been for Indigenous health staff. They reported being either ‘wholly responsible for all things Aboriginal health’, or treated as tokens, with limited substantive participation in decision-making over the content and control of curricula. When working in medical schools myself, I had a similar experience, where a

senior public health academic had chosen not to collaborate with me as the only Aboriginal health academic in the medical school on a project regarding cultural safety, yet contacted me late one Thursday afternoon asking me to participate in the project on the reference committee. She said:

I've just picked myself up off the floor. I've been working so hard on this project and at the final hour, have been told I have to collaborate with Aboriginal communities if I am to get this project through ethical considerations. I had no idea! If I had known, I would have spoken to you about this long ago! It's due tomorrow. Do you know of any way I could get a last minute letter of support or indication of in-principle support?

I suggested to her that the National Health and Medical Research Council's guidelines regarding health research impacting on Aboriginal and Torres Strait Islanders had been well known for some years, and underpins all research with Indigenous Australians. It would be surprising had she not been aware of the implications of cultural safety on Aboriginal health. Regardless of her motivations, I felt it was quite rude to expect support from me, as an academic, in the capacity of a reference committee member, rather than say, a co-investigator or even chief investigator. In essence, this person was asking me to be an addendum to the main act—a less powerful academic non-entity or assistant to legitimise her research rather than be involved in content as an academic with equal intelligence and contributions to make. I have no idea as to the reasons for this person's reticence to invite my contributions earlier on, other to suggest that research is a competitive market, where control of intellectual property and resources regarding Aboriginal health is contested. This person was, wittingly or unwittingly, enacting unequal power relations and structural violence.

Third, I am struck by questions of how the academic head of medicine in this case, and in similar cases around the country, must have been construing Aboriginal health – was it an optional extra for him? Or was Aboriginal health a core part of medicine? If, for example, the

AMC had asked for an update or report on the teaching of biomedical sciences and related infrastructure, I am sure there would be a strategic and continuous review process.

Organisations and medical schools adopt numerous quality review measurements, processes and strategies. Yet, apparently, in this case, Aboriginal health did not warrant it, even though it was required by the AMC to be a core part of medical education (Australian Medical Council 2007).

CASE STUDY 5 – STAFF CAPACITY

In the late-2000s, staff of a medical school that had been operating for approximately forty years were preparing for their medical school accreditation process. They had employed one Aboriginal person as an academic (level B, three days a week) whose role it was to develop and implement an Indigenous health curriculum. This academic was a general practitioner by training, and this was his first academic appointment. He had been in the role for two years. A senior non-Indigenous Professor, who was the direct supervisor for the Aboriginal academic, told me she was concerned about the role and the likelihood anyone would have the capacity to carry out the full range of expected duties, given the Aboriginal academic was asked to undertake not only teaching and research, but also Indigenous community engagement and Indigenous student support and recruitment. Additionally, there was concern expressed by the Dean that the role may become harder to sustain, given both the medical school's budget and the Aboriginal academic's family circumstances. The medical school undertook its accreditation process and the Australian Medical Council (AMC), the accrediting body, raised questions in its report about the sustainability of the Indigenous health program, in terms of capacity, resources and the scantness of Indigenous health curricula through the course, and made recommendations based on these questions. The Dean expressed to me his delight that the Indigenous health recommendations were given clear

attention by the accreditation team, and vowed to look at the issues involved and make changes where possible. Approximately one year later, I spoke to the Aboriginal academic involved who informed me that he had left the medical school because of lack of adequate support to expand the program. Others in the medical school did not appear to understand the effort and resources it took to maintain Indigenous community engagement. The academic said he felt that senior staff in the medical school hierarchy thought of Indigenous community engagement as an optional add-on, rather than a core part of curriculum development and implementation, and of the recruitment and support of Indigenous medical students. The medical school received accreditation after a one year follow up by the AMC. In relation to Indigenous health, the AMC took on good faith the explanations given to the review team by the medical school. The medical school cited the individual circumstances of the Aboriginal academic as a reason why the Indigenous health curriculum could not be improved at that time, but that they had planned to do so in the future.

Reflection

This case study contains several pertinent issues to delivering Indigenous health in medical curricula, particularly resourcing and accreditation processes.

A Person-centred or Strategic Approach?

In terms of resourcing, the appointment level of the Aboriginal academic is significant, in that the position was paid at a low to mid-level position and on a fractional (three days a week) basis. When the appointment level was raised with the Dean, he argued that this appointment assisted the academic, given the academic had requested time apart from the medical school to undertake other clinical work, and that the academic skills of the particular person seemed to match a level B appointment, rather than any higher. This response was telling, not

because any of the particular circumstances of the individual academic were in dispute, but because the medical school's sole strategic investment in Indigenous health at this time was centred on the personal circumstances of an individual, rather than any institutional or broader organisational approach.

This person-centred approach would seem to be consistent with findings of the audit of Indigenous health curricula in medical schools and review of implementation of curricula and student support initiatives. Both of these documents found that relying on individual champions rather than strategic approaches was not optimal and more likely to prove unsustainable (Phillips 2004a, Medical Deans Australia and New Zealand and Australian Indigenous Doctors' Association 2012).

Workforce Supply

Another dimension to this approach is that the Dean had argued that it was critical to have an Indigenous person leading the program, and that he felt particularly fortunate to have an Aboriginal academic with medical training, given that nationally, they were in short supply (National Aboriginal and Torres Strait Islander Health Council 2009). While this is true, he seemed to be associating medical academic workforce shortages with a lack of strategic direction for the organisation; that if there were more Indigenous medical academics available, then his organisation could take a more strategic rather than a person-centred approach. A more strategic approach might actually take into account workforce shortages and plan for them through workplace professional development and employment strategies, rather than using shortages as an excuse for a person-centred approach.

Indigenous Leadership and Self-Determination

This person-centred approach also seems to raise an important racial element to strategic direction. It has been noted that it is crucial to let Indigenous people, academics and health professionals lead the development of Indigenous health programs for reasons of self-determination (Anderson, Crengle et al. 2006, Cornell 2006). Specifically, Chandler and La Londe (1998) have found that those First Nations communities in British Columbia with high levels of participation in self-governance and decision-making had lower youth suicide rates than those communities who did not. In Indigenous health workforce matters, leadership has been noted as a key factor in determining the success or failure of policy imperatives (National Aboriginal and Torres Strait Islander Health Council 2009).

For these reasons, it is understandable and appropriate that the Dean in the above case study considered that the Aboriginal academic should lead the Indigenous health program of the medical school. Yet what seems to have occurred is that strategic leadership and implementation have been conflated, particularly when implementation of an Indigenous health strategic approach requires curriculum development, teaching, research, Indigenous student support and Indigenous community engagement. These implementation issues were raised by the Aboriginal academic, the supervisor, and the accrediting body, the AMC.

Implementation

The Aboriginal academic in question was asked to carry out both strategic and practical implementation of an Indigenous health approach. This included strategic leadership, curriculum development, teaching up to four hours per week, conceiving of and undertaking original research projects, supporting Indigenous medical students in their cultural and academic support needs, supporting non-Indigenous students with their emotional reactions

to confronting the poor state of Indigenous health and their own whiteness (Rasmussen 2000), and educating and supporting their peers; other staff who have no idea about Aboriginal health, or who question the relevance and importance of it.

This last task – Aboriginal academics having to educate their non-Aboriginal colleagues about the importance of Aboriginal health – has been documented as occurring in most Australian medical schools (Medical Deans Australia and New Zealand and Australian Indigenous Doctors' Association 2012). At The University of Western Australia, two senior academics in Indigenous health told me that one of their greatest frustrations in maintaining and growing an Indigenous health curriculum program in medicine was the high rotation of year and subject co-ordinators, such they had to start with each new person to assess their level of readiness to teach, co-teach or merely accept the place of Indigenous health in the medicine course. Paul and colleagues (2011) has reported that there was an intellectual and emotional education process involved which could take several years for students or teachers who had not been previously exposed to positive accounts of Indigenous people to ‘turn a corner’. The repetitive nature of this task contributed to the likelihood of burn-out (Paul, Carr et al. 2006). Even if a medical school were to take a genuinely strategic approach to Indigenous health, rather than rely on individual ‘champions’, it would seem that there is a specific role for someone or a few people to carry out professional development with other non-engaged staff to teach them about the rationale and motivation for teaching Indigenous health curricula to medical students.

The varying aspects of implementing a strategic approach to Indigenous health in medical schools would seem to require the human resources of more than one staff member, particularly if they are on a fractional appointment. In this particular case study, the

accrediting body noted that it was unsustainable situation and make specific recommendations for the medical school to change or consider different approaches. Rather than focus on the individual skills of any particular leader or Aboriginal academic, the medical school was asked to consider strategic approaches that observed Indigenous leadership while ensuring one worker did not have to perform all of the plethora of tasks outlined, all of which have their own unique skill sets.

Indigenous Community Engagement

Another key task identified in implementing an Indigenous health strategy is that of Indigenous community engagement. Indigenous community engagement is important to the task of curriculum design and implementation for three reasons.

First, there is an extremely important cultural concept that Aboriginal academics are obliged to observe, and which non-Aboriginal academics would benefit immensely from observing – that of place, traditional ownership, and sovereignty regarding decision-making occurring on one's traditional lands (Anderson 1989). In many Aboriginal and Torres Strait Islander cultures, the traditional owners of a particular tract of land and/or waters should be involved in key decision-making regarding activities that take place on that land or water. For example, if a program or initiative is being run in region A, then the traditional owners and broader Aboriginal and Torres Strait Islander community in that region could be invited to participate in decision-making regarding the development of curricula and Indigenous student support. If a similar task were to be completed in region B, the traditional owners from that region would be the relevant decision-making authorities, not the traditional owners or Aboriginal people from region A. This is similar to people in France not being asked to make decisions about a project in Denmark without having spoken to the Danish government and/or people,

and vice-versa, or people in South Australia not being asked to make decisions for people and projects in Queensland. Implicit in this is the concept of sovereignty; Aboriginal and Torres Strait Islander peoples lay claim to their sovereignty as not having ever being ceded to the British Crown. This means that the people of the land should be involved in decision-making over activities that occur on their lands. Many medical school academics do not observe the landscape in which they are situated in this way. They may be happy to ask local Elders to do a welcome to country at a conference, or perhaps ask them to raise a flag at a NAIDOC week event, but they are often not willing to respect that Elder as an owner and sovereign decision-maker over activities occurring on their lands.

Observance of this cultural protocol is an important way to build trust with local Aboriginal and Torres Strait Islander communities, and this represents the second reason why Indigenous community engagement is critical to curriculum design and implementation. Building and maintaining this trust can be time consuming and not appear to be a legitimate part of the academic enterprise. For example, the appropriateness of going to local community events such as community meetings, sporting carnivals, high school graduations and smoking ceremonies is often questioned by senior staff in the medical school. But if time is spent building and maintaining trust with traditional owners and other Aboriginal communities, then they are more likely to participate and support any activities one might wish to undertake on their lands.

Explanatory Models – Problems and Solutions

Third, the concept of place and traditional ownership is important to curriculum design and implementation of Aboriginal health strategies, as discussed in Chapter Three. Understanding the explanatory models of a local community is important to not only understand the cultural

worldviews, but how to observe and respectfully incorporate them in the design of programs; that is, how to intervene.

Aboriginal communities have long stated that they understand the social determinants of Aboriginal health outcomes to be based on factors like language, history, spirituality, religion, gender, socio-economic status and so on. Thus, in an Aboriginal explanatory model, it is entirely logical and consistent to intervene most effectively using models that take into account of all of these factors. Three approaches most cited by Aboriginal health leaders as being effective are holistic approaches, community development approaches and strengths-based approaches. This is similar to Amartya Sen's (1985) and others' (Nussbaum 2005) insistence on a capabilities approach rather than an efficiency approach in economic development and measurement of labour.

Thus, while local Aboriginal communities often have differing subtle and complex diversity in explanatory models, what can be agreed in common is that with their focus on holism, community development and strengths-based approaches, they are anathema to the biomedical model. Biomedicine uses an explanatory model where individual sickness is caused by diseased cells of the body, and thus in this explanatory model, it is entirely consistent and logical to intervene using approaches which aim to repair the sick cells or parts of the bodies of individuals. Biomedicine problematizes the sickness of the individual, rather than build on the capabilities or strengths of the individual, family and community.

This discord in explanatory models between Aboriginal and Torres Strait Islander communities is one reason why senior medical school staff express difficulty in understanding the rationale and justification for time and resources being spent on Indigenous community engagement.

The other reason for Aboriginal communities preferring a community development and holistic approach to intervening in health problems is that in their explanatory model, community development requires reciprocity, capacity building and knowledge exchange. This implies an equal power balance in decision-making, where partners and stakeholders in any given community work together equally both to share the responsibility for change, and also to reap the collective rewards and benefits of two-way learning and development.

If medical schools are to develop curriculum which teaches medical students how best to work with and intervene in Aboriginal health, they have been advised to not only support Aboriginal academics to build and maintain a steady program of Indigenous community engagement for reasons of efficacy and appropriateness in curriculum design, but because clinical skills delivered in real life settings ignorant of local explanatory models will not deliver the best patient outcomes, nor will they represent best practice.

Implementing a strategic Indigenous health approach cognisant of the importance of Indigenous community engagement across a whole medical school would appear, then, to require many more different skill sets and workers than expecting one person to carry the load by themselves.

Sustainability of Strategic Approach

In this case study, an Aboriginal academic working three days a week was expected to lead and implement a strategic approach to Indigenous health for the whole medical school. For many of the reasons outlined above, this approach would seem to be an individual-centred rather than strategic approach, and according to internal and external observers, unsustainable

(Medical Deans Australia and New Zealand and Australian Indigenous Doctors' Association 2012).

This raises the question then of what resources would be required to make a strategic approach to Aboriginal health curriculum sustainable in medical schools?

The CDAMS Indigenous Health Curriculum Framework suggested resources including “Indigenous staff across the school, including dedicated roles in three separate areas: academia, Indigenous student support and retention, and administration,” along with suggestions for professional development of non-Indigenous staff regarding Aboriginal health, operations and management, curriculum materials and curriculum partnerships (Phillips 2004b: 26-27).

The national review of implementation of the curriculum framework and Indigenous student support initiatives found that while the amount of Aboriginal health curriculum being taught in medical courses had increased since publication of the curriculum framework, there were no measurements or indications that the quality of curriculum, nor increases in resourcing were apparent (Medical Deans Australia and New Zealand and Australian Indigenous Doctors' Association 2012).

Irihapeti Ramsden, in her work on cultural safety in nursing schools in New Zealand identified that even before operational issues such as the number of staff, their roles and training are addressed, issues like the values of the organisation and the values of partners are integral to developing more meaningful partnerships and relationships (Ramsden 1993, Ramsden 2002).

From the case study presented above, some important clues emerge as to what optimal support medical schools could implement in developing a strategic approach. Recognition of the following are important: strategic approaches are desirable, strategic approaches should not be individual-centred, there is a distinction between leadership and implementation, implementation will require more than one individual – some suggest at least three workers, implementation consists of executive leadership, academic teaching and research, Indigenous student support, and support for non-Indigenous students, and training and support for non-Indigenous staff (Phillips 2004b, Phillips 2005, Paul, Allen et al. 2011, Medical Deans Australia and New Zealand and Australian Indigenous Doctors' Association 2012).

Given that the above issues have been articulated clearly by both Medical Deans Australia and New Zealand themselves, the accrediting body and academic literature, it is worth considering the situation dean's face in deciding how to respond to such suggestions, recommendations and policy guidelines.

The Dean in this case study expressed three reservations about developing Indigenous health: the individual circumstances of the Aboriginal academic (fractional appointment and personal health issues), a small talent pool of Aboriginal medical academics, and the lack of more funding to employ more staff. Given that the first two issues have been previously discussed, I shall focus on the issue of budgets and resourcing here.

Budgets for Indigenous Health in Medical Faculties

If budgets are so constrained in medical schools that they cannot find more dollars from within their budget for a strategic approach to Aboriginal health, what are the factors influencing this decision? Every budget within a large organisation such as a medical school

has a range of competing pressures and strains, and leadership and management depend on written strategic plans, objectives, and key performance indicators, among others, to focus and prioritise the organisation's activities.

In medical schools, whether or not Aboriginal health is considered a strategic priority is a matter open to debate. While Medical Deans Australia and New Zealand (MDANZ), the peak advocacy body representing medical schools, has stated strategic objectives and goals for Indigenous health and have conducted a number of projects and strategic activities, it does not appear that every individual medical school has adopted the same approach. The Australian Medical Council, the accrediting body, includes a specific standard for medical schools to ensure Aboriginal and Torres Strait Islander or Maori health is a stated strategic objective in each school's mission statement and strategic planning documents. The MDANZ review (2012) found that not every school makes specific mention of Indigenous health as a priority, or does so in a way which marginalises any focus on it. For example, schools often include Indigenous health as 'population health needs of the disadvantaged', or 'the social determinants of health, including for Aboriginal people, the disabled and women', if at all.

EXEGESIS

The theory of structural violence and its links to neoliberalism and power relations and are coupled with my reflections on the case studies to form the basis for the following exegesis. I deal with three major themes: priorities, responsibility and accreditation.

The Priorities of Medical Faculties

The case study illuminates the differences in priorities that exist within the medical school.

Roberta's priority was to plan and review the quality of Aboriginal health curriculum content

in a considered way, so that when accreditation reports and visits were made, this strategic approach could be relied and reported upon. While the head of medicine told Roberta they (he and his colleagues) were “committed to Aboriginal health,” and made representations and public statements at medical education and Aboriginal health conferences and meetings, their statements about commitment did not seem to match the level of effort and resources invested in the planning and review of Aboriginal health curriculum content.

In terms of human resources to teach Aboriginal health curricula content, there was one Aboriginal health lecturer across the whole faculty apart from Roberta, and this lecturer taught some Aboriginal health curriculum content in a rural health rotation at one of the medical school’s several rural clinical training locations. This meant that not all of the medical student cohort in any given year would receive this content – only those at that particular rural clinical location. Additionally, there was a lecture on the social determinants of Aboriginal health in first year, a scenario based learning module in second year, and Aboriginal health placement electives in the advanced clinical years – all of which were coordinated and taught by non-Aboriginal staff. This curriculum map was not brought together in an overall curriculum map for Aboriginal health, nor was there a strategic approach to curriculum planning and review.

Additionally, the governance and accountability or review mechanisms were not clarified. This meant that while the concept of ‘Indigenous leadership and faculty responsibility’ attempted to share the workload and ensure a partnership approach, the terms of that partnership and their underlying power relations, were not enunciated or applied in everyday planning and program operations.

Roberta made known her disagreement with the way the head of medicine was responding to accreditation, and by extension, curriculum planning and review. Roberta had raised this as an issue by asking the head of the medical program to convene a longer meeting of key academics at the overseas conference, by seeking and gaining agreement that the head of medicine would take a more strategic approach and call a meeting when everyone had returned to Australia, and by specifically asking the head of medicine a second time to convene a meeting. At each of these three stages, the head of medicine agreed with the suggestions and undertook to implement a more comprehensive approach to Aboriginal health curriculum review than ‘a five minute chat’.

Aboriginal health curriculum at this school became a ‘tick-box priority’, where minimal or no resources or efforts were invested in quality improvement as a valuable and important task. Instead, it seems that the head of medicine saw it as a priority to *appear* committed to Aboriginal health (i.e. a five minute chat, a two page report, attendance at another AMC visit), rather than to actually invest or take action in terms of developing and implementing a more strategic approach.

This raises a series of questions regarding what type and level of strategic priority Aboriginal health curriculum represented for the medical school. Aboriginal health was not reflected in the curriculum map of the medical degree at that point. Aboriginal health was not listed among the graduate student outcomes. Aboriginal health was not listed as a strategic priority for the organisation as a whole, by being reflected in its mission or purpose statements.

More broadly, while Aboriginal health was often spoken of as a priority for the university, it was not listed in strategic planning documents, or mentioned as part of its graduate student

outcomes. Instead, it was mentioned under social inclusion policies. This implies that Aboriginal and Torres Strait Islander people and their knowledge should not be included in the life of the university and across curriculum areas, but that a more benevolent approach to the 'inclusion' of Aboriginal students was being taken. Similar to the medical school, it was unclear what resources (financial, human, in-kind) were invested in ensuring a strategic, sustainable and quality approach.

In 2012, the federal government commissioned eminent scholars to conduct a review into Indigenous higher education outcomes (Behrendt, Larkin et al. 2012), and this review found that university culture and sector governance were critical factors in the likelihood of Aboriginal and Torres Strait Islander people succeeding at university, and in terms of university's commitments to Indigenous advancement; stating that for parity to be achieved:

Vice-chancellors will need to lead from the top and, together with faculties, drive change in university culture and governance, so that there is shared responsibility for Aboriginal and Torres Strait Islander higher education outcomes across each university leadership. Improving Aboriginal and Torres Strait Islander higher education outcomes should be integral to the university's core business (2012: xv).

Further, Universities Australia compiled a report and best practice framework for cultural competence in the areas of teaching, research, employment and community engagement (2011). The report recommended five guiding principles which, if implemented, would be considered marks of a culturally competent higher education institution, insofar as Indigenous education is concerned. The report's guiding principles, developed in part by Indigenous and non-Indigenous scholars and administrators, are:

1. Indigenous people should be actively involved in university governance and management.
2. All graduates of Australian universities should be culturally competent.
3. University research should be conducted in a culturally competent way that empowers Indigenous participants and encourages collaborations with Indigenous communities.
4. Indigenous staffing will be increased at all appointment levels and, for academic staff, across a wider variety of academic fields.

5. Universities will operate in partnership with their Indigenous communities and will help disseminate culturally competent practices to the wider community.
(2011: 8)

While those principles concerned with governance and partnerships are clear, it would seem from the above case studies that the issue is how these are applied as daily planning realities.

Support for Medical Schools

To assist medical schools in the process of the development of Aboriginal health curricula, a number of significant resources were available at the time of the request for ‘a five minute chat’. The Committee of Deans of Australian Medical Schools (CDAMS) had developed and disseminated the CDAMS Indigenous Health Curriculum Framework (Phillips 2004b) as a set of guidelines for suggested subject areas and learning outcomes, pedagogical principles and optimal resourcing for Aboriginal health in medical schools. CDAMS also developed a network of Aboriginal and non-Aboriginal medical educators and health professional stakeholder bodies, called The Leaders in Indigenous Medical Education (LIME) Network (Haynes, Collins et al. 2013). The LIME Network currently hosts bi-annual professional development conferences for medical schools to share knowledge and experience about the development, implementation and evaluation of Aboriginal and Maori health curriculum in medical schools in Australia and New Zealand. CDAMS and The LIME Network also developed a Critical Reflection Tool for medical schools to consider key questions and organisational considerations in planning and implementing curricula (The LIME Network 2014). Further, the accrediting body for medical schools, the Australian Medical Council (AMC) endorsed the CDAMS Indigenous Health Curriculum Framework, and changed their accreditation standards in 2006 to reflect both the curriculum framework and broader organising principles like Aboriginal sovereignty in shared decision-making about curricula

resources (Australian Medical Council 2007). I discuss the details and implications of these accreditation standards in greater detail later in this Chapter.

Thus, it would seem that medical schools had a number of resources available to them in designing, implementing and evaluating their Aboriginal health curriculum for a number of years. Given the head of medicine in Case Study 4 had attended and made public representations about Aboriginal health at these conferences and meetings, it would seem reasonable to assume he was aware of the existence and utility of the resources mentioned above. Further, there seemed to be no accountability mechanism whereby the medical school might report to a senior university administrator responsible for Indigenous curriculum, for example, a deputy vice-chancellor concerned with 'Indigenising' the curriculum (Williamson and Dalal 2007).

An awareness of the existence and utility of these resources had not been matched by action to implement or actually use any of them. A key pedagogical principle of the curriculum framework states that "Indigenous staff are key curriculum developers and enhancers" (Phillips 2004:17), and that "in order to facilitate the most effective learning possible, partnerships with local Indigenous individuals, organisations and communities will need to be developed (Phillips 2004:19). The AMC accreditation guidelines stated that, regarding education expertise as a standard for basic medical education, it is incumbent upon medical schools to "ensure appropriate use of educational expertise, including the educational expertise of Indigenous people, in the development and management of the medical course," and that:

Indigenous health is a school-wide responsibility that will require appropriate guidance and leadership in Australia by Aboriginal and Torres Strait Islanders and in New Zealand by Maori, as well as adequate resources for training and professional

development of all staff, engaging with local communities and other appropriate networks (AMC 2006:5).

If the resources of the curriculum framework had been used, and if the accreditation guidelines had been appropriately implemented, it would seem highly unusual that a head of a medical school could ask for ‘a five minute chat’ to discuss the accreditation of Aboriginal health curriculum, not once but on three occasions.

An important observation here is that the context of the medical school, or the enabling environment of the medical school and broader university is also an important factor in quality Aboriginal health curriculum. That is, general university-wide policies like anti-racism strategies, or Indigenous employment strategies, or reconciliation action plans, or Indigenous education policies and strategies, could play an important role in determining the likelihood of success of any faculty or school based initiative. It would not necessarily preclude or inhibit faculties or schools from acting and leading on Indigenous education matters in their particular faculty, but it seems likely that university-wide enabling strategies and approaches could be important facilitators for growth in faculties and schools.

Accountability and Quality

The enabling environment for Indigenous health and medical education is important in two ways. First, if the medical school had prioritised Aboriginal health in its curricula map, graduate student outcomes statement, strategic plans and mission/purpose statement, and if the university had similarly planned at the broader institutional level, then this would publicly communicate the organisation’s intentions and priorities. The absence of these explicit written commitments in this case study could well be a contributing factor to the less than optimal experience, of ‘a five minute chat’ rather than a more strategic approach. This is

because if commitment are not written or publicly stated, they are then harder to identify or measure.

Second, when organisations set, write and commit to strategic priorities in their public planning documents, it often is accompanied by organisational commitments to resources and monitoring frameworks. Yet in this medical school, while the head of medicine has made public verbal commitments to Aboriginal health curriculum, and was bound by the AMC's accreditation standards, it appears no actual written public commitments had been made in their strategic planning documents. No Aboriginal staff were directly employed by the medical school, but they did ask Roberta, in this case study, who had a faculty-wide appointment, to contribute to re-designing one theme within the medical course. They did not ask Roberta to contribute to reviewing the whole medical degree, nor did they commit any resources to find others who might reasonably contribute. No quality review or continuous quality review process had been initiated, thus, it seems, Aboriginal health curriculum was considered a priority when the AMC accreditation team visited, rather than as part of a strategic or continuous approach to curricula development and improvement.

Critically, even if a medical school identified Aboriginal health as a strategic priority, there were limited accountability mechanisms to review either the implementation of curriculum (the 'what'), or the processes of governance and decision-making (the 'how') encapsulated in the schools' approach.

In summary, the issue of the level of priority Aboriginal health is given within a medical faculty can in part be measured by public written commitments in strategic planning

documents, the level of resource investments, and if there are established processes for governance and decision-making, accountability, and continuous quality improvement.

Responsibilities: Shared or Confused?

The case study presents another important issue – responsibility for improvements in Aboriginal participation in higher education, and in this case, specifically, medical schools. Is the responsibility for improving Indigenous participation in higher education an organisational and institutional commitment, or is it the commitment of certain individual ‘champions’, as found in a national audit of medical schools (Phillips, 2003)?

Certain markers would indicate institutional and organisational responsibility, such as a university or medical school identifying improvements to Indigenous participation in their strategic planning documents (eg mission statements, value statements, strategic plans). This public acknowledgement of the intentions and goals an organisation sets for itself, as well as commensurate timeframes, resources and measurement and evaluation tools, are important markers of an organisation’s direction, purpose and intentions. They represent public documentation of commitments to and responsibility for programs, services and actions.

Other kinds of indicators of responsibility are employment strategies, resource allocation and level of commitment to professional development and training for staff.

If medical schools and the universities within which they operate set themselves a strategic goal, such as improving Indigenous participation in higher education, a number of issues arise that would differentiate those invested in making a difference and those using platitudes to appear to. First, who decided this was a priority? Was it an individual champion, such as a director of an equity program? Or was it the goals of the Board only, or the whole senior

management team? Second, for what reasons did the organisation set the goal; what was their motivation? Was it to meet funding criteria for 'social inclusion' program? Or because the organisation thought it was 'the right thing to do' with not much more thought as to why? Third, did the organisation communicate the goal and the rationale for it to their own middle and junior staff and client base? Have strategies been considered for recalcitrant or non-aligned staff? Has it been communicated to the public? Have appropriate resources been allocated to ensure the strategic goal is achieved? Have timeframes and responsibilities been clearly defined?

If the medical school and the university within which it operates both have not strategically or publicly committed to written goals and monitoring of implementation, it is reasonable to ask whose priority is Aboriginal health - is it an organisational priority, or an individual one, or an Aboriginal community priority?

Given the repeated delays of the need to take a strategic approach to Aboriginal health curriculum review and design in this case, it is reasonable to conclude that perhaps Aboriginal health curriculum was not a high a priority for the head of medicine as it is for the Aboriginal health academic. At the very least, it appears the level of commitment to implementing Aboriginal health as a strategic priority in this case differed between the head of medicine and the Aboriginal health academic. If this is so, this medical school would appear to have been in breach of their accreditation requirements (Australian Medical Council 2007). If this is not so, and given that monetary investment is a good indicator of the strategic priorities of an organisation, how can a medical school publicly state verbal commitments to Aboriginal health, but not match that with resources, public written strategic commitments and monitoring frameworks?

In this case study, an added layer of complexity was evident: there appeared to be confusion over who ‘owned’ Aboriginal health curriculum in the medical degree – the governance, decision-making, accountability and quality mechanisms were not clarified. The head of medicine and the deputy curriculum director, as the staff members formally in charge of medical curriculum, could potentially be deemed responsible for Aboriginal health. Yet, given the calls for Aboriginal and Torres Strait Islander leadership in curriculum (The LIME Network 2014), perhaps it could be construed that Aboriginal health staff were responsible for Aboriginal health curriculum, even if the teaching was delivered in a bachelor of medicine. In this case, there appeared to be an administrative head for Aboriginal health for the Faculty, but not an academic one, in that Roberta had no formal ownership of curricula or teaching income derived from it. This means that there were no clear lines of responsibility, ownership or decision-making when working across medicine or nursing or other health science courses. The Aboriginal health academic in the rural location was a relatively junior staff member without organisational authority and decision-making responsibility – they controlled no budgets or clear program lines. Yet in the rural health teaching location, the junior Aboriginal health academic was often nominally or informally referred to by non-Aboriginal staff when matters of Aboriginal health arose for fear of ‘doing the wrong thing’, and also to ‘tick the box’ that says Aboriginal people had been consulted in the design of curricula.

Thus the absence of a formal academic head or lead for Aboriginal health, who is in charge of and ‘owns’ Aboriginal health curricula, and who had access to the teaching income derived from it, could lead to Aboriginal health being ‘watered down’. Alternatively, these roles risk being reduced to administrative rather than academic functions. In the absence of clarity, it could be argued that this particular medical school has settled for an ambiguous reporting

relationship, where neither the head of medicine or Aboriginal health are responsible and own Aboriginal health curriculum in the medical degree. In this unclear structural arrangement, inadvertently, structural violence may be said to be a result, given Aboriginal leaders in this medical school do not have any real power over academic quality or teaching income, but are presented as administrative leaders to satisfy public relations and tick-box motivations. In this environment, others get to own Aboriginal health curriculum and teaching income, while Aboriginal health staff apparently get to wear responsibility for change. That is, the terms of inclusion of Aboriginal health into the organisational life of this medical school, while well-intended, produced a structurally violent and token level of participation. Power was not shared. It was only shared in administrative and public relations, but not budgetary or academic senses.

An alternative may be for the head of medicine to take formal responsibility, but share power regarding curriculum, ownership, resources and teaching income with Aboriginal stakeholders and supporters in curriculum committees. This type of arrangement could be strengthened by reporting to a senior education academic with responsibility for university-wide Indigenisation of the curriculum. Alternatively, Aboriginal health program heads could own curricula (e.g. subjects, modules, cases) in medicine or nursing or allied health courses in an academic sense, with the clear lines of responsibility and budgetary implications that implies.

Anecdotal reports from Aboriginal health staff across the universities in which I have worked over the last decade all provided similar examples and recounted similar dynamics to those present in this case study. Heads of faculties and schools of medicine, and their curriculum directors, were typically unaware or unwilling to address the ambiguity about who 'owned'

Aboriginal health, because it meant they could maintain their decision-making power and control of financial resources, and yet still ‘tick the box’ that Aboriginal people were ‘involved’ or ‘included’ in curriculum committees. Aboriginal health academics were routinely ‘referred to’ and asked to take responsibility in redesigning Aboriginal health curriculum, but for were not given equal or leadership status, and more tellingly, no control of resources, to implement curriculum. When it came to curricula review and accreditation requirements, Aboriginal health academics were often asked for the equivalent of a ‘five minute chat’, with no strategic continuous quality review process in use. There was no sharing of power.

This placed Aboriginal health academics in an impossible situation, in that their loyalties were divided between telling visiting accreditation teams about the meagre resources and disempowerment they felt in planning, implementing and reviewing curriculum, yet their need to work in a professional teamwork manner and present their school’s positive achievements to the Aboriginal community, the public and their medical school competitors, despite all of the obstacles.

This raises the question of the Australian Medical Council’s accreditation requirements regarding Aboriginal health curricula, and how they assess or ensure the standards are being met.

Accreditation and Aboriginal Health

I explore here three aspects of medical school accreditation in relation to Aboriginal and Torres Strait Islander health: the process used for accrediting medical schools, the guidelines

themselves, and the experience of working with the medical school accrediting body, the Australian Medical Council (AMC).

Accreditation Process

The AMC prides itself on being a peer reviewed accrediting body, whereby colleagues, medical professionals, educators and stakeholders are invited to be a part of their accreditation teams. When medical schools are assessed, at the upper end of the scale, they may be given by the AMC team an accreditation assessment for ten years, with an update and mid-accreditation check-in at five years. On the lower end of the scale, a medical school may be given a one year provisional accreditation assessment if there are serious issues with clinical training, infrastructure, quality or other issues. Most medical schools assessments tend to result in being awarded a period of five years of accreditation.

The AMC recruits potential accreditation team members, and offers them an introductory training program. If this is completed, the assessors can go on the AMC's database of assessors, and be asked to participate in accreditation teams for medical schools and programs with which they have no conflicting interests. When the accreditation team is chosen, they will meet and prepare; preliminary reports will be forwarded by the medical school, the team will tell the medical school which aspects they'd particularly like to know more about and which questions they'd like to ask, and the medical school hosts and pays for a one week intensive visit from the accreditation team. During this week, the accreditation team will interview key staff members and students, inspect facilities and infrastructure, sometimes visit teaching or community partner sites, and ask further questions about the medical school's written reports and potential issues in implementing the medical curricula against the guidelines and standards. After the accreditation visit, a report is prepared by the

team and forwarded to the medical school for comment and clarification of outstanding matters. The accreditation team then compiles a final report and makes a recommendation to the Medical School Accreditation Committee (MSAC), a sub-committee of the AMC, regarding how long the medical school should be accredited for, and what issues should be re-visited half way into the period of assessment – for example, if a medical school receives a five year accreditation assessment, the AMC will usually do a mid-cycle visit at the two and a half year mark to check on progress.

Where professional bodies are involved in accreditation – for example, in medicine, nursing, dentistry, psychology etcetera – there are clear processes in the university and clear acknowledgement of the right to accredit by the outside body. Yet this is not translated from professional to community questions of quality – that is, consumer or community concerns may not necessarily be translated as part of the overall accrediting process, or where they are, the terms of that translation is unclear or less than optimal. I give some examples of the accreditation process in relation to Aboriginal and Torres Strait Islander health below.

Accreditation Guidelines

The AMC develops guidelines and standards for accrediting medical schools in Australia, and makes recommendations to the equivalent New Zealand body regarding accreditation of that country's medical schools (Australian Medical Council 2012).

After lobbying from Aboriginal medical education scholars and medical professional bodies, the accrediting body for medical schools, the Australian Medical Council (AMC), acknowledged the sovereignty of Aboriginal and Torres Strait Islander and Maori peoples in its accreditation standards (Australian Medical Council 2007). Once these changes were

made, these same scholars asked the AMC to consider how it would assess its assessment techniques, and raised a number of questions relating to appropriateness of accreditation team membership, questions, quality assurance and evaluation when teams visited medical schools and prepared their reports. The AMC was not forthcoming in this series of discussions, and instead chose to focus on growing the pool of Aboriginal and Torres Strait Islander assessors, as if only Aboriginal assessors should be concerned or equipped in asking and assessing responses regarding Indigenous health. The AMC did not take up the standing offer of Aboriginal scholars and advocates to discuss and find solutions to issues of ensuring quality in accreditation assessments. The AMC reviews its medical school accreditation requirements, as a matter of course, approximately every five years. In 2012, the AMC released its new standards, with significantly less representation of and references to Aboriginal and Torres Strait Islanders and Maori peoples and their health (Australian Medical Council 2012). There was no consultation with Aboriginal medical education scholars or Aboriginal medical professional bodies, and it would seem that the new standards reflected a belief that Indigenous health was about meeting the needs of another ‘underserved population’. Thus, while Aboriginal people argued for equal partnerships in decision-making around medical curricula and accreditation, it appeared that the Deans of Medicine and the AMC could only conceptualise Indigenous health as charity and benevolence dressed up as ‘addressing the needs of the underserved’, or, as an optional add-on – good for diversity of content, but not critical to the practice of medicine or integral to accreditation.

The Experience of Working with the AMC

In the early periods of the development of the curriculum framework, a relationship was cultivated with a key and senior staff member of the AMC. This relationship was critical to the eventual inclusion of specific Aboriginal health standards in the medical school

accreditation guidelines, in that this senior executive member advised on AMC processes, and brought the issue to the attention of the CEO and relevant committees and the Council itself; ensuring the matter was addressed. The initial step was to ask the AMC to endorse the curriculum framework, on the recommendations of the Deans. This endorsement was forthcoming in late 2004. Then in 2005 a request was put to the AMC to change the actual standards themselves to reflect the pedagogical principles and content espoused in the curriculum framework. The same senior executive ensured resources were allocated for a working party of Indigenous and non-Indigenous medical educators to consider and recommend changes to the standards. I was a member of the working party, and for approximately four months, we embarked upon a process of considering and recommending changes to the standards. These included specific Indigenous health standards regarding graduate attributes (knowledge, skills and attitudes); governance, medical course management, funding and expertise; staff resources and promotion; the mission and outcomes of the medical school; curriculum design, implementation and monitoring; and student admissions policy and selection.⁵

When these recommendations were put to the relevant Committees, we expected reluctance, obstruction and debate, for no other reason than we perceived the organisation to be extremely conservative. At the first meeting, chaired by Professor David Prideaux, an eminent Australian medical educator, our recommendations were presented and accepted in full, yet there was a strange and deathly silence from the participants in the room who were reviewing our recommendations. We were not sure what this was about, but we gladly welcomed their acceptance of our work.

⁵ The changes are set out in Appendix 4.

The AMC published these recommendations (2007), and medical schools were supposed to begin implementing them if they had not done so already. This same working party of Indigenous medical educators then recommended to the AMC that they might consider more fully how they were to assess quality implementation as part of the accreditation process. Given I had left the employment of the CDAMS curriculum project by then, I was employed by the AMC as an independent consultant to consider how best the AMC could ensure quality in accreditation. A range of recommendations were made, including: principles for participation in assessment teams; that the AMC itself consider its governance mechanism for Indigenous participation in its relevant committees and operations, that a strategy for engagement with medical colleges be developed; that continuous quality approach to assessing the quality of curriculum implementation and accreditation be utilised; that Indigenous people be included on all accreditation teams for 2009; that the pool for Indigenous assessors be grown; that accreditation team chairs and non-Indigenous assessors be briefed and upskilled; that the guidelines for site visits be reviewed so as to include culturally safe and appropriate Indigenous health teaching settings; the consideration of a special 'off-line' reporting round for all medical schools to report specifically on their implementation of the Indigenous health standards; and that a support system for Indigenous assessors be developed.

Anecdotal evidence suggests only two of these recommendations – relating to medical college engagement and growing the pool of Indigenous assessors – had been implemented, despite the many representations made by myself, LIME Network representatives, and the Australian Indigenous Doctor's Association (Mokak 2013). The Medical Deans Review (2012) cited similar concerns regarding the measurement and quality of curriculum implementation. For some reason, these calls went unanswered.

In 2012, the AMC changed its accreditation guidelines again, as the guidelines are routinely reviewed every five years. In the current version of the guidelines, Indigenous health is referred to far fewer times and in less detail than in 2007.⁶ Thus, despite years of the cultivation of a close working relationship with senior staff, the AMC being congratulated for their commitments to Indigenous health, the amount of money and time the AMC invested in 2007 in changing the guidelines, and a clear set of industry generated recommendations concerning quality in accreditation and curriculum implementation, the AMC chose to change the guidelines yet again, with no discussion with key Indigenous stakeholders.

Two weeks ago at the time of writing this chapter, an AMC officer contacted me asking me to co-chair “a Planning Advisory Group to develop, over a period of up to 9 months, the terms of reference, and membership charter of a more formal Indigenous health or Indigenous medical education committee that fits with the AMC’s mission and purpose.” I immediately accepted the invitation, and asked what the background to the request was, particularly since there had been a period of three to four years of extremely limited engagement and communication. The officer responded with:

This request comes about from the external review conducted of the AMC – in part the review noted ‘the AMC should have a more structured, visible and powerful representation by Indigenous leaders, practitioners, students, medical school staff and community members across its accreditation and assessment functions from representative, policy, educational and service organisations’.

While such invitations are welcome and positive, it would appear the accrediting body for medical schools was struggling with barriers to communication and engagement with Indigenous medical educators, and that these barriers were overcome when there was an external review, rather than at the urging of their own consultant’s recommendations.

⁶ See Appendix 4.

Conclusion

In this chapter, I have theorised structural violence as it relates to Indigenous health and medical education, and drawn particular distinctions between charity, development and social justice approaches. I have highlighted the limitations of the social determinants of Aboriginal approach to improving health outcomes if the underlying power relations are not exposed. Similarly, I have identified that where the state's parameters of public health, in particular its application of public health apparatus, are employed in an uncritical manner, then the state is prone to simply choose which upstream factors to address, rather than admitting their own complicity in the production of those factors. I have identified and addressed the consequences of not addressing structural violence and power in Aboriginal health and medical education by using the example of the development of CDAMS curriculum framework project, and also two case studies of individual medical schools. Where issues of governance, decision-making and quality are not addressed, both curriculum implementation and accreditation become curtailed, to the extent of increasing frustration and ill-health for Indigenous and non-Indigenous champions, and minimising the likelihood of sustainable improvements in curricula, Indigenous student and scholar participation and resources. Indigenous studies curriculum in Australia is inherently political (Foley and Muldoon 2014), by virtue of those with the power viewing individual Aboriginal people as problematic (Fogarty 2013, Foley and Muldoon 2014), and contributing systemic factors as incidental or unimportant. This omission of consideration of the relations of power and equity of Aboriginal decision-making, unwittingly produces structural violence, where Aboriginal inclusion is less than optimal, and the potential of individual and collective agency is again compromised.

CHAPTER SIX – WHITENESS AND WHITE POWER

Our demand is for a non-racial society... We are fighting for a society where people will cease thinking in terms of colour... It's not a question of race, it's a question of ideas. – Nelson Mandela (2010)

In this chapter, I discuss the concept of whiteness as it relates to Aboriginal health and medical education, and theorise the interplay between whiteness, racism, privilege, power and colonisation. In exploring this dynamic interplay, I present two case studies – one where use of the terms ‘racism’ and ‘whiteness’ were controversial in an Aboriginal health roundtable discussion, and one where whiteness and power were at play in a university medical faculty. I conclude with an analysis of the ways in which racism and whiteness imbues Aboriginal and non-Aboriginal relations in Australia.

WHAT IS WHITENESS?

Whiteness as a concept has its roots in Du Bois’ ‘the psychological wage’, where he suggested that because Black labourers did the same work as white labourers and yet were paid less, they had to contribute an unseen and unacknowledged psychological wage to see themselves as of equal value (1998). This is similar to the concept of emotional labour, where the emotional stress of particular jobs, such as for nursing, social work and airline hostesses, often goes unacknowledged, yet is a significant contributing factor to workplace retention and job satisfaction (Henderson 2001, Brotheridge and Grandey 2002, Hochschild 2012). Subsequently, whiteness has been identified as a part of post-colonial theory (Fanon 1961), orientalism (Said 1978), feminism (hooks 1981), critical post-colonial theory (Spivak 1999), othering (Moreton-Robinson 2000), and history (Killsback 2013). Deloria has described whiteness in contemporary typologies of Aboriginality, where notions of authenticity and

validity are bestowed on Indigenous peoples according to white perceptions. This is a re-working of early twentieth century notions of race and racism, in that the earlier versions concentrated on physical and mental characteristics, whereas nowadays Indigenous peoples' actual existence is disputed (Deloria 1997).

Whiteness is not a biological category but a social construction (Thompson 2001), where “the invisible means against which other races are judged in the construction of identity, representation, decision-making, subjectivity, nationalism, knowledge production and the law” (Moreton-Robinson 2006). Thompson (2001) makes the distinction between euro-centrism as ignoring others' values and seeing European values as normal, and the extended phenomenon of whiteness as derived from the devaluation of others' values and beliefs. This implies that whiteness is relational – one group's identity (and perceived racial superiority) is dependent on the denial and subjugation of other groups' identities, and conversely, that non-white peoples can start to believe and adopt an ‘inferior’ position.

In Australia, the relational and actualised nature of whiteness is played out through colonisation and the relations between Indigenous peoples and the state (Foord 2004, Ravenscroft 2004, Moreton-Robinson 2006). In particular, whiteness and its manifestation has been documented in terms of low rates of Indigenous participation in higher education (Gunstone 2009, Fredericks 2009b), poor access to health care and poor health status (Anderson 2005, Kelada 2008, Fredericks 2009a), Aboriginal government policy generally (Altman and Hinkson 2007), the politics of asylum seekers (Koerner 2010), and multiculturalism (El Khouri 2012). McAllan (2011) argues that whiteness manifests in Australia in the politics of the so-called ‘post-racial’ state, where “the premise that racial

difference has less purchase in an increasingly multi-cultured paradigm risks disengagement with the racist mechanisms fundamental to white hegemonies” (2011: 1).

In these examples, whiteness in Australia dates from the English invasion of Aboriginal lands and the myth of *terra nullius* (empty land). Aileen Moreton-Robinson asserts that although this lie has been legally dismissed, by the High Court’s recognition of native title in *Mabo and Others v Queensland No. 2 (1992)*, the myth-making of white ownership continues, whereby a possessive patriarchal logic manifests itself in daily social and political life (2004). Moreton-Robinson goes on to interrogate notions of whiteness as they relate to sovereignty:

Whiteness operates through the racialized application of disciplinary knowledges and regulatory mechanisms, which function together to preclude recognition of Indigenous sovereignty ... race is discussed ... but Whiteness remains invisible as a significant characteristic of the biopolitical state (2006: 387).

Thus, whiteness is the emotional and psychological hangover of the myth of *terra nullius*. While the English encountered and engaged with Aboriginal peoples from the moment of first contact, legally and socially, they utilised this myth to justify their actions (Reynolds 2000). Whiteness was expressed through the invention of a lie.

Further, the White Australia Policy is a direct consequence and expression of whiteness. In this policy, non-white non-desirables were expressly kept from migrating to Australia until the last remnants of the policy were dismantled in 1973 (Department of Immigration 2013). Given that the policy began at the federation of Australia in 1901, it can be inferred that the Australian modern-nation state was founded on racism and whiteness.

In Australia, whiteness manifests contemporaneously as the keeping out non-white non-desirables, and the continued assertion of regimes of white normalised hegemony and

dominance, defined as white sovereignty. Whiteness in Australia not only asserts and replicates itself to maintain power, but the very notion of the country of Australia depends on the subjugation of undesirable others. This is evident in the ‘race clauses’ in the constitution which grant the Commonwealth extraordinary powers of making laws for one race to the exclusion of others (Behrendt 2001). The Australian state, its sovereignty, depends on and simultaneously denies the subjugation of Aboriginal ownership of the lands.

Yet whiteness has asserted and hidden itself at the same time, in that the state has ‘included’ Aboriginal claims to sovereignty on the state’s terms. The Mabo decision, which overturned the myth of *terra nullius* and described Aboriginal prior ownership of lands, came to be expressed in Australian common law as ‘native title’ – the state professed to ‘include’ Aboriginal peoples while covertly denying their sovereignty (Stephenson and Ratnapala 1993).

The dynamic of depending on the subjugation of others for legitimacy can also be seen in asylum seeker policy, whereby the Australian government considers its sovereignty to be in question because leaky boats of undesirable others arrive. If Australian sovereignty and national identity were more solid and self-assured, it would not need to feel threatened because visitors arrive unannounced. The neighbourly and legal (by virtue of international human rights law and the UN Refugees Convention) thing to do, particularly if people are fleeing from war crimes and persecution, would be to welcome people until they are settled, and to assess their needs before deciding to act and find assistance (Kelly 2006). Yet fear of the other runs unfettered, and disingenuously appears as concerns regarding the nature of the arrival of the asylum seekers, their worth, value and goodness as human beings (Koerner 2010), and the idea of the sovereign state (Watson 2006, Giannacopoulos 2006b).

These two areas of policy – Aboriginal affairs and asylum seeker policy – are inter-related in that the Australian state's identity and existence is dependent on the denial of Aboriginal sovereignty. This in turn contributes to Australian state insecurity in its identity, hence its overly aggressive response when new visitors arrive on our shores (Giannacopoulos 2006a). I suggest that this insecurity in the national identity – the psyche of the nation – would be less pronounced or perhaps non-existent if the Australian state's existence was more solid; if Aboriginal and non-Aboriginal relations were resolved. Previous Prime Ministers have sought to heal these wounds – Paul Keating's Redfern Park speech, which acknowledged massacres and poisonings publicly for the first time (1992), and Kevin Rudd's Apology to Australia's Indigenous Peoples (2008), were critical first steps. However, these have not been followed by national truth-telling, mass education, atonement or memorialising (Manderson 2008). The word genocide is still highly controversial and unacknowledged in public discourse, the words 'past mistreatment' or 'settlement' are preferred (Barta 2001).

The terms of the Australian state – that of white ownership – continues as both a psychological and cultural myth and a politico-military reality. Australia continues to depend on the subjugation of others, and whiteness is the psychological regime that allows this phenomenon to exist and continue. This is the enabling environment in which all legislative, political, policy and strategic matters are decided. Matters of higher education, health, medical workforce, medical education, education more generally, human rights, race relations and reconciliation – all matters impacting on Aboriginal health and medical education – therefore operate on, and are decided within, a regime of undiagnosed whiteness. This enabling environment allows overt and covert racism to operate as normal and accepted.

Greta Bird has written about whiteness in Australia as often unconscious: “I acknowledge here that the construction of my white citizen’s subjectivity in a raced nation entails a racism lodged in my unconscious” (2008: 1). This would partly explain why some white Australians feel aggrieved and affronted when it is suggested to them that whiteness is at play in Aboriginal health. This does not fit their discourses of benevolence, charity and helping the disadvantaged (Farmer 2005). It does not fit the model of inequality of access, and thus, consciously or unconsciously, white Australians feel their power and place in the world as ‘experts’ is threatened.

This dynamic of both asserting and hiding whiteness simultaneously, either consciously or unconsciously, can be revealed in apparently ethical and moral movements such as the environmental movement and in environmental education; parallels between Australian and Canadian colonization can be seen:

Whiteness is a socio-spatial process that constitutes particular bodies as possessing the normative, ordinary power to enjoy social privilege. Within the Canadian colonial context, whiteness has been produced historically through the violent confiscation of land and resources from Indigenous Peoples. This violence has been silenced through grand narratives of Canadian “tolerance,” and white-settler fantasies of the Canadian landscape as empty and wild. Many environmental education programs continue to rely upon and reproduce these colonial ideas of race and space. Escaping the classroom, Canadian environmental education programs propose to advance personal and educational decolonization through experiential land-based learning... Whiteness continues to be normalized within environmental education through various dominant narratives of Canadian nation building, such as: the disaffiliation of whiteness from the violence of colonialism, reifying Canadianness as goodness and innocence; the ongoing erasure of Indigenous Peoples and histories from the land; and the reification of wilderness as an essentialized, empty space. These narratives continue to entitle white people to occupy and claim originary status in Canada, signifying wilderness and the environment as a white space.

(McLean 2013: 354)

Yet whiteness, as I theorise it, is not only about white people, white skin colour or the arbitrary and simplistic binaries of Black and White. If whiteness is a mindset – a set of

normalised actions based on normalised ideas, values and beliefs – some unconscious and some calculating, then a person from any ethnicity can subscribe to or take on these mindsets of a normalised white hegemonic regime. This approaches what Bourdieu (1990) calls habitus, where he “confers a great importance on the idea of false consciousness, but refers to it as the ‘misrecognition’ of power relations to explain why individuals are not aware of their own subordination to powerful agents” (Navarro 2006: 14). Thus, whiteness denies that it exists. It can exist in Whites, Blacks, and in people of all colours and ethnicities.

Barnor Hesse’s (2007, Hesse 2011) work is particularly illuminating here. He states that since white hegemonic power and control has for so long controlled and defined the identities of other peoples while normalizing its own, the sub-altern should return the gaze and create ethnographies of whiteness (Spivak 1988, Guha 1997, Louai 2012). His typology of white identities outlined here⁷ provides a useful framework with which to analyse white power, and with which to delineate white ethnicity from whiteness:

1. **White Supremacist**
Clearly marked white society that preserves, names and values white superiority
2. **White Voyeurism**
Wouldn’t challenge a white supremacist; desires non-whiteness because it’s interesting, pleasurable; seeks to control the consumption and appropriation of non-whiteness; fascination with culture (eg. consuming Black culture without the burden of Blackness).
3. **White Privilege**
May critique supremacy, but a deep investment in questions of fairness/equality under the normalization of whiteness and white rule; sworn goal of ‘diversity’

⁷ These are notes from a lecture given by Professor Barnor Hesse at North Western University. See <http://nativnuance.tumblr.com/post/58266820547/the-8-white-identities>.

4. **White Benefit**
Sympathetic to a set of issues but only privately; won't speak/act in solidarity publicly because benefitting through whiteness in public; some People of Colour (PoC) are in this category as well
5. **White Confessional**
Some exposure of whiteness takes place, but as a way of being accountable to PoC of after; seeks validation from PoC
6. **White Critical**
Take on board critiques of whiteness and invest in exposing/marking the white regime; refuses to be complicit with the regime; whiteness speaking back to whiteness
7. **White Traitor**
Actively refuses complicity; names what's going on; intention is to subvert white authority and tell the truth at whatever cost; need them to dismantle institutions
8. **White Abolitionist**
Changing Institutions, dismantling whiteness, and not allowing whiteness to reassert itself.

In summary, whiteness refers to the social construction of white values and beliefs as normal and invisible, is dependent on the subjugation of others' values and beliefs (is relational), and can consciously or unconsciously ensure white power is maintained. Using a Foucauldian analysis, Moreton-Robinson asserts that whiteness in Australia is dependent on "the possessive logic of white patriarchal sovereignty" (2004: 2).

Whiteness is therefore both a justification for and means to maintain state power in Australia. Australia remains the only country in the world whose constitution allows the parliament to make specific laws for any one race to the exclusion of others, *Section 51(xxvi)* (Williams 2000). While the infamous White Australia Policy was formally fully disbanded in 1973 (Department of Immigration 2013), the psychological toll of it still plays out in the nation's psyche, and its precepts continue in other laws.

The Interplay between Whiteness, Racism, Power and Privilege

In this section, I explore the varying definitions of whiteness, and discuss these in relation to concepts of racism, power and privilege.

Thompson (2001) gives a useful typology of theoretical approaches to whiteness. She explains that material theories of whiteness relate to and explain the material privileges attached to being white. Discursive theories of whiteness, she suggests, concern the normalisation of white values, assumptions and beliefs in language and public discourse. Institutional theories see material and discursive theories combined in action in institutional settings, while personal/relational or psychological theories suggest how “white privileging mechanisms find a home in our relationships, our sense of self and our assumptions about growth, morality and decency” (2001:3). Thompson separates those theories relating to ethnically white people and those with white skin colour (material theories of privilege), with those concerned with maintaining and implementing the beliefs and assumptions that suppose white superiority and normalcy (discursive, institutional and personal).

I suggest that material whiteness is about white privilege – the tangible privileges afforded to people of white skin colour and ethnicity. There are other sorts of privilege, such as male privilege, or heteronormativity, and these imply an oppressed/oppressor or powerful/less powerful relationship, where those with more power and the power to oppress others are the privileged. With white privilege, there are ways in which white skin colour and ethnicities associated with white people bring privilege. While there is no one ‘white race’, the diaspora of European peoples have maintained and continued a social and racial elitist position – that white peoples are more superior, advanced and intelligent than ‘others’. This is where the relationship between whiteness and racism is clear. If material whiteness is about white

privilege, then the belief system that maintains the normalcy of this arrangement is racism.

Racism is one expression of material whiteness.

Discursive, institutional and personal theories of whiteness are more concerned with identifying the underlying sets of values, beliefs and assumptions that some white peoples presume are normal. These norms are replicated throughout the world as ‘value free science’ and objectivity, while maintaining white power and subjective state control. Yet these beliefs, assumptions and values cannot be attributed to white people alone. They are one aftermath of colonisation – that science and religion can be used to justify one race or group of peoples’ inferiority/superiority over another. In this way, both the oppressed and oppressor can be affected by the normalisation of whiteness. Whiteness, as characterised by colonisation’s insistence on science and religion as proof of racial superiority, still continues.

Whiteness is the belief system and set of values that allowed science and religion to be used as justifications for colonisation and the extension and maintenance of white economic, social and political power over others’. Whiteness justifies the greed and fear of colonisation and patriarchy.

Thus, whiteness is the belief system and habitus, colonisation is its consequence, racism is an expression of it, and the maintenance of white power and privilege are its ends.

In addressing white power and privilege as ‘equal access’ and diversity programs, whiteness is maintained as the norm. Addressing only racism is like addressing the consequences of a wound rather than the causes of the wound – and expresses itself in saying sorry without changing the thought system, attitudes, actions, and institutional and structural disadvantage

that led to the behaviour. If nations try to address colonisation alone by simply replacing white minority rule with 'Black' majority rule (e.g. India, Zimbabwe), and not simultaneously dismantling the whiteness imbued in colonial systems of government and re-investing in shared power for all of its citizens, then the result will be the maintenance of whiteness, this time with 'Black' people running it, and benefitting from its power imbalances and privilege.

Nelson Mandela's South Africa suggests that it is possible to dismantle the prevailing regime of whiteness (material, discursive, institutional and personal), and attempt to re-invest, re-distribute and share power between all citizens. That subsequent Presidents Mbeki and Zuma have not been able to maintain and implement the promise of the rainbow nation testifies both to the greatness of Mandela and Tutu's moral leadership (Kane 2001, Ramphela 2008), and to the after-effects of whiteness; particularly in health care, where it has been identified that old social contracts no longer guarantee equity in health care access or outcomes (Harris, Eyles et al. 2014).

Addressing power, privilege, racism and colonisation cannot be truly effective without also addressing whiteness and its underlying values, beliefs and motivations.

Having explored the interplay between it and racism, privilege, power and colonisation, I now present two case studies which highlight how these concepts play out in medical education as it relates to Aboriginal health curriculum.

CASE STUDY 6 – RACISM ROUNDTABLE

When writing this thesis, I was contacted by an Aboriginal academic colleague at another university, and was asked if I would facilitate a roundtable discussion on racism in Aboriginal health, which they were hosting along with two research partner institutes and two Aboriginal health organisations. I was invited and paid as a consultant, and I had no plans to use any of the material or outcomes in this thesis. Given the importance of some of the outcomes and deliberations of the roundtable, however, I sought and obtained written retrospective permission and consent from the convenor of the roundtable to write about it. Identifying characteristics have been changed here, including names of individuals, employers, and affiliations.

The roundtable was a two day event, with the first day dedicated to an open discussion about racism and its effects in Aboriginal and Torres Strait Islander health care. The forum was attended by international guest Indigenous academics and educators, and was a free event open to members of the general public. Approximately 150 people attended throughout the day. Presentations were made by Aboriginal and non-Aboriginal academics, policy makers, health care providers and community members. These presentations focused on measuring the effects of racism on the body and mind (e.g. cortisol levels and other stress effects); examining the links between racism and the social determinants of health; analysing how racism played out in health care settings and what could be done about it; exploring the roles that education, research, and policies could play; measuring the effectiveness of interventions; and hearing from workers and professionals ‘at the pointy end’ of racism in health services. I was asked to facilitate the last session of day one, which aimed at summarising the day’s deliberations and focussing attention for day two.

The second day, which I facilitated, was an invitation-only roundtable discussion, where speakers and guests were given the task of identifying collaborative research opportunities, education solutions, and potential policy directions. Approximately fifty Aboriginal and non-Aboriginal researchers, educators, health and education workers and professionals, policy makers and community members were present.

On day one, I noticed that two or three times, the use of the terms ‘racism’ and ‘whiteness’ had been questioned. In two or three subtle and less subtle ways, Aboriginal and non-Aboriginal participants suggested that these terms were problematic in an Australian health care context, and that “it got people’s backs up too much” and “it fell on deaf ears.” There were minimal clarifications of, or responses to, these points. However, I tentatively took these comments to mean that because some Australians in health care and health care education settings (workers, professionals, policy makers, planners) did not want to hear about racism, or that this sort of discussion was difficult to manage, then other terms should be used instead.

Further, one presenter suggested that whiteness as a social construct was invisible in society. This notion was challenged with a reply from me, as facilitator: while I understood what the presenter was trying to say – whiteness often goes undiagnosed – whiteness was really only invisible to those who have it, not to most Aboriginal people or others affected by it. I suggested that rather than talking about whiteness as invisible, perhaps we could speak about whiteness as denied. However, for reasons of time and the fullness of the day’s schedule, these points were neither clarified nor resolved.

Reflecting on the day's proceedings, I later surmised that perhaps the comments were an example of old-fashioned denial. Maybe some people just did not want to name the problems. Yet I was very unsure and interested in what these comments represented or meant, and on what basis they were made.

On day two of the discussions, these points came up again, and similarly, participants engaged with the issues only minimally. It struck me as unusual that during a two-day discussion about the effects of racism, these sophisticated participants seemed unclear or had such different understandings about the use and meanings of the terms racism and whiteness. During the lunch break on day two, I asked the convenor if, after the group 'report back session' and summary of the day, I could raise questions about issues of terminology. He agreed, within the context of moving towards shared collaborative directions.

After the group reporting and summary sessions, I asked participants for clarification, feedback and discussion on the use of the terms racism and whiteness, and asked why there had apparently been some reluctance to use the terms. By way of introduction, I said that perhaps people intended to identify racism and whiteness, but felt they needed to be careful about when and how the terms were used when dealing with 'the unconverted' in health care or education settings or planning hierarchies – to 'pick one's battles'. Two white academics, both of who had been working in Aboriginal health for many years, indicated that they preferred not to use the terminology, because using the terms caused too much angst and led to people ('the unconverted') resisting the rest of what was being said. They preferred the terms 'power' and 'privilege' when trying to educate students or health professionals about issues affecting Aboriginal health.

What was a fairly low energy post-lunch session on a Friday afternoon suddenly turned into a passionate, almost fiery, discussion about whether the terms racism and whiteness were helpful or hindered people's ability to addressing racism in health care. Some argued that it was impossible to deal with racism and whiteness unless it was clearly named. Others said it was better not to name 'it' because people could not or would not hear subsequent information. One Aboriginal person said emphatically that she did not like or want the term whiteness to be used because "the opposite of it is blackness, and it will give ammunition to people to talk about us in a negative way."

In an attempt to come to some common understanding of the terms, I asked for some liberty to explain, on the basis of the scholarly literature, what the terms meant. I used the broad 'racism equals discrimination plus power' definition, and described whiteness as "not about skin colour or ethnicity, but a mindset of colonisation. Anybody, culturally or ethnically black or white or multicultural, can have whiteness as a mindset." This created further highly passionate discussion. The two white academics strongly defended their credentials in Aboriginal health, and one stated that "in twenty years of working in Aboriginal health, I know what racism and whiteness is and I agree with those concepts! But it's just impossible to get people to listen to Aboriginal health education if you use them [the terms]". The Aboriginal person who strongly disliked the term whiteness said she still didn't like it even though she understood I was not talking about white people, but rather a mindset: "I don't care. I still don't like it!" Another Aboriginal person at the back of the room became visibly upset, so I invited him to share his views. He said my definitions of racism were incorrect and that 'the literature' said other things, but he did not clarify the comments. This particular comment is a lovely example of the privilege accorded to the published word over lived experience, and how academics sometimes refute and close discussion with this privilege.

As facilitator, I tried to calm the conversations down by making some final observations. I said that it was fascinating that after two days of deliberations about what to do about racism towards Aboriginal people in Australian health care, we seemed still to not agree on what racism and whiteness were, or on how to deal with emotional reactions to them. I suggested that in the interests of scholarship and learning, we didn't all have to agree, but that perhaps we could simply acknowledge there were differing approaches, meanings and definitions. I also suggested that given the reactions that had just occurred, perhaps we needed more safe spaces and time to explore the range of opinions and emotions that were expressed.

The convenor stepped in to calm the meeting, and made closing comments about the overall workshop, summarised outcomes, and thanked everyone for their insights, time and commitment to moving forward with collaborative research, education and policy initiatives.

I was conscious that perhaps I had overstepped the line as facilitator. The discussions were almost out of control, and I was an active participant in them, rather than remaining a detached facilitator. In an effort to separate my views on what had just occurred from the views of others, after the workshop had officially ended, over afternoon tea, I spent some time informally interviewing six participants to elicit their interpretation of the last session. I started each of the short discussions by saying that originally, when differing use and meanings of the terms whiteness and racism became apparent, I thought it represented old-fashioned denial, but that the highly emotional reactions expressed in that last session seemed to me to represent something entirely else. I asked what they thought it all meant.

One Aboriginal participant stated that she thought participants did not really understand what whiteness was, that to some participants it was a new concept when really it had been used in

the literature for ages, and therefore, “they could not separate the term whiteness from white people or skin colour.” An international Indigenous participant said, “You’re using the terms whiteness and cultural safety slightly differently to how we use them, but the dynamics of what happened there are almost the same as at home.” Another participant stated, “It’s just interesting to me that the two people in the room who were most strongly opposed [to usage of the terms] were white people working in Aboriginal health for years... presenting themselves as the experts.” When I asked for clarification, she suggested that it was the two white people’s own fears of not being ‘the expert’ in Aboriginal health if racism and whiteness were exposed. Another said, “It was really interesting why that Aboriginal woman said she didn’t like the term whiteness because she thought the opposite was blackness and that she was scared of being targeted for that. Yet she introduced herself as having very black skin and being very proud of it though.”

Reflection

Reflecting on this case study, I have come to two conclusions. First, most people seemed agitated by the discussion, and a lot of painful and uncomfortable emotions were expressed. Talking about racism and whiteness was uncomfortable for both Aboriginal and non-Aboriginal people.

In attempting to effect a positive change to the attitudes, knowledge and skills of health students and professionals, the participants in the workshop seemed to be making a fundamental choice based on a false dichotomy: to name racism and whiteness and risk difficult emotional reactions, or to use alternative terms such as privilege, which might pacify and calm possible emotional reactions. It seemed to some participants that their only choices when faced with potential hostile reactions were to change the speaking of the truth about

whiteness, because the emotional reactions may be too difficult to deal with, and risk in this approach not addressing a central tenet and dynamic of power in Aboriginal health care. Or, name the terms and concepts, and awkwardly deal, or not deal with, the potential fallout.

The reactions in the room suggest to me a second, deeper dynamic. After engaging with the six participants post-workshop, and after further reflection, the reactions during the seminar reminded me of an experience while I was attempting to include Indigenous health curriculum in an Australian medical school. Talking about racism and whiteness in relation to Aboriginal health in Australia seemed to uncover power imbalances between Aboriginal and non-Aboriginal people. While some participants seemed comfortable talking about these underlying power imbalances, it was interesting that apparently discussing racism and whiteness was not encouraged. I analyse this notion of ‘editing’ and power in the exegesis below.

CASE STUDY 7 – ESTABLISHING A DEPARTMENT OF ABORIGINAL HEALTH

When starting a new position at a medical school, I asked myself what things would truly make a difference to medical education, such that an Indigenous health curriculum might be sustainably established and maintained. As the CDAMS Project found (see Chapter One above), it would be critical to take account of both content and context – that is, to include Indigenous health curricula content well, thought would have to be given to factors like decision-making, staff development, resource allocation and community participation in the design and evaluation of curricula. With the Dean’s imprimatur, rather than getting straight into operational matters (teaching, planning curriculum, et cetera), I embarked on a strategic planning process that looked at the whole medical faculty. I asked stakeholders such as existing Aboriginal and non-Aboriginal academic staff, Aboriginal community stakeholders,

university representatives external to the faculty, Aboriginal health professional organisations, and middle and senior managers within the faculty, about the issues in Aboriginal health that the Faculty should address.

Varying motivations and ideas about Aboriginal health emerged in this process among senior members of the faculty. One suggested, seriously, that we should immediately go to the Northern Territory and start working on diabetes projects. The head of the School of Psychology suggested he was unsure whether Aboriginal health and mental health were related at all. The head of the School of Biomedical Sciences suggested that school was “only concerned with the science of [the body’s] cells, so why should my students have to learn Indigenous health?” On the other hand, there were others, such as the head of Rural Health, heads of clinical schools, and senior staff in general practice and public health, who seemed very supportive and interested. Others again, including the head of the School of Public Health, seemed disengaged and indifferent.

I expected this mixed reaction. I had actually thought we might only get one or two ‘champions’ or supporters initially. I previously understood that in many mainstream white organisations with a limited or non-existent history of engagement with Aboriginal and Torres Strait Islander peoples in Australia, it was common for Aboriginal and Torres Strait Islander peoples and their supporters (‘the converted’) to experience a range of responses from the listeners (‘the unconverted’). At one end of the scale, subtle or not so subtle racism or indifference could be encountered; at the other end of the scale, a range of levels of engagement or understanding of the issues presented by Aboriginal health may ensue.

I expected some opposition, less from negativity than from lack of experience. After twenty years of experience working in Aboriginal health, I understood that part of the unwritten job description was to expect and plan for white opposition, particularly in a mainstream white organisation. This was the unacknowledged and unwritten, but very real, emotional labour that Aboriginal people and our supporters had to undertake in order to get the actual or written job description accomplished.

However, I was surprised on this occasion that approximately seventy-five percent of the people in a Faculty Executive meeting reported positive messages of support and encouragement. I surmised that some people in the room had a deep commitment and understanding, and could be counted as a part of the ‘converted’, by virtue of their past professional working life as known champions of Aboriginal health and other social equity issues. Yet I also estimated that some of the professed supporters might have a more superficial commitment to and understanding of the issues. I wondered if perhaps some of them were supporting the idea primarily because of the Dean’s leadership and tabling of Aboriginal health as a priority, rather than any deeper understanding or commitment.

In deciding to accept the offer of employment and undertake the strategic planning process, and fully expecting initial disengagement and transformative unlearning, I attempted to identify what might be the ‘bullet-proofing’ factors, aside from all the positive platitudes and professed commitments, that would make a white medical school commit to and progress Indigenous health to sustainable and quality implementation.

From seeing many organisations profess commitment but then falter when Aboriginal people asked for equality or shared power in decision-making, I knew only two things would protect

me and the work of Indigenous health from the detractors. These things were a leader (the Dean) who understood what was required, and money. That is, the hierarchical nature of medical schools meant a dean's commitment, leadership and championing of Aboriginal health could go a long way to ensuring success, as long as she or he understood why deep commitment was needed. Also, I understood that money speaks all languages – that universities and medical schools needed to survive on business models that were economically sound, rather than only educational or moral motivations.

The strategy took account of all of these issues, and identified objectives and reform initiatives across the domains of Aboriginal community participation in shared decision-making (that the Aboriginal community wanted an equal role in governance, rather than being posited as representatives on a committee charged as merely advisory), curriculum content, research ethics, research projects, environmental matters (professional development and cultural safety training for all staff), and Indigenous student support and retention. The strategy was endorsed by senior staff within the faculty and university hierarchy, and an agreement was signed with a leading Aboriginal community health organisation as a way of ensuring Aboriginal community participation in all aspects of the faculty's work in Indigenous health.

A major initiative of the strategy was to establish an academic department of Indigenous health, which would be a leader of Indigenous health academic work (teaching and research), and also co-ordinate and work with other parts of the faculty to share responsibility for matters like research ethics, Indigenous student support, and cultural safety training for all staff. It was conceptualised by the strategy writers that a clear delineation of responsibility was established – that Aboriginal people should lead an Aboriginal health department to lead

reform, but that they were not alone responsible for implementation and reform across portfolios.

Soon after the strategy and agreement were completed, a philanthropic funder contacted the university looking for exciting and new projects. The university put forward half a dozen projects; the new Indigenous health strategy and department was one. The funder was impressed by the faculty's strategy of commitment to, and agreement with, Aboriginal community organisations. The philanthropist's family members expressed strong interest in Aboriginal and rural health, and after much deliberation, felt it worthy to pledge millions of dollars to support the strategy (approximately sixty percent of the total budget), on the proviso that the faculty and university pledged the remaining funds.

The announcements of these pledges were greeted with much enthusiasm and celebration by the faculty and university senior leadership, the Aboriginal community organisation, the state and federal governments, and more broadly national Indigenous health networks and national organisations. A high profile public launch of the department and the philanthropic partnership was held.

I assumed that, because my two major bullet-proofing factors were in place – a dean's strong commitment and leadership (and an understanding as to why that was required), and serious financial backing, that it was worth devoting my time and energy into building an Indigenous health program within a mainstream white organisation. I knew that the transformative unlearning of individuals and the organisation as a whole was a necessary, if unacknowledged part of the job description, but that it was worthwhile. Yet I was naïve.

Reflection

Three important lessons were learned. First, strong commitment from the dean as leader is not always or necessarily reflected across the organisation, and when the dean moved to a new position, things had to be done to embed the strategy in the organisation, and to ensure other senior managers and university officials were on side for the right reasons and shared the right commitments. This implied that the ‘unconverted’ – faculty members who had doubts or different motivations, such as economic or intellectual ones – could be identified and worked with.

Second, some faculty members who expressed support, openly or covertly, quite potentially had very different motivations. I thought that broadly speaking, those individual academics, and departments and schools of the faculty, who had been teaching or researching in Aboriginal health might be very happy and supportive of a new department of Aboriginal health. I was wrong. Some of these individuals and departments understood the evidence and practice in Aboriginal health that Aboriginal people should lead and make decisions about Aboriginal health, and when they did, the chances of success were more likely (Chandler and Lalonde 1998, Cornell 2006, Edwards and Sherwood 2006, Fredericks 2009a). Others seemed committed in public only, but were very concerned about their own economic and intellectual investments and interests in Aboriginal health. There was passive-aggressive behaviour exhibited to the department (see the case study in Chapter Four above). In particular, the School of Rural Health, which until then had been the only funded section of the Faculty for Indigenous Health, used extremely underhanded tactics to simultaneously seem “very committed” to Indigenous health, while fighting hard to retain teaching and research funding, control and intellectual leadership of Indigenous health. Its academic staff generally seemed committed to Indigenous health only if they remained in control of the

decisions and money, but not if a department of Indigenous health were to lead or implement a Faculty-wide reform process. They saw a Department of Indigenous Health as a rival, rather than as colleagues or facilitators of change.

My lesson was that when those with power are used to speaking for the disempowered, and the disempowered finally get a voice of their own, then those with power start acting very strangely. They profess support, while acting to maintain their power. This is how whiteness is enacted, as I was reminded of in the Indigenous health and racism roundtable.

Money was the key driver in both university and individual survival. Thus, broad moral arguments about including Indigenous health because ‘it was the right thing to do’, or even because of the appalling health statistics, fell on deaf ears if there was not economic backing for the initiatives.

Eventually, the dean left for another position, and the philanthropic foundation pulled out of the project for two reasons. First, the foundation had not anticipated the global financial crisis, and lost the financial resources it proposed to commit; this contributing factor to its withdrawal was acknowledged by the university. Further, the university did not acknowledge that a binding contract was not signed with the foundation in exchange for naming rights for the department, and this was a crucial mistake the university were at pains to admit. Second, the university appeared to have differing motivations to those of the Aboriginal community organisation: this reason was not acknowledged by the university. This meant the two bullet-proofing factors had been eliminated. What would happen to the Aboriginal health strategy and department?

I made representations to the vice-chancellor that I was very concerned about a new dean potentially not being supportive of Indigenous health initiatives through educational reform, especially at such an initial and fragile stage of development. I was assured that whoever was successful in the position, “it would be a pre-condition of their employment that they be a supporter of Aboriginal health.” The new dean was eventually appointed, and was widely considered to be a ‘hard scientist’, a laboratory-based biomedical researcher with apparently limited understanding and little interest in the social aspects of health care and particular questions about social exclusion, affecting Indigenous Australians especially.

I spent the next two years working with the new dean to try and bring him around to a fuller understanding not only of what had to be done, but why. I understood that while the new dean expressed support for Indigenous health, his own background in the basic sciences meant he had very little idea (and interest) about *why* it was important. He was primarily concerned with financial and public relations motivations, not intellectual, ethical and moral ones.

When the pledged philanthropic money evaporated, the university hierarchy pressed me to take the easiest fall-back option – partnerships with mining companies. I expressed some reservations about this, given that Aboriginal communities had differing views on the ethics of partnerships with companies who were digging up Aboriginal lands and contributing to cultural and material degradation, and that cultural identity was a strong protective factor for good Indigenous health. I was angrily attacked, sidelined and dismissed as naïve. Despite this, a small group of supporters and I fought to find other sources of financial support so we might honour our commitments to the Aboriginal community stakeholders with whom we were in formal agreement, and whose expectations we had raised.

I watched three years of planning and negotiation with local Indigenous and academic communities collapse; Indigenous health was apparently dispensable, or valued only if special monies were attached. At the same time, my mother was diagnosed with breast cancer, and the prognosis was uncertain. This took a heavy toll emotionally and psychologically; I became depressed and briefly suicidal. It became very clear that I needed a break, and I took an extended period of study and personal leave. While on leave, the faculty and university retracted previous financial commitments to the strategy and department, and disestablished the department. No formal explanation was ever given to the broader Aboriginal community, many of whom had been very excited about the strategy's and department's potential to make a difference for them.

EXEGESIS

In the case of the roundtable discussion above, deep pain and discomfort emerged when talking about racism and whiteness. In the second case study, those who professed to be committed to Aboriginal health turned out to have differing and varying motivations. In this section, I examine the underlying issues at play.

Whiteness and Racism in Public Discourse

In conversations where the term racism is used in Australian public discourse, discussions ensue regarding definitions of racism, what part of the behaviour or actions were racist or not racist, and what should or could be done about racism. These discussions are often adversarial, characterised by dismissal of racist incidents as isolated, with hand-wringing about how 'we can all just move on' without maximum interruption to normalised daily life. Racism as a notion in Australian public discourse is toyed with, but rarely addressed or resolved.

Yet racism is merely one expression of an underlying set of values and assumptions. In this case, whiteness is an ingrained mindset or habitus born of colonisation and the hangover of the White Australia Policy. Using the term whiteness is an even more potent and emotionally provocative term than racism. In a political and social enabling environment where denial of racism is the norm, where notions of racism are toyed with but not resolved or addressed in public discourse, it follows that those same powerful interests who deny or dismiss racism do not welcome a discussion about the inherent mindset, values and beliefs underlying it.

Discussions about whiteness reveal not only racism as one expression of whiteness, but the inherent ongoing power imbalance in whiteness itself. Racism can be dismissed as an isolated incident or as just limited to one or two perpetrators. Whiteness is systemic; it reveals the underlying benefit, privilege and power imbalance that everyone in white Australia enjoys. Using the term whiteness appears to disrupt the normalised inherent power imbalance of oppressed-oppressor relationship dynamics, such that both the oppressed (Roberts, Demarco et al. 2009) and oppressor (Deutsch 2005, Friere 2007) are deeply challenged and afraid of what might come next.

The terms racism and whiteness are like scabs on a deep wound – the second it is mentioned, the scab is lifted, and a range of emotional and psychological reactions and feelings ensue for both the oppressed and oppressors. The oppressors feel challenged, affronted and afraid that their apparently ‘normal’ positions of power to decide what is normal and acceptable, and what values should be used in making decisions, are under threat. This is often experienced as an unconscious threat, a confusing welling up of feelings in the oppressor. This is no surprise if the oppressor doesn’t even know they have these ‘tendencies’ towards ‘normal’; if they don’t even know they have whiteness as a *modus operandi* or as habitus.

Whiteness can be calculated, conscious or mercurial. It can change and shape-shift itself, hiding behind (white) society's professed rules of inclusion, equality and normalcy, while simultaneously and calculatingly seeking to maintain the 'invisibility' (denial of) and maintenance of white power, privilege and control.

Whiteness is an undiagnosed psychological, emotional and spiritual disease, which can be expressed in individuals, groups, institutional structures or societies – the enabling environment. The individual 'carriers' of this disease – a society's citizens and institutions – most often do not know they have it. They acknowledge racism, power and privilege, and may work daily to protect and replicate them, but they often do not know what motivates or drives this set of embodied actions and behaviour, that is, their habitus.

This unconscious habitus is what allows people who have sworn goals of 'equity' and 'to expect that equity comes about by using their own unseen and unsaid values as 'normal' (Hesse 2007, Hesse 2011). That is, the powerful set the parameters within which the powerless should act (Foucault 1982), and those who have power expect those who have less power to be thankful for it. The powerful want equity and diversity for the powerless on their own terms. This is whiteness masquerading as equity, diversity or inclusion (Fredericks 2009c). This is congruent with what Farmer (2004) refers to as charity and benevolence towards the 'disadvantaged' in medicine, rather than taking a capabilities and strengths-based (Sen 1985, Nussbaum 2005) or social justice approach (Farmer 2005).

Has Colonisation Ended?

Given that the colonisation of Australia is one consequence of whiteness – values, mindset and habitus of embodied values and beliefs – it follows that this set of values and beliefs has

imbued the colonisation process and the acting out of its ongoing effects. This set of on-going effects of colonisation may be referred to as neo-colonisation, and raises the question of whether discourse about the 'post-colonial' is in fact a misnomer. Post-colonial studies and Orientalism acknowledge and refer to the after-effects of colonisation as whiteness, privilege and the benefits of colonisation (Spivak 1999). Yet these discourses presume two things: that colonisation has finished, and that whiteness is a consequence of colonisation, rather than its precursor or concurrently acting interlocutor. Stuart Hall (1996) clarifies that 'the post-colonial' is often used as "a concept celebratory of the so-called end of colonialism", but that it "grossly underplays 'capitalism's structuring of the modern world'. Its notion of identity is discursive not structural. It repudiates structure and totality" (1996: 243).

Colonisation has not ended (Morseu-Diop 2010). The set of values and beliefs which gave rise to it live on. Post-colonial studies and orientalism refer to these after-effects as 'post-colonial' as a way of explaining that the original physical invasion of lands and subjugation of peoples has chronologically ended. However, the physical invasion of Indigenous peoples' lands continues in Australia today, as does the subjugation of Aboriginal and Torres Strait Islander peoples. Though this ongoing invasion may be referred to as 'land title' or 'compulsory acquisition' or 'relocation' under Australian common law or policies of economic or social development, it still remains as the state exercising power over original owners of the land. Gelder and Jacobs' (1994) account of the post-colonial in Australia is instructive here, in that they assert that there are complex entanglements where:

the postcolonial is here conceived as a set of processes rather than as a temporal moment which permeates a neat... sidestepping of the many particular historical moments and struggles through which Indigenous and minority claims on the modern nation come to circulate in the public sphere (Goldsmith 1998: 1).

Further, it could be argued that subjugation of Aboriginal and Torres Strait Islander people have continued unabated, as expressed in the Northern Territory Emergency Response ('the Intervention'), for example (Altman and Hinkson 2007).

If whiteness were defined simply as an after-effect of colonisation, where white people inherently believe they should have entitled access to power and privilege, then we potentially ignore the fact that the English crown believed in this entitled privilege before they got to Australia. While the inter-relationships of changes in ideology and material relationships over time requires more research (Reynolds 2000), any conception that whiteness was consequential to colonisation rather than a precursory phenomenon, could also imply that colonisation has ended, and that we are now in a 'post' colonial space. While colonisation's practices have changed – the underlying belief system of whiteness is constant.

More correctly, public and academic discourse could acknowledge the neo-colonial. The neo-colonial more correctly acknowledges that colonisation lives on. Colonisation lives on because whiteness - the values and beliefs that preceded it – have not changed or ended. They have only become expressed in different ways, and are a common factor in policies through the colonial and neo-colonial history of Australia – from original invasion, to massacres and poisonings, protection, assimilation, the White Australia Policy, quasi-self-determination, reconciliation where white values prevail, and now apparently economic development as an all-encompassing answer to the 'problems' of Aboriginal and Torres Strait Australia. Writing about postcoloniality and the artifice of history, Chakrabarty (2000) has asserted:

Insofar as the academic discourse of history – that is, "history" as a discourse produced at the institutional site of the university – is concerned, "Europe" remains the sovereign, theoretical subject of all histories, including the ones we call "Indian," "Chinese," "Kenyan," and so on. There is a peculiar way in which all these other histories tend to become variations on a master narrative that could be called "the

history of Europe.” In this sense, “Indian” history itself is in a position of subalternity; one can only articulate subaltern subject positions in the name of this history.
(2000: 27)

Thus, through all the policy phases of government and colonisation in Australia, whiteness as the habitus or mindset of embodied and actioned values and beliefs is the common factor.

Whiteness allows the fallacy of the inclusion of Aboriginal and Torres Strait Islander peoples into the Australian state apparatus under the guise of ‘equity’, ‘diversity’ and ‘human rights’, while maintaining a legal lie that Australia is owned and ruled by the English Crown. Dirlik (1992) and Shohat’s (1992) work “explains why a concept which is intended to be critical should appear to be complicitous in the consecration of hegemony” (Hall 1996: 243). In this social enabling environment where the Australian state is built on a legal lie of ownership, and relies on politico-military means of subjugation to maintain it, then it is logical that its underlying values of whiteness affect most people caught up in its embrace. Whiteness is accepted in Australia as the normalised state of being, thinking and doing. Whiteness replicates whiteness.

Put another way, the whiteness inherent in colonisation has lingering after-effects on the colonised and the coloniser:

So for Aboriginal people, the whole of life is a spiritual experience, and so the whole of sickness is a spiritual process. The spirit cannot be in balance if it is out of balance with the body. If you’re spiritually unwell, you can’t help but affect the whole of your being... See, the impact of colonialism has been huge... we Aboriginal people are spiritual people and we are still recovering because of colonialism... There’s not a lot of understanding about the part of white Australia because they have this misguided belief that colonialism doesn’t affect them. Of course it does! It’s made them into the people they are today, which means they cannot hear what Aboriginal people are telling them... Many are trying to run away from their own history... As they get older and more mature [chuckles], hopefully they’ll have a better understanding...
(Elder Aunty Lilla Watson, in Phillips, 2003: 26)

WHITENESS' AFFECTS

Whiteness does not only affect the powerful, or white people alone; it effects the less powerful as well, given that through no choice of their own, Aboriginal and Torres Strait Islander peoples and all who now live in Australia are affected by an enabling environment characterised by this unseen, but all-encompassing, whiteness regime. Whiteness affects Black, white and other peoples in interesting ways, and this section explores some of those dimensions.

In my earlier discussion of the racism and Indigenous health roundtable, not only did white people who had 'worked in Aboriginal health for twenty years' display unusual reticence and strong emotional reactions to using the term whiteness; so too did an Aboriginal person react emotionally to the term. These reactions were an indication that whiteness' supposed normalised rules of oppressed-oppressor and powerful-powerless were being challenged; it hit a deep nerve. The emotions were about fear – fear for the powerful white academics that they might not have a powerful role as 'the experts' in Aboriginal health if whiteness were unmasked, even though their roles were not in material jeopardy, and fear by the Aboriginal person that they might not have a role as 'the victim' or 'the disadvantaged' if the power imbalance of whiteness was uncovered. Essentially, talking about conflict can lead to denial of the existence of conflict – 'the one big happy family' myth (Arieli, Friedman et al. 2012), or to further attacks between and within oppressed and oppressor groups (Loan Tran 2013).

In the second case study, of the faculty which tried to establish a department of Indigenous health, the powerful – those with vested financial, public relations, academic and hierarchical control interests – professed to care about Indigenous health, yet were incensed and fought hard to retain power when the embryonic department attempted to identify and share power

imbalances in decision-making, leadership and control. The motivations of the powerful were considerably different to the less powerful. When the less powerful pointed the differences in motivation out, those with greatest power reacted angrily and indifferently. The less powerful – members of the Aboriginal community organisation and me as lead academic, despite trying repeatedly to implement power re-balancing, were naïve as to the lengths to which whiteness would hide itself. We were naïve that the powerful would ‘logically’ match their professed moral and intellectual commitments to Indigenous health with commensurate financial and power-sharing arrangements. This resonates with what Foucault refers to as philosophy’s role in keeping watch over the “excessive powers of political rationality”, and that reason alone in redressing power is not effective (1982: 777). Despite individual commitments from various senior executive leaders, most people in the faculty and university wanted to ‘include’ Aboriginal health on their own terms, not the terms or values that were jointly shared or negotiated with the Aboriginal community stakeholders.

Using the term ‘whiteness’, therefore, can disrupt the otherwise normalised acceptance of whiteness’s values and beliefs, and the power imbalance this implies, as normal. This can cause unique and interesting emotional reactions for both the powerful and the powerless. Those who hold power can unconsciously or intentionally seek to maintain their economic and intellectual power and control, while professing goals of inclusion, diversity, equity, charity and benevolence. The less powerful seemingly must choose between options in a false dichotomy. One is to consciously disrupt whiteness’s power imbalances and risk an onslaught of angry or passive-aggressive emotional responses from the powerful and others with less power, and risks the threats to their personal integrity and wellness this might produce. Alternatively, some educator’s might choose to placate whiteness’ control, arrogance and emotions by using different terminology, thereby staying comfortable in addressing the

effects of racism by addressing ‘access’ and ‘equity’ issues, rather than one of the potent underlying causes of racism – whiteness and its values.

Whiteness as Domestic Violence

In this way, after two centuries of whiteness, expressed through neo-colonialism and currently still accepted as *a fait accompli* in political, legal and social terms, it has come to be characterised as akin to a domestically violent relationship.

I use domestic violence here as an analogy only. Notwithstanding the specific gender (Saunders and Evans 1992), race (Huggins and Thomas 1992), class (Wall 2014), whiteness (Moreton-Robinson 2000) and intersectional aspects of domestic violence in Australia (Stubbs and Tolmie 1995, Kripps 2014), the general analogy of the power dynamics in many domestically violent relationships can be instructive of the political and social power relations between Aboriginal and non-Aboriginal peoples.

In classic domestic violence relationships, with, say, a physically or emotionally violent powerful male, and a less powerful abused woman, both the male and the female are often buying in to a sick relationship. Let’s say a white man, with the benefit of patriarchy, and using physical and psychological power, oppresses and abuses a white woman. He is invested in a relationship where he gets to blame the woman for his physical behaviour – the classic ‘she made me do it’ excuse, while attempting to ignore his responsibility for his actions. The man attempts to make her believe she is worthless and powerless. He may feel guilt and remorse for his actions, and if he does not get outside support or help, may come to internalise his guilt and shame, and justify his emotional feelings with yet more rage. He comes to internalise his role as a powerful perpetrator, but also as a victim.

Through no fault of her own (the physical violence), the woman also unwittingly emotionally buys in to the sick relationship. After having been abused and scorned for so long, if she is unable to access support or outside help, she may come to believe that she deserves the behaviour, and deserves no better. She may come to use rationalisations for staying in the violent relationship, such as ‘I need a father for my children’, for example. She may need him to be able to blame someone else – her victim status may become so ingrained that it becomes internalised; her victim status may become normalised – her identity. In this way, she may come to depend on him for her identity as a victim. She may unwittingly come to need him to keep abusing her to satisfy this need for identification with a victim role. Her buy-in to the relationship is now about fulfilling this role, and this sometimes overcomes her personal need for safety.

In relationships where underlying needs are not identified or met, and no outside help is sought, violent behaviour may become an extreme consequence. If this violence continues with rationalisations and blaming on from both parties on to the other, then internalisation of false beliefs and roles as victims may ensue. This victimhood, and its underlying guilt, shame and remorse, become the catalysts for yet further negative and emotionally, mentally and spiritually violent behaviour, this time from both parties.

This is the dynamic of whiteness in Australia.

The powerful white regime, consciously or unconsciously, exerts its power and control over Aboriginal and Torres Strait Islander peoples. It sometimes feels shame, guilt and remorse about its behaviour. And it sometimes apologises for its mistakes. However, it continues to exert its need for power and privilege through blaming the victims of its oppression. Because

outside help and support, or mechanisms such as truth telling and truth and reconciliation processes, are not used, then no new energy or assistance can be given.

Whiteness in the Australian state and society continues to ignore its negative feelings and hope they go away. It harbours deeply ingrained insecurities about its origins as a people. The psyche is one of feeling isolated from psychological white parentage in England and the USA England and from the new Uncle America, also white. This feeling of isolation is exacerbated by feelings of rejection – ‘why were we sent as convicts to this strange and hostile land?’ We do not belong here, we cannot make peace here, unless we control the land and abuse it, clinging to its beaches for dear life. The whiteness regime does not feel comfortable in Asia. It feels isolated. It is an island nation. It ring-fences itself in, and puts up barriers to protect its whiteness (Ganley 2003). It gets paranoid about its borders. Its sense of place and peace in this land, this part of the world, depends on whiteness. It ignores and denigrates its Aboriginal/Black past, or only acknowledges it out of guilt and shame or out of fascination and benevolence – the myth of inclusion. The white state owns Australia, apparently, and must protect itself from anything that challenges this white superiority, this whiteness. The powerful white regime is domestically violent to others to maintain its deep-seated insecurities and internalisation of victimhood. They get to Blame Blacks for their violence.

Though not all white or Caucasian origin peoples in Australia may believe or feel this way, many may choose different levels of reaction and action (Hesse, 2008) – some as racists, some as liberators – yet all benefit from its privileges. They may become comfortable in this role of denial, because it is familiar. All are caught up in its embrace.

On the other hand, Aboriginal and Torres Strait Island Peoples, after more than two centuries of genocide – the primary wounding, denial of genocide and colonisation – the secondary wounding, and on-going neo-colonisation through a regime of white power and control – the tertiary wounding, are posited as victims, charity cases and ‘disadvantaged’. Some Aboriginal and Torres Strait Island Peoples may internalise this victimhood, and may internalise and consciously or unconsciously accept whiteness’ supposed normalised rules of oppressed-oppressor relationship. Aboriginal and Torres Strait Island Peoples may internalise disadvantage as identity, such that sometimes, any personal or communal progress is greeted with suspicion and false equations of poverty with Aboriginality. Some Aboriginal and Torres Strait Islander peoples choose to ‘ignore or forget the past’, and ‘just move forward in the real economy’. While the daily requirements of food and shelter necessitates Aboriginal and Torres Strait Islander participation in the white state’s economic, legislative and political machinery, it in doing so, some may consciously or unconsciously accept the underlying whiteness regime as normal. Some Aboriginal and Torres Strait Islander people come to see their victimhood status, and their internalised sense of being powerless as an identity, as normal. Some get to blame whites for their victimhood. Some feel comfortable in this role because it is familiar.

While not all Aboriginal and Torres Strait Islander peoples live out identities characterised by victimhood – many are very clear about the difference between participation in the white state’s machinery for daily survival, and proud actions as sovereign peoples who do not accept the whiteness regime’s ‘normal’ rules of domination. Yet all are caught in its embrace. This daily individual and collective psychological and spiritual tussle between survival and the terms of survival is what makes dealing with a whiteness regime so distressing. The daily challenge is to participate enough to survive, thrive and succeed, but to do so on one’s own

terms, while not compromising cultural and spiritual values and status as sovereign and free peoples. Dealing with whiteness requires intense daily emotional labour. We are all caught up in this embrace.

Thus, the whiteness is a regime is akin to a domestically violent relationship, where the oppressor maintains their power by abusing others and by blaming the victims for their own actions. Their remorse is short-lived, and secretly the oppressor continues to exert power so their needs as the most powerful are guaranteed and their insecurities about their identity (internalised victimhood) are suppressed. The oppressed in this relationship are so physically, emotionally, psychologically and spiritually dominated, that they may internalise victimhood as their cultural identity, and find daily struggles of survival and participation while not compromising personal agency/sovereignty/freedom, extremely distressing. They may feel become uncomfortable leaving this sick relationship and uncomfortable in regaining their power. Some will choose to stay in the relationship because it has become familiar. This familiar relationship between Aboriginal and Torres Strait Islander peoples and white Australians is what characterises the whiteness regime, the white Australian state, the enabling environment, as one of domestic violence. Both the perpetrator and victim blame each other, and both come to internalise their perceived victimhood or insecurity as the basis for their identity.

The Familiar and the Unfamiliar

In defining or deciding on what is familiar or unfamiliar, comfortable or uncomfortable, known or unknown, similar or different, humans make a plethora of quick decisions about others all the time. There are three distinct steps in deciding what is familiar or unfamiliar. The first is a visual cue about difference or sameness (race, gender, class, dis/ability,

sexuality etcetera), the second is a set of judgements and values based on one's own beliefs about that visual cue represents, and the third is a set of actions based on the previous two steps.

In terms of markers of difference or similarity in relation to whiteness and racism, these three steps can play out in interesting ways, and are related to the psychology of stereotype, where perceived social identity can affect a person's performance or socio-economic status by virtue of social expectation about their abilities (Steele, Spencer et al. 2002). First, someone visually perceives a person with a different skin colour to their own. While, every human being may not rely on visual cues alone to perceive similarity or difference; for example, blind people may rely on auditory and other senses to perceive differences or familiarity. Yet, even if a seeing person is viewing someone of the same skin colour as themselves, the viewer nevertheless perceives familiarity or unfamiliarity based on the initial cue of skin colour alone.

Second, after the initial visual or auditory cue, people will use their own set of values, beliefs, feelings, thoughts, habitus, actions, and social and cultural influences to make meaning out of this visual or auditory perception – they will decide what that different or same skin colour means for them (Maddox 2006). It provokes a whole series of decisions, judgements and actions based on pre-conceived ideas about what that visual cue represents. For instance, if a man sees a woman, he may instantly perceive his physical strength as being greater than hers, or may instantly perceive his psychological state as one of a being more 'stable', 'reliable' or 'intelligent'. Further if a white man sees a black woman, he may perceive her to be both less talented and worthy of promotion in the workplace by virtue of her gender, and less intelligent or reliable by virtue of her skin colour; together he may see these two visual cues

as markers of a woman who is sexually available and dangerous (hooks 1992). A person on a bus may see a disabled person in a wheelchair and feel 'sorry for' them or have thoughts of pity and judgement of them as 'weaker' (Abberley 1987, Nario-Redmon 2010).

Third, based on the perception of difference and the meanings given to that perceived difference, people will then implement a set of actions that makes sense in their world. A male boss may not recommend a female colleague for promotion because he believes her gender makes her less reliable; a white person may not feel safe with a black person entering an elevator, and so cover their belongings and move away; a physically abled person on a bus may stare at a person in a wheelchair because they perceive their physical body difference as being different, weaker, and therefore fascinating.

What is interesting is that with each step, feelings of ambivalence and discomfort may be evoked in the perceiver. A white person may feel shame at noticing a black person's skin first, or an able bodied person may feel shame at noticing and feeling pity for someone in a wheelchair, for example. These feelings of discomfort are often difficult to admit (Lentin and Lentin 2006, Grzanka 2011). In the second step, having made a series of judgements about 'the other' based on the initial visual cue, people may experience a range of conscious or unconscious guilt and shame about that series of judgements – 'Should I think the person in a wheelchair is weaker?' 'Should I think the black person is a thief?' 'Should I think women are overly irrational?' These thoughts and feelings are often difficult to name or admit. Third, a white woman may feel guilty about covering their purse when a black woman enters the elevator, but does it anyway; a man may feel guilty for being domineering in a meeting with women because he perceives them all to be weaker, but does it anyway.

These examples are intentionally focussed on the powerful party and their visual cues, thoughts and judgements and actions – on men, white people and able-bodied people. The less powerful people – women, Black people and disabled – are the people being judged and reacted against in these examples, as a way of highlighting the structural power imbalances that exist between the powerful and less powerful.

While visual cues, judgements and subsequent actions can be seen among less powerful people towards the powerful, the critical disclaimer here is those visual cues, judgements and actions are not sanctioned or seen as normal by the whiteness regime, or the male privilege regime, or the able bodied privilege regime. Power and structural imbalances in society is the critical confounding factor here, such that there is no such thing as reverse racism, reverse sexism or reverse discrimination against the abled (Rahman 2013). For example, a woman seeing visual values of male gender, judging him to be violent and sexist, and acting based on her values and beliefs in a way that avoids him, is not the same as a man doing the same to women. A man acting in this way to a woman is sanctioned, normalised and expected among most of his male colleagues and the patriarchal power structures they have created. A woman acting this way with a man is not supported by society's normalised rules and what is expected of her as a subservient beneficiary of men's benevolence. Similarly, a black person judging a white person is not the same as a white person judging a black person. The black person does not have the legal, social, economic and political capital in society to sanction or support their beliefs and values.

In short, the structural and societal playing field is not even for the less powerful, so their actions have less consequence and their actions are not supported by the system and state (Mosse 2010). This does not suggest it is acceptable for anyone to discriminate against others

based merely on familiar or unfamiliar visual cues, resulting judgements and actions alone, yet it does suggest in using this three-step framework for understanding familiarity, that overriding societal structural power imbalances must be taken into account.

Interesting too, is the relations of power within and between oppressed groups, known as intersectionality (Crenshaw 1993, Moreton-Robinson 2000). This field of research is critical to understanding the ways power is employed within and between these groups, yet it is essential to understand that central to oppressed group behaviour (Roberts, Demarco et al. 2009) is lateral violence (Clark 2012), or acting out unresolved powerlessness on others who are the same (Middelton-Moz 1999, Phillips 2003). Thus, while intersectionality is important, in the context of whiteness, it is also critical to understand the relations of power between those who exercise power in such a dominant way – the state and its agents – and those who are the subject of that power – citizens. One cannot, for example, understand intra-violence between oppressed peoples of colour before understanding the political realities of their existence in an enabling environment of whiteness and state control (Levine-Rasky 2011).

This three-step process of the ‘othering’ of familiarity and unfamiliarity is at play in the Australian whiteness regime. First, it judges Aboriginality by skin colour alone, so that darker skinned Aborigines are presumed somehow less intelligent and more unreliable, and fair-skinned Aboriginal people are somehow less Aboriginal and more fraudulent. Second, based on whiteness’ values and beliefs about child-rearing and work ethics, for example, the visual cue of skin colour will be used to judge Aboriginal mothers as less loving and capable, and Aboriginal workers as less intelligent or reliable.

Given these values and beliefs of whiteness remain undiagnosed and unquestioned in public or policy discourse, both Aboriginal and non-Aboriginal actors act within those parameters of what is 'normal' to try to produce a 'culturally appropriate' response for Aboriginal peoples. Here, white benevolence is accepted as normal, Aboriginal people are problematized and viewed through a deficit lens, Aboriginal people's strengths in child rearing or work practices are rarely considered, and what attempts to be implemented as a culturally appropriate program ends up reifying the whiteness regime rather than supplanting it. The state will accept cultural difference, as long as it is within its own parameters for normalcy, as long as it is on the state's terms.

Are we teaching Aboriginal health or the unlearning of whiteness?

Being clear on the process of othering – deciding what is familiar and what is unfamiliar – is crucial to the process of teaching Aboriginal health.

This seems congruent with Rasmussen's (2000) and Paul's (2011) work, which suggest that the emotional reactions of learners, who presented with Aboriginal health or Aboriginal history for the first time, often have hostile emotional reactions. This is partly because they are experiencing a deficit of learning or curriculum about Aboriginal people in primary and secondary schools, and partly because of negative media, cultural and social representations of Aboriginal and Torres Strait Islander peoples.

Ryder and colleagues (2011) refer to a process of transformational unlearning, where introductory learners must first unlearn racism, whiteness and privilege before they are ready to be educated about Aboriginal peoples and their health. They suggest that given the deficit in learning about Aboriginal peoples in primary and secondary education, and the need to

deliver equitable access to health services, “it is not just a matter of what members of the dominant culture do with the ‘others’ but what they do with ‘themselves’ and their practices” (2011: 781). Dennis McDermott (2012) suggests it is essential to analyse racism in medical education, rather than ignore it or dumb it down. David Paul and colleagues (2006) found similar dynamics; that it consistently took medical students and educators three to four years to unlearn their barriers before they could learn about Aboriginal health, and to have an ‘a-ha’ moment (Paul, Allen et al. 2011).

Whether the primary topic of an education session is ‘Aboriginal health’ or ‘racism’, ‘whiteness’ or ‘inequity’, talking about Aboriginal-non-Aboriginal relations and issues seems fraught in Australia. Amplifying similar power dynamics found in the racism and Indigenous health roundtable case study presented in this chapter, a recent public email discussion highlights this. In 2013, a national research team was engaged to develop a multi-disciplinary Aboriginal and Torres Strait Islander health curriculum framework for all health professional courses. In the process of developing this national curriculum approach, the research team have invited comment on their proposed Aboriginal & Torres Strait Islander Health Curriculum Graduate Capabilities Matrix. The research team emailed the following email to a group of approximately thirty health academics, including myself. It read:

Thank you very much for taking the time to participate in our on-line survey in June, which asked for your feedback on the proposed Entry to Practice Graduate Capabilities Model for the Aboriginal and Torres Strait Islander Health Curriculum Framework. We deeply appreciate the time and thinking that you gave, and your feedback has been extremely important in the revisions and improvements to the Model.

Please find attached the revised Entry to Practice Graduate Capabilities Model based on your feedback. Your feedback highlighted overwhelming support for the proposed Capabilities and Learning outcomes, with minor revisions to the model to improve the statements.

Key points that came back from the survey were:

1. Foregrounding 'cultural safety' as a core learning outcome
2. Removing descriptive terms that are unrealistic or unnecessarily demanding (such as achieving 'confidence', 'courage', 'mutual benefits')
3. Identifying key words/ phrases to be included at lower level curriculum mapping learning outcomes (such as respect; listen; promotes; holistic; trust)
4. Revising notions that may be unnecessarily problematic (notably removing 'white' from the term 'white privilege') without diluting depth of learning experience.⁸

This case clearly highlights five particular dynamics. First, that the definition of whiteness is misunderstood, where it is seen as being about the actions or beliefs of ethnically or racially white people alone. Second, notions of blame and responsibility have been conflated, where the listener or reader is perceiving that all white people are being blamed, when what is really being said is that all white people benefit from whiteness, and therefore, all white people do bear some responsibility to de-privilege themselves. Third, this illustrates denial of white privilege and whiteness, and fourth, that those who have provided such feedback feel emotionally uncomfortable in dealing with their own feelings surrounding the facts of genocide and continuing oppression. Last, this suggests that there is such a thing as 'reverse racism', so 'privilege' allows 'white privilege' and the myth of 'people of colour privilege' to co-exist. Removing 'white' from 'white privilege' "...without diluting depth of learning experience" is like attempting to teach address sexism and misogyny by using the word 'privilege' instead of 'male privilege'.

Debates about racism and white privilege in higher education and across Australia are deeply problematic, illustrated by those in positions of influence over Aboriginal and Torres Strait Islander health curriculum unnecessarily wielding their whiteness as a position of power.

⁸ Email, Project Manager, Curtin University, 4 August 2014. See Appendix 5.

The false dichotomy between ‘privilege’ and ‘white privilege’ suggests the need for more discussions about racism and whiteness in Australian health care, higher education and Australia in general. It also suggests that these discussions need to happen in a safe space, with highly skilled facilitation or tutorial staff, and adequate time for discussions and dealing with the range of emotional reactions that are expressed. The transformational unlearning of racism and whiteness can be tracked, learned and dealt with, yet there seems few examples of such approaches to education in Australia at present. The STAR (Stand Together Against Racism) Project from James Cook University (Grant 2013) and Courageous Conversations About Race (Singleton 2005) are notable exceptions.⁹ It seems that more training and professional development for educators may be an answer – learning how to teach transformational unlearning, racism and whiteness. In essence, dealing appropriately with the emotional reactions of potentially hostile learners is an essential component of teaching Indigenous health, as is challenging such beliefs within the academy.

Further, in the case of establishing a department of Aboriginal health in a medical faculty, I expected that similar to the process of transformational unlearning for students, the teachers or decision-makers in organisations in relation to Aboriginal programs who may be ‘unconverted’ or have a range of different understanding of the issues involved, also needed to be educated. Decision-makers and leaders may need their own process of transformational unlearning before they could make more informed decisions in relation to Aboriginal health.

This expectation is both a sad indictment on Aboriginal and non-Aboriginal relations and the prevailing political and social enabling environment – the regime of whiteness – but more

⁹ These projects focus on teaching techniques to identify and manage common emotional and hostile reactions to discussions of race, racism and Aboriginal health.

generally, a sad indictment on relationships between two sets of human beings enacting false or misleading expectations within the context of a domestically violent relationship.

Conclusion

In this chapter, I have defined whiteness as a set of values and beliefs, a mindset or embodied habitus, where white values and beliefs are normalised and accepted in society. I have discussed the interplay of whiteness, racism, colonisation, power and privilege, and concluded that whiteness is the belief system or mindset and habitus, colonisation is a consequence of it, racism is an expression of it, and the maintenance of white power and privilege are its ends.

Using case study material, I have examined how whiteness in public policy discourse reveals a social and political enabling environment where white ownership and values reign supreme and unquestioned, and where it is believed colonisation has ended. I suggest that whiteness as the values and beliefs, the embodied habitus of the Australian state, lives on through neo-colonisation and on-going policies which see Aboriginal and Torres Strait Islander people as charity cases to be included in an Australian state owned by white people and their values. I have suggested the on-going conscious or unconscious regime of whiteness, after more than two hundred years colonisation and neo-colonisation, has produced a sick relationship akin to domestic violence, where both the oppressor and oppressed act as victims and blame each other for their actions, and are uncomfortable discussing their emotional reactions, and the inherent power imbalances that underlie them. I have also examined how familiarity and unfamiliarity, the process of othering, plays out in the Australian state's whiteness regime; noting that notions of 'reverse racism' ignore the power imbalances and power relations inherent in state control.

In summary, white and Aboriginal Australians feel more comfortable talking about disadvantage, equity and racism, than terms like whiteness. This is because terms like disadvantage and equity play into the white bio-political state's regime of whiteness, where its values are unquestioned, and ownership is based on a lie. This false ownership then, makes it possible for the state's whiteness regime to feel benevolent to 'include' Aborigines as charity cases in a state apparently owned by whites and their values alone. In medical and higher education, and in general public discourse, we need to be clearer about what exactly it is we are teaching, how we are teaching it, and what the foundational precepts of familiarity or discomfort are that we employ.

Clarity about how to educate medical students in regards to Aboriginal health requires addressing questions of definition, teaching technique, ownership and decision-making for Aboriginal health, medical curricula and Australia in general.

Not doing so means two once proud, but now very unwell peoples, cannot, as Aunty Lilla Watson says, hear each other. It's not a question of colour, but a question of our ideas, said Nelson Mandela. Resolving the impasse in hearing and ideas is the focus of the concluding chapter.

CHAPTER SEVEN – VISIONING CHANGE

The two methods most frequently employed to solve our toughest social problems – either relying on violence and aggression, or submitting to endless negotiation and compromise – are fundamentally flawed. This is because the seemingly contradictory drives behind these approaches – power, the desire to achieve one’s purpose, and love, the urge to unite with others – are actually complementary. As Dr Martin Luther King Jr. put it, “power without love is reckless and abusive, and love without power is sentimental and anemic.” But how do you combine them?

(Kahane 2010: back cover)

The dilemma enunciated by Kahane here is, in many ways, the dilemma that defines the nature of Aboriginal-state relationships. It is a dance of power, where the state sets the terms of interaction and holds sway over Aboriginal individuals it sees at its subjects, and Aboriginal peoples try to extricate themselves from this state power by expressing desires for agency, autonomy and sovereignty through movements of self-determination, self-governance, treaties, social justice and human rights (Alfred 2005). These desires for independence, however, are frequently frustrated by the very state apparatus Aboriginal peoples from which they seek to be independent; the state covertly and overtly subsumes and consumes these concepts and movements into its architecture. For example, social justice movements become incorporated into the rubric of human rights, and are monitored by the state (Moreton-Robinson 2006); treaties and agreements become a kind of sovereignty monitored and managed by the state (Alfred 1999); self-governance and autonomy become legislated within state parameters (Iorns 1992, Turner 2006); and self-determination becomes a concept ignored whenever the state feels like it (O'Malley 1996, Altman and Hinkson 2007).

One way in which this absorption of Aboriginal autonomy and independence occur is the politics of definition and interpretation. For example, Aunty Mary Graham (2014), Elder and

philosopher, clarifies what is meant by relationality for Aboriginal peoples, and responds to Martin Weber's (2014) idea that international states hold positions instead of relations:

There is no Aboriginal equivalent to the Cartesian notion of "I think therefore I am", but, if there were, it would be – I am located therefore I am. Place, being, belonging and connectedness all arise out of a locality in land... In the Aboriginal notions of autonomy, a place isn't a position. A place can't be a position because it's a matrix of relations, narratives, obligations – it has neither rigidity nor flexibility, it has soft, inclusive structure, spirit, agency and memory. And while position can also have the same kind of matrix as place, it has not come into the world to preserve relationality (like place) – it comes to contain, define and dominate relationality... It may seem unrealistic, even ludicrous to some, to propose or advance the notion that an ancient, non-agricultural culture may have some pertinent knowledge about the dilemmas of relations between states or Weber's 'the parametrics of social-logic inquiry'. However, the ancient society's notions may very well have some cogency if only in the sense of refusing to see relationality as some lost social artefact. Modern technology informs and dominates relationality, where really it should be philosophy re-asserting its authority in this area.

(2014: 2, 5)

Graham's treatise makes clear two things. First, that Aboriginal notions of autonomy, relationships and independence might utilise the same English words to describe these phenomena, yet these phenomena are redefined, reinterpreted and absorbed into state apparatus on state terms. Second, Graham suggests that the motivation for action between states could be relationality, rather than power and domination, and that if it were, Aboriginal notions of autonomy and place would be a far more effective principles for conducting international relations than positionality or what the state thinks is relationality.

Under whiteness' affect, however, clarification of the politics of definition and interpretation and Aboriginal knowledges and philosophies are never seriously considered as relevant to geopolitics. Without serious consideration of these matters, the Crown continues to hold power and control over Aboriginal peoples in Australia, and Aboriginal people's concepts and movements of independence can actually become the toys of state control.

Facing the brunt of these pervasive and sinister power and control techniques, Aboriginal people apparently are faced with only two choices. The first is to try to avoid this tussle, or dance, of power, by seeking to be included on more peaceful terms, or terms which get the intended funding or program results, despite the control techniques implicit in these contracts. Yet this is to accept inclusion on white terms, and is reminiscent of Foucault's (2003a) ethics of the concern of self as a practice of freedom. In this treatise, he warns that religion, science and the state use coercive practices to replace personal agency and freedoms with a belief that individuals cannot exist without state parameters; they become coerced and cajoled into believing they have no agency. People internalise power and control by the state as normal. In the case of colonisation of Australia, Aboriginal peoples sometimes internalise the power and control of white people and white institutions as normal.

This gives rise to concepts and movements like reconciliation, where, in Australia, the overarching goal is to include Aboriginal peoples into the rubric of neo-liberal state control – just get a job and everything will be okay (Phillips 2014). This implies that the state no longer needs to acknowledge or address centuries of white power, white theft of lands and children, or continuing techniques of power and control. Reconciliation, as it has been constructed in Australia, is structurally violent, in that it has individualised Aboriginal people themselves as the problem: white people are comfortable in their whiteness when they consume Aboriginal cultures as objects of curiosity, rather than as organising principles of life, agency, autonomy and sovereignty. This is most clearly seen in Reconciliation Action Plans (Reconciliation Australia 2012), where corporations are encouraged to feel good about including Aboriginal people in their businesses as employees (economic control), and where a mining magnate effectively sets national Indigenous affairs policy (Forrest 2014), despite the obvious conflict of interest over the value and meaning of land.

In the academy, this dance of power can be seen clearly where Indigenous people are rightly arguing strongly for recognition of Indigenous knowledges, yet fail to also acknowledge the terms of power and to identify and change the structural violence implicit in white institutions. In this context Indigenous knowledges are at risk of simply becoming subsumed, consumed and owned by the very white academy Indigenous scholars seek to decolonise (Briggs and Sharp 2004).

On the other hand, Aboriginal people often report they have no choice but to illuminate and decolonise whiteness' affects, as in Case Study 6 of the racism roundtable, where Aboriginal scholars argued strongly for the value of using any hostile and emotional reactions to the transformative unlearning (Ryder, Yarnold et al. 2011) of racism as a teachable moment, rather than something to be avoided. Yet this path of the longer road is fraught with difficulty for scholars from non-white backgrounds; marking the space as non-white and challenging the white terms of power can bring all sorts of personal and professional barriers and assaults for those who dare to (Ahmed 2007). Yet that is what is required – developing language and skills to respond to racism and denial in a sophisticated way is essential.

I have argued in this thesis that the notion of inclusion is problematic in Aboriginal affairs, Aboriginal health and in medical curriculum, in that it fails to acknowledge the implicit, normalised and unacknowledged terms of power – that of whiteness, white power and control as normal. In identifying how inclusion is problematic, I have shown how fighting the state for power becomes a kind of frustrating and domestically violent dance, full of the plasticity of governmentality, where the people in governments and white institutions shape, shift and dance their way around Aboriginal social justice and independence. Yet so too do 'nicer' notions – reconciliation, cultural awareness, Aboriginal health as individual epidemiology

equality, diversity – represent a domestically violent dance; designed to feign allegiance to sworn goals of equity while maintaining white power, neo-liberalism and inequity as *a fait accompli*. The power dance is reckless and abusive. The love dance is sentimental and anemic.

Mai-Anh Boger's (2014) work theorises the problems of inclusion as a trilemma of anti-racism, where normalisation sees Black people seeking to be included in white institutions 'like any other', empowerment sees them advocating Black ways of doing things within white institutions, and deconstruction is concerned with tearing down whiteness' affects. She suggests there is a paradox in this trilemma, in that Black peoples cannot simultaneously undertake all three, and a series of compromises must be made with reference to any particular context or situation. She concludes that any strategic approach to anti-racism and whiteness must be a balance between the head and the heart.

So what of Aboriginal scholars, Aboriginal health and medical schools? How can Aboriginal scholars and universities resolve this apparent impasse and false dichotomy between power and love? How can Indigenous and non-Indigenous leaders in medical education move into a more effective, balanced space, where the underlying power imbalances are redressed, and improvements in health outcomes are realised?

What have medical schools achieved?

The review into Indigenous health and medical education clearly showed some vast improvements in medical schools' performance: more Indigenous health curriculum content was being taught in 2012 than in 2003, and more Indigenous medical students were being enrolled, at a rate just above parity (Medical Deans Australia and New Zealand and

Australian Indigenous Doctors' Association 2012). That medical schools and medical deans have engaged with Aboriginal and Torres Strait Islander health professionals, scholars, educators and community members over a sustained ten year period is to be congratulated. Yet I have identified here certain pervasive and critical remaining problems.

WHAT NEEDS TO BE RESOLVED?

Regarding Aboriginal health in white institutions such as medical schools, four critical areas need to be further clarified and addressed: the values and motivations for action; the funding and economic control of Aboriginal health; the architecture of decision-making, partnership and governance; and accreditation, quality and accountability.

Values and Motivations for Action

In the introduction and methodology chapters, I raised the question of whose medical paradigm was being used. In Case Study 1 – The Elder, the Aboriginal health scholar and Aboriginal community involved were clearly using an Aboriginal paradigm of health; one that is holistic, comprehensive, solutions-focussed and concerned with a pedagogy of place that had the social determinants of health, social justice and community development at its core. The Director and other staff of the clinical school, however, were concerned with an individualised, epidemiological and bio-medical health paradigm, where the apparent ‘norms’ of white ownership were unquestioned, even though they conceptually identified with isolation as a result of their rural locale. In this way, questions of ownership of paradigms, curricula, decision-making and the teaching space is hidden, and Aboriginal concerns about health care were relegated to the domain of ‘culture’, and ‘cultural awareness’ or ‘cultural safety’ training, rather than being seen as central to the practice of medicine and medical education.

In her ground-breaking work on cultural safety, Ramsden (2002) identifies that this question of ownership of the terms of curricula and pedagogy is representative of a deeper set of meaning, values and motivations. That is, the terms of power can only be equalised if the values and motivations of the parties are explicitly and openly discussed and accounted for; this takes on particular meaning when viewed in the context of decolonising practices between Maori and pakeha. She argues that this explicit discussion may take months or years, and that it is an essential pretext before any strategising or partnership building is undertaken.

This crucial first step of discussing and negotiating the implementation of values and motivations is often missed in Australia, and this can be seen clearly in Case Study 7 regarding the establishment of a department of Aboriginal health – the university relied on special monies, and did not identify the competing interests and motivations of other departments as critical contributing risk factors in the initiative’s success.

In broader society, this dynamic of differing values and motivations, leading to uneven relations of power and control, can be seen in the art industry: Richard Bell’s (2003) artwork, entitled ‘Bell’s Theorem’, has emblazoned across its surface the words, “Aboriginal art: it’s a white thing.” This is pertinent, given that white people control ownership of the terms of power, profits and philosophical underpinnings of the art and tourism industries. This is where Aboriginal art and culture is consumed as a part of normalised whiteness, as with my the tour group’s consumption and ownership of Kakadu on their own terms.

Funding and Economic Control of Aboriginal Health

The economic control of Aboriginal health can be clearly seen in Case Study 3 regarding nursing curricula, in Case Study 5 regarding staff capacity, and in Case Study 7 regarding the

establishment of a department of Aboriginal health. In these case studies, control of economic resources was the subtext of decisions about curricula, staffing capacity and organisational structures. The Aboriginal scholars tried to account for these factors by arguing for Indigenous leadership and self-determination in decision-making. What happened in reality was that those who appeared to support Aboriginal health, including nursing, medical, public health and rural health departments or schools, were in fact economic competitors and controllers of Aboriginal health programs.

Further, the Medical Deans review (Medical Deans Australia and New Zealand and Australian Indigenous Doctors' Association 2012) found that in terms of the number of Aboriginal health scholars whose job it was to design and deliver Indigenous health curricula in medicine, no more resources were being invested in Aboriginal health programs in medical schools in 2012 than in 2004: the number of full-time equivalent staff was the same or negligibly different. The same number of Aboriginal health curriculum staff were simply teaching more Indigenous health content with no more resources. The question could therefore be raised: were medical schools waiting for special monies to develop their Indigenous health programs? Frustrated by this apparent intransigence, as a member of Medical Deans Australia and New Zealand's Indigenous Health Technical Advisory Group, I asked the deans on this committee directly in 2012, why they would not consider lobbying for extra dollars for clinical school training in Indigenous health settings. One dean emphatically replied, "It's not our role to lobby the Commonwealth for money. That may be more the role of NACCHO or the Indigenous Doctors". I was taken aback at this response. I wondered to myself whether the Deans would shy away from lobbying the Commonwealth for more anatomy or paediatric teaching programs. So on the one hand, it appears some medical

schools were waiting for special government or philanthropic investments for Aboriginal health, yet on the other, some deans appeared unwilling to lobby for it.

This raises the question of whether the deans consider Indigenous health curricula to be core business in training the national medical workforce, or an optional extra. In 2014, there is strong anecdotal evidence that some deans still consider Indigenous health as an area of health that only some medical schools should be asked to specialise in, despite endorsing the CDAMS Indigenous Health Curriculum Framework, and medical school accreditation, which both state explicitly that Indigenous health is core to medical training. Thus, Indigenous leadership and self-determination were agreed to in the principles of the accredited CDAMS Indigenous Health Curriculum Framework, but not in *implementation* by medical school faculty hierarchies.

Similarly, in my time as a consultant with various non-government health organisations, I have witnessed many of them being certain they want to ‘do Aboriginal health’ and ‘help close the gap’. Yet because they are unwilling to make clear their economic motivations at the outset, and profess a desire for ‘equal partnerships’, they continue to control all the funding and program decisions under the normalised rules of whiteness; thereby further marginalising their Aboriginal community partners as unequal.

The Architecture of Decision-Making, Partnerships and Governance

The case studies concerning the physiotherapy student (Case Study 2) and the racism that emerged at Indigenous health roundtable (Case Study 6) clearly show the dynamics of power in medical schools and faculties. Aboriginal students, people and perspectives were only included on terms comfortable to and familiar with those in power, and where whiteness and

its inherent power imbalances were accepted as normal and unquestioned. Aboriginal people were expected to participate in higher education on apparently normal parameters set by white people. When Aboriginal scholars questioned and named these terms of power, uncomfortable and hostile emotional reactions ensued from those exerting their apparently invisible white power – the planners, teachers and controllers of Aboriginal health curricula.

Thus, if access and participation in higher education are to be improved for Aboriginal peoples, and if Aboriginal health outcomes are to be achieved, the previously unquestioned structural violence of the normalisation of white power must be disrupted. Disrupting this power imbalance in curricula and in decision making about Aboriginal health is essential prior work. Before Indigenous health can be optimally taught, a process of transformative unlearning must occur, where racism, whiteness and structural violence is identified and addressed in individuals and systems. This is laying the groundwork for a cultural safe enabling environment in which Aboriginal health programs and curricula should be able to be delivered.

The architecture for decision-making must be clarified and explicitly addressed before program planning and implementation occur. This means Aboriginal communities must be equal decision-makers in the design, delivery and evaluation of Indigenous health curricula, with equal power and resources. Instead, Aboriginal people are usually only invited by white institutions to participate in an advisory capacity. This reifies white power and marginalises Aboriginal agency. While appearing to break down the barriers for Aboriginal peoples in accessing white institutions such as universities, those institutions are intent on maintaining and reproducing white power under the rubric of equality and diversity. Similarly, the Australian state is intent on maintaining white power and whiteness in health planning, where

Aboriginal individuals are constructed as the problem rather than the solution, under the rubric of ‘closing the gap’.

Rosalie Kunothe-Monks, a respected Elder, community leader and actress, railed against this problematisation of herself and her people, with the emphatic statement on a live national television broadcast that:

You know I have a culture, I am a cultured person. 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 an Arrente, Alywarra, first nation’s person. A sovereign person from this country. I speak my language, and I practise my cultural essence of me. Don’t try and suppress me, and don’t call me a problem, I am not the problem!
(Kunothe-Monks 2014)

Aboriginal people have articulated clearly the desire to be self-determining in decision-making regarding Aboriginal health, and the evidence suggests health outcomes improve when this is observed. However, medical schools and faculties seemingly have a hard time comprehending and implementing this principle in action, despite a clearly stated goal and accreditation standard articulating this as essential. Some deans, curriculum committees, managers, year and subject co-ordinators and administrators appear not to have comprehended the implications of this evidence and set of strategic goals.

Accreditation, Quality and Accountability

When undertaking the CDAMS curricula project in 2003, one of the first deans I encountered candidly stated: “the only things that make medical schools jump are accreditation and money”. Here I highlight and summarise the issues of accreditation, such as in Case Study 4, where a well-meaning head of medicine repeatedly demonstrated that a five-minute chat

would suffice for Indigenous health curriculum review and evaluation, despite platitudes he would not continue to do so.

Two conclusions can be drawn from this case study and from the persistent question marks hanging over the quality of Indigenous health curricula in medicine (Downing, Kowal et al. 2011, Medical Deans Australia and New Zealand and Australian Indigenous Doctors' Association 2012). First, Indigenous health would continue to be considered by some medical schools and deans as an optional extra, rather than core component of teaching the medical workforce. Second, a serious question needs to be answered about the quality and transparency of accreditation assessment. While the Australian Medical Council changed its standards in 2007 to include strong Indigenous health standards and endorse the Deans' curriculum framework, it did not follow up with specific recommendations to ensure the quality of its assessment questions, processes and techniques. Further, in 2012, it simply changed the medical school accreditation guidelines back to weaker standards than before 2007, with no consultation or engagement with Aboriginal health scholars and educators or Indigenous doctors, both groups with which it had relationships and formal partnership agreements at the time. It could be argued that the whiteness of medicine prevailed in the AMC. The terms of inclusion argued for by Aboriginal scholars and doctors apparently did not match the intentions or motivations of the AMC, and thus, the AMC's values, motivations and power prevailed. Even if this were not true, still the AMC only appeared to take this question of the quality of accreditation assessment seriously at the direction of a national review of accreditation standards, rather than on the advice of its formal partners in Aboriginal health – the Australian Indigenous Doctor's Association and other Aboriginal scholars.

If quality in medical workforce training is to be assured, both curricula evaluation and accreditation assessment processes in relation to Indigenous health need to be improved and made more transparent.

To summarise, realising improvements in medical education and Aboriginal health workforce training can only be achieved when the nature of inclusion and exclusion is made more explicit (including whose values, motivations and medicine paradigms are privileged); power relations and the control of economic resources and decision-making (governance and the nature of partnerships) are explicitly equalised; and the terms of measuring and defining quality, accreditation and accountability are clarified and equalised.

SOLUTIONS

From the literature reviewed, the case studies presented, reflective analysis on the experience of attempting to include and implement Indigenous health and cultural safety into medical curricula, two key tasks emerge, which potentially provide the basis of effective solutions for improving quality. The first is to define more clearly a conceptual framework for, and definitions of, Aboriginal health and cultural safety. The second is to articulate the essential elements of a culturally safe implementation framework. I turn to these tasks here.

Implementing Aboriginal Health and Cultural Safety

In the final stages of the writing of this thesis, I was fortunate to share some time with one of my mentors and teachers, Aunty Lilla Watson. When I told her my thesis topic, she related to me this story:

Aboriginal children are taught from a young age to share food. This is critical because it teaches them what Aunty Mary Graham refers to as the reflective motive. It teaches them to be aware of and consider the needs of others. Researchers have just found that

empathy is best taught in the early years, and that if this is taught properly, it encodes empathy in the person from a young age. This is why Aboriginal people are teaching their children to share food very early, and even have lullabies for it. This reflective motive is why it is more important to consider how you teach, rather than what you teach. Aboriginal people teach by doing and showing context. White people's education is often based on facts only – the focus is on the 'what'. But unless you teach the 'how', you won't have built empathic human beings, you will only have built competitive ones. Teaching equality, such as in feminism, only encourages competition between the sexes. But teaching congeniality in a community and group way helps build empathy.

This profound teaching about group dynamics and teaching strategies brings into sharp relief many of the issues this thesis has dealt with. It is a story of pedagogical principle – that place and context is critical to the effectiveness of learning. It is a story of pedagogical strategy – that how one teaches is more important than what one teaches: in this case, teaching transformative unlearning in a decolonised space is as important, or perhaps more important, than teaching Indigenous health as deficit and of epidemiologic concern alone. Finally, she teaches that students, doctors and all humans could most correctly be taught empathy rather than competitiveness from a young age. Prestige and competition, rather than empathy, is something the medical profession and medical education continue to grapple with.

I translate this cultural teaching, the evidence presented, and the still unresolved need to improve the quality of medical education and accreditation, into an applied model (See Figure 8, below).

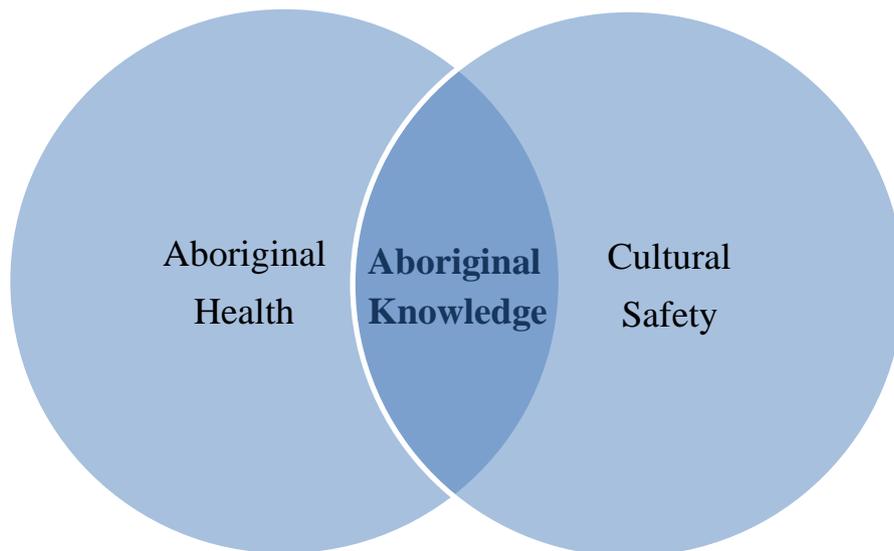


Figure 8: Applied Model of Aboriginal Health and Cultural Safety in Australia

In this model of applied Aboriginal health and cultural safety, cultural safety is defined as the internal work an institution should undertake in order to provide a safe enabling environment for the practice of Aboriginal health. This safe enabling environment includes action at the individual and institutional level, is transparent and accountable, and is concerned with continuous quality improvement. In this model, cultural safety is a decolonising process that considers medicine and health as social justice, rather than as a case of special treatment or as trying to ‘close the gap’ using a deficit epidemiological and individualised model. Rather, cultural safety is the essential institutional pretext to using a paradigm of Aboriginal health to deliver better Aboriginal health outcomes. In other words, the institution must transformatively unlearn its whiteness both for reasons of social justice and ‘levelling the playing field’, and as an explicit acknowledgement that Aboriginal paradigms of health can and do offer better health care solutions and models for all. Cultural safety is about decolonising individuals and institutions, because it’s good for everyone. I clarify the practical components of cultural safety an institution must address below.

In this applied model, Aboriginal health is defined as Aboriginal and Torres Strait Islander people leading the delivery of, and decision-making for, health services, health education and medical curricula, using an Aboriginal paradigm of health. This Aboriginal health paradigm is solutions-focussed, cognisant of the social determinants of health, holistic in that it focusses on the patient experience throughout various aspects of the sickness and wellness journey, is individual and community focussed, is strengths-based, and privileges Aboriginal autonomy, agency and sovereignty.

In this applied model, the implementation of both Aboriginal health and cultural safety are reliant on local Aboriginal knowledges, context and place; also known as the Aboriginal Terms of Reference (Watson 1990). That is, effective Aboriginal health planning, service delivery or curricula can only be optimal if it is contextualised in the physical and phenomenological space in which it occurs and if it is relevant to the local mob, even if delivered by Aboriginal people from other clans or nations. Similarly, cultural safety programs cannot be delivered for any race or ethnic group if it does not contextualise such work in the perspectives, histories, languages and cultures of local Aboriginal and Torres Strait Islander peoples. For example, a common response to cultural awareness or cultural safety programs for Aboriginal and Torres Strait Islander peoples in non-decolonised (white) health care and health education settings, is that health care planners and administrators privilege Indigenous peoples over the cultural safety needs of other cultural and ethnic groupings. Yet decolonising white institutions is not about political minorities or people of colour climbing a ladder of white institutional favour. It is true that institutions should be culturally safe for all different ethnic and cultural groupings. But it is not true that one can do this without naming, identifying and redressing whiteness and structural violence in the bones and foundations of the institutional white home of power. Decolonising the institution

requires local Aboriginal and Torres Strait Islander perspectives and contexts to be privileged, not as a measure to redress inequity for individual Aboriginal peoples using a deficit lens, but as an emphatic statement that Aboriginal Terms of Reference are essential to the delivery of good health care for all.

Applied cultural safety principles

In summary, applied cultural safety in health care operates on two levels – both in terms of individual change, and systemic or institutional change. This includes:

- awareness of cultural differences
- sensitivity and reflexivity to the implications of one's own beliefs and values and their impact on others
- an understanding of the effects of systemic racism, privilege and whiteness
- an understanding of the effects of structural violence
- respect for other's and one's own cultures
- respect for the history of mistreatment and a commitment to competence in applying these learnings in patient settings in a way that does not harm the patient further
- a commitment to change both individual actions and institutional processes that privilege white knowledge and habitus, ignore racism and whiteness and posits Aboriginal peoples as charitable cases in need of white benevolence, and,
- a commitment to share power, resources and decision-making in relation to Aboriginal health values, planning, strategy, implementation and evaluation.

Practical implementation of this applied model and principles are set out in Table 3 below.

Table 3: Practical Implementation Framework for Aboriginal Health & Cultural Safety

DOMAIN	ABORIGINAL HEALTH	CULTURAL SAFETY
Leadership	Aboriginal led, with non-Aboriginal support	Institutional led, with Aboriginal direction
Responsibility for Implementation	The whole institution	The whole institution
Teaching & Learning Focus	Aboriginal health paradigm; Aboriginal health service delivery; Aboriginal ethics; Aboriginal Terms of Reference	Social justice; decolonisation; transformative unlearning of racism, whiteness and structural violence
Values and Motivations for Action	Improving Aboriginal health outcomes	Decolonisation and social justice, as an essential first step to improving health outcomes
Funding and Economic Control	Aboriginal equal decision-making in planning, implementing and monitoring spending	Aboriginal equal decision-making in planning, implementing and monitoring spending
Governance, Partnership and Decision-Making	Aboriginal equal decision-making, with representatives from local groups as core partners	Aboriginal equal decision-making, with representatives from local groups as core partners
Accreditation, Quality and Accountability	Aboriginal equal power in deciding and assessing the terms of review and accountability	Aboriginal equal power in deciding and assessing the terms of review and accountability

Implicit in this applied model and practical framework for implementation is the fact that Aboriginal health are inter-related, but not the same thing. They are both reliant on and informed by local Aboriginal knowledges, or the Aboriginal Terms of Reference. In Table 4, I present some of the specific tasks which institutions can undertake to ensure cultural safety flourishes and Aboriginal health is implemented effectively.

Table 4: Specific Tasks in Implementing Aboriginal Health and Cultural Safety

	Aboriginal Health	Cultural Safety
Specific Tasks	<ol style="list-style-type: none"> 1. Discussions and negotiations about values and motivations with local Aboriginal communities 2. Negotiation on the terms of partnership, decision-making and accountability, including location and reporting requirements for responsible Aboriginal and non-Aboriginal staff 3. Joint planning, strategy and funding decisions 4. Ensuring Aboriginal people are on boards, committees and accountability review panels 5. Ensuring Aboriginal people lead strategic direction and are employed at senior levels, but making sure the whole of institution reports on outcomes 6. Aboriginal targets mentioned in mission statements and strategic documents as core business 	<ul style="list-style-type: none"> • Cultural awareness (educating individual staff and students) • Cultural safety (decolonising institutional policies, processes, strategies) • Aboriginal employment strategies • Aboriginal people employed at all levels of the organisation • Anti-racism strategies enforced • Reconciliation Action Plans • Aboriginal & TSI flags on site, on websites • Acknowledging Traditional Owners on websites, public documents and at public conferences or ceremonies • Public communication of Aboriginal health goals, rationale and respect for the Aboriginal Terms of Reference • Institutional formal partnerships with local Aboriginal communities • Reviewing structural arrangements to ensure cultural safety, as per below.

In terms of structural arrangements within the medical faculty or institution, it would seem that Aboriginal health programs in medical faculties would benefit from:

- a) Structural location of Aboriginal health programs should be at a faculty wide level, so people do not misconstrue Aboriginal health as belonging only to ‘rural health’ and by implication only working with Aboriginal people in rural areas. If programs are to

be located within a particular school, it should be made clear their ambit is faculty-wide;

- b) clear delineation and public communication of a faculty-wide leadership role for Aboriginal health, in the same way that, say, a head of cardiac research program might be clearly understood as the faculty's lead in that area;
- c) clear communication of teaching, curriculum and research protocols, whereby Indigenous leadership within Faculties should oversee the quality of curriculum, teaching and research partnerships between Indigenous and non-Indigenous staff, with the terms of collaboration and collegiality clearly defined and encouraged; and,
- d) Clarity about the resourcing of Aboriginal health so that vested and competing economic interests do not by necessity mean colleagues attempt to outdo or exclude each other in otherwise rich opportunities for collaboration. Specifically, at present the only recurrent federal funding program on offer for Indigenous health in universities is a rural health program, and this structurally sets up competing interests between those rural health interests who want to do Aboriginal health for monetary gain, and Aboriginal or other people interested in Aboriginal health for all.

In this section, I have sought to make clear the definitional issues surrounding Aboriginal health and cultural safety by providing an applied model. I have identified principles for applied cultural safety, and identified a practical implementation framework for improving power and resource sharing. Further, I have identified some specific tasks and structural arrangements which will support the inclusion of Aboriginal health and cultural safety into medical curricula on a decolonised social justice basis. In doing so, I have opened up discussion of the third space; the space of the Aboriginal Terms of Reference.

POST SCRIPT TO KAKADU

There is a lovely post-script to my time in Kakadu with my swimming team mates. On my return to Melbourne, the experience of Kakadu stayed with me for weeks. There was something so soulful and spiritual about the country that it seemed to seep into my consciousness, my dreams, my very being. I talked about this with my friend who helped me debrief while on the tour, and she said she felt similarly. We talked about the fact that I thought perhaps my team mates might want to ask me ‘Aboriginal questions’ about family, history, culture, politics. I had been in the club for ten years, and had sensed that some people wanted to ask me things about these matters, but reluctant to do so because they didn’t want to ask the wrong thing or offend me in any way. So I suggested to my team mate that maybe I could offer a cultural awareness discussion in my home, based on our shared experience of Kakadu. My friend said she felt this was long overdue, and that it would be really important. So I sent an email to my swimming team’s e-list inviting them to have a yarn.¹⁰ Twenty-five people responded eagerly, and three weeks later, on a Saturday afternoon, twenty-one team mates turned up with a plates of food and lots of questions.

We spent the first hour just catching up and eating and sharing general Kakadu memories. Then we sat down, and I asked them to share why they had come and what effect Kakadu or other spiritual places in Australia had on them. This opened up a general discussion about history, language, culture. I shared with them some of my family’s story and history. Then the discussion moved into otherwise more controversial subjects such as native title, land rights, identity, and the politics of representation in contemporary Australia. It was an enagaging and satisfying gathering for all attendees, as evidenced by their evaluation

¹⁰ See Appendix 6.

comments afterwards. Many participants stated that they had other family members who wanted to participate.

This positive experience was assisted by a number of factors. First, there was a pre-existing set of friendships and relationships; this was helpful in maintaining and mediating a respectful tone for engagement and learning. Second, the space where we met was in the lounge room of one of my swim team mates; thus enabling both a comfortable, familiar and neutral territory for discussions. Third, I asked people to prepare some questions and email them to me prior to the workshop, and I also suggested some pre-reading. This enabled me to prepare for and design the yarn appropriately, and for the participants to do some thinking about the yarn before we got there. Finally, and most critically, the conversation was constructed as taking place in a 'safe space', a space free from politically controversial or sickly anemic discussion. In other words, the safe space was the essential pretext for learning about Aboriginal people and Aboriginal health; the pedagogy of place was important. The safe space was created by employing concepts of relationality, place, preparation and respect. The safe space enabled a consciousness shift away from domestic violence or anemia towards balance and change.

At the end of the yarn, some participants asked what they could do as individuals and as a club. I said as a starting point, they could read and educate themselves more, and also start these conversations with their friends and family members, so that the burden of teaching cultural safety for all does not fall on Aboriginal and Torres Strait Islander peoples alone. I suggested that beyond those things, perhaps the group could come up with some ideas of their own. Two weeks later, one participant emailed the group saying he thought the team should have an acknowledgement of country on the team's website, and that at our annual interclub

meet, we could acknowledge country publicly. These suggestions were enthusiastically received by the other participants, and the club President took it on himself to draft and seek the Committee's approval and input. The President asked for my input, which I provided, yet I was careful to ensure I did not write it for the group. I wanted to ensure that the group engaged with the text and its meaning, and that it was not seen to be something that I alone was pushing.

While small gestures of peace-making such as the actions of my swimming club are not to be mistaken for the redress of any power imbalances or whiteness that might exist in sporting clubs, social groups and in society, they are very important demonstrations of respect and acknowledgement. This example demonstrated what is possible with respect – the group were open to learning; a safe space was created and shared; the group expressed a desire to do more; I did not give them easy answers, but instead asked them to come up with their own solutions; I was invited to, and provided, guidance and direction about the wording, but was careful not to lead implementation – this was the group's responsibility; and finally, ownership of the ideas, words and implementation was shared equally.

This positive ending to what could have been an awfully alienating experience for me in Kakadu was dependant on a number of things, including my awareness of whiteness and its affect, and my willingness to not fall into the trap of the false dichotomy of choice between being 'nice' in the face of whiteness, or alternatively, confronting whiteness head on. Looking back on it now, I had decided on the rock escarpment in Kakadu to engage with a consciousness shift out of the dance of domestically violent whiteness, and into the third space of consciousness raising, balance and change. I entered a space where relationships were more important than confrontation. I chose not to make my experience in Kakadu about

white people and their whiteness, but to make it about the country. In doing so, for that moment, I employed the Aboriginal Terms of Reference; I entered the Dreaming.

ABORIGINAL HEALTH, CULTURAL SAFETY AND THE LONGER ROAD

Medical schools and Aboriginal doctors and scholars have begun a relationship. Despite the best efforts and important achievements of many Aboriginal community members, doctors, scholars and students, deans and other stakeholders, this relationship has not been equal in terms of power and in terms of its philosophical underpinnings. In many ways it has been a story of the shorter road – the short cut to including Aboriginal health in medical curricula and in health workforce planning. But in identifying the gaps and the seeming chaos this structural violence and whiteness sometimes causes, there is opportunity. There are opportunities for medical schools, Deans, Aboriginal peoples, the AMC and the medical profession to go further; to take the longer road. In doing so, they may yet provide a model and example for the rest of the country to follow.

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APPENDIX 1 – PhD Study Description

‘Aboriginal Health, Cultural Safety and Medical Education’

Gregory Phillips
12 November 2012

Overview

This is a theoretical analysis of the concepts ‘Aboriginal health’ and ‘cultural safety’ in medical education and public health in Australia.

Research Questions

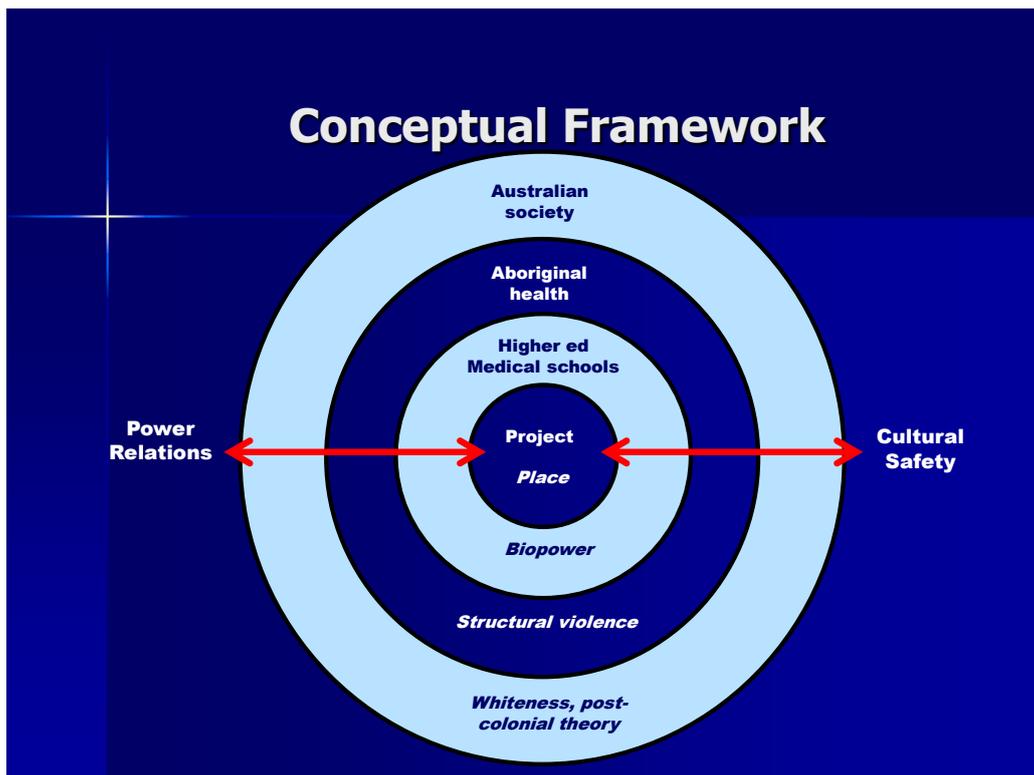
1. What is the experience of including Aboriginal health and cultural safety into medical school curricula, hospitals and non-government organisations?
2. What does this reveal about Aboriginal health in Australian society?

Methodology

- Indigenous (Denzin, Lincoln et. Al. 2008) and western research paradigms
- Literature Review – search terms – Aboriginal health, cultural safety, medical education, Australia
- Describe the development of the CDAMS Indigenous Health Curriculum Framework (Phillips 2004b) using publicly available material – project documents, AMC accreditation reports, government policy
- Case studies – illuminate the definition, meanings, usage and application of ‘Aboriginal health’ and ‘cultural safety’ in:
 - medical education – policy, auto-ethnography (Ellis and Boschner 2008)
 - hospital reform – public policy documents, comparison of accreditation processes in Canada and Australia
 - NGOs – public documents – strategies, policies, evaluation reports
- Development of clearer definitions and a new model of applied cultural safety

Supervisors

Professor Lenore Manderson, Inaugural ARC Federation Fellow, Monash University
Professor Steve Wesselingh, Executive Director, SAHMRI



Ethics

This study will adhere to the *NH&MRC's Values and Ethics: Guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander Health Research* (2003), and submit an ethics application to Monash University's Ethics Committee.

Background and Rationale

This work is important given the high burden of disease that Aboriginal and Torres Strait Islander peoples experience (Australian Institute of Health and Welfare 2012), the related and complex effects of the social determinants of Aboriginal health – lower outcomes in education, housing and income (Marmot 2011) and the continuing effects of past-government policies on health outcomes (Zubrick, Silburn et al 2005) If the nation is to 'close the gap' in life expectancy outcomes between Aboriginal and non-Aboriginal Australians, a health workforce cognisant of the needs, cultures and particularities of delivering health care in Aboriginal Australia will be required (Mackean, Mokak et al 2012). Health workforce trainers will need clearer definitions and models in order to ensure continuous quality improvement (Johnstone and Kanitsaki 2007).

APPENDIX 2 – Support Letters from the Australian Indigenous Doctor’s Association and Medical Deans Australia and New Zealand



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PO Box 3497
Manuka ACT 2603

Phone 02 6273 5013
Fax 02 6273 5014
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ABN 84 131 668 936

1 February 2013

Chairperson
Monash University Human Research Ethics Committee
muhrc@monash.edu

re: Mr Gregory Phillips - letter of support

On behalf of the Australian Indigenous Doctors' Association (AIDA) Board of Directors, in my capacity as AIDA Chief Executive Officer, I write this letter in support of Mr Gregory Phillips' application to the Monash University Human Research Ethics Committee to undertake his PhD study.

I understand that the proposed area of study will involve a theoretical analysis of the concepts of 'Aboriginal health' and 'cultural safety' in medical education and public health in Australia.

We look forward to Mr Phillips work in this area as it will both have specific relevance to AIDA's work in both medical education and workforce development as well as wider application to Aboriginal and Torres Strait Islander affairs and public policy.

Mr Phillips enjoys widespread recognition for his innovative thinking, policy and program development and engagement capability. Completing a PhD in the area identified will add to his already impressive list of contributions and achievements, but most importantly will have significant utility in an often confused and contested space.

I reiterate AIDA's strong support for Mr Phillips application and should you have further questions please do not hesitate to contact me on (02) 6273 5013.

Yours sincerely



Romlie Mokak
Chief Executive Officer

Cc: Mr Gregory Phillips

Leadership, Partnership, Scholarship

**PhD Study: Aboriginal Health, Cultural Safety and Medical Education
Letter of support for Ethics Application**

Medical Deans Australia and New Zealand Inc (Medical Deans) is the peak body for professional-entry level medical education, training and research in Australia and New Zealand. Its members comprise the Deans of the 18 medical schools in Australia and the two New Zealand medical schools.

Medical Deans is pleased to provide a letter of support to accompany the ethics application for the proposed study on Aboriginal Health, Cultural Safety and Medical Education to be undertaken by Mr Gregory Phillips as part of his studies toward to award of a PhD.

Mr Phillips has had a long association with Medical Deans. He was first engaged in the early 2000s to undertake a national audit of Indigenous Health curriculum in Australian medical schools. From this work, Mr Phillips, under the auspices of the Deans, developed an Indigenous Health Curriculum Framework to be implemented in all medical schools, and which was approved by Medical Deans in 2004. The Australian Medical Council, the medical schools' accrediting body, subsequently adopted the Curriculum Framework as part of its accreditation standards for all medical schools in 2005. More recently, Mr Phillips has acted as an advisor to a joint national review, undertaken by Medical Deans and the Australian Indigenous Doctors Association, of the implementation of that Indigenous Health Curriculum Framework some 5 years later. Mr Phillips has also been a long standing member of the Medical Deans' Leaders in Indigenous Medical Education (LIME) Network, and has been engaged in a number of capacities over the years, assisting Medical Deans as an organization, and individual medical schools, in Indigenous Health curriculum and capacity building issues. Mr Phillips' contributions to medical education over the last decade are highly regarded by Medical Deans.

Medical Deans acknowledges the importance of this study given the high burden of disease that Aboriginal and Torres Strait Islander peoples experience, the related and complex effects of the social determinants of Aboriginal health, and the continuing effects of past government policies on health outcomes. It supports in general the view that if the nation is to 'close the gap' in life expectancy outcomes between Aboriginal and non-Aboriginal Australians, a health workforce cognizant of the needs, cultures and particularities of delivering health care in Aboriginal Australia is required.

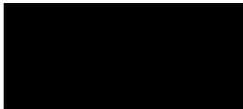
Medical Deans understands the proposed study will be undertaken as a theoretical analysis of the concepts of 'Aboriginal health' and 'cultural safety' in medical education and public health in Australia.

Mr Phillips has informed us he will be undertaking no formal original interviews of Deans or their staff for this study. We acknowledge however that Mr Phillips may use anecdotes from his previous work in medical schools in a de-identified and respectful manner.

Mr Phillips has agreed to cover all associated costs with this study.

The issues involved in Aboriginal health, cultural safety and medical education are important to ensuring quality health outcomes for Aboriginal and Torres Strait Islander peoples. Medical Deans supports Mr Phillips in his endeavours.

Professor Justin Beilby



President, Medical Deans
January, 2013

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APPENDIX 3 – Monash University Ethics Approval



MONASH University

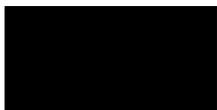
Monash University Human Research Ethics Committee (MUHREC)
Research Office

Human Ethics Certificate of Approval

Date: 12 April 2013
Project Number: CF13/441 - 2013000182
Project Title: Aboriginal health, cultural safety and medical education
Chief Investigator: Prof Lenore Manderson
Approved: From: 12 April 2013 To: 12 April 2018

Terms of approval

1. The Chief investigator is responsible for ensuring that permission letters are obtained, if relevant, and a copy forwarded to MUHREC before any data collection can occur at the specified organisation. **Failure to provide permission letters to MUHREC before data collection commences is in breach of the National Statement on Ethical Conduct in Human Research and the Australian Code for the Responsible Conduct of Research.**
2. Approval is only valid whilst you hold a position at Monash University.
3. It is the responsibility of the Chief Investigator to ensure that all investigators are aware of the terms of approval and to ensure the project is conducted as approved by MUHREC.
4. You should notify MUHREC immediately of any serious or unexpected adverse effects on participants or unforeseen events affecting the ethical acceptability of the project.
5. The Explanatory Statement must be on Monash University letterhead and the Monash University complaints clause must contain your project number.
6. **Amendments to the approved project (including changes in personnel):** Requires the submission of a Request for Amendment form to MUHREC and must not begin without written approval from MUHREC. Substantial variations may require a new application.
7. **Future correspondence:** Please quote the project number and project title above in any further correspondence.
8. **Annual reports:** Continued approval of this project is dependent on the submission of an Annual Report. This is determined by the date of your letter of approval.
9. **Final report:** A Final Report should be provided at the conclusion of the project. MUHREC should be notified if the project is discontinued before the expected date of completion.
10. **Monitoring:** Projects may be subject to an audit or any other form of monitoring by MUHREC at any time.
11. **Retention and storage of data:** The Chief Investigator is responsible for the storage and retention of original data pertaining to a project for a minimum period of five years.



Professor Ben Canny
Chair, MUHREC

cc: Mr Gregory Phillips

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APPENDIX 4 – Changes to Medical School Accreditation Guidelines in Relation to Indigenous Health: 2007 to 2012

By comparing the two sets of guidelines (below), the following can be reported:

1. **The number of standards or notes in which Aboriginal peoples and their health is mentioned or referred to:**

Indigenous Health Referred to	2007	2012
Standards	10	10
Notes	14	N/A
Total	24	10

2. **The Number of times the terms ‘Aboriginal and Torres Strait Islander and Maori’ or ‘Indigenous’ are used in the guidelines:**

Terms Used	2007	2012
Aboriginal and Torres Strait Islander and Maori	17	7
Indigenous	30	6
Total	44	13

3. **Summary** - While it could be argued that the same number of standards (n=10) is consistent between 2007 and 2012, the content and quality of those standards is not assured. This is particularly so given that there are no supporting notes in the 2012 guidelines (n=14 in 2007), and that the total number of times Aboriginal and Torres Strait Islander, Maori or Indigenous peoples and their health and medical needs are mentioned at all is hugely variable (n=44 in 2007 versus n=13 in 2012).

2007 - AMC Guidelines for Medical School Accreditation – Excerpts Where ‘Aboriginal and Torres Strait Islander’, ‘Indigenous’ or ‘Maori’ health is mentioned, either in the standards themselves, or in the accompanying notes.

Section	Page	Text
Part 2 - Attributes of Graduates – General Statements	1	<p>Standard - Doctors must be able to care for individual patients by preventing and treating illness, assisting with the health education of the community, being judicious in the use of health resources, and working with a wide range of health professionals and other agents. They must be able to work effectively, competently and safely in a diversity of cultural environments, including a diversity of Indigenous health environments.</p> <p>Australia has special responsibilities to Aboriginal and Torres Strait Islander people, and New Zealand to Māori, and these responsibilities should be reflected throughout the medical education process.</p> <p>Doctors work in a context in which the Indigenous peoples of Australia and New Zealand bear the burden of gross social, cultural and health inequity. Doctors must be aware of the impact of their own culture and cultural values on the delivery of services, historically and at present, and have knowledge of, respect for and sensitivity towards the cultural needs of Indigenous people. In this context, beginning doctors need to be able to relate the knowledge and understanding, skills, and particularly attitudes set out below specifically to Indigenous peoples.</p>
Part 2 - Graduate Attributes - Knowledge & Understanding (11/12)	2	<p>Standard - Indigenous health, including the history, cultural development and health of the Indigenous peoples of Australia or New Zealand.</p>
1.3 Medical Course Management	6	<p>Notes - The curriculum committee should develop a wider perspective on the content of the curriculum to recognise local and national needs in health care and service delivery. This might incorporate particular teaching and learning on local or national health priorities, such as the health of Australian Aboriginal and Torres Strait Islanders and/or New Zealand Māori.</p>
1.4 Educational Expertise	6	<p>Standard - The school ensures appropriate use of educational expertise, including the educational expertise of Indigenous people, in the development and management of the medical course.</p> <p>Notes - Indigenous health is a school-wide responsibility that will require appropriate guidance and leadership in Australia by Aboriginal and Torres Strait Islanders and in New Zealand by Māori, as well as adequate resources for training and professional development of all staff, engaging with local communities and other appropriate networks.</p>
1.5 Educational Budget and Resource Allocation	7	<p>Notes - Health initiatives relating to Australian Aboriginal and Torres Strait Islanders, and in New Zealand to Māori, should be considered as core responsibilities within medical school business and reflected accordingly within the budget. These initiatives should not rely solely on special, additional or external resources.</p>
1.6 Interaction With the Health Sector	7	<p>Standards - The medical school recognises the unique challenges faced by the Indigenous health sector and has effective partnerships with relevant local communities, organisations and individuals.</p> <p>Notes - Medical education and training are dependent on a wide range of</p>

		<p>external educational partners including strong and supportive State-financed health services. Many benefits accrue to health care institutions through being centres for undergraduate medical education. Research shows that these institutions can offer a better standard of care. A student's positive learning experience in an institution can mean the student will want to return as a junior medical officer. Teaching hospitals are the venues where technology-intensive services requiring special expertise, equipment and staff are provided. Medical students benefit from access to patients and teachers within institutions administered through State governments. The AMC considers it essential that there is a supportive State health authority and that appropriate channels of communication are available to the medical school to allow problems to be addressed and initiatives to be developed.</p> <p>Increasingly, clinical training occurs in a broad range of community settings in addition to public and private hospitals, including general practices, rural and remote and Indigenous health settings. Clinical training partnerships need to be flexible enough to accommodate the different needs of students and clinical training partners in these settings. In Indigenous health settings, cultural awareness must underpin the partnership arrangements.</p>
1.8 Staff Resources	9	<p>Standard - Staff recruitment includes active recruitment by Australian schools of Aboriginal and Torres Strait Islander people and by New Zealand schools of Māori, together with appropriate training and support.</p> <p>Notes - In Australian schools, Aboriginal and Torres Strait Islander staff and, in New Zealand schools, Māori staff should be actively recruited, trained and supported, and their unique skills, roles and responsibilities recognised and remunerated accordingly. The needs of Australian Aboriginal and Torres Strait Islander and New Zealand Māori staff or guest lecturers and tutors should be appropriately met, including preparation of a culturally safe teaching environment, adequate and comparable remuneration, and recognition of their relevant areas of expertise and generosity in contributing to the course. Suitable recognition may include academic titles.</p>
1.9 Staff Appointment, Promotion and Development	10	<p>Notes - In relation to Australian Aboriginal and Torres Strait Islander and New Zealand Māori staff, the medical school should actively respond to their professional development needs, including recognising that their work covers roles both within the medical school and in maintaining external responsibilities to, and relationships with, Indigenous communities.</p>
2.1 Outcomes of the Medical Course - Mission	11	<p>Standard - The school's mission addresses Indigenous peoples and their health.</p> <p>Notes - Medical schools should clearly identify leadership, responsibilities and reporting structures for the coordination and implementation of an overarching Indigenous health strategy (including curriculum, student admission, recruitment and support, teaching and research). Indigenous people are a critical part of, but not solely responsible for, the strategy.</p>
3.2 Curriculum Structure, Composition and Duration	12	<p>Standards - The course provides a comprehensive coverage of:</p> <ul style="list-style-type: none"> • basic biomedical sciences, sufficient to underpin clinical studies • scientific method, inquiry skills, critical appraisal and evidence-based medicine • clinical sciences relevant to the care of adults and children • the pathological basis of disease • clinical skills (medical history construction, physical and mental state examination, diagnostic reasoning skills, problem formulation and construction of patient management plans) • management of common conditions, including pharmacological, physical,

		<p>nutritional and psychological therapies</p> <ul style="list-style-type: none"> • acute care skills and procedures relevant to practice at the level of an intern • communication skills • population, social and community health • an understanding of the culturally diverse nature of Australian or New Zealand society and the development of appropriate skills and attitudes for medical practice in a culturally diverse society • Indigenous health (studies of the history, cultural development and health of the Indigenous peoples of Australia or New Zealand) • personal and professional development • law and ethics • patient safety and quality of health care • interprofessional education. <p>Notes (Pg 13) - The AMC believes that the most effective tool to enable students to develop clinical competence and judgment is participation in a variety of clinical clerkships. In addressing patient problems during a clerkship, students engage in active learning and develop the clinical sophistication required for practice under supervision at graduation. With appropriate supervision, clinical clerkships can be offered in small hospitals, ambulatory health care centres, urban and rural general practice, and Indigenous health settings, as well as large metropolitan hospitals. Students should have an opportunity to interview and examine a sufficient number of patients, with an appropriate case mix to achieve the educational objectives for the attachment.</p> <p>Notes (pg 14) - The AMC has endorsed the Indigenous Health Curriculum Framework adopted by the Committee of Deans of Australian Medical Schools. The Framework stresses the need to deliver Indigenous health as a discrete subject or stream but also to ensure that Indigenous health is integrated into the wider curriculum in order to provide a more rounded education. A searchable curriculum map is an invaluable tool to aid in demonstrating the course's achievement of these aims.</p>
5.4 Assessment Quality	20	<p>Notes - Students undertake their clinical training at a wide variety of clinical sites. Some students will undertake more than half their clinical training at rural clinical schools and some, potentially, in Indigenous health settings. At some universities, students will have the opportunity to undertake a substantial proportion of their clinical training overseas. It is essential that medical schools have systems that ensure consistency in assessment across clinical teaching sites.</p>
6.1 The Curriculum – Monitoring and Evaluation: Ongoing Monitoring	21	<p>Notes - Australian Aboriginal and Torres Strait Islander and New Zealand Māori students should be consulted, as appropriate, but should not be expected to provide 'expert' advice on all matters 'Indigenous' within teaching and learning environments or public settings.</p>
6.3 Feedback and Reporting	22	<p>Notes - Medical schools should monitor and, where appropriate, respond to community perceptions about the qualities of doctors graduating from their schools. The AMC encourages medical schools to seek community representation on committees with responsibilities for governance, curriculum development and evaluation, including Australian Aboriginal and Torres Strait Islander or New Zealand Māori community members. Liaison with the medical boards is also desirable.</p> <p>Those with an interest in the school's outcomes include education and health care authorities, representatives of the community, relevant Australian Aboriginal and Torres Strait Islander people, and/or New Zealand Māori, individuals and organisations, and professional organisations and</p>

		postgraduate education bodies including the specialist medical colleges.
7.1 Student Intake	24	Standard - The school has clearly defined the nature of the student cohort, and quotas for students from under-represented groups, including Indigenous students and rural origin students.
7.2 Admission Policy and Selection [Students]	24	<p>Standard - The school has specific admission and recruitment policies for Australian Aboriginal and Torres Strait Islander or New Zealand Māori students.</p> <p>Notes (Pg 25) - The AMC recognises that there is no agreed method of selecting the most appropriate medical students, and supports diverse approaches by medical schools that include both academic and vocational considerations. In relation to Aboriginal and Torres Strait Islander students, the Australian Indigenous Doctors' Association Healthy Futures Report and Framework is a key resource to assist schools in the development of their strategy.</p> <p>Recruitment and admission policies relating to Australian Aboriginal and Torres Strait Islander and New Zealand Māori students should be designed, implemented and evaluated periodically ensuring relevant involvement of the Australian Aboriginal and Torres Strait Islander and/or New Zealand Māori communities (Elders, health services, community leaders).</p>
7.3 Student Support	26	Notes - Appropriate support services include access to counselling services with trained staff, a student health service, student academic advisers, and more informal and readily accessible advice from individual academic staff. Indigenous students should be particularly considered.
8.3 Clinical Teaching Resources	28	<p>Standards - The school has sufficient clinical teaching facilities to provide a range of clinical experiences in all models of care (including primary care, general practice, private and public hospitals, rooms in rural, remote and metropolitan settings and Indigenous health settings).</p> <p>The school has sufficient clinical teaching facilities to provide all students with exposure to Indigenous health settings.</p> <p>Notes (pg 29) - Students need broad exposure to patients with a range of common medical, surgical, paediatric, gynaecological and psychiatric problems. They should have the opportunity to work in rural, suburban, community and private hospitals, in general practice, in community health centres, in nursing homes and in centres for those with chronic intellectual or physical disability. All students should be given an opportunity to work in Indigenous health settings. Since many hospitals now have only limited outpatient facilities, medical schools should consider the use of specialist private practices to provide the necessary clinical experience of ambulatory care.</p> <p>Pg 30 - The medical school also needs to allocate sufficient resources to teaching in general practice, Indigenous health settings, the community and smaller hospitals.</p>
Membership of Working Groups	31	<p>Working Group on Indigenous Health Curriculum Framework</p> <p>Professor Michael Hensley (Chair)</p> <p>Dr Ngiare Brown</p> <p>Assoc. Professor Gail Garvey</p> <p>Ms Catherine Henderson</p> <p>Mr Romlie Mokak</p> <p>Mr Gregory Phillips</p>

2012 - AMC Standards for Assessment and Accreditation of Primary Medical Programs

Section	Page	Text
Graduate Outcome Statements - Domain 3.4 - Health and Society: the medical graduate as a health advocate	3	Understand and describe the factors that contribute to the health and wellbeing of Aboriginal and Torres Strait Islander peoples and/or Māori , including history, spirituality and relationship to land, diversity of cultures and communities, epidemiology, social and political determinants of health and health experiences. Demonstrate effective and culturally competent communication and care for Aboriginal and Torres Strait Islander peoples and/or Māori .
Domain 3.8	4	Describe the attributes of the national systems of health care including those that pertain to the health care of Aboriginal and Torres Strait Islander peoples and/or Maori .
Standard 1.4.1 – The Context of the Medical Program – Educational Expertise	5	The medical education provider uses educational expertise, including that of Indigenous peoples , in the development and management of the medical program.
Standard 1.6.2 – The Context of the Medical Program – Interaction With Health Sector and Society	6	1.6.2 The medical education provider has effective partnerships with relevant local communities, organisations and individuals in the Indigenous health sector to promote the education and training of medical graduates. These partnerships recognise the unique challenges faced by this sector.
Standard 1.8.3 – Staff Resources	6	1.8.3 The medical education provider actively recruits, trains and supports Indigenous staff.
Standard 2.1.2 - The Outcomes of the Medical Program - Purpose	7	The medical education provider’s purpose addresses Aboriginal and Torres Strait Islander peoples and/or Maori and their health.
Standard 3.5 – The Medical Curriculum – Indigenous Health	8	The medical program provides curriculum coverage of Indigenous Health (studies of the history, culture and health of the Indigenous peoples of Australia or New Zealand).
Standard 7.1.2 - Implementing the Curriculum – Students	12	The medical education provider has defined the nature of the student cohort, including targets for Aboriginal and Torres Strait Islander peoples and/or Maori students, rural origin students and students from under-represented groups, and international students.
Standard 7.2.3 – Admissions Policy and Selection	12	The medical education provider has specific admission, recruitment and retention policies for Aboriginal and Torres Strait Islander peoples and/or Maori .
Standard 8.3.3 – Clinical Learning Environment	14	8.3.3 The medical education provider ensures the clinical learning environment provides students with experience in the provision of culturally competent health care to Aboriginal and Torres Strait Islander peoples and/or Maori .

APPENDIX 5 – Email Exchange With Project Manager at Curtin University

From: Project Manager

Sent: Monday, 4 August 2014 4:36 PM

Subject: Stage 2: Your feedback on the Aboriginal & Torres Strait Islander Health Curriculum Graduate Capabilities Matrix

Good afternoon

Thank you very much for taking the time to participate in our on-line survey in June, which asked for your feedback on the proposed *Entry to Practice Graduate Capabilities Model* for the *Aboriginal and Torres Strait Islander Health Curriculum Framework*. We deeply appreciate the time and thinking that you gave, and your feedback has been extremely important in the revisions and improvements to the Model.

Please find attached the revised Entry to Practice Graduate Capabilities Model based on your feedback. Your feedback highlighted overwhelming support for the proposed Capabilities and Learning outcomes, with minor revisions to the model to improve the statements.

Key points that came back from the survey were:

- Foregrounding ‘cultural safety’ as a core learning outcome
- Removing descriptive terms that are unrealistic or unnecessarily demanding (such as achieving ‘confidence’, ‘courage’, ‘mutual benefits’)
- Identifying key words/ phrases to be included at lower level curriculum mapping learning outcomes (such as respect; listen; promotes; holistic; trust)
- Revising notions that may be unnecessarily problematic (notably removing ‘white’ from the term ‘white privilege’) without diluting depth of learning experience

(NB: A full public report will be made available of the findings of this consultation in the coming months).

Also attached is the *Graduate Capabilities Curriculum Matrix*. This Matrix articulates the Learning Outcomes of the Graduate Capabilities Model across three levels i) novice ii) intermediate and iii) entry to practice.

We would like to invite you to give us your feedback on this Matrix. You are welcome to put comments/ track changes in the attached document, or simply reply to this email with your thoughts.

Some questions you may consider in your feedback are:

- Do you think the different learning outcomes described in the matrix adequately reflect the capabilities they are aiming to develop?
- Is there anything you feel is missing?
- Do you have any suggestions for how the matrix could be improved?

If you wish to participate, please return your feedback to me COB Monday 11th August.

On behalf of the Aboriginal and Torres Strait Islander Health Curriculum Framework Project team, we look forward to receiving your feedback!

Warm regards

**Project Manager | Aboriginal and Torres Strait Islander Health Curriculum Framework
Curtin Teaching and Learning
Curtin University**

Reply from Aboriginal Health Academic at The University of Queensland 7 August

Hi [Project Manager],

Thanks for your email. I must confess I'm a little intrigued by the wording and revision of the final item:

- Revising notions that may be unnecessarily problematic (notably removing 'white' from the term 'white privilege') without diluting depth of learning experience

I'm not sure from whose perspective this is written, in terms of notions that are 'unnecessarily problematic'. Though it becomes a little clearer when reading the more recent consultation document that was distributed today. For example: there were claims that naming white privilege resorts to 'colourism' - which demonstrates a complete lack of awareness of the concept and fails to recognise the concept as explored within the literature review undertaken as part of this work.

I wonder what is problematic about naming 'white privilege' but more importantly, at whose request is it being removed? I'm more concerned about how it operates in producing poor health outcomes for Indigenous people to be honest. Having attended a consultation forum, I noted that many of the participants found topic areas of 'racism' and 'whiteness' problematic and expressed their desire to have these removed from the curriculum (mostly non-Indigenous participants). I wonder if Indigenous knowledges and perspectives are to be embedded into the curriculum, how is this reflected in the process of developing the curriculum framework? Whose voices and concerns are privileged in these processes (overtly or inadvertently?)

In reference to:

4.4 "Privilege" and 4.4.1 [which] Recognises that some social groups are afforded privileges and advantages that give them greater access to power than others. Describes own social positioning in terms of power and privilege.

Rendering 'whiteness' invisible in this framework is problematic, particularly given the recent Beyond Blue study which revealed that the 'privilege' approx. 50% of Australians are most concerned about is the supposed privileges that Indigenous people receive. We need to name who has it (even if it is confronting for those who are beneficiaries of it). But further, naming white privilege is an inherent part of anti-racist pedagogy. White privilege "oppresses when it operates as the invisible regime of normality". Thus to omit 'white' (even just in name) is a powerful act in itself that I would really encourage further reflection on. While debates may abound about how 'white privilege' operates, it is a legitimate area of academic inquiry and the curriculum framework I believe should be modelling the appropriate terminology for this concept.

Reply from Gregory Phillips

11 August

Dear [Project Manager],

I completely agree with [Academic from UQ]. Removing 'white' from 'white privilege' is like removing 'male privilege' from 'sexism'. It's absolutely ridiculous, and plays into the dangerous arguments about reverse racism, as if there is such a thing. It dumbs down the realities of racism and whiteness in the health system, for which there is ample evidence.

If students are uncomfortable with the terms, or it causes hostility for the students or lecturers, then this is a key learning opportunity. See Courtney Ryder and colleagues' work (Flinders) on transformational unlearning and Maggie Grant's work on the Standing Together Against Racism project at JCU. Both these projects state that to best teach Aboriginal health, white privilege and racism must be addressed, otherwise, you will end up with a far less than optimal learning experience. Also, Helen Milroy and David Paul (and others) at UWA have documented the change in medical students' perceptions and reactions from 'why do we have to learn this shit' in first year, to 'thank god we learned this stuff' in final years. That transformation did not occur by avoiding racism and white privilege, but by confronting it.

I suggest very strongly that this particular set of recommendations are sent directly to Aboriginal and Torres Strait Islander people, who are also health academics.

This is like trying to remove Aboriginal studies from P-12 education because people don't want to talk about genocide and massacres. Bloody outrageous and unacceptable.

Thanks,
Greg

APPENDIX 6 – Email to Swim Team for a Yarn

From: Gregory Phillips
Date: 29 May 2014 3:23:44 pm AEST
Subject: [GLAMS Swim Team] Kakadu follow up

Dear Glams,

For those of you who came to Kakadu, and to everyone else as well, you may know what I'm talking about when I say the country and water there had a profound impact on me... It was something about the rocks and paintings, but mostly the water, that I really enjoyed - maybe it was the silica in the water, as they suggested, that cleansed and refreshed me on some level...? Charles, you being so spiritual, you'll know what I mean ;) For those who didn't come to Kakadu, I'm sure you've felt this in some way in other natural places... Wilson's Prom, Uluru, Great Barrier Reef, Grampians etc etc...

Anyways, this led me to suggest something that I have been thinking about for a while, and that a couple of Glams have asked me about - a yarn about Aboriginal stuff... I know that some of you have some questions and things you'd like to know about Aboriginal peoples, cultures, the lands, and maybe about my family and things. There's not always a safe place to discuss these things without the heat of politics, so I thought I'd offer one. If you'd like to yarn about what we experienced in Kakadu, or what thoughts or questions you have, how about a meal and a yarn? I'm happy to host something at my place.

I can't promise I'll be able to answer all your questions, but I am more than happy to try.

For those of you who have no idea what this is about, lol, no worries, just ignore...

Thanks,
G xo

APPENDIX 7 – Addendum

Changes made to the original submitted version (19 September, 2014) are:

- Page 11, second para, first sentence – delete “Marjorie Thorpe” and add “Marjorie Baldwin-Jones (later, Jilpia Nappaljari Jones)”
- Page 13, third para – delete “Mildura hospital”, and add “Griffith hospital”
- Page 23, first para, first sentence – delete “Aboriginal Health Taskforce” and add “Aboriginal Taskforce”
- Page 70, second para, first sentence – delete “Mooji (Basil) Sumner” and add “Moogy (Major) Sumner”
- Page 234, first para – add “Post-colonial studies and Orientalism acknowledge and refer to the after-effects of colonisation as whiteness, privilege and the benefits of colonisation (Spivak 1999). Yet these discourses presume two things: that colonisation has finished, and that whiteness is a consequence of colonisation, rather than its precursor or concurrently acting interlocutor. Stuart Hall (1996) clarifies that ‘the post-colonial’ is often used as “a concept celebratory of the so-called end of colonialism”, but that it “grossly underplays ‘capitalism’s structuring of the modern world’. Its notion of identity is discursive not structural. It repudiates structure and totality” (1996: 243).”
- Page 234, second para – add “Gelder and Jacobs’ (1994) account of the post-colonial in Australia is instructive here, in that they assert that there are complex entanglements where:

the postcolonial is here conceived as a set of processes rather than as a temporal moment which permeates a neat... sidestepping of the many particular historical moments and struggles through which Indigenous and minority claims on the modern nation come to circulate in the public sphere (Goldsmith 1998: 1).”

- Page 235, last para, after first sentence – add “Dirlik (1992) and Shohat’s (1992) work “explains why a concept which is intended to be critical should appear to be complicitous in the consecration of hegemony” (Hall 1996: 243).”
- Page 238, second para – add “I use domestic violence here as an analogy only. Notwithstanding the specific gender (Saunders and Evans 1992), race (Huggins and Thomas 1992), class (Wall 2014), whiteness (Moreton-Robinson 2000) and intersectional aspects of domestic violence in Australia (Stubbs and Tolmie 1995, Kripps 2014), the general analogy of the power dynamics in many domestically violent relationships can be instructive of the political and social power relations between Aboriginal and non-Aboriginal peoples.”
- Page 239 (original) or page 240 (current), first para, first sentence – delete “The man, using his patriarchal and physical power, oppresses and abuses the woman”, and add “Let’s say a white man, with the benefit of patriarchy, and using physical and psychological power, oppresses and abuses a white woman.”
- Page 239 (original) or Page 240 (current), second para – delete “The woman also buys into the sick relationship” and add “Through no fault of her own (the physical violence), the woman also unwittingly emotionally buys in to the sick relationship.”