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A thesis submitted in fulfilment of the requirements for the Degree Doctor of Philosophy

Faculty of Science Health Education and Engineering (FOSHEE)
University of the Sunshine Coast
June 2017
Lynne Stuart – Staff Photo (1986) – Nambour Hospital, Queensland, Australia
ABSTRACT

Background: An Indigenous health workforce is urgently needed to provide culturally safe care to Indigenous people to help address poorer mortality and morbidity experienced by Indigenous Australians compared to their non-Indigenous counterparts. To provide this workforce it is necessary for universities to continue to engage Indigenous nursing academics to attract Indigenous students into nursing and midwifery programs and encourage critical mass within the Indigenous health workforce. It has, however, been challenging for universities to attract and retain Indigenous nursing academics.

Aim: The aim of this research study was to describe and analyse the stories of eight Aboriginal nursing academics to explore the meaning that they derived from their experiences as nursing academics. The analysis of these unique narratives can then inform the development of recommendations for optimal support of Indigenous nursing academics in the tertiary sector.

Method: A qualitative interpretive narrative inquiry methodological approach was used for this research study. Eight Aboriginal nursing academics were interviewed. Data analysis involved a three-step process: (1) narrative analysis; (2) thematic analysis; and (3) the identification of constituent themes within the narratives to create a core story.

Results: The core story entitled ‘Maroochy Dreaming’ was crafted from the analysis. Four themes that were identified as being influential in the experience of becoming, and being, an Indigenous nursing academic included: 1) becoming a nurse and journeying into nursing and academia; 2) being situated in the Indigenous academic world; 3) racism, and the whiteness of nursing; and 4) building resilience to further develop leadership.

Conclusions: The themes collated from this research provide an in-depth description of the factors affecting the experiences of Indigenous nursing academics in the tertiary education sector, and a roadmap for a way forward. The hidden workload unofficially allocated to Indigenous nursing academics has the potential to impact on the retention rate of this cohort. This hidden workload can also impede academic progression and potential leadership roles, and hinder the opportunity to develop a research portfolio.
Ensuring the university space is culturally safe for both Indigenous nursing academics and Indigenous students is paramount to attract and grow these cohorts. This safe space can be facilitated by addressing structural racism in universities and ensuring that non-Indigenous nursing academic staff are provided with cultural awareness training as a position requirement.

For future-proofing career advancements for Indigenous nursing academics, the provision of resilience training is necessary to enable them to grow professionally and transition into leadership roles in Indigenous health. If these areas are not addressed, and recommendations arising from this study are not implemented by universities, the retention of Indigenous nursing academics will likely continue to be an issue for the university sector. Furthermore, the retention and graduation rate of Indigenous nursing and midwifery students may decline. Deficits in the numbers of Indigenous people in Australia’s healthcare workforce will leave Australia’s Indigenous health crises unaddressed, with the potential to widen the gap in life expectancy between Indigenous and non-Indigenous Australians.

Implications for Practice and University Policy: Recommendations from this study highlight that university schools of nursing and midwifery need to provide effective, culturally appropriate support for Indigenous nursing academics who, in turn, actively contribute to effective support, education, and skill development of Indigenous nurses.
STATEMENT OF ORIGINAL AUTHORSHIP

The work contained in this thesis is my own account of research undertaken by me; and, the thesis has been wholly completed during candidature, and within this timeframe includes a transfer of enrolment from the University of Southern Queensland (USC) higher degree by research program. The thesis contains no material previously published or written by another person, except where due reference is made. The thesis does not contain as its main content any work or material which is embodied in a thesis or dissertation previously submitted by me or any other person for a university degree or other similar qualification at this or other higher education institution. I acknowledge the support of the Australian Government's Research Training Program Scholarship. Professional editor Dr Blake Chapman (Blake Chapman Communications) provided copyediting and proofreading services for this thesis, according to the guidelines laid out in the university-endorsed national guidelines for editing research theses.

Signature:

Date:
ACKNOWLEDGEMENTS

Many people have supported and encouraged me throughout the years of my PhD candidature. On reflection, it has been a worthwhile and satisfying journey and I would like to acknowledge and express my sincere gratitude to the following people:

- The ‘Black Swans’ that feature in my ‘Maroochy Dreaming’ Thesis; without your remarkable stories this thesis would not have eventuated;
- My ‘Tiddas’, Barbara Beilby, Elaine Ferrier, Kim Walmsley and Bronwyn Fredericks who have been ‘the wind beneath my wings’ throughout this journey.
- My supervisors, Professors Jeanine Young and Marianne Wallis, and Emeritus Professor Anne McMurray. My three outstanding PhD supervisors generously mentored and supported me throughout my candidature. They continuously challenged and tested me and forced me to grow until my thinking was transformed. It was through this process of continuous consultation and critical feedback that I started to see, feel and think about research processes differently. I began to interpret things in a new way, which facilitated the creation of new knowledge within my thesis. I would like to sincerely thank each of my supervisors for providing me with scholarly academic writing skills and research wings, which over a period has equipped me to refine and produce this document. This newfound experience of learning deeply about research processes will enable me to move forward and build a strong Indigenous health research agenda;
- My beautiful family who are the epicentre of my universe: my husband Neale (my rock) and our three beautiful children, Jade, Todd and Jayme. My parents, Ruth and Trevor, for giving me a great life, and sisters Julie and Alison (Jacob 10/06/17). Thank you all for your encouragement and patience throughout this lengthy candidature. I would also like to acknowledge our human family dog, Lolly; and
- My friends and colleagues at the University of the Sunshine Coast (USC): Professor Greg Hill (Great White Elder), Professor Birgit Lohmann, Professor John Bartlett, Professor Joanne Scott, Professor Margaret Barnes, Associate Professor Patrea Anderson, Robyn Stainkey and ‘Elder Black Swan’ Leone Smith. From the University of Southern Queensland (USQ): Professor Don Gorman, Dr Kaye Price, Professor Cath Rogers, Associate Professor Cheryl Perrin, Professor Janet Verbyla and Debbie O’Reilly. Thank you for your support while I was at USQ.
GLOSSARY OF INDIGENOUS TERMS

(as utilised in this thesis)

Aboriginal: in this thesis, ‘Aboriginal’ refers to a mainland Indigenous person of Australia

Abbo: a derogatory term used by some non-Indigenous people of Australia to describe Indigenous Australians

Blackfella; an informal term used in Australia to refer to Indigenous people. It is considered a neutral term and is used by both black and white Australians

Bussamarai: a Mandandanji Aboriginal resistance warrior in the 1800s

Coon: a derogatory term used by some non-Indigenous people of Australia to describe Indigenous Australians

Dreaming: in this thesis, ‘Dreaming’ refers to Aboriginal values, laws and knowledge passed down through song, dance, painting and storytelling

Gubbi Gubbi/Kabi Kabi: the Aboriginal people and custodians of the land in the Sunshine Coast region, Queensland, Australia

Indigenous: in this thesis, ‘Indigenous’ refers to Aboriginal and Torres Strait Islander people of Australia

Mandandanji: the Aboriginal people and custodians of the land in the Maranoa district of Queensland, Australia

Maroochy: the Aboriginal word for ‘Black Swan’ in Gubbi Gubbi/Kabi Kabi language

Mob: in this thesis, ‘mob’ is used to describe a group of Aboriginal people connected to one another, e.g. people, or extended family

Murri: in this thesis, ‘Murri’ refers specifically to Aboriginal people from the state of Queensland, Australia

Torres Strait Islander: an Indigenous person whose ancestors originate from the Torres Strait Islands, Australia

Yarning: in this thesis, ‘Yarning’ refers to the Indigenous peoples way of talking and sharing experiences

NOTE: Throughout this thesis, the term ‘Indigenous’ and ‘Aboriginal and Torres Strait Islander’ have been used interchangeably. The term ‘Aboriginal nursing academic’ has been used to represent the research participants in this study.
ACRONYMS

ACN: Australian College of Nursing
AIATSIS: Australian Institute of Aboriginal and Torres Strait Islander Studies
AIEF: Australian Indigenous Education Foundation
ANF: Australian Nursing Federation
ANMAC: Australian Nursing and Midwifery Accreditation Council
ANMC: Australian Nursing and Midwifery Council
CATSIN: Congress for Aboriginal and Torres Strait Islander Nurses
CATSINaM: Congress of Aboriginal and Torres Strait Islander Nurses and Midwives
COAG: Council of Australian Governments
CLD: Culturally and Linguistically Diverse
DEEWR: Department of Education, Employment and Workplace Relations
FOC: Faculty of Color
GCTT: Graduate Certificate in Tertiary Teaching
IHEAC: Indigenous Higher Education Advisory Council
INEWG: Indigenous Nursing Education Working Group
NHMRC: National Health and Medical Research Council
NMBA: Nursing and Midwifery Board of Australia
RCNA: Royal College of Nursing Australia (now Australian College of Nursing)
SONMs: Schools of Nursing and Midwifery
TABLE OF CONTENTS

ABSTRACT ................................................................................................................................................iii
STATEMENT OF ORIGINAL AUTHORSHIP ......................................................................................... v
ACKNOWLEDGEMENTS ....................................................................................................................... vi
GLOSSARY OF INDIGENOUS TERMS ................................................................................................... vii
ACRONYMS ...............................................................................................................................................viii
TABLE OF CONTENTS ............................................................................................................................ ix
LIST OF TABLES .........................................................................................................................................xi
CHAPTER 1: INTRODUCTION .................................................................................................................. 1
  Background ............................................................................................................................................. 1
  Significance ............................................................................................................................................. 2
  The beginning of the narrative ............................................................................................................... 4
  Research problem .................................................................................................................................. 6
  Aim of the study ...................................................................................................................................... 7
  Research design and methodology ....................................................................................................... 7
  Structure of the thesis ............................................................................................................................ 8
  Summary ................................................................................................................................................ 9
CHAPTER 2: LITERATURE REVIEW ......................................................................................................... 10
  Introduction ........................................................................................................................................... 10
  Literature review strategy .................................................................................................................... 10
  Indigenous health and Indigenous nursing .......................................................................................... 13
  Knowledge is power: the academic environment .............................................................................. 34
  Nursing in the academic environment ................................................................................................. 56
  Summary ................................................................................................................................................ 73
CHAPTER 3: METHODOLOGY ................................................................................................................... 76
  Introduction ........................................................................................................................................... 76
  Guidelines for undertaking research with Aboriginal and Torres Strait Islander people............... 76
  My position in the study ....................................................................................................................... 78
  Ethical considerations ........................................................................................................................... 93
  Research rigour and quality ................................................................................................................ 94
LIST OF TABLES

Table 2.1 Quantitative studies exploring the extent of, and factors influencing, social disadvantage in Indigenous peoples in Australasia ................................................................. 14
Table 2.2 Qualitative studies exploring racism as experienced by Indigenous people in Australia, New Zealand and the USA ................................................................. 21
Table 2.3 Qualitative research studies exploring the challenges faced by Indigenous nursing students ................................................................. 29
Table 2.4 Female academics’ experiences ........................................................................ 36
Table 2.5 Experiences of Indigenous academics ................................................................. 41
Table 2.6 Studies involving Indigenous university/high school students .................. 50
Table 2.7 The importance of cultural safety ................................................................. 57
Table 2.8 Timeline – Congress of Aboriginal and Torres Strait Islander Nurses, Congress of Aboriginal and Torres Strait Islander Nurses and Midwives, and Indigenous nursing and midwifery advancements ................................................................. 63
CHAPTER 1: INTRODUCTION

Background

In Australia, the health status of Aboriginal and Torres Strait Islanders is poorer than any other demographic. Current statistics show that the gap is widening between the health of Indigenous and non-Indigenous Australians and that this trend is set to continue. The ninth Closing the Gap report for 2017 acknowledges that ‘the target to close the gap in life expectancy by 2031 is not on track based on the data since the 2006 baseline’ (Department of the Prime Minister and Cabinet, 2017, p. 7), and that progress needs to accelerate. One way that progress can accelerate in this area is through the development of a strong Indigenous nursing and midwifery workforce, which could address the health inequalities between Indigenous and non-Indigenous Australians (Taylor, Kickett and Jones, 2014). Recommendations on how this workforce can be developed and supported are proposed in this thesis.

This thesis presents the narratives (including my own) of eight Aboriginal nursing academics who have been employed within schools of nursing and midwifery (SONMs) between 2003 and 2013. The study considered each participant’s story, as told by the ‘storytellers’ themselves, within the broader context of nursing academia; and, as suggested by Martin (2003), has been told from a position of Aboriginal knowing, being and doing. These stories are told through the voice of Aboriginal nursing academics who originate from an ancient Aboriginal culture, which makes their stories unique from non-Indigenous nursing academics. Each participant’s story is articulated from a strong Aboriginal perspective. Indigenous academics are continually forced to stride between two cultures within academia; one that is their own and the other that oppresses their beloved culture. Participants’ stories reveal their experiences within the academic environment from a personal, professional and academic perspective, and clearly identify enablers and barriers that they have endured and navigated to continue their employment. From their individual stories, a combined ‘core story’ has been created to provide a greater insight into Aboriginal nursing experiences within the academic environment. In the ‘core story’, the Aboriginal nursing academics are represented as ‘Black Swans’, which in the Aboriginal Gubbi Gubbi/Kabi Kabi language translates as ‘Maroochy’.
In this chapter, the motivation and primary aim of the study is presented along with the methodological approach. The significance of the study to the development of Indigenous nursing scholarship is also outlined. The chapter concludes with a summary of the thesis structure and the components contained within each chapter.

**Significance**

In Australia, there is currently an insufficient number of Indigenous nurses and midwives to adequately provide culturally safe care for Indigenous people who access health care facilities. The nursing and midwifery workforce in Australia is predominantly comprised of non-Indigenous Australian nurses, which leaves Indigenous clients with little opportunity to be cared for by someone from their own culture. There is a mutual understanding among cultural groups about what constitutes health and wellbeing that is framed and nurtured within both the individual and the group. Health care delivery from Indigenous nurses toward Indigenous patients has been identified as very important in achieving optimal health outcomes (Stuart and Nielsen, 2011). This means that Indigenous nurses are a unique health workforce (CATSINaM, 2016) gifted with strong cultural nursing knowledge. Their specific understanding and attention to the health needs of Aboriginal and Torres Strait Islander patients makes them a valuable resource within Australia’s health care workforce. The low number of Indigenous nurses currently practising in Australia is partially due to past government policies, where Indigenous nurses and midwives were restricted from pursuing a career in nursing or midwifery, as these professions were only seen as suitable for white people. Instead, Indigenous people were often relegated to the ranks of domestic service (Best and Gorman, 2016). It has also been highlighted in studies by Indigenous nursing academics that racism and lack of cultural safety for Indigenous nursing and midwifery students in the university environment can hinder retention rates, thereby preventing student completion (Best, 2011; West, 2012).

The current deficit in Indigenous nurses in Australia’s healthcare workforce highlights an urgent need, as a larger Indigenous health workforce is essential for improving Indigenous health (Taylor et al, 2014). In the Australian Indigenous context, West states, ‘Indigenous nurses are less than 1% of the workforce while Indigenous
Australians occupy 3% of the nation’s population’ (ACN, 2014, p. 10). This indicates that the Indigenous nursing workforce in Australia is way below parity, and it is argued that increasing the number of Indigenous nursing academics to support Indigenous nursing students could help counteract this situation (Alford, 2015; West, 2012). The need for more Indigenous nurse leaders is a continual challenge, and has been highlighted by several Indigenous nurse researchers (Best and Stuart, 2014; CATSINaM, 2014; CATSINaM, 2016; Stuart and Nielsen, 2011; West et al., 2014). Therefore, a study of the experiences of Aboriginal nursing academics is warranted to gain greater and deeper insight and understanding into what they experience daily in the university environment. This information can then inform, and contribute to, the development of effective strategies to attract and retain more Indigenous academics.

Universities and SONMs must take the lead in closing the gap, as they have not previously met their obligations to Australia’s Aboriginal and Torres Strait Islander peoples. Recommendations have been set out by Indigenous nursing and health researchers to assist in closing the gap by developing a strong Indigenous health workforce, yet few have been implemented; evidenced by the persistent gap. Universities in Australia are built on the tribal lands of Indigenous peoples, and we have an obligation to honour the first nation people from these lands. Universities Australia has recognised, and is making strong efforts towards, increasing the benefits of Indigenous social capital through higher education attainment (Universities Australia, 2017). Increasing numbers of, and support for, Indigenous nursing academics will help them to be more effective in their positions and provide intelligentsia for the development of university and health workforce policy to assist in promoting sustainable progress in addressing Indigenous health in Australia.

Understanding the experience of Indigenous nurse academics will allow us to identify common and unique stressors and workload issues. It will also provide a breadth and depth of understanding of these issues. Finally, it might point to ways in which we can improve a) early pathways of entry to the professions of nursing and midwifery for Indigenous Australians and b) strategies to support and develop Indigenous academics to reduce repetition and focus on ‘improvement’.
The beginning of the narrative

My name is Lynne Stuart and I am a direct descendant of the ‘Mandandanji’ Aboriginal people from the Roma. I am the author of this thesis, ‘Maroochy Dreaming’. I don't think that anything can prepare you for the challenges involved in undertaking a PhD, and many times I have had to dig deep for inspiration to continue to complete this lengthy journey. I have found this inspiration by connecting to culture and drawing strength from my Aboriginal ancestors. When I think about our Mandandanji Aboriginal resistance leader 'Bussamarai' and how hard he fought for our people, I feel extremely indebted to him and his warriors who died fighting for our people. I know that no matter how hard things become in my life, it will never be as hard as what my Aboriginal ancestors had to endure and fight against. Knowing that the blood in my veins originates from them, for me, is awe-inspiring beyond words, and this knowledge makes me believe that I can achieve anything.

My Aboriginal mother, Ruth, and my white father, Trevor, married on our Mandandanji ancestral land in 1952. In 1963 they made the decision to relocate our family to the Sunshine Coast. This decision was made due to the threat of a government policy being actioned whereby fairer-skinned Aboriginal children were being ‘stolen’ from their Aboriginal mothers while their white fathers were away working. I was born on the Sunshine Coast in 1964, and my birth placenta is buried on our old rainforest property on Buderim Mountain on Gubbi Gubbi/Kabi Kabi ancestral lands. In 1968, when I was four years old, our family moved back to our ancestral lands at Roma.

In 2013, I relocated back to live on the Sunshine Coast with my husband Neale. Our three adult children live nearby. I now work at the University of the Sunshine Coast as a senior lecturer in nursing in the School of Nursing, Midwifery and Paramedicine (SONMaP). This thesis (which culminates my fifth university qualification) was written just over half of a century after my birth on these lands. My PhD journey has been a celebration of so many successes that I have achieved, and which I attribute to the resilience that was instilled in me by my Aboriginal ancestors. My work here at the University of the Sunshine Coast has involved many days of writing the chapters of my PhD. It has been my connection to the Sunshine Coast that has inspired me to give my thesis the title of ‘Maroochy Dreaming’.
I acknowledge and pay my respects to the ‘Black Swan’ storytellers in my thesis, as this is how ‘Maroochy Dreaming’ was originally shaped. In this narrative, ‘Maroochy’ is used as a metaphor for Aboriginal nursing academics, and the word ‘Dreaming’ is an Aboriginal term that encompasses all areas of interconnectedness of Aboriginal culture, including storytelling (Alber, 2016; Geia et al., 2013a). ‘Maroochy Dreaming’ holds special cultural significance for me as an Aboriginal nursing academic.

The narrative starts with my own personal experiences of navigating the nuances of academic life in my early academic nursing career as a ‘Black Swan’. The regional university where I was employed as an Aboriginal nursing academic presented me with many challenges in my attempts to grow and help graduate Indigenous nursing undergraduates. Due to these challenges, I started to develop my own solutions to counteract the challenges and barriers that I identified. I tested and refined my own empirical data to determine what the most effective support methods were for recruiting, retaining and graduating Indigenous nurses. I achieved great success in these endeavours; with this regional university becoming a national leader in this area and was where the Indigenous Nursing Support (INS) model ‘Helping Hands’ was created (Best and Stuart, 2014).

In the spirit of being clear and open about my influences and the influence I have on the data analysis included in this thesis I would like to point out that I am one of the authors of the publications by Stuart and Nielsen (2011) and Best and Stuart (2014) referred to in the following text. Understanding the factors that contribute to the development of the Indigenous nursing workforce and nurturing Indigenous nursing students in their journey to become a member of the nursing profession has been a passion of mine for many years. The earlier research I completed during the period 2011-2014 became the catalyst for the study undertaken in this thesis.

While I was having measurable success in recruiting, retaining and graduating Indigenous nurses, it came at a considerable cost. I worked overtime most nights and weekends so I could keep on top of my academic teaching load and research commitments, while still completing the hidden workload of supporting Indigenous nursing students. Owing to a dramatic increase in Indigenous nursing enrolments from 10 to 60 over a two-year period, I was provided with much needed support in the form of an additional Indigenous nursing academic. My experience was exceptionally exciting and exhausting, simultaneously, and yielded notable productive outcomes in
the form of Indigenous nursing graduates. However, I often contemplated whether my experience was similar to the experiences of other Aboriginal nursing academics. This curiosity combined with my earlier research became the motivation for this research study. I felt that if I could learn more about Aboriginal nursing academics and share their experiences, system improvements for growing and nurturing more Aboriginal nursing academics could be developed. Systems that provide greater, more effective and more culturally appropriate support within the university sector will promote the recruitment and retention of more Indigenous nursing students.

**Research problem**

Nurses represent the largest health profession in Australia’s health care workforce. The low numbers of Aboriginal and Torres Strait Islander nurses and midwives in Australia compared to non-Indigenous counterparts is extreme, with the Indigenous nurses and midwives sparsely distributed across states and territories (Alford, 2015). Within the Australian university system, Indigenous nurse and midwife completion rates are low and declining. ‘About a third of Aboriginal and Torres Strait Islander students complete nursing degrees, compared with two thirds of non-Indigenous students’ (Alford, 2015, p. 23). This may be a factor in the perpetuation of the gap in life expectancy between Indigenous and non-Indigenous people.

An Indigenous health workforce is needed to provide culturally safe care to Indigenous people to help address their poorer mortality and morbidity compared to non-Indigenous Australians. To provide this workforce it is necessary for universities continue to engage Indigenous nursing academics to attract Indigenous students into nursing and midwifery programs and encourage critical mass within the Indigenous health workforce. It has, however, been challenging for universities to attract and retain Indigenous nursing academics. What is unclear is what are the specific problems faced by Indigenous nurse academics and how best can universities support their development.

Giving voice to Indigenous nursing academic experiences may provide valuable information that can be used to improve the support provided to them. This improved support may achieve better outcomes for their recruitment and retention levels that will
contribute to the critical mass of skilled Indigenous nursing professionals required to deliver culturally appropriate health care for Australian Indigenous peoples.

**Aim of the study**

The aim of this research study was to describe and analyse the stories of Aboriginal nursing academics to explore the meaning that they derived from their experiences as nurses and as nurse academics. The analysis of these unique narratives informed the development of recommendations for optimal support of Indigenous nursing academics in the tertiary sector.

**Research design and methodology**

A qualitative interpretive narrative inquiry methodological approach was used. The rationale for the selection of a qualitative interpretive approach for this study was that the research focus was primarily on the subjective human experience, which allowed a deeper insight and understanding of the participants’ human consciousness (Taylor, Kermode and Roberts, 2006). This form of narrative methodology was used as it is harmonious with Indigenous oral culture and communication. Aboriginal nursing trailblazer, Sally Goold (2004) states ‘We are an oral people and we are face-to-face learners’ (Goold, 2004, p. 1). This strongly indicates that in Aboriginal culture there is a considerable emphasis on passing on knowledge from one generation to the next via storytelling. Sandelowski (1991) argued that qualitative nursing researchers should see the participants as narrators or storytellers, and the interview data as actual stories. This notion has also been echoed by several other scholars in the field (Thackrah and Scott, 2011; Bailey and Tilly, 2002). Face-to-face semi-structured interviews were used to gather the data over three months. Interviews were conducted at a time and place acceptable and convenient for each of the participants. The digital voice recordings of participants’ interviews were transcribed verbatim.

The research data were analysed for common themes and patterns within the narratives. Finally, the initial interview transcripts were reconstructed into narratives via a narrative analysis process. Eight Aboriginal nursing academics shared their
stories and from their interviews, a core story was created entitled ‘Maroochy Dreaming’.

**Structure of the thesis**

The following thesis is comprised of five chapters. Chapter one introduces the background to the thesis, the beginning of the narrative, study aims, the study overview, the significance of the study and the structure of the thesis. Chapter two provides a critical review of the literature related to Indigenous nursing academics, their role in improving healthcare for Indigenous peoples and what is currently known about their development and experience in the academic environment. The key areas are: (1) Indigenous health and Indigenous nursing; (2) Knowledge is power: the academic environment; and (3) Nursing in the academic environment. These areas encapsulate themes sourced from the literature. Chapter three provides an overview of the study’s methodological approach and the methods used to collect and analyse data. A narrative methodological approach was utilised due to being compatible with Aboriginal methods of storytelling, based on the aim of the research study and as justified by relevant literature. The population sample of Indigenous nursing academics and the position of the author as researcher and participant is outlined.

Chapter four presents the narratives of eight Aboriginal nursing academics. These stories were told by the participants through a semi-structured interview process. A core story was subsequently created, entitled ‘Maroochy Dreaming’. The themes within this story are: (1) becoming a nurse; (2) journeying into academia; (3) teaching from Indigenous knowing; (4) building a sense of community; (5) helping Indigenous nursing students; (6) coping with racism; (7) exposing the whiteness of nursing; (8) being a leader; (9) showing the resilience of our mob; and (10) setting personal and professional boundaries. Chapter five synthesises the themes identified through analysis of participants’ stories with the current literature to advance knowledge from the study findings. The discussion is framed within four major themes generated from the research study. The thesis concludes by providing recommendations for universities to make organisational change and suggestions for future research. Steps needed to close the gap are also identified.
Summary

Chapter one provided justification for the study and outlined the potential significance of a study of the experiences of Indigenous nursing academics. The personal and professional narrative of the researcher was outlined, providing a platform of cultural significance that can be linked to the core story, ‘Maroochy Dreaming’. The research problem was identified and the aims, research design and methodology justified. Expected outcomes were presented and the structure of the thesis provided. The following chapter reviews relevant literature.
CHAPTER 2: LITERATURE REVIEW

Introduction

This chapter provides a critical review of the literature related to Indigenous nursing academics, their role in improving healthcare for Indigenous people, and current knowledge of their development and experience in the academic environment. The approach used for the literature review is based on recommendations for a narrative literature review proposed by Cronin, Ryan and Coughlan (2008). This approach instructs the author to firstly research a wide body of literature, then summarise and synthesise information to draw topical conclusions. The topics are collated into a logical order to focus on the specific, extend more broadly, and then return to the specific areas that relate to the primary research question. A summary of primary information sources from this review is contained in tables for clarity.

Using Cronin, Ryan and Coughlan’s (2008) approach, three key topic areas were identified and are included in this literature review together with related subtopics. The topic areas include: (1) **Indigenous health and Indigenous nursing**: issues and solutions (historical factors, self-determination), closing the gap, Indigenous leadership in maintaining health, racism towards Indigenous people/nurses, racism and whiteness of nursing, Indigenous nursing students’ experiences, challenges and opportunities in developing the next generation of Indigenous nurses; (2) **knowledge is power: the academic environment**: female academic experiences, Indigenous academics and invisible workloads (including gender and Indigeneity), Indigenous university/high school students and their experiences; and (3) **nursing in the academic environment**: importance of cultural safety, CATSIN/CATSINaM national and local (Qld) issues in preparing Indigenous nurses to address Indigenous health, Queensland health, Indigenous nursing academics in higher education.

Literature review strategy

The literature search was initially undertaken in 2010-11 and updated regularly over the next six years. It included a variety of broad sources from electronic databases, Indigenous health organisations and information sites. Electronic databases including Blackwell Synergy, CINAHL (EBSCOhost), Google Scholar, PubMed, SAGE full text
collections and Science Direct were accessed over a period of six years. The primary search terms used were: Indigenous, Indigenous health, Indigenous academics, Indigenous nursing academics, Indigenous nursing academics perceptions and experiences, Indigenous/nursing/nursing students, Aboriginal, Aboriginal health, Aboriginal academics, Aboriginal nursing academics, and Aboriginal/nursing/nursing students. Secondary search terms were: closing the gap, racism in nursing, whiteness of nursing, female academics, Indigenous students, Aboriginal students, cultural safety in nursing, Indigenous health workforce, and Indigenous nursing workforce. A search of the grey literature was conducted and identified websites, including the Australian Indigenous HealthInfoNet website, which contains Indigenous specific journal publications and reports; the Closing the Gap website, which contains Closing the Gap initiatives, Closing the Gap reports and current statistics; and the Health Workforce Australia website, which focuses on Indigenous health and the Indigenous nursing and midwifery workforce. In addition, websites for Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM), the Nursing and Midwifery Board of Australia (NMBA), and the Australian Nursing and Midwifery Accreditation Council (ANMAC), which discuss cultural safety in nursing, Indigenous nurses and midwives, and racism and whiteness of nursing, were utilised. The Universities Australia (UA) website was accessed, and material relating to Indigenous higher education and academics, females in academia, Indigenous academics and Indigenous nursing academics, the higher education student experience, and cultural safety in higher education were sourced and reviewed. A hand search of literature containing content relating to the above terms and topics was conducted, and sources included textbooks, health reports and grey literature, such as newspaper articles and speeches by notable Indigenous academics. A search of the National Digital Thesis Program was also done to review relevant digital theses of mainstream academics, Indigenous academics and Indigenous nurse scholars and their corresponding reference lists. This search strategy was implemented on a regular basis to keep up-to-date with the literature. Searches revealed a plethora of literature relevant to researching Indigenous peoples; however, there were limited studies reflecting the experiences of Indigenous nursing academics specifically, perhaps due to the presence of Indigenous nursing academics in schools of nursing and midwifery (SONMs) being a relatively new phenomenon.
The literature reviewed spans the timeframe of 1960 to February 2017, ensuring the inclusion of all relevant literature. This timeframe was selected to mirror the gradual decline in government policies that restricted Indigenous people embarking on nursing careers prior to the 1960s (Best and Gorman, 2016). The 1960s is also the period that many Indigenous nursing trailblazers embarked on their nursing careers in hospital settings (Goold and Liddle, 2005). For specific topics, where there is considerable recent research, abstraction of information from relevant studies, related to methods and results, has been undertaken to assist with critical review.

The review of the literature is presented under several thematic headings. Each includes theoretical, contextual and historical underpinnings, as appropriate. Where there is research-based literature related to the issues being addressed, tables are presented to facilitate a detailed discussion of the current levels of research-based knowledge. Key headings include: (1) Indigenous health and Indigenous nursing; (2) Knowledge is power: the academic environment; and (3) Nursing in the academic environment.

The review begins with an exploration of issues surrounding Indigenous health in Australia. Literature pertaining to the important role of the Indigenous health workforce in advocating and educating the public to embed and sustain culturally appropriate health care is reviewed and critiqued. In this review, I explore how education and advocacy influence mainstream (non-Indigenous) health providers, and empower Indigenous people to improve their own health outcomes. It can be argued that an educated Indigenous health and nursing workforce could be an effective instrument in influencing health policies, as well as health care practice (CATSINaM, 2013). Education is therefore one way to achieve empowerment, change and improvement in Indigenous health.

This chapter also reviews studies related to the continuing poor health status of Indigenous Australians. The term ‘Indigenous health’ in this context is used to represent the condition of Indigenous people’s health in Australia. It is widely understood that the decline in health for this population commenced shortly after first contact with non-Indigenous people, and continues today (Campbell, 2002; Lovett, 2014). The decline in Indigenous health has been attributed to introduced diseases for which Indigenous people had no immunity, dietary changes, being forcibly removed
from traditional lands, and policy decisions that were detrimental to the ways of knowing and being for Indigenous Australians (Lovett, 2014).

**Indigenous health and Indigenous nursing**

*Issues and solutions*

A range of research studies were identified that focused on factors influencing social disadvantage in Indigenous peoples in Australasia (Table 2.1), the experience of being an Indigenous nurse (Table 2.2) and the experience of being an Indigenous nursing student (Table 2.3).

Many issues and some solutions have been identified in the literature. The wide-ranging review undertaken by Gracey and King (2009) shows the extent of research undertaken to explore and quantify the patterns of mortality and morbidity in Indigenous populations around the world. In this review, along with the companion piece (King, Smith and Gracey, 2009), the determinants of health and the factors influencing continuing poor Indigenous health are clearly articulated. As shown in Table 2.1, more recent studies focusing on Indigenous social disadvantage have employed both large scale epidemiological methods and comprehensive qualitative methods. In Table 2.2, a much smaller body of work related to the specific impact of racism on health is presented. Both small qualitative studies and small-to medium-sized epidemiological studies have been undertaken. While this provides an introduction to the issues, it does not address or provide evidence on how to improve the situation. Table 2.3 summarises several qualitative and mixed methods studies describing the experiences of Indigenous nursing students within higher education.
Table 2.1 Quantitative studies exploring the extent of, and factors influencing, social disadvantage in Indigenous peoples in Australasia.

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<thead>
<tr>
<th>Author, Year and Country</th>
<th>Aims of the Study</th>
<th>Research Design</th>
<th>Sample/Participants</th>
<th>Data Collection Method</th>
<th>Findings</th>
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<tr>
<td>Anderson et al. (2016)</td>
<td>To describe the health and social status of Indigenous peoples relative to benchmark populations from a sample of countries.</td>
<td>Mixed methods to measure Indigenous health data.</td>
<td>Indigenous peoples in 23 countries and 28 populations, representing the largest study done to date.</td>
<td>Systematic collation of data in consideration of the United Nations sustainable development goals.</td>
<td>National responses needed to address Indigenous health. Improved access to health services and improved access to Indigenous data needed.</td>
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<tr>
<td>Biddle (2014)</td>
<td>To measure social capital for the Indigenous population and link the indicators to well-being.</td>
<td>Qualitative, cross-sectional survey design.</td>
<td>Nationally representative sample of (n=7823) Indigenous Australians aged 15 yrs and over.</td>
<td>Individual household survey, measuring sadness and happiness.</td>
<td>Social capital was found to be associated with, and is an indicator and determinant of, well-being.</td>
</tr>
<tr>
<td>Durey and Thompson (2012)</td>
<td>To reduce Indigenous health disparities by exploring the effects of ‘white’, Anglo-Australian cultural dominance in health service delivery to Indigenous Australians.</td>
<td>Qualitative, case study.</td>
<td>Non-Indigenous medical practitioners (n=3) who are experienced and have insights into Indigenous health.</td>
<td>In-depth interviews from 40-120 minutes that occurred over several months until there was repetition of themes.</td>
<td>Racism emerged as a key issue that stalled progress in improving the health of Indigenous Australians.</td>
</tr>
<tr>
<td>Vos et al.</td>
<td>To identify risk factors that cause the greatest burden</td>
<td>Quantitative, mixed methods to</td>
<td>Sample - National study of health data</td>
<td>Population data were accessed publicly and via data requests from</td>
<td>Findings identified diseases and risk factors that</td>
</tr>
<tr>
<td>Author, Year and Country</td>
<td>Aims of the Study</td>
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<tr>
<td>Wilson and Barton (2012)</td>
<td>To explore Māori experiences of hospitalisation in surgical or medical settings and how these might influence length of stay.</td>
<td>Mixed method Māori-centred case study.</td>
<td>Sample - medical-surgical discharge data, a structured review of the literature and interviews (n=11) with Māori females (n=9) and males (n=2).</td>
<td>Interviews. Triangulation of qualitative and quantitative data sources simultaneously.</td>
<td>Hospital environments marginalise Māori; therefore, Māori choose to discharge themselves as early as they possibly can.</td>
</tr>
</tbody>
</table>
The five studies, four from Australia and one from New Zealand, presented in Table 2.1 clearly show that Indigenous people are socially disadvantaged in the healthcare system. Anderson et al. (2016), Biddle (2014) and Vos et al. (2008) conducted quantitative studies by collating existing data from health databases and surveys. Anderson et al.’s study represented the largest on Indigenous people (covering 23 countries), whereas Biddle (2014) and Vos et al. (2008) focused on Indigenous people from Australia only. The three studies highlighted the significant social disadvantage in Indigenous populations, which were associated with poor access to health care, limited social capital and pre-existing health factors that impact on Indigenous people’s health status. Durey and Thompson’s (2012) qualitative study revealed that racism was a key factor that stalled progress in improving the overall health of Indigenous Australians. Wilson and Barton’s (2012) mixed method study, which focused on the Indigenous Māori population in New Zealand, found that Māori patients who felt marginalised made personal decisions to shorten their length of stay and discharge themselves from the hospital environment. Both studies indicate that the hospital environment is not a culturally safe place for Indigenous people in both Australia and New Zealand to remain for extended periods (Durey and Thompson, 2012; Wilson and Barton, 2012).

Closing the gap

In response to the overwhelming weight of evidence that a) Aboriginal and Torres Strait Islander people have much poorer health outcomes than the rest of the population and b) racism and consequent social disadvantage are the principal factors implicated in these outcomes, there have been numerous attempts at the public policy level to address the issue. Closing the Gap is a national campaign aimed at closing the life expectancy gap between Indigenous and non-Indigenous people of Australia within a generation (AHRC, 2013). The Australian Bureau of Statistics (2013) report that the inequality in life expectancy is narrowing between Indigenous and non-Indigenous Australians. The life expectancy gap of Indigenous Australians is now 10.6 years for males, compared to their non-Indigenous Australian counterparts, and 9.5 years for females. This is an improvement from 2008, when the life expectancy gap was up to 20 years for both males
and females (Pink and Albion, 2008). The reported reduction in the gap indicates that there has been significant progress.

On closer inspection, however, the Close the Gap Steering Committee suggested that the narrowing of the gap was partly related to a lower mortality rate of Indigenous children, indicating that the gap is not closing as broadly across all areas as purported. McMurray (2011, pp. 35-36) argued that ‘measuring of the gap is problematic’, and productivity should instead focus on a common commitment to inclusive social policies that work towards redistributing resources and opportunities where they are most needed, including maternal and child health, housing, education, food and water, safe living, and care of the environment. There are also methodological problems in measuring the gap, including ‘the size of the Indigenous sample, the nationally representative sample, non-Indigenous comparison, information across the life course and Indigenous specific measures’ (Biddle, 2014, p. 26). There is also an issue with Indigenous under-identification; therefore, data available and reported is an underestimate of the gap.

Pholi, Black and Richards (2009, p. 11) argued that placing emphasis on only the statistical data to describe Indigenous people is harmful, and stated, ‘This tendency of the dominant majority to continually reduce Aboriginal and Torres Strait Islander people to the demoralising and disempowered status of a numeric problem shows the true nature and magnitude of the “gap” between Indigenous and non-Indigenous Australia’. Altman (2014) further explained that the targets are different for each specific Indigenous health area, and that designated goal timeframes to address each of these separate areas range from five years to a generation. Therefore, considering Indigenous health issues as only numerical data reduces the dimensions of the issues to abstract statistics rather than representing the real and cumulative impact on health outcomes.

Since the inception of the Closing the Gap campaign, there have been significant policies developed with the intention of addressing the gap by supporting the establishment of an appropriately sized Indigenous nursing and allied health care workforce to address the deficit in providing culturally appropriate care (New South Wales Department of Health, 2011; Queensland Health, 2010). While there has been great emphasis on building the capacity of Indigenous health workers for outreach to Indigenous areas and providing
cultural safety in healthcare delivery, there is also a need for the health industry to support health professionals, such as nurses and midwives, to progress, particularly at policy level. In his social justice report, Aboriginal and Torres Strait Islander Social Justice Commissioner, Tom Calma, asserted that Australia has the professional expertise and resources necessary to carry out a successful Closing the Gap campaign based on empowering Aboriginal and Torres Strait Islander people to provide culturally safe health care to their own families and communities (Calma, 2005).

*Indigenous leadership in maintaining health*

The history of the Indigenous health nursing workforce shows little evidence that Indigenous health issues, although existent, had previously been identified as a concern for governments or nursing bodies prior to 1979. This was the year the House of Representatives Standing Committee on Aboriginal Affairs (1979) sent out an urgent call for more Indigenous nurses. It stated, ‘There are no Aboriginal doctors, few nurses and nurse trainees, and a limited number of nurse aides. One important way of improving Aboriginal health is to have Aboriginals themselves filling these positions. It is therefore necessary that as many Aboriginals as possible be trained in this profession in the shortest possible time’. This call for Indigenous nurses and midwives continues today (Mohamed, 2015), almost four decades later, to increase the number of Indigenous nurses. Despite the rhetoric and many policy documents about increasing the numbers within the Indigenous health workforce, there is still a low number of Indigenous people with expert qualifications in the health field (Taylor, Kickett and Jones, 2014). With the small number of Indigenous people in Australia’s health workforce, holding professional health qualifications, closing the gap is not likely.

*Racism towards Indigenous people/nurses*

As the previous section indicated, a key factor in perpetuating Indigenous disadvantage in Australia and worldwide is racism. Table 2.2 presents studies related to the experience of racism by Indigenous people and nurses and what the effects of this racism are for
these groups. Table 2.2 consists of seven studies from Australia (n=4), New Zealand (n=1), the United States (n=1) and Canada (n=1). Most of these studies (n=5) were qualitative with small sample sizes (n=5-22 participants). Larson et al. (2007) and Paradies and Cunningham (2009) conducted studies using cross-sectional survey designs in Australian settings, achieving considerable sample sizes of (n=639) and (n=312) Indigenous Australian participants for both studies, respectively. These two studies revealed that the experiences of racism are prominent for Australian Indigenous people in healthcare (both patients and Indigenous nurses) and should be recognised as a determinant of health, leaving those who identified strongly with culture, at greater risk.

With the phrase ‘whiteness of nursing’, researchers are alluding to the fact that nursing is predominately a white profession, made up of nursing staff from non-Indigenous backgrounds. As such, the professional nursing work culture reflects many aspects of white society (Huria et al, 2014; Mapedzahama et al., 2012; Robinson, 2014; and Vukic et al., 2012). However, more investigation is needed into the whiteness of nursing.

*Racism and the whiteness of nursing*

Goold (2001) cited racism, discriminatory practices, historical disadvantage and the oppressive relationship dynamic between black and white women in Australia as being responsible for the low participation of Aboriginal and Torres Strait Islanders in the nursing profession. Goold called for action to address these issues within our SONMs, noting that retention of Indigenous nursing students will continue to be a major issue if racist attitudes and behaviours continue. She acknowledged Indigenous nurses as a great asset to SONMs, as they can provide valuable input into nursing and midwifery curriculum development to address potential barriers due to racism (Goold, 2001).

Racism and the whiteness of nursing were common themes reported by participants in more recent studies addressing Aboriginal nurses’ experiences. Puzan (2003) conducted research into the phenomena of the whiteness of nursing and a decade later, Vukic et al. (2012) and Nielsen, Stuart and Gorman (2014) described the whiteness of nursing as existing in a variety of domains of power within the nursing profession. These studies originate from three different countries, but reveal common barriers that deter many
Aboriginal nurses from choosing a nursing career and continuing along this professional pathway. The findings support the view that racism and the whiteness of nursing continue to be global issues for the worldwide nursing profession.

Armstrong (2004) provides an outline of Indigenous health issues that converge on the connection between the Indigenous health workforce and how this workforce can realistically improve Indigenous health outcomes. She argued that there is an urgent need to address Indigenous workforce capacity issues. She suggested that the transfer of nursing training to universities made it more difficult for Indigenous people to embark on a career in nursing as they often lacked the educational preparation required to enter the nursing profession at university level.

In 2010, Goold (2010) reported that the Council of Australian Governments (COAG) and the Close the Gap reports had identified Indigenous health as a primary area for immediate funding. She proffered that these reports had targeted Indigenous nurses and midwives as the vital workforce to achieve reductions in health disparities between Indigenous and non-Indigenous Australians. She also drew attention to the gap between policy and implementation by highlighting the importance of the Working Future Report. This report built on all policies, programs and targets to promote engagement, and described engagement as more than the undertaking of a consultation process, instead being the sharing of responsibility to create better health outcomes. This approach is the progressive action that is required to make unified and significant progress in Indigenous health outcomes, and one that needs to be revisited in contemporary Australian health workforce plans.
Table 2.2 Qualitative studies exploring racism as experienced by Indigenous people in Australia, New Zealand and the USA.

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<tr>
<th>Author, Year and Country</th>
<th>Aims of the Study</th>
<th>Research Design</th>
<th>Sample/Participants</th>
<th>Data Collection Method</th>
<th>Key Findings</th>
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<tbody>
<tr>
<td>Huria et al. (2014) New Zealand</td>
<td>To explore experience and impact of racism on Māori registered nurses within NZs health system.</td>
<td>Qualitative interpretive, using Kaupapa Māori Research (KMR)</td>
<td>Māori RN’s (n=15), aged 21-67 yrs, having clinical experience of 2-40 yrs.</td>
<td>Face-to-face semi-structured interviews consistent with KMR principles. Interviews comprised of 23 questions, with four key areas.</td>
<td>Māori nurses faced numerous challenges related to racism, both at institutional and interpersonal levels.</td>
</tr>
<tr>
<td>Larson et al. (2007) Australia</td>
<td>To investigate if the experience of interpersonal racism has a measurable effect on the health of Aboriginal Australians.</td>
<td>Quantitative cross-sectional survey design.</td>
<td>Aboriginal Australians (n=639) resident in rural Australian towns; (n=183/639) were Aboriginal; (n=456/639) non-Aboriginal.</td>
<td>Questionnaires sent via random selection to residents by post.</td>
<td>Aboriginal respondents were twice as likely to report negative racially based treatment, which impacted negatively on their health. Experience of racist treatment needs to be recognised as a social determinant of health.</td>
</tr>
<tr>
<td>Mapedzahama et al. (2012) Australia</td>
<td>To examine how skilled African migrant nurses working in Australia forge social and professional identities within their transnational, cross-cultural existences.</td>
<td>Qualitative interpretive, critical analysis.</td>
<td>African migrant nurses (n=14), female (n=13) and male (n=1) ranging in age from 30-47 yrs.</td>
<td>Semi-structured interviews, recruited through personal and professional contacts via the snowballing technique.</td>
<td>Exposed new ‘oppositionist accounts of race’, and conceded that the only ‘witnesses’ of racism in nursing is that against whom it is practised. More academic inquiry into racism in nursing needed.</td>
</tr>
<tr>
<td>Author, Year and Country</td>
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<td>Nielsen, Stuart and Gorman (2014) Australia</td>
<td>To understand the cultural challenges of Aboriginal registered nurses working in mainstream services.</td>
<td>Qualitative, descriptive, narrative.</td>
<td>Aboriginal registered nurses (n=5).</td>
<td>In-depth interviews.</td>
<td>Whiteness of nursing is a deterrent for Aboriginal nurses working in mainstream nursing.</td>
</tr>
<tr>
<td>Paradies and Cunningham (2012) Australia</td>
<td>To measure the experiences of racism in urban Indigenous Australians.</td>
<td>Mixed method, survey questionnaires to measure the Indigenous racism experience.</td>
<td>Indigenous participants (n=312) over 15 years who had lived around Darwin.</td>
<td>Human health samples (blood and urine) and questionnaire data that measured responses to racism.</td>
<td>70% of Indigenous people experience interpersonal racism in their everyday lives; there is a greater risk for those that identify strongly with their culture.</td>
</tr>
<tr>
<td>Robinson (2014) United States</td>
<td>To describe how racism affects black nurses, their delivery of care, their motivation and coping strategies, and what support they need to promote a safe work environment.</td>
<td>Mixed method case study.</td>
<td>Black nursing faculty (n=9) at various academic ranks.</td>
<td>Likert scale (uploaded in survey monkey) was used to collect demographic data and in-depth narrative interviews.</td>
<td>Racism continues to be prevalent in nursing. Nurses that subscribe to the color-blind perspective contribute to the problem by not identifying race as a variable of conflict. 100% of respondents had experienced racism.</td>
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<tr>
<td>Author, Year and Country</td>
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<tr>
<td>Vukic et al. (2012)</td>
<td>To strengthen the current rate of the recruitment and retention of Aboriginal nurses.</td>
<td>Qualitative participatory research employing the grounded theory.</td>
<td>Aboriginal nurses (n=22).</td>
<td>Snowball sampling, face-to-face interviews conducted over six months.</td>
<td>Themes: cultural context of work life, becoming a nurse, navigating nursing, racism and nursing, socio-political context of Aboriginal nursing, and the way forward. Racism was the common thread in these themes.</td>
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The focus on addressing the limited number of Indigenous nurses within the Australian health care workforce has again been brought to the forefront by CATSINaM Chief Executive Officer (CEO) Janine Mohamed. Mohamed (2015) provided the Indigenous nursing and midwifery figures for Australia as of March 2015, and recommended optimal numbers necessary for addressing the burden of disease in Australia’s Indigenous population so that Close the Gap targets can be met. ‘We currently have 1,745 Indigenous registered nurses. We need 7.3 times that number, or 12,727. When it comes to Indigenous midwives we’ve only currently got 186, and we need 862’ (Mohamed, 2015, p. 1). These conservative estimates of healthcare professionals required indicate that there is ample room for growth in this workforce. Recent (2017) projections published by CATSINaM supports these figures and suggest that we currently have only a third of the 9000 Aboriginal and Torres Strait Islander nurses and midwives needed to address Close the Gap targets (Close the Gap Campaign Steering Committee, 2017).

West’s Australian College of Nursing (ACN, 2014) speech directs Australia’s nursing leaders to substantially grow the numbers of Indigenous people in the Australian nursing and midwifery workforce. West used this national ACN platform as a prime opportunity to launch an appeal to Australia’s nursing and midwifery professions to take a strong stand and make Indigenous health a national priority (ACN, 2014). West’s call for action draws attention to the already significant growth in the Indigenous health workforce achieved by affirmative action approaches at federal, state and local levels. The affirmative action method in growing the Indigenous health workforce has been proven successful (West, 2012), and West’s scholarly recommendation that this approach continues is widely supported by clinicians, academics and the mainstream public (West, 2012).

Alford’s (2015) report is positioned from an economic approach to closing the gap in health, education and employment for Indigenous Australians. One of the major findings of this report shows an insufficient number of Indigenous nurses to keep up with the continuing health disparities occurring in the Indigenous population (Alford, 2015). Her report revealed that costs for the delivery of healthcare will escalate if funds are not invested in developing an Indigenous nursing workforce for the coming years. The potential for fiscal damage will not only be immediately felt, but will also impact more long-term individual and societal burdens relating to health issues that are not being addressed
in a timely manner during Indigenous client’s primary health checks. Alford’s recommendations are aligned with the Closing the Gap strategies to build a stronger Indigenous nursing workforce, and propose the employment of Indigenous nursing academics into positions within SONMs to provide academic and referral services that are linked with Indigenous education units. The recommendation to specifically increase the number of Indigenous nursing academics is timely for this doctoral study. This report is comprehensive and has the relevant content for CATSINaM to make real change if these recommendations are embraced and implemented by SONMs and Australian nursing bodies (Alford, 2015).

The literature review for the Indigenous health and Indigenous nursing area looks firstly at Goold (2001), who poses the question, ‘Can our Australian nurses and midwives meet the challenge of caring for an Indigenous person?’ The aim of Goold’s research was to address the poor preparation of mainstream nurses in relation to caring for Indigenous people. However, Goold wrote the opinion piece from her own perspective as an Indigenous nurse; there was no mention that training more Indigenous nurses was the answer. Another approach proposed for caring for Indigenous people emerged from research conducted by Stuart and Nielsen (2011), where two Aboriginal nurses combined their masters research work to propose a model that supports the premise that black nurses caring for black patients facilitates good health outcomes; further adding that caring is inherent in Aboriginal nurses. Stuart and Gorman (2015) also argued the importance of building a strong Indigenous nursing workforce to address poor Indigenous health outcomes in Australia.

Goold (2001) supports the ethos of Stuart and Nielsen (2011) in a sense by expressing her concern that non-Indigenous nurses lack training in cultural safety and the majority have a poor understanding of Indigenous history, culture and how to care for Indigenous people in the health care setting. This concurred with previous arguments that there was an urgent need to educate the non-Indigenous nursing workforce to care more appropriately for Indigenous people. Armstrong (2004) provides an overview of Indigenous health and strategies. Some have been demonstrated to work, whereas others have not yet been implemented, despite a decade having passed since the recommendations were made. Armstrong suggested that if Indigenous health strategies
are not being implemented, then maybe it’s time for refreshed Indigenous health policies. She commented that the lack of recognition of the need for a treaty in Australia continues to exacerbate the poor health outcomes and powerlessness of Indigenous people.

In later years, an editorial by Indigenous nurse Sally Goold (2010) again argued the professional Indigenous nursing perspective on how Indigenous nurses and midwives can be instrumental in closing the gap. Goold’s (2010) work elaborates on this notion and indicates that closing the gap is a two-fold process dependent on addressing the social determinants of Indigenous health, as well as educating a culturally appropriate nursing and midwifery workforce. Goold’s professional position at the time of writing her opinion pieces in 2001 and 2010 was CEO of the Congress for Aboriginal and Torres Strait Islander Nurses (CATSIN), a position she held for over a decade. Goold’s views, therefore, are held in high regard. Outstanding strengths in Goold’s 2001 work included highlighting the importance of cultural safety in nursing care practice, recommending the embedding of cultural safety into nursing education and curricula and a focus on providing cultural guidelines for non-Indigenous nurses to assist them in providing culturally appropriate care to Indigenous people.

*Indigenous nursing students’ experiences*

If overt racism, or continuation of a whiteness culture of nursing is still observable when directed toward registered and enrolled nurses, the experiences of students also requires exploration. Table 2.3 summarises 11 studies conducted within the last decade that qualitatively explored the experience of Indigenous nursing students in Australia, New Zealand and Canada. While some of these studies were largely descriptive in nature (e.g. Best and Nielsen, 2005; Martin and Kipling, 2006), some (e.g. Mills et al., 2015) were focused on exploring student responses to strategies aimed at improving their experiences with university study. Although these studies were small qualitative studies, the findings from each of the studies are similar. Stuart and Nielsen’s (2011) findings indicated that more Indigenous nursing students are needed in the health workforce to provide culturally safe nursing care for Indigenous patients. Stuart and Gorman (2015) highlighted that although it is important to build an Indigenous nursing workforce, it is
important that they are first to succeed in their nursing studies, therefore support is needed to help them overcome the many barriers and challenges to attain successful study outcomes.

Some of the barriers that have impacted on the study progress of Indigenous nursing students, as highlighted by the literature are: experiences of racism, struggling financially, lack of childcare, lack of support and understanding from academic staff surrounding cultural issues, poor academic preparation to succeed in higher education and family and community responsibilities (Best and Nielsen, 2005; Martin and Kipling, 2006; Stuart and Gorman, 2015; Usher et al., 2005a). Enablers that improved study outcomes and successful results of Indigenous nursing students were: receiving strong academic and cultural support, success in building emotional intelligence through mentoring circles, cultural affirmation from nursing academics, connecting with other Indigenous nursing students, support from Indigenous nursing academic role models, good clinical nursing placement experiences and inclusion of Indigenous curricula (Meiklejohn, Wollin and Cadet-James, 2003; Mills et al., 2015; Simon, 2006; West, Geia and Power, 2013b; West et al., 2014; Wilson, McKinney and Rapata-Hanning, 2011).

**Challenges and opportunities in developing the next generation of Indigenous nurses**

A study by Meiklejohn, Wollin and Cadet-James (2003) examined strategies to recruit and retain Indigenous students in nursing programs. The method of supporting and retaining Indigenous nursing students to complete their studies was a combined effort by the university’s Indigenous studies unit and a key person in the school of nursing. Although some studies report that there are high success rates when Indigenous nursing academics are involved in the support of Indigenous nursing students (West, 2012), there is no mention by (Meiklejohn et al, 2003), that key personnel in the nursing department were, or should be, Indigenous nursing academics.

A PhD study by Indigenous nurse Roianne West used a mixed methods approach to investigate Indigenous Australian participation in pre-registration tertiary nursing courses (West, 2012). Department of Education, Workforce Relations and Higher Education statistics were collected and analysed, and interviews with participants were conducted,
which revealed the success stories of the Indigenous nursing students. Narratives revealed that students were motivated by the premise that they could make a difference, pride in their culture, healing connections, and having good cultural and academic support to complete their nursing studies, including support with resisting racism.

Recommendations from the study by West (2012) included appointing an Indigenous nursing academic in all SONMs to work in conjunction with Indigenous education units; provide better pathways for Indigenous students into university; provide student resilience training; develop critical nursing curricula that students could participate in and talk about their own experiences; and introduce cultural awareness training for all nursing academics. A final recommendation was to use the recommendations proposed to influence future nursing and midwifery policy (West, 2012).

West, Usher and Foster (2010) examined how the number of Australian Indigenous nurses in Australia’s nursing workforce could be substantially increased to contribute to closing the gap. Their paper highlighted effective strategies to provide support for Indigenous nursing students to enhance retention and completion rates. The report also placed emphasis on the success (determined by high enrolment numbers and completion rate) of Indigenous nurses from a specific Queensland university, which was attributed to the delivery of an accelerated nursing program, Indigenised nursing content, and two Indigenous nursing academics who were employed to provide tailored academic and culturally specific support for Indigenous nursing students. West, Usher and Foster (2010) recommended that Indigenous nurses be employed as academics in SONMs across Australia to teach Indigenous health, to act as support persons and role models for Indigenous nursing students, to instigate the inclusion of appropriate Indigenous content in nursing curricula and to facilitate Indigenous health research and support the adoption of critical Indigenist curricula. Implementing these changes was suggested as a means of actively progressing the growth of Indigenous nurses and helping to close the gap.
Table 2.3 Qualitative research studies exploring the challenges faced by Indigenous nursing students.

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<tr>
<th>Author, Year and Country</th>
<th>Aims of the Study</th>
<th>Research Design</th>
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<tr>
<td>Best and Nielsen (2005)</td>
<td>To explore the challenges of Indigenous nursing graduates and identify strategies they used to succeed.</td>
<td>Qualitative, descriptive.</td>
<td>Indigenous nursing graduates (n=50) who had undertaken university nursing education.</td>
<td>In-depth interviews (with a support person present), length of time determined by the participant.</td>
<td>Indigenous nursing students experienced challenges in the university environment, which included experiences of racism.</td>
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<td>Martin and Kipling (2006)</td>
<td>To identify factors that shape Aboriginal nursing experiences.</td>
<td>Qualitative, critical ethnography.</td>
<td>Volunteer Aboriginal nursing students were recruited from two schools of nursing (n=31): nurses (n=5), faculty (n=24) and key informants (n=16).</td>
<td>Five Aboriginal nurses were recruited to assist with issues in conducting research with Aboriginal people, face-to-face audiotaped interviews were used to collect data.</td>
<td>Timeframe for study completion was five years. Nursing students were financially challenged and unable to afford childcare, sometimes having to send their children back to their communities for care, causing further study stress.</td>
</tr>
<tr>
<td>Meiklejohn, Wollin and Cadet-James (2003)</td>
<td>To examine strategies to recruit and retain Indigenous nursing students in nursing programs.</td>
<td>Qualitative, descriptive.</td>
<td>Indigenous students (n=24) without traditional educational backgrounds were interviewed to evaluate the students’ ability to commence an undergraduate study.</td>
<td>Individual in-depth interviews with Indigenous nursing students over nine years from 1994-2003.</td>
<td>A key person in the SONM to support these students facilitated the successful completion of Indigenous nursing students in an undergraduate nursing degree.</td>
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<tr>
<td>Author, Year and Country</td>
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<td>Mills et al. (2015)</td>
<td>To measure and improve emotional intelligence of Indigenous nursing students, to assist them in having improved university experiences.</td>
<td>Qualitative, action research.</td>
<td>Australian Torres Strait Islander and Aboriginal nursing students (n=68), using artifacts.</td>
<td>Via video-conference team meetings, which developed a structure to conduct mentoring circle meetings.</td>
<td>Through mentoring circles, participants developed their emotional intelligence, which improved their university experience.</td>
</tr>
<tr>
<td>Simon (2006)</td>
<td>To address the question of what constitutes Māori nursing practice, and to develop an understanding and evaluate the influence of a Māori nursing program.</td>
<td>Qualitative, Kuapapa Māori Research (KMR).</td>
<td>Māori nurses (n=5) took part in the study, all graduates of a Māori nursing program.</td>
<td>Semi-structured in-depth interviews.</td>
<td>Māori can be characterised by five features, the promotion of cultural affirmation, access to Māori networks, adoption of Māori models of health, proactivity of Māori nurses and the validation of Māori nurses as effective health professionals.</td>
</tr>
<tr>
<td>Stuart and Gorman (2015)</td>
<td>To describe Indigenous health workers and their journeys in becoming registered nurses.</td>
<td>Qualitative, interpretive.</td>
<td>Indigenous health workers (n=5).</td>
<td>Semi-structured in-depth interviews.</td>
<td>There are a myriad of barriers and challenges experienced by Indigenous health workers that affect their progression in the nursing program.</td>
</tr>
<tr>
<td>Author, Year and Country</td>
<td>Aims of the Study</td>
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<tr>
<td>Stuart and Nielsen (2011) Australia</td>
<td>To explore how Aboriginal nurses are best suited to care for Aboriginal patients.</td>
<td>Qualitative, descriptive.</td>
<td>Two research projects, consisting of five Aboriginal participants each.</td>
<td>Semi-structured in-depth interviews.</td>
<td>Aboriginal nurses caring for Aboriginal patients is best practice, and an increase in the number of Aboriginal nurses and midwives is urgently needed.</td>
</tr>
<tr>
<td>Usher et al. (2005a) Australia</td>
<td>To identify the challenges Indigenous nurses face within their university nursing studies to inform strategies to address these challenges.</td>
<td>Mixed methods, survey.</td>
<td>Indigenous nursing students (n=22) enrolled in undergraduate degrees across Australia.</td>
<td>Demographic questionnaire and in-depth interviews.</td>
<td>Students are challenged by financial hardship, staff insensitivity to cultural issues, discrimination, lack of Indigenous mentors, poor study skills, lack of adequate educational preparation, lack of resources, and ongoing family commitments.</td>
</tr>
<tr>
<td>West, Geia and Power (2013) Australia</td>
<td>To determine current rates of enrolment, progression and completion of Indigenous nursing students in Australia, barriers to completion and strategies for success.</td>
<td>Quantitative, mixed methods.</td>
<td>Purposeful sample of 3rd year Indigenous nursing students (n=8) and academics (n=13).</td>
<td>Quantitative data were sourced from the DHESU, an annual study of higher education institutions. Qualitative data were collected via in-depth semi-structured interviews.</td>
<td>Completion rates between Indigenous and non-Indigenous students remain wide. Barriers to completion are constant, except for financial support. Success strategies included connecting with other Indigenous nurses and making the most of support.</td>
</tr>
<tr>
<td>Author, Year and Country</td>
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<tr>
<td>West et al. (2014) Australia</td>
<td>To determine staff perceptions of Indigenous nursing students’ completions - part of a larger study undertaken to explore the factors involved in Indigenous nursing students’ enrolment and completion.</td>
<td>Qualitative, 'Indigenist'. Part of a larger qualitative study.</td>
<td>Academic staff (n=15): female (n=13), male n=2), aged 32-60 yrs, sourced from universities in QLD (n=5) involved in supporting Indigenous nursing students.</td>
<td>Purposeful sampling, semi-structured in-depth interviews, including questions relating to staff perceptions.</td>
<td>Indigenous nursing academics are needed to graduate Indigenous nursing students. Partnerships need to be developed between SONMs and Indigenous education units. Cross-cultural awareness is needed in SONMs.</td>
</tr>
<tr>
<td>Wilson, McKinney and Rapata-Hanning (2011) New Zealand</td>
<td>To identify the obstacles that comprised the academic advancement of Indigenous nursing students.</td>
<td>Qualitative, mixed methods, cross-sectional surveys.</td>
<td>A purposive sample of respondents (n=108) from nursing schools (n=16) with Māori students enrolled.</td>
<td>Surveys with a self-report questionnaire distributed to Māori nursing students.</td>
<td>Indigenous nursing students’ academic advancements are assisted by Indigenous role models, mentors, clinical experiences, supportive learning environments and the inclusion of Indigenous curricula.</td>
</tr>
</tbody>
</table>
Research by Best and Nielsen (2005) investigated the experiences of Indigenous nursing graduates who had undertaken university nursing education. One participant in the study reported that her success was primarily due to the ongoing support provided by the Indigenous nursing academic employed within the department. All participants in the study collectively provided the opinion that the Indigenous nursing academic provided them with needed cultural and academic support, specific to the discipline of nursing, which was not available through the university’s Indigenous student support centre. The participants all reported that the level of cultural and academic support improved substantially when the Indigenous nursing academic commenced his/her appointment in the nursing department. Findings from this study reported many challenges associated with experiences of racism by Indigenous nursing students within higher educational facilities.

West et al. (2011) outlined a nursing education model ‘Tjirtamai’ – which translates into ‘to care for’. This rural and remote education nursing model was developed to increase the number of Indigenous nurses, used Indigenous nursing coordinators to support students, and sourced support from the local Indigenous community. The ‘Tjirtamai’ model was based on work and recommendations generated from the Indigenous nurse education working group (Goold et al., 2002), as well as more recent findings from West’s (2012) doctoral work.

Another Indigenous nursing support model ‘Helping Hands’ was featured in a paper by Best and Stuart (2014). This model describes an Aboriginal nurse-led model that provides a five-step approach to supporting Indigenous nursing students: Recruitment, Orientation, Retention, Graduation and a Resources kit. Like the ‘Tjirtamai’ model (West et al., 2011), these five steps are embedded within an Indigenised cultural framework. The ‘Helping Hands’ model was first initiated at one Queensland university, and between 2000 and 2012, this university successfully graduated 80 Indigenous nurses and midwives, the largest cohort of any university nationally (Best and Stuart, 2014). Both Indigenous nursing support models (‘Tjirtamai’ and ‘Helping Hands’) stress the importance of having Indigenous nursing academics to lead and implement these strategies.
Knowledge is power: the academic environment

This section of the literature of the review examines the literature pertaining to the difficulties encountered by female academics and Indigenous academics, and will be followed by the experiences of Indigenous university students. As shown in Table 2.4 and Table 2.5, the large majority of the research conducted is focused on the challenges experienced by female and Indigenous academics in the higher education sector, respectively. Most of the studies are small due to addressing minority groups in academia. Of note was that women were acknowledged as growing in number at a rate proportionately faster than Indigenous academics; however, both groups still struggle to achieve academic promotion. Table 2.6 shows a large body of work highlighting the experiences of Indigenous students within higher education.

Seven studies were identified that describe the experiences of female academics in higher education (see Table 2.4): four from Australia, and one each from New Zealand, South Africa and the United Kingdom. Studies by Baker (2010) and Thanacoody et al. (2006) used qualitative designs and comprised relatively large sample sizes (n=30 participants). Both revealed that, despite equal opportunity policies in place, male academics were perceived by the participants to have more opportunities to progress their academic careers than females, and gender prejudices were found to still exist. Roberts and Turnbull’s (2002) study specifically focused on nursing academia and found that males were overrepresented in the field of nursing academia.

Research by Poole, Nielsen and Skoien (1995) and Potts (2003) revealed similar findings to Caplan’s (1993) book, highlighting that the introduction of females into the world of academia was not easy, and faculty salaries tend to be lower for women than for men (p.23). Indigenous female scholar White (2001) laments that entry into academia is even more difficult for females of Indigenous heritage. Findings in studies by Schulze (2005) from South Africa, and Wright, Thompson and Channer (2007) from the United Kingdom, also emphasised the challenges that black female academics in higher education experience in making progress in their academic careers. Poole, Nielsen and Skoien (1995) wrote of the constraints and oppression of women academics in Australia with a focus on career pathways available. Findings revealed five major career pathway issues...
significant for women: career support, learning and the career, gender-based constraints, major regret, and career ambitions and motivations (Poole, Nielsen and Skoien, 1995, p. 34).

Baker (2010), Thanacoody et al. (2006) and Potts (2003) also revealed gender-biased issues within academia. Poole, Nielsen and Skoien’s (1995) study focused on senior level women academics, while Potts (2003) took a broader approach, focusing on life histories of five Australian female academics over the 20-year period from 1965-1985. Potts revealed that academic life for those five participants was often difficult. This was evidenced by the participants having to ‘teach large classes, work long hours, and cover many classes’ (Potts, 2003, p. 90). The literature revealed that women, in general, faced many challenges, including gender issues in academia, while Indigenous women experienced gender issues in addition to contending with racial discrimination (White, 2010).
### Table 2.4 Female academics’ experiences.

<table>
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<tr>
<th>Author, Year and Country</th>
<th>Aims of the Study</th>
<th>Research Design</th>
<th>Sample/Participants</th>
<th>Data Collection Method</th>
<th>Findings</th>
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<tr>
<td>Baker (2010) New Zealand</td>
<td>To investigate female confidence and expectation of academic promotion in relation to mentoring experiences, domestic life, division of labour, perceptions of promotions, commitment to profession and job satisfaction.</td>
<td>Qualitative, interpretive.</td>
<td>Academics from two universities (n=30): females (n=18) and males (n=12).</td>
<td>In-depth Individual interviews.</td>
<td>Being male is an advantage in advancing academic careers, due to reduced family responsibilities. Mentoring programs are beneficial for females to make academic progress. Female academics have increased confidence, although the gender gap still remains.</td>
</tr>
<tr>
<td>Poole, Nielsen and Skoien (1995) Australia</td>
<td>To investigate contextually the career paths of a group of senior female academics. To include major variables, and major external (e.g. social, cultural) factors that influence, restrict and create choices.</td>
<td>Qualitative, interpretive.</td>
<td>Australian senior managerial women (n=14) from one higher education institute.</td>
<td>In-depth interviews were carried out within a month timeframe, interviews ranged from 1 to 3 hours in duration.</td>
<td>Participants felt that it was harder for them to be successful than it was for a man. Lack of support for women was found, despite equity policies. Overall, every woman believed that the workplace needs to be more aware of lifestyle issues that influence women’s careers.</td>
</tr>
<tr>
<td>Author, Year and Country</td>
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<td>Potts (2003) Australia</td>
<td>To examine a group of female academics’ life histories over 20 years to determine whether their careers reflected the position of women academics generally.</td>
<td>Qualitative, narrative to obtain life histories.</td>
<td>Female academics (n=5) who worked during the period 1965-1985.</td>
<td>In-depth interviews to collect data, which were then collated into life histories.</td>
<td>Larger studies carried out within the same timeframe had parallel findings. Women in academia do not have it easy, and academic workloads are often larger than for male academics.</td>
</tr>
<tr>
<td>Roberts and Turnbull (2002) Australia</td>
<td>To determine if nursing academics were gaining more academic qualifications and ascending into the higher ranks of university.</td>
<td>Quantitative, mixed methods.</td>
<td>Consisted of information about nursing academics from across Australian universities.</td>
<td>Data was collected from university websites and databases.</td>
<td>There was a rise in qualifications, and a change in the disciplines in which nurse academics obtained their qualifications. Males were still over-represented in academia.</td>
</tr>
<tr>
<td>Schulze (2005) South Africa</td>
<td>To determine the levels of job satisfaction in black females in higher education.</td>
<td>Qualitative, phenomenology.</td>
<td>Black female academics (n=10).</td>
<td>Purposeful sampling was used and data was collected by semi-structured interviews.</td>
<td>Participants have a strong teaching orientation and need a supportive environment. Job satisfaction of black female academics could only be partially confirmed. Management needs to consider factors that influence satisfaction and dissatisfaction to improve the wellbeing of this group of academics.</td>
</tr>
<tr>
<td>Author, Year and Country</td>
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<tr>
<td>Thanacoody et al. (2006)</td>
<td>To investigate the career experiences of female academics in a western and an Indian cultural setting to gain an in-depth understanding of the factors contributing to their career progression.</td>
<td>Qualitative, case study.</td>
<td>Involved two universities in Australia and one in Mauritius. Female academics (n=30), from across all university hierarchical levels.</td>
<td>Interviews using 15 questions.</td>
<td>Despite equal opportunity, women academics still face significant barriers to career progression. Gender prejudices were found to exist. More senior women in Australian universities than in the Mauritian university.</td>
</tr>
<tr>
<td>Wright, Thompson and Channer (2007)</td>
<td>To examine the experience of black female academics in British universities.</td>
<td>Qualitative, descriptive narrative.</td>
<td>Black women academics (n=8) of African Caribbean origin, aged between 38-49 yrs.</td>
<td>One-to-one semi-structured interviews.</td>
<td>Black women in academia experience marginalisation and are highly scrutinised. Fanon’s ‘white mask’ in academia makes progress slow, and gender and race issues and being ‘othered’ result in slow progress for black female academics.</td>
</tr>
</tbody>
</table>
It is evident that it has been challenging for females, and especially Indigenous females, to enter and progress their professional careers in the academic world over a long period. In a study by White (2001) on women in the professoriate in Australia, it was noted that women in academia have not reached critical mass, despite the equity programs instituted over the last few decades. The varied difficulties and challenges experienced by senior female academics were previously cited in Poole, Nielsen and Skoien (1995). White (2001) argued that the trend was unlikely to change in the future. For example, there are already very few female professors, and when they do leave their positions it is perceived that this is because they have difficulty meeting the ‘benchmark men’ (2001, p. 70). Other difficulties women face are that they are generally targets of negative and covert discrimination, they often have dual family responsibilities, and they become dispirited and lack the energy needed to push onwards to senior academic levels (White, 2001).

Experiences of female academics

Caplan (1993) focused on the ongoing mistreatment of Canadian female academics and explored the status of women in academia, comparing their plight to ‘lifting a ton of feathers’. She interviewed hundreds of women in all areas of academia from 1990 to 1993; ‘women of colour, Indigenous women, immigrant women, older women, women with disabilities, lesbian and bisexual women, as well as some white, younger, native born, able-bodied and heterosexual women’ (Caplan, 1993, p. xiv). Caplan lamented that in her study, an ancient truth of male dominance emerged, where change was hard and slow, and those males who have the most power are unyielding and often reluctant to give up that control. This finding alone motivated her to devise a guide for women and their survival in the academic world because it was so hostile to their presence. The survival guide included tactics useful for navigating the maleness of the university environment, how to identify woman-positive institutions and advice on applying for tenure positions and promotions (1993, p. 23).

The studies included in Table 2.5 clearly identify that Indigenous academics, like Indigenous students, experience many barriers to success in the higher education
environment. The eight studies summarised in Table 2.5 were conducted in Australia (n=5), New Zealand (n=1), Canada (n=1) and the United States (n=1). Asmar and Page (2009), who interviewed a cohort of Indigenous Australian academics working in higher education, identified that racism from students and peers, teaching stress, workload, career satisfaction and identity contrasted markedly to the experiences of their non-Indigenous colleagues. Hassouneh and Lutz (2013) also highlighted the struggles of American black nursing academics in higher education and their challenges with racism. In a qualitative study by White (2010), findings showed that, in addition to racism and sexism (for Indigenous female academics), there was also ‘horizontal violence’ experienced from other Indigenous academic peers. In contrast, Mercier, Asmar and Page’s (2011) study of Māori academics found that the largest support for Māori academics in higher education were fellow Māori academics.

Studies by Bourque-Bearskin et al. (2016) and Jackson et al. (2013) highlighted that Indigenous nurses and academics use their cultural knowledge to improve patient and transformative educational outcomes for teaching Indigenous health. This assists them in honouring their Indigenous nursing knowledge. All studies highlighted the importance of growing more Indigenous nursing academics to improve the inequities experienced by Indigenous people worldwide.
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<tr>
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<tbody>
<tr>
<td>Asmar and Page (2009)</td>
<td>To draw on nation-wide research with Indigenous academics to further explore their experiences of university teaching, and the highs and lows of how they experience their roles.</td>
<td>Qualitative, 'Indigenist'.</td>
<td>Indigenous academics (n=23): female (n=12), males (n=11), ranging from associate lecturers to professors.</td>
<td>Structured open-ended interviews, which were analysed using the software package NVivo.</td>
<td>Indigenous academics’ sources of personal and professional satisfaction - as well as stress - appear qualitatively different from those commonly associated with academic work, eg. teaching stress, workload, satisfaction, career and identity.</td>
</tr>
<tr>
<td>Bourque-Bearskin et al. (2016)</td>
<td>To better understand Indigenous nursing experience in First Nations, Inuit and Metis communities. To honour Indigenous nursing knowledge.</td>
<td>Qualitative, 'Indigenist'.</td>
<td>Indigenous nurse scholars (n=4) and first author (n=1).</td>
<td>Participant observation, self-reflective writing, one-on-one conversations, and research circles of understanding.</td>
<td>Indigenous nurses drew on their inherited Indigenous knowledge to deliver nursing care to Indigenous people. Their identities as Indigenous persons was integral to their identities as nurses.</td>
</tr>
<tr>
<td>Hassouneh and Lutz (2013)</td>
<td>To explore the influence of racism on nursing faculty of color (FOC), identify</td>
<td>Qualitative, grounded</td>
<td>FOC (n=23) across all levels of hierarchy.</td>
<td>Collected over a 22 month period by in-depth interviews via telephone,</td>
<td>There is value in increasing diversity in nursing education. Despite the many</td>
</tr>
<tr>
<td>Author, Year and Country</td>
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<td>United States</td>
<td>strategies to support the recruitment and retention of nursing FOC, and explore the experiences of FOC in European schools of nursing.</td>
<td>theory/critical theory.</td>
<td>(n=15) and via face-to-face meetings in focus groups (n=8).</td>
<td>barriers and experiences of racism to FOC, they are still able to influence students, other FOC and their school’s cultures and communities.</td>
<td></td>
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<tr>
<td>Jackson et al. (2013)</td>
<td>To evaluate a transformative learning innovation workshop taught exclusively by Indigenous academics that delivered Indigenous health content to university students.</td>
<td>Mixed methods, transformative learning theory.</td>
<td>University students (n=30) who responded to the survey out of a cohort (n=56).</td>
<td>On-line survey featuring a mix of closed-answer and open-ended questions. Student emails and letters were also used as data.</td>
<td>The workshop day was described as a transformative and deeply meaningful educational event, and attendees felt better equipped to work in Indigenous health. The Indigenous teaching team reduced vulnerability, but re-enforced Indigenous authority.</td>
</tr>
<tr>
<td>Mercier et al. (2011)</td>
<td>To present a framework for which Māori, Indigenous and minority academics' work may be better understood in the university space. This study replicated a national study conducted in Australia.</td>
<td>Qualitative, ‘Indigeneist’.</td>
<td>Māori academics (n=12).</td>
<td>Interviews that were audio-recorded, and carried out by the Indigenous members of the research team.</td>
<td>The biggest support for Māori academics are Māori academics. Although the university is inclusive of Māori, there were emotional and physical costs to the participants interviewed.</td>
</tr>
<tr>
<td>Page and Asmar (2008a)</td>
<td>To expose the teaching iceberg (support of Indigenous students) that is experienced by Indigenous Australian universities (n=11) in states (n=7). Indigenous</td>
<td>Qualitative, ‘Indigeneist’.</td>
<td>Snowballing was used across universities and states, and semi-</td>
<td>Indigenous academic support roles are often just the tip of the iceberg, and the time they spend</td>
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<td>Author, Year and Country</td>
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<td>Australia</td>
<td>academics, but which is not acknowledged and is hidden within their academic workload.</td>
<td>Qualitative, interpretive.</td>
<td>Indigenous academics (n=23): females (n=12) and males (n=11).</td>
<td>Structured interviews were conducted.</td>
<td>supporting Indigenous students has been under-reported and is not visible, or recognised in academic workloads.</td>
</tr>
<tr>
<td>Page and Asmar (2008b)</td>
<td>To reconsider Indigenous teaching roles in 'mainstream' Australian universities.</td>
<td>Qualitative, interpretive.</td>
<td>Indigenous academics (n=23): females (n=12) and males (n=11), from associate lecturers to professors across universities (n=11).</td>
<td>Structured open-ended interviews, analysed using the software package NVivo.</td>
<td>Stress in relation to teaching resistant/racist students was an issue, as was workload, job satisfaction and the negative impact on their Indigenous identities. There was also the emotional labour of working with non-Indigenous staff who lacked cultural awareness skills.</td>
</tr>
<tr>
<td>White (2010)</td>
<td>To explore how university educated Indigenous Australian women negotiate their careers, education and</td>
<td>Qualitative, ethnographic.</td>
<td>Indigenous female graduates (n=11): Aboriginal (n=9) and Torres</td>
<td>Via in-depth interviews and focus groups.</td>
<td>Indigenous women face incredible pressure in the workplace. They informally deliver cultural awareness to colleagues on a regular</td>
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<td>Author, Year and Country</td>
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<td>leadership, in a post-colonial context.</td>
<td>Strait Islander (n=2).</td>
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<td>basis. Apart from racism and sexism there is ‘horizontal violence’ from other Indigenous people.</td>
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Indigenous academics and invisible workload

Within the higher education university structure, the role of the academic is generally as a lecturer, a researcher, or both. Historically, males make up the largest number of academics in universities in Australia and around the world. However, this proportion is slowly changing and more women and notably, but to a much lesser degree, Indigenous people in Australia, are entering a career in academia. While the presence and struggles of female academics in Australia is an ongoing phenomenon, the struggle for Indigenous female academics to remain and progress in academia is more recent, but equally challenging. Fredericks (2009) articulated her own knowledge using an auto-ethnography approach as a senior female Indigenous academic working at a series of Australian universities. Fredericks brings attention to academic roles within the wider university campus, which can insidiously overburden the workload of Indigenous academics. These include participation in equity committees, working parties and curriculum review panels, regardless of whether they have expressed interest or have skills and abilities in those areas. Fredericks further contends that Indigenous academics are often in competition with non-Indigenous academics for employment in Indigenous studies, and for Indigenous research grants focused on the welfare Indigenous people (Fredericks, 2009).

These findings are echoed in White’s (2010) auto-ethnography, which is positioned on Indigenous Australian women in leadership and the many challenges they face due to gender and post-colonial racist views. White justifies her use of auto-ethnography as she herself originates from a marginalised group; with these groups the individual’s lived experience is often the only account available. She discusses Indigenous women in contemporary society, oppression in Indigenous communities and Indigenous women in leadership. She also draws attention to the past models of leadership in Indigenous communities, where the wisdom of the Indigenous Elders and decision-making were executed according to an Elder’s role, age and skill. These conditions, which are not viable under white university governance, make it difficult for Indigenous academics to fulfill their traditional leadership roles, as well as their academic responsibilities.

Although there have been increases in recent years, the number of Indigenous academics in Australia is still less than satisfactory. Indigenous university staff comprised less than
one percent of Australian academic staff, yet Aboriginal and Torres Strait Islander peoples represent 2.5 per cent of Australia’s population (Larkin, 2012). This information demonstrated nil growth in Indigenous academic numbers in Australia’s higher education sector over a period of six years from 2006-2012, which should attract urgent attention. In 2006 there were fewer than 300 Indigenous academics across the entire sector, and of that group, only 37 were holding appointments above senior lecturer; while one in eight possessed a doctorate, compared with half of all academic staff in Australia (Indigenous Higher Education Advisory Committee, 2008). Larkin (2012) reported on the role of Indigenous staff in unlocking potential when addressing the National Tertiary Education Union Future of Higher Education Conference.

Page and Asmar (2008a) supported the notion that the presence of Indigenous academics working within universities promotes the retention of Indigenous students in higher education. They proposed that Indigenous academics are the most crucial link in facilitating successful outcomes for Indigenous students in higher education. They described many of the Indigenous academic positions advertised in Australian universities as being dual academic and student support roles. They labelled the Indigenous student support component of the position the ‘Indigenous Teaching Iceberg’ (p. 112). Their analogy was used to depict the many layers of support that Indigenous academics are expected to provide for Indigenous students, including social, cultural and financial support. They concluded that Indigenous academics often must meet the Indigenous community’s expectations, as well as the rigours of academia, which has frequently proved challenging (see Table 2.5).

Andersen, Bunda and Walter (2008) noted that most Indigenous academics in universities are located within Indigenous education units, which places Indigenous academics, staff and students as both separate and different to the wider university. This division has the potential to disadvantage Indigenous staff and students from progressing in their careers and studies and benefiting from the educational opportunities available to students in the wider university. Andersen, Bunda and Walter (2008) recommended that situating the Indigenous education centre within easy access points on the university campus, and within the university hierarchy, speaks volumes to Indigenous students as it confirms their
level of acceptance and belonging within the university, more than university mission statements or memoranda of understanding.

Asmar and Page (2009) focused on experiences surrounding the sources of satisfaction and the stress levels of Indigenous academics. Findings revealed that although the Indigenous academic participants mostly enjoyed their teaching workload, they experienced multiple conflicts with trying to manage their hidden workloads, their dilemmas with limited career progression opportunities, and their struggles in maintaining a strong Indigenous identity. They found elevated stress levels experienced by Indigenous academics were due to regular encounters from resistant and often racist mainstream students who they were required to teach, which was exacerbated by trying to protect Indigenous students from racist staff and students (see Table 2.5).

Asmar and Page's (2009) findings are congruent with Harlow's (2003) comments about 'emotional labour' that reported similar effects on African-American academics when they are required to teach students who are inherently racist. Harlow’s research focused on the emotional labour of the job and how professors’ racial and gender identities are affected by experiences of teaching predominantly white undergraduate students. Findings revealed that black male academics had difficulty with students, as they felt the students were always questioning their level of competency, while black female academics were challenged with both racial and gender dynamics. Academics who were female and/or black, lamented that they were expected to do more work, making their jobs more difficult than those of white male academics (Asmar and Page, 2009).

Indigenous university/high school students

This section of the literature review examines the experiences of Indigenous students in higher education and those that come into higher education from high school. Thirteen relevant studies were identified and are presented in Table 2.6. Most studies were conducted in Australian settings (n=12) with one study situated in New Zealand. The large majority of these studies used qualitative and mixed methods designs and comprised large sample groups. A study of Indigenous students by Chirgwin (2015), although a small qualitative study, produced rich data content about the burdensome barriers that
Indigenous post graduate students face, and how this impedes their study success and subsequent course completion. Rochecouste et al. (2016) examined elements important in making the higher education environment culturally safe for Indigenous students, while Hall et al. (2015) and Milne, Creedy and West (2016) placed considerable importance on building resilience in Indigenous students to assist them in safely navigating the higher education environment. Young et al.’s (2007) study clearly identified why some Indigenous students choose to leave the higher education system (see Table 2.6).

Larkin (2011) emphasised the importance of making the study environment racially inclusive for Indigenous students. He reported that there were 10,400 Aboriginal and Torres Strait Islanders in higher education, demonstrating that this group was underrepresented in Australia’s higher education sector as they only represented approximately 1.3% of students. The latest statistics published by the Australian Bureau of Statistics showed that in 2013, there had been little change, with Aboriginal and Torres Strait Islanders comprising just 1.4% of Australia’s domestic higher education students (ABS, 2013). Ideally, Indigenous university representation should be proportionate to the percentage of the Indigenous population in Australia; currently 3% (ABS, 2013). In 2017, Universities Australia released figures from 2015, stating that “there were 15, 585 Aboriginal and Torres Strait Islander students enrolled in universities”, and have set ambitious targets in their ‘Universities Australia Indigenous Strategy 2017-2020’ to continue this trend (Universities Australia, 2017, p. 25)

James, Bexley and Maxwell (2008) identified two main factors that contribute to the challenge of increasing the participation of Indigenous students in higher education: (1) a lack of preparation of Indigenous students in high school to attend university and (2) the <50% completion rate for Indigenous students who enrol in higher education. These factors underline the challenge that lies in the ability for Indigenous students to both enrol in higher education and complete their studies. These factors are also highlighted in the Universities Australia Indigenous Strategy for 2017-2020. This research validates that Indigenous academics are an important consideration in addressing these factors.

Willsteed et al. (2008) conceded that the ability for Aboriginal and Torres Strait Islander students to assimilate to western methods of teaching would, in turn, produce sustainable
retention and completion rates. In contrast, however, some Indigenous students may have strong Indigenous cultural backgrounds and identities, and attempts to assimilate these students into universities without any consideration of their cultural groundings could result in more harm than good. Nakata, Nakata and Chin (2008) emphasised the importance of having a strong approach to academic skills support, which would equip Indigenous students with the tools necessary for engaging with the content of the Western disciplines. Curtis et al. (2015) supported this notion, and noted that support for Indigenous students was multi-faceted and that they require culturally responsive teaching and learning approaches.

Hossain et al. (2008) conducted research into the needs and aspirations of potential and current Indigenous university students. Surveys and focus groups were conducted with 50 Indigenous senior high school students and 30 first-year Indigenous university students. Findings indicated that the students were not aware of university programs and support for Indigenous students attending university, although there was some variation. Some students said that if the course became too hard, they would pull out of university; which is congruent with findings of Bodkin-Andrews et al. (2012). One Indigenous student in the study articulated that they would feel more confident in telling their problems to an Indigenous academic and said, ‘because I know that they would understand me’ (Hossain et al., 2008, p. 13). This is evidence that the presence of Indigenous academics is vital to encourage the retention of Indigenous students. DiGregorio, Farrington and Page (2000, p. 302) described this phenomenon for Indigenous students as ‘newness to study, to each other and to their academic environment’. They further add that the presence and visibility of Indigenous academics within the university environment is paramount to the retention of Indigenous students. This is congruent with an overarching finding that institutional support from Indigenous nursing academics is needed to facilitate future successful completions of Indigenous nursing students (West, Foster and Usher, 2016).
Table 2.6 Studies involving Indigenous university/high school students.

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<thead>
<tr>
<th>Author, Year and Country</th>
<th>Aims of the Study</th>
<th>Research Design</th>
<th>Sample/Participants</th>
<th>Data Collection Method</th>
<th>Findings</th>
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<tr>
<td>Bodkin-Andrews et al. (2012) Australia</td>
<td>To test whether Aboriginality affected disengagement from schools.</td>
<td>Mixed methods, surveys</td>
<td>Four public high schools across rural and remote NSW. The sample was a total of (n=1,211) students with a mean age of 13.5 yrs.</td>
<td>The survey was administered in school halls under exam conditions. To control literacy levels, the survey was read aloud using a microphone. This process was repeated six months later with data from both sets of surveys analysed.</td>
<td>Indigenous Australians hold lower academic self-concepts, and may possess a higher tendency for academic disengagement when compared to their non-Indigenous peers.</td>
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<tr>
<td>Chirgwin (2015) Australia</td>
<td>To analyse how burdensome some barriers can be to Indigenous academic success.</td>
<td>Qualitative, case study.</td>
<td>Indigenous higher education students (n=3) enrolled in Masters, but who had to withdraw.</td>
<td>Two students participated in an initial questionnaire that involved specific questions. The third student completed questions using email surveys. The three students had follow-up telephone interviews.</td>
<td>Institutions that enroll Indigenous higher degree research students cannot ignore burdensome barriers to Indigenous academic success. More appropriate support strategies should be employed.</td>
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<td>Author, Year and Country</td>
<td>Aims of the Study</td>
<td>Research Design</td>
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<td>Curtis et al. (2015) New Zealand</td>
<td>To investigate the teaching and learning practices that help or hinder Indigenous student success in higher education health programs.</td>
<td>Qualitative, Kaupapa Māori Research (KMR)/critical incident technique.</td>
<td>Māori health students, (n=95): medicine (n=56), health sciences (n=21), nursing (n=13), and pharmacy (n=5). 38 accepted the invitation to participate.</td>
<td>Semi-structured face-to-face/telephone interviews. Critical incidents were identified and classified as either helping/hindering student success.</td>
<td>Academic success for Indigenous students requires multi-faceted, inclusive, culturally responsive and engaging teaching and learning approaches from educators and student support staff.</td>
</tr>
<tr>
<td>DiGregorio, Farrington and Page (2000) Australia</td>
<td>To research the motivations of Indigenous students to enroll in higher education and find out their definition of academic success, and their challenges in the school.</td>
<td>Qualitative, using an Aboriginal researcher on the team.</td>
<td>Indigenous students, female and male (n=12) enrolled in a Diploma of Health Sciences course at an urban university.</td>
<td>Intensive, semi-structured interviews were undertaken each time students returned to campus for block instruction.</td>
<td>It is important to have Indigenous academics present within the university environment. Student’s motivations to enroll in university study include obligations to their community.</td>
</tr>
<tr>
<td>Hall et al. (2015) Australia</td>
<td>To explore how a program designed for Indigenous students goes beyond academic skills and helps students build resilience and knowledge about how they can be successful in higher education.</td>
<td>Qualitative, narrative.</td>
<td>Indigenous students (n=18) told their stories. This is a sample size of 40% of the 45 Preparation for Tertiary Success (PTS) graduates.</td>
<td>Semi-structured interviews were undertaken with each student six months after completing their PTS course. Each story went back to the student to make changes if needed.</td>
<td>The stories of the students show that resilience is a multifaceted construct, and that they built their resilience from Indigenous people that have come before them and drawing on Indigenous knowledge systems.</td>
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<tr>
<td>Author, Year and Country</td>
<td>Aims of the Study</td>
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<td>Hossain et al. (2008)</td>
<td>To identify the needs and aspirations of Indigenous university students.</td>
<td>Mixed methods, surveys.</td>
<td>Indigenous students (n=50) in years 10-12 from high schools (n=5) including 1st year Indigenous university students (n=30).</td>
<td>Surveys and focus groups.</td>
<td>Students were not aware of university programs and support for Indigenous students attending university. Students would feel more comfortable telling their problems to an Indigenous academic.</td>
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<td>Milne, Creedy and West (2016)</td>
<td>To evaluate interventions to improve Indigenous student success and resilience.</td>
<td>A systematic review involving a reframed standpoint theory (RST) perspective.</td>
<td>16 research studies met the inclusion criteria of peer reviewed research articles from scholarly journals.</td>
<td>Multiple databases were searched between October 2014 and January 2015. Filters were applied to narrow down the search. Results are presented per RST.</td>
<td>There was a gap in current research evaluating strategies to improve Indigenous student success and resilience, and that multi-layered support was crucial for Indigenous student success.</td>
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<tr>
<td>Pechenkina, Kowal and Paradies (2011)</td>
<td>To conduct research surrounding Indigenous students’ participation in higher education, exploring the role of the university.</td>
<td>Qualitative, mixed methods.</td>
<td>Indigenous student participation across Australian universities.</td>
<td>Data was accessed from DEEWR and university websites. Data were collated and analysed.</td>
<td>Dual system exists in Australian universities: one group excelled at attracting Indigenous students; other group excelled in completion rates. Indigenous students who have completed school studies are well prepared to complete university studies.</td>
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<td>Author, Year and Country</td>
<td>Aims of the Study</td>
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<td>Rigby et al. (2011)</td>
<td>To identify helpful strategies to prepare, empower and retain Indigenous nursing students. To inform academics about how to improve support and provide culturally safe learning environments.</td>
<td>Qualitative, action research framework.</td>
<td>Four groups of Indigenous nursing students: 1st year, 2nd year, 2nd/3rd year and 3rd year.</td>
<td>Four focus group discussion sessions were held during the final residential school in the course. The sessions were not taped – written notes were taken.</td>
<td>High importance needs to be afforded to ensure the cultural safety of Indigenous nursing students in the higher education sector.</td>
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<tr>
<td>Rochecouste et al. (2016)</td>
<td>To examine which factors can be improved upon in both teaching and support capacities for Indigenous students in higher education answering the question, what should universities do?</td>
<td>Qualitative, case study.</td>
<td>Those working/involved with or in Aboriginal centres. Participants (n=25) were both Indigenous and non-Indigenous, female and male.</td>
<td>Interviews by the lead author, with findings developed into case studies.</td>
<td>Best practice extends past teaching and learning, and applies more broadly, including policy-making and future directions.</td>
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<tr>
<td>Sharrock and Lockyer (2008)</td>
<td>To focus on Indigenous student retention and attrition. To find out if block visits retain Indigenous students at risk of discontinuing their studies.</td>
<td>Mixed methods, cross-sectional surveys.</td>
<td>Indigenous Australian university students who attended block visits (n=80); 95% response rate.</td>
<td>80 surveys with 23 questions.</td>
<td>Block visits were effective in retaining Indigenous students, due to students having one-on-one and face-to-face support.</td>
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<tr>
<td>Author, Year and Country</td>
<td>Aims of the Study</td>
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<tr>
<td>West, Foster and Usher (2016) Australia</td>
<td>To describe Indigenous nursing students’ experiences of enablers for successful course completion and to develop a narrative of student experiences.</td>
<td>Qualitative, mixed methods, concurrent Indigenist transformative.</td>
<td>Indigenous nursing students across four nursing schools that were in their final year of study (n=8).</td>
<td>Analysis of government statistical data on retention, progression and completions. Purposeful sampling was used and participants undertook semi-structured interviews using the Dadirri approach.</td>
<td>Key findings included six threads of experience, key success factors, and highlighted the need for institutional support from Indigenous nursing academics to facilitate successful completions.</td>
</tr>
<tr>
<td>Young et al. (2007) Australia</td>
<td>To address the retention rates of Indigenous students enrolled in health science courses at a regional university by investigating the reason for their attrition.</td>
<td>Qualitative, interpretive.</td>
<td>Indigenous students (n=33) who had been, or were currently enrolled in health science courses between the years 2000 and 2005.</td>
<td>Telephone interviews were conducted.</td>
<td>Findings revealed some students left because the career was not right for them; others because they were in a vulnerable group, studying externally, older, or experienced change. There was positive feedback about scholarships and flexible study modes.</td>
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</table>
Pechenkina, Kowal and Paradies (2011) conducted research on Indigenous students’ participation in higher education, exploring the role of the university. The methodology used collected two sets of data, online statistics from the Department of Education, Employment and Workplace Relations (DEEWR) web site, and information directly available on university websites (Pechenkina, Kowal and Paradies, 2011). Analysis of both sources indicated that large commencement numbers of Indigenous students were present where there were high numbers of Indigenous staff employed; however, this did not necessarily translate into high completions. The key finding for this study was that Indigenous students who had completed school studies were well prepared to complete university studies.

A study by DiGregorio, Farrington and Page (2000) focused on what motivates Indigenous students, their definition of success, and their challenges in education. This study revealed findings comparable to Hossain et al. (2008), highlighting financial, cultural and academic challenges. However, one of the major findings of this study was that students were not aware of the supports available to them which, had they known about them, may have alleviated some challenges (Hossain et al., 2008). A commonality between the studies by DiGregorio, Farrington and Page (2000) and Hossain et al. (2008) was that both cohorts of Indigenous students voiced the importance of having Indigenous academics and professional staff employed by Universities to provide them with cultural and academic support. This need for employing Indigenous academics and professional staff concurred with the findings of Sharrock and Lockyer (2008) on the retention and attrition rates of Indigenous students at an Australian university, which found that one-to-one and face-to-face student support was superior to other forms of student support when building trust and rapport between staff and students.

Rather than focusing solely on building strong student supports, Nakata, Nakata and Chin’s (2008) study stressed the importance of Indigenous students building a stronger academic skill base. This study also encouraged the strengthening of students’ ability to engage with the content of western disciples to facilitate their study success. This approach is not commonly mentioned in the other studies, although Pechenkina, Kowal and Paradies (2011) recommended ensuring that Indigenous students are well-prepared
academically in high school to support their transition into university and their university candidature.

**Nursing in the academic environment**

This review examines the literature pertaining to nursing in the academic environment, the importance of cultural safety, and the role and achievements of CATSINaM in supporting and promoting the advancement of Indigenous nursing and midwifery. The supporting literature in this review is summarised in Table 2.7 and Table 2.8.

Table 2.7 focuses on cultural safety and the six studies presented were from Australia (n=5) and the United States (n=1). Three studies used a qualitative research approach and the remaining three used a mixed methods approach. Participant samples for the six studies were moderate to large in size and revealed rich data. Josipovic (1999) found that culturally and linguistically diverse (CALD) nurses had an advantage over mainstream nurses when it came to providing nursing care in a culturally safe way, due to their innate understanding of culture. This was the only study that focused on CALD nurses, specially. Weaver (1999) focused on Native American social workers, and highlighted the importance of having cultural competence, adding that decolonisation of the thought processes of social workers is beneficial for promoting culturally safe communication with Native American clients.
Table 2.7 The importance of cultural safety.

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<tr>
<th>Author, Year and Country</th>
<th>Aims of the Study</th>
<th>Research Design</th>
<th>Sample/Participants</th>
<th>Data Collection Method</th>
<th>Findings</th>
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<tr>
<td>Downing and Kowal (2011) Australia</td>
<td>To investigate how registered nurses saw the role of Indigenous cultural training, and the impact that this training had on their practice.</td>
<td>Qualitative, interpretive.</td>
<td>Female registered nurses (n=6).</td>
<td>In-depth interviews with nursing staff.</td>
<td>If cultural training is to have a meaningful impact in healthcare, it needs to be situated in a systematic framework of health service provision. It must be supported by policies and structural change in the health sector. Indigenous cultural training is commonly placed on the shoulders of health workers, purely because they have received cultural training.</td>
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<tr>
<td>Johnstone and Kanitsaki (2007) Australia</td>
<td>To explore and describe what is known and understood about the notion of cultural safety and its possible application to and in Australian healthcare domains.</td>
<td>Qualitative, naturalistic inquiry.</td>
<td>Staff working within an Australian healthcare context (n=145).</td>
<td>Individual and focus group interviews. Interviews were semi-structured and guided using open-ended questions. The length of each interview ranged from 45 to 90 minutes.</td>
<td>The notion of cultural safety is conceptually problematic, poorly understood, and under-researched and, unless substantially revised, cannot be meaningfully applied to the cultural context of Australia.</td>
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<td>Author, Year and Country</td>
<td>Aims of the Study</td>
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<td>Josipovic (1999)</td>
<td>To look at the skills, experience and qualifications of nurses from culturally and linguistically diverse (CALD) backgrounds, and use this knowledge in nursing curricula to meet the challenges of caring for culturally diverse patients.</td>
<td>Mixed methods, surveys, descriptive ethnographic.</td>
<td>Educational institutions (n=5) and 150 questionnaires to nurses with a response rate of a total of 49. Interviews conducted with 16 CALD nurses.</td>
<td>Questionnaires developed from themes explored in the literature review. From these questionnaires, there were in-depth interviews. Field notes were also collected.</td>
<td>CALD nurses show that practice is in-tune with meeting the cultural needs of their clients from the countries where they have practised. This means that they are a fountain of cultural nursing knowledge, and they are a useful resource in understanding the needs of multicultural patients.</td>
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<tr>
<td>Omeri et al. (2003)</td>
<td>To undertake a systematic review, to explore ways that challenges associated with cultural diversity in the academic setting can be met.</td>
<td>Mixed methods, systematic review.</td>
<td>34 studies were found to be appropriate: from Australia (n=22), North America (n=7), the UK (n=3) and Australia and Singapore (n=1). There was input from authors with experience working with CALD students in higher education.</td>
<td>Computer searches, hand searches of selected journals, reference lists, other available resource lists and personal experiences of contributing authors. Knowledge data was collected from authors.</td>
<td>Areas in need of improvement are educational strategies, both in planning and delivery, student support, staff education and support.</td>
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<tr>
<td>Author, Year and Country</td>
<td>Aims of the Study</td>
<td>Research Design</td>
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<td>Rochecouste, Oliver and Bennell (2014) Australia</td>
<td>Examination of the cultural safety offered to Australian Aboriginal and Torres Strait Islander students within their university environments, including measures to address racism.</td>
<td>Mixed methods, surveys, case study.</td>
<td>Aboriginal students (n=56) of whom (n=5) attended a focus group, and both Aboriginal and non-Aboriginal staff members of Aboriginal centres (n=25). Students (n=96) also responded to a national on-line survey.</td>
<td>Interviews developed into case studies, focus groups, and on-line surveys.</td>
<td>Findings support previous research that cultural safety is an issue that needs to be brought to the attention of governing bodies within the higher education sector.</td>
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<tr>
<td>Weaver (1999) United States</td>
<td>To help in defining cultural competence services for Indigenous people, and for these services to then be incorporated into the social work profession.</td>
<td>Mixed methods, surveys.</td>
<td>A national sample of Native American social workers (n=62).</td>
<td>Snowballing was used to identify participants. Batches of surveys were then sent to these participants to collect data. Three questions were used in the surveys.</td>
<td>Findings show clear data for social worker practice needed when working with Native Americans. They must, understand diversity, know the history and culture, have good listening skills, be aware of their own biases, have a willingness to learn, be respectful and non-judgmental, value social justice and be prepared to decolonise their own thought processes.</td>
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The Australian studies by Downing and Kowal (2011), Johnstone and Kanitsaki (2007), Omeri et al. (2003) and Rochecouste, Oliver and Bennell (2014) concentrated on making changes in cultural training programs at an institutional level. Downing and Kowal (2011) suggested the use of systematic frameworks to support cultural training to encourage structural change and to remove the burden of responsibility for training staff away from health workers, who were used because they had this learned knowledge. Johnstone and Kanitsaki (2007) argued that the notion of ‘cultural safety,’ which is so successful in the New Zealand context, is poorly understood in the Australian context. This identified need for more education is supported by Rochecouste, Oliver and Bennell (2014), who implored that cultural safety needs to be initiated by governing bodies within our higher education sector. Omeri et al. (2003) conducted a large systematic review on cultural diversity in the academic setting, with findings that concurred with Johnstone and Kanitsaki (2007) and Rochecouste, Oliver and Bennell (2014): improvements in navigating cultural issues in higher education could be improved with better educational strategies, both in the planning and delivery stages for student support and staff training.

The importance of cultural safety

The first step in improving the health of Aboriginal and Torres Strait Islander people is to embed cultural safety into health care practice. Cultural Safety was defined in 1992 by the Nursing Council of New Zealand as: ‘The effective nursing of a person/family from another culture by a nurse who has undertaken a process of reflection on their own cultural identity and recognises the impact of the nurses’ culture on owning nursing practice’ (Papps and Ramsden, 1996, p. 491). In 1992 the Nursing Council of New Zealand made ‘cultural safety’ a mandatory inclusion in the educational preparation of nurses and midwives (Papps and Ramsden, 1996). Several Australian Indigenous nurses have publicly emphasised the importance of implementing culturally safe practices in nursing and midwifery, and increasing the Indigenous nursing workforce, as a strategy to address Indigenous health outcomes. For example, Indigenous nurse Best (in Shave, 2010, p. 9) argued that, ‘Indigenous nurses and midwives are the preferred medical experts for many Aboriginal and Torres Strait Islander patients, because of their ability to
provide accessible and culturally safe health care’. Cultural safety has been strongly supported in research conducted by Indigenous (Māori) nurse leader and cultural safety trailblazer Irihapeti Ramsden (2002), whose doctoral thesis has been used as the foundation of cultural safety practices in the delivery of healthcare in both New Zealand and Australia. Ramsden’s (2002) recommendations included: ‘that a nurse caring for and engaging in discourse with a patient must first understand their own culture, beliefs and attitudes and power differentials in the situation to ensure that they do not impose these on the patient for whom they are providing care’. Ramsden added the recommendation that nurses should undertake a process of decolonisation to ensure that they do not diminish, demean or disempower others through their actions.

Blackman (2009) challenged Australian nurses to apply cultural safety in the Australian context. She extended Ramsden’s idea of cultural safety, highlighting the need for nurses to be ready and willing to practice in a culturally safe way; to listen and communicate in a culturally appropriate way; to gain local knowledge of Aboriginal health systems; and to work towards acceptance from the local Aboriginal community. Blackman’s (2009) study reported issues that Indigenous students encounter with racism and the many challenges they have navigating cultural safety issues between Indigenous and non-Indigenous perspectives.

McMurray and Param (2008) underlined the importance of tailoring culturally safe care to specific traditional beliefs and cultural norms, given the multitude of Indigenous cultures in Australia. Having insight into these beliefs and norms is essential to working in partnership with Indigenous clients, which is the key to promoting empowerment and self-determination in their health care decisions (McMurray and Param, 2008). Canadian scholars agree, commenting on similar inequities generated by colonial, economic and political agendas in that country (Gerlach, 2012; Stout and Downey, 2006). These social and political factors require acknowledgement and they need to be addressed before real progress can be made in Indigenous health. Healthcare workers need to understand that culturally safe practice includes recognising and respecting that Indigenous people know how to care for themselves, and have their own ways of surviving against adversity (Stout and Downey, 2006).
Pon (2009) cautions against some of the rhetoric of culturally appropriate healthcare, especially the notion of cultural competency. When constructed from a ‘whiteness’ perspective, this can endorse racial and stereotypical views of cultural groups, thereby reinforcing power differentials, further exclusion and ‘othering’ of those who are different by justification of the normal state of colonial power. Pon (2009) extends Ramsden’s recommendation on health professionals needing to undertake decolonisation to become more understanding of how the past informs healthcare practice.

Lowe and Archibald (2009) focused their work on the cultural diversity of nursing academics in the United States (US) workforce. An aim of workforce strategies was to grow personnel numbers, but progress has been slow. The authors highlighted the need to employ nurses from diverse cultural backgrounds, representative of their community’s composition. Their recommendation responded to societal expectations that nurses should be culturally competent, despite the difficulties of meeting the needs of the cultural composition of the US population. This is further reiterated by Taylor, Kickett and Jones (2014) and in the National Aboriginal and Torres Strait Islander Health Plan 2013-2023. (Australian Department of Health, 2013, pp 14-16), who highlight the importance of health professionals being both clinically as well as culturally competent to genuinely advance Indigenous client health outcomes.

The following publications provide a timeline of Indigenous nursing and midwifery progress that has been made since the establishment of the Congress for Aboriginal and Torres Strait Islander Nurses (CATSIN) in 1997, and then following on from CATSINaM in 2013.
Table 2.8 Timeline – Congress of Aboriginal and Torres Strait Islander Nurses, Congress of Aboriginal and Torres Strait Islander Nurses and Midwives, and Indigenous nursing and midwifery advancements.

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<tr>
<th>Year</th>
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<td>2000</td>
<td>RCNA (2000). Position Statement, <em>Nursing Education for Aboriginal and Torres Strait Islander Peoples.</em></td>
<td>Position Statement - Strategy set out by the Royal College of Nursing Australia (RCNA) to recruit Aboriginal and Torres Strait Islander people into nursing careers to provide a valuable resource for the nursing profession. (Revised 2003)</td>
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<td>2001</td>
<td>Goold (2001). <em>Can We Meet the Challenge of Caring for the Australian Indigenous Person?</em></td>
<td>Journal/keynote address by Sally Goold - This work was the catalyst that signaled the start of including Indigenous history/culture/health and cultural safety into nursing education, and suggested recommendations for how to care for Indigenous people.</td>
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<td>2002</td>
<td>Goold et al. (2002). <em>Getting em n keeping em.</em></td>
<td>Report - The Indigenous Nursing Education Working Group (INEWG) undertook a research project with 30 schools of nursing and midwifery (SONMs), and made recommendations to the government about how to build a strong Indigenous nursing and midwifery workforce. There were 28 recommendations, which included recommendations for curriculum development and implementation, where Indigenous, history/culture and health was to be embedded across all nursing and midwifery curricula.</td>
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<tr>
<td>2004</td>
<td>Goold (2004). <em>Sally Champions Aboriginal Nurses.</em></td>
<td>Newspaper Article - Sally Goold highlights that, due to the move from hospital nursing training to university nursing training, Indigenous nursing numbers have declined. Sally advocated for making Indigenous health a part of every nurse’s university training.</td>
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<td>2005</td>
<td>Goold and Liddle (2005).</td>
<td>Book - <em>In Our Own Right: Black Australian Nurses’ Stories</em> highlights the personal and professional stories of Aboriginal and Torres Strait Islander nurses. The strength and determination of these Indigenous nurses’ stories are an inspiration for all Indigenous nurses today.</td>
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<td>2006</td>
<td>RCNA and ANF (2006). Joint Position Statement, <em>Indigenous Australian People and Nursing Education.</em></td>
<td>Joint Position Statement – In 2006 a joint position statement was prepared by the Australian Nursing Federation (ANF) and the RCNA. This was in response to supporting CATSIN’s position, to educate non-Indigenous people, within a historical framework to understand the appalling</td>
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*In 1997 the Congress of Aboriginal and Torres Strait Islander Nurses (CATSIN) was established.*
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<td></td>
<td>Queensland Health (2007a). Aboriginal and Torres Strait Islander Nursing and Midwifery Position Paper (2007 – 2010).</td>
<td>Strategic Policy - The Queensland (QLD) Health documents of 2007 signaled the beginning of Indigenous nursing progress in QLD. The first position of its kind an ‘Indigenous Nurse Advisor’ (INA) to the Office of the Chief Nursing Officer (OCNO) commenced, and concluded in 2013. Between 2007 and 2013 there was a significant impact in the progress of Indigenous Nursing advancements in QLD due to this position. The INA developed an Indigenous nursing profile on the QLD Think Nursing website, featuring Cathy Freeman, who reached out to Indigenous people interested in a career in nursing and midwifery. The INA also established an Indigenous Nursing Director position in Northern QLD (Townsville). During this period, record numbers of Indigenous nursing and midwifery students graduated due to their success in completing QLD Health cadetships.</td>
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<td>2007</td>
<td>ANMC (2007). Inclusion of Aboriginal and Torres Strait Islander people’s health and cultural issues in courses leading to registration or enrolment.</td>
<td>Policy – This was the first time that a recommendation had been made from the Australian Nursing and Midwifery Council (ANMC) to SONMs across Australia to include Indigenous content in their nursing and midwifery curriculum to prepare their graduates for working with Aboriginal and Torres Strait Islander people.</td>
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<td>2012</td>
<td>ANMAC (2012). <a href="http://www.anmac.org.au/">http://www.anmac.org.au/</a></td>
<td>Policy - The Australian Nursing and Midwifery Accreditation Council (ANMAC) set benchmarks for SONMs to meet accreditation standards that require them to embed Aboriginal and Torres Strait Islander knowledge and perspectives in their nursing and midwifery curriculum. This move has made curriculum more culturally inclusive for Indigenous nursing academic staff and students.</td>
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<td>2013</td>
<td>CATSIN (2013). Position Paper: Towards a shared understanding of terms and concepts: strengthening nursing and</td>
<td>Position Paper – The CATSIN position paper (June 2013) highlighted guidelines, terms and concepts that need to be collectively used by nurses and midwives in relation to Aboriginal and Torres Strait Islander peoples and health. The paper also includes reference to the Nursing and</td>
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<td><em>midwifery care of Aboriginal and Torres Strait Islander peoples.</em></td>
<td>Midwifery Board of Australia (NMBA), and highlights the importance of referring to the historical context of Australia’s colonial past, which has impacted negatively on the health outcomes of Indigenous Australians today.</td>
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<td><strong>In 2013 CATSIN was re-named to include Indigenous midwives, becoming the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM).</strong></td>
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<td>2013</td>
<td>CATSINaM (2013). <em>Strategic Directions (2013-2018) - Unity and Strength Through Caring.</em></td>
<td>Strategic Policy - Strategic Directions 2013-2018 provided a comprehensive framework for CATSINaM to continue to progress. Progress is to be achieved through the development of four strategic directions: elevating the CATSINaM profile, advocating for Aboriginal and Torres Strait Islander nurses and midwives, improving the recruitment/retention of Aboriginal and Torres Strait Islander nurses and midwives, and developing innovative projects that are specifically aligned with CATSINaM’s strategic vision, purpose and core values.</td>
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<td>2013</td>
<td>Queensland Health (2013). <em>Strengthening health services through optimising nursing strategy and action plan (2013-2016).</em></td>
<td>Strategic Policy - This nursing strategy and action plan was led by the QLD Health Chief Nursing and Midwifery Office. Aboriginal and Torres Strait Islander clients are not listed specifically, but are included in a group with high health needs and rural and remote clients. The document does not refer to previous achievements in Indigenous nursing and midwifery workforce goals or strategies, nor does it provide a rationale for discontinuing these. The impact of this lack of focus on Indigenous health/health workforce as a priority area may over the next few years increase the over-burdening of health issues on the Indigenous population.</td>
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<td>2014</td>
<td>ACN (2014). <em>ACN Nursing Oration: Professor West calls for Indigenous health to be a national priority at the ACN.</em></td>
<td>Oration - The Australian College of Nursing (ACN) oration delivered by Professor Roianne West titled ‘Rising to the challenge of our time: better health and wellbeing for our Nation’s First People’ focused on a call to action for the nursing profession to commit to Indigenous health as a national priority. This speech was a significant event and positioned CATSINaM to influence the actions of the ANMAC. Through this speech, CATSINaM also lobbied for the NMBA to set specific reference to Aboriginal and Torres Strait Islander people (as the Australian College of Midwives had done) and not have them integrated within broader cultural groups.</td>
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<td>2014</td>
<td>Best and Fredericks (2014). <em>Yatdjuligin: Aboriginal and Torres Strait Islander Nursing and Midwifery Care.</em></td>
<td>Textbook - This Aboriginal and Torres Strait Islander nursing and midwifery care textbook was an outcome of the QLD Health Indigenous Nurse Advisor position (2007-2013). The textbook is one of the first of its kind published in Australia and is written solely from an Indigenous perspective.</td>
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<td>2014/2015</td>
<td>Mohamed (2014). <em>Janine Mohamed on the 2,212 Indigenous nurses and midwives in Australia.</em> Mohamed (2015). <em>Campaign for more nurses, midwives.</em></td>
<td>Newspaper Articles - Janine Mohamed, CEO of CATSINaM, made two consecutive calls for Indigenous nurses and midwives almost four decades after the first call. Mohamed provides current statistics of Indigenous nurses and midwives in Australia, which indicate that there is more work to be done to increase the number of Indigenous nurses and midwives in Australia’s healthcare workforce.</td>
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<td>2015</td>
<td>Alford (2015). <em>A cost effective approach to closing the gap in health, education and employment: investing in Aboriginal and Torres Strait Islander nursing education, training and employment.</em></td>
<td>Report - This report is positioned from an economic approach to closing the gap in health, education and employment. A major finding of the report is that there is an insufficient number of Indigenous nurses and midwives. Also, the report indicates that the cost of delivering healthcare will escalate if funds are not invested in developing an Indigenous nursing workforce. Alford’s recommendations are aligned with the <em>Closing the Gap</em> campaign, and propose developing Indigenous nursing academic positions in SONMs.</td>
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<td>2015</td>
<td>Power et al. (2015). ‘Indigenous leadership in nursing: Speaking life into each other’s spirits’.</td>
<td>Book Chapter - Indigenous nursing leadership in a mainstream nursing leadership textbook. This book chapter is written by Indigenous nursing academics who attained doctoral qualifications. The chapter highlights that Indigenous leadership is different; Indigenous knowledge about leadership has been handed down by Indigenous Elders, who are respected Indigenous scholars. Previously, these issues were written about by non-Indigenous researchers, now Indigenous nursing academics are leading this area.</td>
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<td>2016</td>
<td>CATSINaM (2016) - Position Paper: <em>Uniqueness of our workforce.</em></td>
<td>Position Paper - Strong Cultural Identity: Indigenous nurses identify with their cultural heritage before their nursing identities, and their cultural stance means they have cultural obligations and commitments to community. This brings the understanding to the wider Australian community that Indigenous nurses and midwives are unique in Australia’s health care workforce.</td>
</tr>
<tr>
<td>2016</td>
<td>The Redfern Statement (2016). An urgent call for a more just approach to Aboriginal and Torres Strait Islander Affairs, of which</td>
<td>Statement – The statement, written by Aboriginal and Torres Strait Islander peak representative organisations, sends an urgent call to the government for a more just approach to Aboriginal and Torres Strait Islander affairs. Most of the representative bodies are Aboriginal and Torres Strait</td>
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<td>there is a strong focus on Indigenous health. Islander health organisations, including CATSINaM. The Redfern statement has now been included in the 2017 <em>Closing the Gap Progress and Priorities Report.</em></td>
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Issues identified by CATSIN/CATSINaM regarding preparing Indigenous nurses for addressing Indigenous health in Australia and Queensland

The CATSIN Indigenous nursing body was formed in 1997, and led by executive director Dr Sally Goold, OAM from 1997-2012. CATSIN was formed by Indigenous nurse ‘trail-blazers’ who had a vision and who continue to serve as inspiration and strong role-models for Indigenous nurses today. CATSIN was renamed as CATSINaM in 2013 to include Indigenous midwives (CATSINaM, 2013). CATSIN/CATSINaM has been the major catalyst in progressing and influencing policy change regarding the inclusion of Indigenous nursing issues (Goold, 2004). Today, CATSINaM’s primary function remains implementing strategies to facilitate increases in the number of Indigenous nurses and midwives in Australia’s nursing workforce.

CATSINaM has made significant progress in advancing Indigenous nursing issues in recent years and has produced a series of documents to support Indigenous nursing and midwifery professionals. These resources have been generated from the Nursing Education Working Group Report Gettin em n keepin em by Goold et al. (2002), and the book detailing stories of Indigenous nurses In Our Own Right written by Goold and Liddle (2005). ‘In Our Own Right’ highlights the lived experiences and stories of some of Australia’s key Indigenous nurse leaders, including Goold, who spoke of her love for nursing, but also the many tears that were shed due to unreasonable superiors and difficult, racist patients.

One of the greatest milestones for CATSIN came in 2006, when the Australian Nursing Federation (ANF) and the Royal College of Nursing Association (RCNA), issued a joint position statement. This position statement ‘Indigenous Australian People and Nursing Education’ (2006) endorsed the 28 recommendations generated from ‘Gettin em n keepin em’. Not all SONMs across Australia have implemented these recommendations, which are fundamentally based on strategies to achieve a higher rate of Indigenous participation in nursing. However, if the recommendations are implemented, the outcome could yield significant change on a grand scale in Indigenous health and Indigenous nursing. There is no direct recommendation that gives instruction for SONMs in Australia to employ Indigenous Nursing and Midwifery academics on their academic staff.
The 2013 CATSINaM position paper was highly beneficial for the nursing and midwifery professions, and another milestone for the organisation. This paper was urgently needed as there was no document available that addressed the use of appropriate Indigenous guidelines, terminology and concepts as a frame of reference for professional nursing bodies. This document, which was prepared and approved by Indigenous nurses and midwives, underlines the need for all nurses and midwives in Australia to utilise clear, uniform Indigenous terminology. The CATSIN (2013) position paper also includes reference to the Code of Ethics for Nurses in Australia from the NMBA and highlights the importance of referring to the historical context of Australia’s colonial past, which has impacted negatively on the health outcomes of Indigenous Australians today.

The most recent advancement that put the national spotlight on Indigenous nursing was the ACN 2014 oration delivered by Professor Roianne West, Indigenous nurse leader and Queensland director of CATSINaM. Her oration on Indigenous health titled ‘Rising to the challenge of our time: better health and wellbeing for our nation’s first people’ was a call to action for the nursing and midwifery professions to commit to Indigenous health as a national priority. She outlined the role of nursing leadership, education and cultural competency and her aspirations of a shared vision for the future.

In her speech, West drew attention to the NMBAs national competency standards for nurses and midwives, where she noted that the standards for nurses refers to the broad meaning of the word ‘culture’, in relation to considering the cultural needs of patients in nursing practice. She explained that the word ‘culture’, used in the context of caring for persons of different cultural backgrounds, renders Indigenous people of Australia as invisible. In contrast, the standards for midwives clearly state that they recognise the specific maternal health needs of Aboriginal and Torres Strait Islander people of Australia as an individual cultural group, making Indigenous people notably visible in this context. This speech was a significant event and useful for CATSINaMs continuing influence on the actions of the ANMAC. ANMAC set benchmarks for SONMs to meet accreditation standards that requires them to embed Aboriginal and Torres Strait Islander knowledge and perspectives within their nursing and midwifery curriculum (ANMAC, 2012). Through the ACN speech, CATSINaM also lobbied for the NMBA to set specific cultural reference to Australia’s Aboriginal and Torres Strait Islander people, as opposed to having them
integrated within broader cultural groups within Australia’s population. This undeniably fueled progress in setting standard mandatory requirements for Australian SONMs to embed Indigenous theories, knowledge, perspectives and experiences into nursing and midwifery curriculum courses and programs (ANMC 2007; ANMAC, 2012).

Janine Mohammed took up the position as CATSINaM CEO in late 2013. Mohammed continues the organisations original overarching campaign of increasing the numbers of Indigenous nurses and midwives (Mohammed, 2014; 2015). She instigated a new position paper ‘*Uniqueness of our workforce*’ (2016), which further galvanises the unique and strong identity of Australia’s Aboriginal and Torres Strait Islander nursing and midwifery workforce.

*Queensland Health*

Queensland is the home of all Indigenous nursing participants involved in this study. Consequently, it is useful for contextual purposes to examine the policy environment in this state. This section will focus on the Strategic Direction for Nursing and Midwifery in Queensland (2007) paper that was instituted to address the issues related to Indigenous health and nursing. One strategy, introduced by the Office of the Chief Nurse in 2007, was the creation of a position within the Queensland Health senior management structure with the title of ‘Indigenous Nurse Advisor’ (Queensland Health, 2007a). This position led projects and created resources to promote nursing and midwifery as a career pathway for Indigenous people, which included an Indigenous nursing focus on Queensland Health’s ‘Think Nursing’ website. In 2011 the website featured footage of the famous Indigenous athlete and role model Cathy Freeman to promote Indigenous nursing cadetships and nursing and midwifery as a career for Indigenous people; however, it is no longer available (Think Nursing, 2011). In 2012 Queensland Health’s Nursing and Midwifery Office made the decision to down size the Indigenous nursing portfolio and relocate the position of ‘Indigenous Nurse Advisor’ to the cultural capability section of Queensland Health. Soon after, this position was discontinued and remains redundant (A Drummond, pers. comm, 7th of October 2013).

In the most recent health plan released by Queensland Health, titled ‘*Strengthening health services through optimising nursing strategy and action plan (2013-2016)*’, led by
the Queensland Health Chief Nursing and Midwifery Office, Aboriginal and Torres Strait Islander clients are not listed specifically in documented priority health areas, but are included in a group, along with high health needs patients and rural and remote clients (Queensland Health, 2013). The document omits to acknowledge previous achievements in advancing Indigenous nursing and midwifery workforce goals or strategies, and does not include a strategy to address Aboriginal and Torres Strait Islander nursing and midwifery workforce goals in the future. This is in direct contrast to the aims of the Queensland Health Aboriginal and Torres Strait Islander Nursing and Midwifery Position Paper 2007-2010 (2007a) and the Queensland Health document ‘Strategic Direction for Nursing and Midwifery in Queensland’ (2007b).

Best and Fredericks (2014) published an undergraduate Indigenous nursing and midwifery textbook, accomplishing one of the key goals set for the Queensland Health Indigenous Nurse Advisor. This long-awaited textbook was one of the first Indigenous nursing textbooks published in Australia. The textbook was written solely from an Indigenous nursing and midwifery perspective; some of the contributing nurses and midwives work within clinical areas, while others work in academia and teach into undergraduate nursing and midwifery programs in SONMs across Australia.

Table 2.8 demonstrates the continuous effort by CATSINaM and nursing bodies of Australia to keep Indigenous nursing issues in the spotlight. There has been considerable investment in the development of an Indigenous and non-Indigenous nursing and midwifery workforce to provide culturally appropriate care for Indigenous Australians. The importance of including a historical and cultural perspective within the education of this workforce and providing educational resources that are relevant to an Indigenous nursing and midwifery context has been highlighted. It has also been demonstrated that targeted government financing to increase in the Indigenous nursing and midwifery workforce would be economically viable and an effective way to help close the gap. The policy dilution to embed Indigenous issues into streamlining Queensland Health’s cultural agenda has been detrimental to progress.
**Indigenous nursing academics in higher education**

The literature on Indigenous nursing academics reveals that, until very recently, there has not been mention of a strategy or emphasis placed on the importance of increasing the number of Indigenous nursing academics, their experiences, or evaluations of their longer-term appointments (Best and Stuart, 2014; West, 2012). To date, no studies exist that specifically examine the experiences of Indigenous nursing academics in Australia. Yet researchers agree that these academics are an asset in attracting, nurturing and supporting Indigenous nursing students until they graduate from their nursing programs (Best and Nielsen, 2005; Best and Stuart, 2014; Stuart and Gorman, 2015 West, 2012).

There are many reasons that the health of Indigenous Australians is poor. Indigenous nursing academics help graduate Indigenous nurses who will enter Australia’s health workforce, which, in turn, will address the poor health status of Indigenous Australians. It is important that Indigenous people are cared for in a culturally safe manner, and it is also important that there are Indigenous nurses in the academic hierarchy to engage in policy-making. CATSINaM continually campaigns to recruit more Indigenous people into nursing and midwifery careers, as many more are needed to engage in the activities outlined in the *Closing the Gap* campaign. To attract, retain and graduate Indigenous nurses, Indigenous academics are needed, many of whom will be women. While the promotional prospects, pay levels, workload and work stress of female academics is high, working conditions appear even worse for Indigenous nursing academics. The number of Indigenous nursing academics hired by Queensland universities was less than eight individuals between 2000 and 2010 (O Best, pers. comm, 1 August 2010). The number had not grown by 2013, and few appointments have been made since. However, there has been a move by some universities to promote their Indigenous nursing staff into senior appointments. At the time of her comment, Best was in the position of ‘Indigenous Nurse Advisor’ at Queensland Health. There is currently little evidence of effective strategies for attracting Indigenous nurses to enter a career in academia, or in providing insight into why those who leave academic positions do so. My research question: What are the stories of Aboriginal nursing academics who have been employed within SONMs in Queensland universities between 2003 – 2013? is aimed at gathering and analysing
evidence from the perspective of those engaged in the role to help fill this gap in knowledge.

Existing literature strongly concludes that increasing and maintaining the number of Indigenous nurses is reliant on increasing the number of Indigenous nursing academics (Best and Nielsen, 2005; Best and Stuart, 2014; Stuart and Gorman, 2015). This indicates that SONMs and nursing bodies need to take appropriate action and employ Indigenous nursing academics on their staff. The literature also indicates a need for Indigenist methodological research approaches. West et al. (2014) focused on academic staff perceptions about Indigenous nursing completions and interviewed 15 nursing academic staff members (Indigenous and non-Indigenous). One non-Indigenous participant stated, ‘the Indigenous nursing academic can talk from a lived experience point of view, rather than the rest of us, which can say, “Well, I’ve worked with Indigenous people but I have not lived it”’ (West et al., 2014, p. 12). West et al. (2014) also reported that both Indigenous and non-Indigenous academics expressed that the responsibility to support Indigenous students, and lead Indigenous academic matters, although not an official role, was generally incumbent on Indigenous nursing academics.

This literature review has revealed an urgent need to explore and develop a deeper understanding of the experiences of the identifiable cohorts of Indigenous nursing academics. This will allow for the identification of additional barriers so that workable strategies can be put in place for improvements, thus providing better support mechanisms for retaining Indigenous cohorts in their relative positions. Further research should not only include Indigenous nursing academics within Queensland universities, but should extend this concept nationally to include all Australian SONMs.

Summary

This review of the literature clearly indicates a paucity of research and information on the experiences of being an Indigenous nursing academic, particularly from the perspectives of Indigenous nursing academics. A range of research studies were identified that focused on factors influencing social disadvantage in Indigenous peoples in Australasia,
The experiences of Indigenous nursing students and then the broader Indigenous student cohort have been examined in a number of studies. The literature surrounding difficulties faced by female and Indigenous academics has also been critiqued and there is little examination of the experiences of female Indigenous academics, particularly in nursing. The literature revealed a large body of information about Indigenous nurses relating to CATSINaM, Queensland Health, and the challenges that Indigenous nurses face on a day-to-day basis with whiteness and racism in nursing. There has been an attempt to summarise what is, and what is not, known about Indigenous nursing academics in higher education; however, the outcome of this literature review reveals that further investigation is needed in order to understand more explicitly how ongoing challenges can be addressed.

Much of the literature focused on improving Indigenous health suggests that when working with Indigenous people and communities, non-Indigenous nurses need to understand that engagement means much more than consultation for building trust and rapport. Indigenous nurses have been shown to be the best suited to care for Indigenous clients and to provide leadership in areas of Indigenous health/nursing. For meaningful progress to occur in Indigenous health and nursing, the literature strongly suggests that racism and the whiteness of nursing in the nursing workforce must be addressed.

In relation to Indigenous higher education, more appropriate support is needed for Indigenous staff and students. Review of the literature indicates that some strategies to improve the status quo have been developed; however, universities often lack innovative recruitment strategies to increase the participation of Indigenous staff and students in higher education. It was revealed that academic skills support in higher education is a strategy employed to cater for the needs of Indigenous learners. Engagement with high schools and vocational institutions for recruiting Indigenous students into tertiary level education is a high priority and is also identified as a useful strategy. Some of the literature suggests that Universities also need to employ more Indigenous academics and
professional staff across disciplines to provide academic and cultural support for Indigenous students.

The literature indicates that a key strategy for the improvement of Indigenous health and closing the gap in health outcomes for Indigenous Australians is to develop the Indigenous health workforce and to educate more non-Indigenous nurses and midwives to provide culturally safe nursing care for their Indigenous clients. To this end, these key areas confirm that there is an urgent need to examine more closely the experiences of Queensland’s Indigenous nursing academics and identify areas in which their professional development can be supported.
CHAPTER 3: METHODOLOGY

Introduction

This chapter provides an overview of the study’s methodological approach and the methods used to collect and analyse data. The choice of methodology is based on the aim of the research study and justified with relevant literature. The aims of the study are also revisited to illustrate how, as the researcher and a research participant, I have described and analysed the stories of the Aboriginal nursing academic participants, including my own. In addition, I have provided an explanation that outlines how I have positioned myself within the study, and the ethical considerations for undertaking research with Aboriginal and Torres Strait Islander people.

Guidelines for undertaking research with Aboriginal and Torres Strait Islander people

From an Indigenous perspective, the term ‘research’ has a strong association with European imperialism and colonialism. Indigenous (Māori) researcher Linda Tuhiwai Smith argues that, ‘the word ‘research’, is probably one of the dirtiest words in the Indigenous world's vocabulary’ (1991, p.1). Smith justifies this comment on the basis that European research processes have ill-treated and exploited Indigenous people around the world, stating that ‘When mentioned in many Indigenous contexts, it stirs up silence, it conjures up bad memories, it raises a smile that is knowing and distrustful’ (1991, p. 1). Smith recalls that a frequently heard catchphrase in Indigenous communities is that ‘We are the most researched people in the world’ (1991, p. 3). Her view is supported by Australian researchers Martin-McDonald and McCarthy (2007) who describe Indigenous Australians as being a marked group receiving a disproportionate amount of research attention when they only constitute 3% of the entire population. Because of being over-researched, Indigenous Australians are suffering research-fatigue, and are inclined to view research agendas with high suspicion (Bessarab and Ng’andu, 2010; Coffin, 2002). It is therefore important that all researchers consider the issue of research-fatigue as well as other ethical issues specific to researching with Indigenous people or communities.
Throughout the past decade, the importance of adhering to ethical standards for undertaking research with Aboriginal and Torres Strait Islander people has become mandatory practice. The processes are comprehensively addressed in the National Health and Medical Research Council’s (NHMRC) 2003 guidelines for ethical conduct in Aboriginal and Torres Strait Islander Health and the *NHMRC Human Research Ethics Handbook* (NHMRC, 2003). More recently, Indigenous researchers and their supporters have been successful in lobbying national funding bodies, such as the NHMRC, to address the issues of over-research of Indigenous people, especially by non-Indigenous researchers. The National Statement on Ethical Conduct in Human Research (2007, updated in March 2014), specifically includes a section on ethical considerations for research with Aboriginal and Torres Strait Islander participants. In addition, the Australian Institute of Aboriginal and Torres Strait Islander Studies (AIATSIS) established research guidelines, which are based on research recommendations from Aboriginal and Torres Strait Islander people and their communities (AIATSIS, 2012). As an Aboriginal researcher, I am familiar with all the above-mentioned research guidelines, and I have taken every measure to ensure that I have adhered to the required ethical standards while conducting my research.

The NHMRC guidelines for ethical conduct in Aboriginal and Torres Strait Islander Health (2003) are underpinned by six values: reciprocity; respect; equality; responsibility; survival and protection; and spirit and integrity - the value that binds the other five values to each other. These six values are integral in the undertaking of research with Aboriginal and Torres Strait Islander health and populations. For this reason, I have ensured ‘reciprocity’ by demonstrating my intent as a researcher to improve the health outcomes of Indigenous people and communities. I have fostered ‘respect’ in research relationships with participants and have worked on building trust that promotes dignity and recognition. I have ensured that all research processes have verified that ‘equality’ is maintained between each of the research participants. I have carried out my research processes demonstrating a measure of ‘responsibility’ ensuring that no harm has been done. I have ensured that ‘survival and protection’ in this research study has been acknowledged by my being aware of the distinctiveness of Aboriginal and Torres Strait Islander culture and people. Throughout this research journey, I have been constantly aware as a researcher.
of the value of ‘spirit and integrity’ and that any behaviour that diminishes this value would compromise the integrity of my research.

The following list outlines measures that I have taken to incorporate the above values into the research process:

- I am of Aboriginal descent, and therefore an insider researcher; however, this does not in any way diminish my accountability to adhere to the NHMRC ethical guidelines in conducting research in relation to reciprocity, respect, equality, responsibility, survival and protection, and spirit and integrity;
- I completed a Masters by Research program in which the research participants were of Aboriginal and Torres Strait Islander descent, and have previous experience with the research processes required to undertake research with this vulnerable population. In my past and present research studies, I followed the research guidelines for ethical conduct;
- I focused the study on an area of nursing research that can promote and potentially advance Aboriginal and Torres Strait Islander nursing leadership. Because of my engagement with Aboriginal and Torres Strait Islander communities, I intend to use the findings as a catalyst for building future nursing leadership capacity for advancing and promoting the health of Aboriginal and Torres Strait Islander people and communities;
- I have enlisted the support and guidance of two cultural mentors to inform my research process. Both are key to this research study. Both cultural mentors are of Aboriginal descent and are registered nurses who hold PhDs in the field.

My position in the study

I, Lynne Stuart (nee Slater) am a strong Mandandanji Aboriginal woman from the Roma district in Queensland, and identify as such in the Australian Aboriginal context. I am both the researcher and a participant in this study, and have included my own story highlighting my personal and professional experiences from my journey as an Aboriginal nursing academic. I have mixed ancestry deriving from both of my parents’ forbears. My mother’s mother was a full-descent Mandandanji Aboriginal woman, whereas my
mother’s father was of Māori, Irish and Scottish heritage. My father’s mother was of English and Irish heritage, whereas my father’s father was of Scottish heritage, originating from the Isle of Skye. As previously stated, I identify as a Mandandanji Aboriginal woman. The story that inspires me about the strength of my Aboriginal descendants was about a Mandandanji Aboriginal resistance leader by the name of ‘Bussamarai’. In the mid to late 1800s he protected our people, and united and led Aboriginal warriors from five nearby tribes to protect our people and land against white invasion. United in the struggle, they kept the white invaders from taking over the land in the Maranoa district in Queensland for close to a decade. That unrelenting and fierce determination in the face of adversity is what inspires me the most. At times when I am feeling challenged in the Indigenous university sphere, by bureaucracy, other academics, students or just the insidious workload of being ‘the’ Indigenous academic, I gain strength from knowing that my ancestors faced far worse, and never gave up. They knew, as do I, that we all have our work to do to ensure the survival of the next generation.

Throughout the research and writing of this doctoral thesis I have often reflected on my Aboriginal ancestry, and my inheritance of Aboriginal warrior blood flowing through my veins. It makes me feel a sense of awe and wonderment, and I reason that if my Aboriginal ancestors had to give of their lives to ensure the survival of my seed, then the least I can do is complete this PhD Thesis. Knowing that I can further contribute to the health and wellness of my people through research that will influence Indigenous health policy, practice and education remains one of the greatest motivations my success in this journey.

The purpose in providing my ancestral heritage is to impress the importance of my Aboriginal heritage in relation to my doctoral research journey. I am an Aboriginal researcher who holds a position as a nursing academic in a School of Nursing, Midwifery and Paramedicine. It is serendipitous that I have come full circle; I have written this thesis in Gubbi Gubbi/Kabi Kabi country, where I am currently employed at the University of the Sunshine Coast (USC), and where I was born just over 50 years ago. My recollections of being on this country as a small child, spending long sunny days with my mother, while my father worked and my four older siblings attended school, are very comforting and empowering.
I have positioned myself within this PhD research as a researcher who, as Patton (2002) recommends, is both an instrument and a source of data. Throughout the project, there have been times that I have felt emotionally and physically exhausted, which Dickson-Swift et al. (2007) identify as a side-effect of qualitative researchers doing sensitive research. My anecdotal contribution to the study represents over seven years of my professional career as an Aboriginal registered nurse, in one of the most difficult terrains: academia. It was my unique career experience in this area that became the catalyst for my research question. As the researcher, I understand that I have responsibilities for leading this research project. I am therefore accountable for ensuring adherence to ethical guidelines for this study.

Methodological approach

To address the research question within an Indigenist methodology, the study was conducted in the interpretive paradigm, using a constructionist approach and narrative inquiry. Creswell (2013) explains that qualitative research 'begins with assumptions and the use of interpretive/theoretical frameworks that inform the study of research problems addressing the meaning individuals or groups ascribe to the social or human problem' (p. 44). Qualitative research is a way to ‘interpret meaning by exploring, explaining and describing things of interest…to make sense out of them’ (Taylor, Kermode and Roberts, 2006, p. 583). Sandelowski (2000) elaborates on the processes involved, explaining that qualitative research consists of simultaneously collecting and analysing data, where both shape each other, and where content analysis transforms data into new insights, ensuring maximal output.

My position of being a nursing academic of Aboriginal descent presented me with cultural and ethical decisions about whether I should position my doctoral studies within an Indigenist specific methodology. On researching the most appropriate methodology to answer my research question, it became apparent that the most suitable methodology for this study would be to adopt an interpretive narrative inquiry. From my standpoint as an Aboriginal researcher, I felt it was important to use a research methodology that would best accommodate Aboriginal nursing academics’ stories (including my own). An
interpretive paradigm using a narrative inquiry achieved the best fit with the aim and study question, and was selected as it was ideally suited to foregrounding participants’ accounts. Narrative inquiry is a specific interpretive method that is compatible with Indigenous ways of knowing. It has long been an observation in Australian literate non-Indigenous society that Indigenous societies can convey information from one generation to the next without written text through telling ‘stories’ (Goold, 2004; Sveiby and Scuthorpe, 2006). A narrative inquiry is therefore appropriate for answering the research question for this study: what are the stories of Aboriginal nursing academics working in Queensland universities between 2003 and 2013?’

My research question concurs with Martin’s (2003) statement that researchers should make every effort to value and respect Indigenous cultural ways of being, knowing and doing when conducting research with Indigenous people, which was a serious consideration for this research. Data for this study was projected to reveal the complex nature of what it is like to be employed as an Aboriginal nursing academic. Beginning the study, I was also aware of my professional boundaries, and that, in addition to being closely engaged with the study participants, I needed to ensure that I distanced myself from their interpretations, to avoid assumptions that may have altered the intended meaning of the interview data.

The rationale in selecting a qualitative interpretive approach for this study is that the research focus is primarily on the subjective human experience, which allows a deeper insight and understanding of the participants’ human consciousness (Taylor, Kermode, and Roberts, 2006). Using a qualitative research approach to engage with Aboriginal and Torres Strait Islander people has also been highlighted by Wilson (2007), as a means of acquiring hidden data that may only emerge when told through the storyteller’s lens. The intent of my research was to analyse and interpret stories through narrative inquiry that recounts people’s experiences. The epistemology underpinning my research is constructionism. Constructionism suggests that individuals learn and generate knowledge from an interaction between their experiences and their ideas, whereby individuals construct their own reality, as opposed to being passive participants (Bruner, 1987; Holloway and Freshwater, 2007). The position of constructionism embodies the view that knowledge and meaningful reality are reliant on human interaction (Crotty, 2003;
Hollingsworth and Dybdahl, 2007). Constructionism provides the foundation for a variety of qualitative research studies, and fits well with this study. This approach allowed me to interact and work closely with the other participating Aboriginal nursing academics as partners as there is less separation between the researcher and ‘the subjects researched’ in this domain (Hollingsworth and Dybdahl, 2007). Aboriginal nursing academics and the researcher were able to co-construct stories from their own perspectives, which placed the emphasis on how they constructed meanings.

Individuals create their stories in a way that holds specific meaning for them and in this study, participants tell their stories through their cultural lens of being Aboriginal women. Sparkes (2004) asserts that as individuals, we can create our own narrative identities during the process of telling stories about ourselves. The epistemology of a constructionist approach is therefore compatible with the theoretical perspective of interpretivism and the methodology of narrative inquiry, which is where meanings are embedded (Squire, Andrews and Tamboukou, 2008).

**Narrative**

Aboriginal nursing trailblazer Sally Goold states ‘We are an oral people and we are face-to-face learners’ (Goold, 2004, p. 1). This strongly suggests that in Aboriginal culture there is considerable emphasis on passing on knowledge from one generation to the next via the method of storytelling. This notion has also been echoed by many other scholars in the field (Bailey and Tilly, 2002; Thackrah and Scott, 2011). Gorman and Toombs (2009) suggest that ‘narrative inquiry’ is an effective way of collecting information from Indigenous people.

In the past, most research was non-narrative, and was based on quantitative data focused on the processes of cause, effect and proof (Pinnegar and Daynes, 2007). However, there is much qualitative data in nursing research today, as researchers have recognised the limitations of quantitative studies. The proliferation of interpretive studies has arisen from the need to plan nursing care based on both scientific information and qualitative data from the perspectives of the recipients of nursing care, including clients and populations. Narrative inquiry is one way of adding the population perspective. In an introduction to
narrative research, Squire, Andrews and Tamboukou (2008) discussed the popularity and
diversity of narrative research in terms of its origins and theoretical divisions, indicating
that there are many narrative inquiry research approaches currently used by a range of
researchers. In these approaches, stories play a key role. Sandelowski (1991) argued
that qualitative nursing researchers should see the participants as narrators or
storytellers, and the interview data as actual stories. Telling stories can be empowering
for groups that rarely have a portal or opportunity to have their voices heard. Reissman
(2008) contends that narrative research has been able to influence better outcomes for
oppressed or marginalised groups by bringing attention to their cause. The advantages
of using narrative inquiry in the health care environment can be especially beneficial when
participants experiencing stressful circumstances have an opportunity to tell their stories
(Holloway and Freshwater, 2007).

The term ‘narrative’ is generally used interchangeably with the term ‘story’, although
narratives are based on people’s individual experiences and may involve multiple
accounts (Polkinghorne, 1988). This study utilised two types of narrative inquiry, based
on Bruner’s (1985) process of the ‘analysis of narratives’, where the researcher collects
the stories from participants and then analyses them; and ‘narrative analysis’, where the
researcher analyses the collective narratives of each participant, and creates a core story
or plot. The latter technique results in one master narrative inclusive of all individual
narratives.

Elliot (2005) refers to a narrative as a summarisation of defining elements of a story, and
recommends that the researcher connects these elements in a meaningful way to make
up a whole story. Narrative inquiry offers the opportunity to create a coherent story from
interview transcripts to create a story with flow and sequence of events (Holloway and
Freshwater, 2007, Paley and Eva, 2005); therefore, it is a good fit for this study. The
process of storytelling is often empowering for participants, as it is designed to capture
the ‘essence’ of the story, using the participants’ words, but shaping the narrative for
readability and enhanced understanding. I remained conscious of using narrative
language skills to tell the participants’ stories throughout the research process so as to
keeping with the narrative methodological approach.
The practice of storytelling or ‘yarning’ has been a customary practice in Indigenous societies from the beginning of the Dreaming as a way of conveying meaning from one person to another. Geia, Hayes and Usher (2013a) refer to the art of storytelling, which can be used interchangeably with yarning, as a technique for obtaining rich descriptions by engaging Indigenous study participants in in-depth discussions. Narratives provide a framework for understanding past life events and future plans for one’s life, and add to the plot by which human existence is made meaningful (Polkinghorne, 1988).

Because the researcher and study participants are all of Aboriginal descent, as well as being academics, narrative inquiry provided an ideal method to describe and co-construct interpretations of the meanings their experiences held for them. As narrative or storytelling is embedded in Indigenous ways of understanding, this methodological approach is compatible with the storytelling approaches described by Sveiby and Scuthorpe (2006). These authors explain that a non–literate society can build and retain knowledge by linking themes and anchoring them in a sequence that forms a storyline. In Indigenous societies, this storyline is passed on by oral dialogue and retained by the receiver of the story in their memory bank. Indigenous people, over thousands of generations, have developed the art of storytelling to a masterful level, passing on stories that were inherited orally from generation to generation.

The research process

For this study, I adopted the five phases of the research process structure espoused by Denzin and Lincoln (2011).

Phase 1: The researcher

In this research process, the researcher comes first. Focus on the researcher is an important part of the research process and the starting point in any research. I am positioned historically in the research, as a research instrument; I am also socially situated within the research and responsible for setting the guidelines and limits for this study. At the beginning of my research journey, I held many assumptions. Mainly, I thought that the experiences of the other participants would be somewhat like my own.
However, in many cases I was reminded of the possibility that the experiences of my peers may be quite different. I also assumed that the SONMs in Queensland would be striving to employ Indigenous nursing academics. I thought that similar studies involving Indigenous nursing academics would be available in the literature. I was careful to collect data from my own experiences first, and uniformly with how I collected data from others.

**Phase 2: Interpretive paradigms**

All qualitative researchers are guided by highly abstract principles that are underpinned by interpretive paradigms. Paradigms are guided by basic belief systems based on ontology, epistemology and methodology (Guba and Lincoln, 1994). Within this study, ontology was represented by the day-to-day experiences of seven Aboriginal nursing academics and the co-construction of their stories into narratives to analyse their everyday multiple realities they experience. I then included my own narrative. Epistemologically, I was positioned as close to the participants as professionally possible, through our shared positions in nursing, health care and higher education and Aboriginality. The methodology used in this research was narrative inquiry.

**Phase 3: Research strategies**

This phase is focused on research strategies used for collecting and analysing the research data. The research design determines the direction and components of the study and is based on the research question. It identifies what information is needed to sufficiently answer the research question, and what strategies are most effective in obtaining this information; that is, (1) the strategies required for the research, and (2) the methods for collecting the data. The research design also connects the researcher with key people and the supporting research materials and processes to conduct the study.

**Phase 4: Methods of collection and analysis**

To achieve the aim of the study, narratives were collected using a conversational/semi-structured interview technique and analysed thematically. The narrative method used storytelling to generate dialogue that would help provide understanding of the meaning of a person’s life experiences. My own narrative was generated by the same method; I was interviewed and asked the same interview questions by an experienced qualitative
researcher (my supervisor). The rationale for these measures stemmed from the fact that Aboriginal people are not one homogenous group, and culture can be markedly diverse and complex between Aboriginal cultures.

*Phase 5: The art, practices, and politics of interpretation and evaluation*

As data is collected and analysed, more precise meaning to the data becomes apparent. On the completion of studies, research results are made publically available through publications, such as reports, manuscripts and various media sources. Research findings can be accessed by government bodies and policy-makers and used to inform future policy. Thus, the research may influence political and social policy.

*Study participants*

The Aboriginal participants for this study were academics. As a literate group within their respective societies, they were chosen to articulate their stories so that people who have not had similar experiences could be informed. Not only were the participants able to convey their experiences through an Indigenous cultural perspective, but as they straddled both Indigenous and non-Indigenous societies, their stories will also have meaning for many cultural groups. Being able to provide multiple perspectives is a significant strength of this study.

This method of data collection was used (rather than including my own narrative in written form) as it provided uniformity in data format and content.

*Participant recruitment*

Purposeful sampling was used as a method for accessing participants. The aim of purposeful sampling is to obtain information-rich cases (Sandelowski 2000). Selecting Indigenous participants with substantial experience in nursing and academia led me to expect that their stories would be information-rich and provide insight into the meaning of their experiences. I solicited recommendations for other potential participants from the first few participants, and in this manner used snowball sampling (Patton 2002) with good effect. The participant group extended outside of the university environment, for example,
to Aboriginal nursing academics who were no longer working in academia, but who still met the inclusion criteria. This flexible approach to sampling is congruent with Patton's (2002) recommendations for sampling, and proved beneficial in identifying some of the barriers for continuing in academia.

To meet the inclusion criteria for this study, participants needed to be nursing academics of Aboriginal decent who had worked for more than three months in a continuing academic appointment within a School of Nursing and Midwifery (SONM) at a Queensland university between 2003 and 2013. Academics who had only been employed casually or on a contract basis were excluded.

Contact was initially made via email with an attached letter to two key persons in Queensland who were high profile Indigenous nursing leaders. These people, who had both held the position of Director of Nursing in Queensland Health, were the most suitable contacts as through this position they would have worked closely with SONMs in Queensland universities. A copy of the letter sent is in Appendix B. The letter described the research project and requested recommendations of individuals who they deemed suitable as potential study participants. Each of the individuals recommended was contacted via email with an attached letter about the study. Each person who met the inclusion criteria was invited to be a study participant. Those who responded with a willingness to participate became the study participants. The consent letter for the study provided to each of the participants prior to their interview invited them to ask questions or express concerns (see Appendix C). It was also explained that confidentiality and anonymity were requirements for conducting ethical research, and participants were assured that their interviews would be kept confidential. When potential participants felt that their questions and concerns were satisfactorily addressed, they were asked to sign a consent form to participate in the study.

**Data collection**

Data collection consisted of in-depth semi-structured interviews recorded in the form of digital voice recordings, which were then transcribed into written interview transcripts. I arranged for my personal interview to be recorded prior to all other interviews so as to not
be influenced by the narratives of the others. Each of the interviews ranged from 45 to 60 minutes in duration. The interviews were scheduled in advance and were held at a time and location that was acceptable and convenient to the participants. The interview questions were open-ended and focused on the participants’ personal experiences.

*The interview questions*

Reissman (1993) advised that open-ended questions are best for extracting narrative content from interviews, and recommended the development of five to seven broad probe questions. For this study, five questions were developed to guide the semi-structured interviews and participants were encouraged to tell their stories about their personal and professional experiences of being an Aboriginal nursing academic. The interview questions were:

1. What is your tribal affiliation?
2. What was it that motivated you to become a nursing academic?
3. Tell me what has the journey been like for you?
4. How do you do it all? What is your method of coping?
5. Do you think that your experiences are different to mainstream nursing academics? How? Can you give me an example of that?

These questions yielded a satisfactory and substantial amount of rich data. Interviews were transcribed from the digital recordings into text.

Interviews are a major part of qualitative data collection and allow access to a body of knowledge reflective of participants’ perceptions (Di Cicco-Bloom and Crabtree, 2006). Rubin and Rubin (2012) explain that when using qualitative interviewing, the researcher speaks with participants who have knowledge and experience in the study area. Through this process, they may learn to view the world from another perspective, even if the researcher has previous knowledge in the area. The qualitative interviewing process results in creating an interactive process, whereby both the researcher and the research participants collaboratively create the data (Richards 2009).
In this study, every effort was made to conduct the interviews in the most authentic way possible to gain quality research data. However, due to the study including participants located across a large geographical area in Queensland, face-to-face interviews were not always possible. Where face-to-face interviews were not feasible due to distance and the resources needed to travel across the state, the alternative method utilised was telephone interviews. Four interviews were conducted face-to-face and four were conducted via telephone.

Data analysis

The raw transcript data consisted of the verbatim accounts from the eight Aboriginal nursing academic participants. The transcripts were then constructed into narratives that contained formal accounts of the author’s additions and omissions; a process advocated by East et al. (2010) and Reismann (2008). A thematic analysis followed to identify themes and ideas in the narratives. Next, the initial interview transcripts were reconstructed into narratives via a narrative analysis process and refined and presented in a core story. The research data was thematically analysed for common themes and patterns occurring in the narratives.

Data analysis involved three steps: (1) narrative analysis using Reissmans (2008) method, advised by East et al. (2010), (2) thematic analysis (Braun and Clarke, 2006), and (3) construction of a core story at the point of data reduction that contained key messages and meanings. To set the scene and introduce the storyline, the core story was presented first, followed then by the narratives. Each of the methods of analysis had different goals. Roberts and Taylor (2002) and Bold (2012) describe thematic analysis as identifying commonalities, essences or patterns within participants’ experiences and generating this research data into themes. The thematic analysis process as set out by Braun and Clarke (2006) was used, and involved the following three steps: (1) transcription - the data were transcribed from narratives; (2) coding - each data item was coded to be thorough and comprehensive; and (3) analysis - data were interpreted and made sense of rather than just paraphrased or described. The interpretive data analysis for this study was carried out directly after data collection. Richards (2009) advises that
the main aim of data analysis in general is to progress towards achieving data reduction to distil the key points, messages and meanings, as achieved in the construction of the core story.

_Narrative analysis_

During narrative analysis, interview transcripts were refined by removing words, sentences, phrases and the interview questions that had no relevance to the flow of the story. The narrative analysis was carried out close to the interview period, and prior to conducting the thematic analysis. The method of Reissman (2008), which refers to narrative analysis as ‘a family of methods for interpreting texts that have common storied form’ (p. 11) was followed. Narratives are rarely told by participants in chronological order, disrupting a logical storyline or plot. Therefore, the plot, or core story, needed to be extracted from the data and constructed accordingly by using the process of narrative analysis. Emden (1998, p. 35) discusses the structure of developing a core story and suggests that the creation of a core story ‘aids the analysis process’. The core story is the reduction of a full-length story (interview transcript) in such a way that no key meanings are altered or lost. As a part of this process, I sought clarification from the participants that the remaining core story was representative of their initial interview and I invited the participants to add, remove or modify data upon their subsequent reflection.

The narrative analysis process was carried out per Emden’s (1998) structure. This included the following steps:

1. Read the full interview text over an extended period to grasp its content;
2. Delete all interviewer questions and comments from the full interview text;
3. Delete all words that detract from the key idea of each sentence or group of sentences spoken by the participant;
4. Read the remaining text for sense;
5. Repeat steps three and four several times, until satisfied that all key ideas are retained and extraneous content eliminated, returning to the full text as often as necessary for rechecking;
6. Identify fragments of constituent themes (subplots) from the ideas within the text;
(7) Move fragments of themes together to create one coherent core story, or a series of core stories; and

(8) Return the core story to the participant and ask ‘Does this ring true?’ and ‘Do you wish to correct, develop or delete any part.

In practice, the narrative analysis process for my interview transcripts was a series of editing sessions repeated to refine the narratives by following the steps set out above by Emden (1998). The core story was then constructed for each individual narrative. It was during this process that I realised that each individual story was deemed worthy of separate study, before I commenced the analysis process across the narratives to construct the composite group narrative. To ensure this worthiness, I was diligent in retaining the character and authenticity of the narratives, carrying out limited editing of cultural idioms and linguistics that could potentially dilute or change the meaning of the narratives. Each of the eight participant narratives contained rich and varied data relevant to the central phenomenon being explored, and therefore each narrative was determined as worthy of inclusion in this study.

The next stage of the narrative analysis process was the construction and refinement of the core story. To arrive at a core story, Cortazzi (1993) recommended following a plot structure to create a basis for identifying common elements within the narratives.

The three criteria proposed by Cortazzi (1993) for identifying a narrative are temporality, causation and human interest. These three criteria were each adapted to the narratives to gain the most comprehensive and authentic representation of the participants’ core stories. Firstly, I included temporality by ensuring that the sequence of events that occurred within the narratives were presented in order and within the time frame they occurred. Secondly, I included ‘causation’ by verifying that the events were connected to each other, and that there was clarification of the inference of these events for the readers and hearers. Thirdly, I included ‘human interest’ by confirming that there was a core story within the narrative that facilitated a measure of human interest, for without this, no narrative would exist.
Thematic analysis

The next step after participant interviews, narrative analyses and development of the core story was to thematically analyse the interview transcripts. Themes are not random, but carefully selected, requiring diligent attention to the text to generate patterns (Roberts, 2002). I read each interview transcript several times to identify possible themes. Through this process, I noted key words and concepts and categorised these into a logical meaningful order to construct the narratives. This process allowed me to recognise the individual truths of each of the narratives to shine through as a prime example of the realities of what the Aboriginal nursing academics experienced. Through this process, my understanding grew and eventually I was able to translate the experiences into a collective and more comprehensive thematic context in which to showcase the Aboriginal nursing academics’ stories.

Braun and Clarke (2006) provide a step-by-step guide to highlight the phases of thematic analysis, offering examples to demonstrate the process. They recommended familiarising yourself with the data: transcribing data, reading and re-reading the data, and noting down initial ideas. The steps include:

1. Generate initial codes: Code interesting features of the data in a systematic fashion across the entire data set, collate data relevant to each code;
2. Search for themes: Collate codes into potential themes, gather all data relevant to each potential theme;
3. Review themes: Check if themes work in relation to the coded extracts, generate a thematic ‘map’ of the analysis;
4. Define and name themes: Ongoing analysis to refine the specifics of each theme, the overall analysis tells the definition and names for each theme; and
5. Produce the report: Finalise analysis with extracts of examples, relate back to the research question and literature, and produce a scholarly report of the analysis.

While undertaking manual thematic analysis, I used highlighters of different colours to identify different key words and themes for coding. I also used scissors to physically cut out phrases and sentences, and pasted them together to construct a picture of the emerging themes and how each theme related to another. Each of these processes
added to the ongoing analysis. Re-reading of content was repeated several times to ensure that no themes were missed, but also to delete themes that were repetitive.

Creswell (2003) recommends that during the analysis of data, the researcher should be posing analytical questions to support the research outcomes. Therefore, during this process, I kept in mind the questions that I wanted to find answers for, so that I would then be able to answer my research question ‘What are the stories of Aboriginal nursing academics working in Queensland universities?’ Specifically, these questions were:

(1) What can we learn from the stories of the Aboriginal nursing academics?
(2) What meanings are inherent in the stories about how Aboriginal nursing academics manage their workloads?
(3) How do Aboriginal nursing academics’ experiences differ from each other, and from their mainstream nursing counterparts?

**Ethical considerations**

Ethics approval was granted from the University of Southern Queensland (Ethics Research no. H12REA193; Appendix A). A copy of the consent form used for this research study is contained in Appendix C. Processes ensuring confidentiality were adhered to. This is congruent with recommendations from the NHMRC Guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander Health (NHMRC, 2003), the NHMRC Guidelines for Ethical Conduct (NHMRC, 2015) and in accordance with the requirements of the university’s Human Ethics Committee. An application for ethical clearance for the study was submitted to the university’s Human Research Committee and permission was obtained prior to the commencement of this study. I offered the research participants the option of using pseudonyms to tell their stories; which each participant accepted. Pseudonyms were selected by each of the individual participants and hold relevance to them only.

All interview data was kept confidential. Only I and my supervisors had access to the data collected. All identifying information was removed directly after the interviews took place to ensure anonymity and the names of the participants were replaced with pseudonyms. All research data and original interviews as digital recordings were stored in a secure
location, and they will remain there for at least five years following the publication of results, then destroyed as per NHMRC guidelines.

**Research rigour and quality**

Creswell (2013, pp. 250-253) suggested eight strategies that are frequently used by qualitative researchers to ensure research rigour and quality, including (1) prolonged engagement and persistent observation, (2) triangulation, (3) peer review or debriefing, (4) negative case analysis, (5) clarifying researcher bias, (6) member checking, (7) rich thick description and (8) external audits. It was recommended that qualitative researchers implement at least two of these strategies to ensure research validity.

Four of Creswell’s (2013) validation strategies were implemented in this study. Prolonged engagement and persistent observation was included, because my experiences mirrored those of the participants. These experiences provided insight and influenced the phenomenon being studied, therefore it was through the process of persistent observation that I could identify certain important aspects, adding greater depth to the study. Peer review or debriefing was an area that I needed to show caution around to prevent research bias, as I shared common cultural knowledge and work experience with the other participants. Because of this cultural and professional commonality there was the propensity for me to show bias. I was aware that this could eventuate if care was not taken. To reduce the risk of bias and mitigate the risk, I ensured that I adhered strongly to the validation strategy, which advocates for external peer review and debriefing.

Throughout this study, I engaged with my supervisors frequently and discussed concerns about research bias as the study has evolved. This approach enhanced trustworthiness, as meeting with my research supervisors on a regular basis allowed discussion and direction when new themes emerged. Member checking was achieved by returning the initial transcripts, as well as the narratives created from the transcripts, to each of the participants for verification that the information contained was accurate. This enhanced rigour in the study by providing an in-depth understanding and an audit trail of processes that can be followed by others. This approach is congruent with recommendations set out by Roberts and Priest (2006). Rich thick description was included as it allowed me to
describe the phenomenon being studied in detail. Through this, I was able to conduct an evaluation and extract conclusions that are applicable to other settings. These four research strategies provided sufficient coverage to verify the research content of this study.

Sandelowski (1986) and Guba and Lincoln (2005) suggest the need to ensure truthfulness in qualitative findings by maintaining credibility, fittingness, auditability and confirmability. I took every measure to ensure that my research processes aligned with these criteria for rigour. Credibility was gained by selecting the appropriate participant sample and member checking, to ensure that the findings ‘ring true’ to participants. This also ensured fittingness and trustworthiness. Liamputtong (2013) and Sandelowski (1986) suggested that credibility is achieved by presenting data in a way that is accurate and truthful, which is congruent with how this study was carried out.

Through methodology and design, I covered all the necessary components to conduct a successful research study. This was achieved by recruiting participants, collecting data by in-depth semi-structured interviews, adding my own narrative, and transcribing each of these interviews. During the data collection processes, both narrative and thematic analysis processes were described.

**Summary**

This chapter provided an overview of the methodology and methods for this research study. I positioned myself as the researcher, and a research instrument in the study, and stated the research aim. The importance of adhering to ethical considerations when conducting research with Aboriginal and Torres Strait Islander people was highlighted. Finally, justification for how the research design, methodology and methods were adapted for this study was provided.
CHAPTER 4: THE NARRATIVES

Introduction

This chapter presents the narratives of eight Aboriginal nursing academics who have been employed within Schools of Nursing and Midwifery (SONMs) in Queensland universities between the period of 2003 and 2013. These stories were told by each of the participants, including myself, during semi-structured interviews. To ensure confidentiality, pseudonyms with significance to each of the participants have been used. The eight participants of this study were: Murtle, Pearly, Ruby, Flora, Pauline, Daisy, Ningi, and Tiche. Pearly and Ruby were key Aboriginal nursing academics to recruiting participants for the study. Narratives were constructed using Sandelowski’s (1991) narrative techniques, and followed Emden’s (1998) guidelines for conducting a narrative analysis. For the final part of the narrative analysis process, I constructed a ‘plot’, or single core story of the narratives. Polkinghorne (1988, p.18) states, ‘without plots, events would appear discontinuous and separate’, and further describes a plot as, ‘able to weave together a complex of events to make a single story’. These processes were described in-depth in the methodology chapter.

My own voice as the researcher is present in the chapter introduction and in a brief description where I introduce each of the storytellers (including myself). It is also present in the core story and in my attempt to weave the content of the findings to support the storytellers’ voices. In undertaking narrative analysis of my own story, I was diligent to ensure that I conducted this process as if I were narrating someone else’s story. I made every effort to minimise my voice as a presiding influence so that each participant’s story was woven into the core story, and could be heard and understood; after all, the core story represents our collective stories. Core story narratives are introduced, followed by the storytellers, by providing an interpretation of the storyline of each narrative. This is followed by the ‘core story’, then the ‘Narratives’.
Introducing the narrative storyline

This story is about an ancient Aboriginal culture on the brink of extinction. However, there is hope of surviving and of breathing life back into the culture via the leadership, actions and strength of the strongest seeds, who in this story, are a group of traditional healers known as Aboriginal nursing academics. These academics have had to continually adapt their cultural ways of knowing, doing and being to not only survive in the academic environment, but make progress in their academic careers. To make this progress sustainable, they are required to strategically stride skillfully and equally between two cultures: one culture that they are born into and familiar with, which is their own; and the other, which is dominant and oppresses their beloved culture. In the academic domain, the latter is represented by the westernised educational system underpinned by the dominant white culture and society. White culture and society have become more accommodating and inclusive of the Indigenous perspective, and is not as harsh as what their ancestors were subjected to for many prior generations. Indeed, greater strength is gained with the arrival of every new generation; each generation that arrives carries the seeds of strength and resilience needed to maintain their culture’s very survival. Currently, these Aboriginal nursing academics are the ones who have been inspired by their ancestors to lead the change. This change is necessary to provide the outcomes of better health and wellbeing for the future survival of their Aboriginal families and communities.

I was struck by the unrelenting connectedness with family, community, culture and land that resonated from the very core of each of the stories of Aboriginal nursing academics. This was reflected in their strong Aboriginal identities and their connection to their mother earth from which they draw their endurance, strength and determination to fulfill their cultural obligations. They take these obligations seriously for nurturing the next generation, to empower them to survive and thrive in the stony academic terrain. This is not because they have chosen this path, but because they have inherited the strength of the seed as their birthright. They have accepted this obligation to teach the next generation and are continually spurred on by their cultural responsibility. They have stepped into the footprints of their ancestors and carry the seed forward to become
stronger; continuing a cycle of empowerment. They have achieved this progress by studying the ways of the white people in an academic context. This helps them to determine what can be done to open the time gates to bring others through so that their load becomes lighter, so that they can grow more and be more effective as individuals, and as a group. Considering the inclusion of Indigenous knowledge systems in academia is a relatively new phenomenon, despite an acceptance by educational leaders of the need to include cultural knowledge in educational curricula. Reluctance remains within SONMs to incorporate cultural protocols in nursing curricula to accommodate a substantial level of cultural respect concerning Indigenous perspectives and cultural knowledge systems. The Aboriginal nursing academics know that they must be patient because embedding cultural knowledge into the nursing curriculum is a complicated and multi-layered process. Yet this endeavour will ultimately yield high cultural safety standards and understanding for new nursing and midwifery graduates. These groups of academics are advocates for human rights, equity and social justice, and are a godsend, because they recognise the struggle of the Aboriginal nursing academics to generate meaningful and sustainable progress. In commencing the core story, I must pay my respects and honour the stories of my ‘storytellers’. I must also begin with honouring their Aboriginal ancestors before them who have brought the seeds of survival this far in the journey of life; for it is the strength of their seed which has sustained Aboriginal culture and bring these story lines alive into today’s world.

The core story: ‘Maroochy Dreaming’

An early European explorer first sighted the ‘Black Swan’ while sailing down a river in what is now called Western Australia. Because of this sighting, the explorer called the river, the Swan River. Prior to this, there had only been sightings of white swans. Sceptics didn’t believe that such a bird could actually exist and had to be convinced that ‘Black Swans existed and really were swans. Today we call this the ‘Black Swan Theory’ explains how perceived impossibilities may occur and have a major effect. The concept/metaphor of the ‘Black Swan Theory’ has tremendous significance in this core story as an analogy and a parable to how fragile any system of thought is; nothing is
possible until it comes into existence. The solutions to Indigenous health inequalities lie predominately within the capacity of Black Swans’, as they are genetically aware of what needs to be done to heal Indigenous people. In contrast, our white health systems have created inequalities. Current ‘solutions’ that use white methods of healthcare are inappropriate. However, by supporting seeds in the Indigenous population (Black Swans) these inequalities could be easily improved.

The Aboriginal word for ‘Black Swan’ translates in the Gubbi Gubbi/Kabi Kabi language as ‘Maroochy’, and the following is a story about ‘Maroochy Dreaming’. This is a story about unrelenting strength, resilience and cultural pride, where ‘Black Swans’ rise to take their rightful place in the world of Australian nursing academia.

We are the ‘Black Swans’ of matriarchal lineage. We wear our black downy and feathery cloak of culture with pride, while holding our long necks erect in an arch. We are proud of our Aboriginal heritage and our strong Aboriginal identities and culture. We are very different to the many white swans, because this great land now known as Australia is the homeland of our Aboriginal ancestors. Through our Aboriginal matriarchal lines, we ‘Black Swans’ have inherited the sacred stories about secret ‘women’s business’ and the song lines of the many strong Aboriginal women from our country who have walked the beaten bush track before us, healing our people.

In the journey to be and become nursing academics we ‘Black Swans’ have had to fight against predators with our wings and our beaks, and paddle against strong currents. We needed endurance and resilience to overcome these challenges, to remain, and to continue in our employment as ‘Black Swans’. These challenges have also been experienced by our flock, our family and community members, because they have been our main supporters in this journey. Along the way, we have sometimes found help and support from white swans, who have collectively risen alongside of us and to help us meet these challenges.

Sadly, the journey has been much harder for some of our ‘Elder Black Swans’. They started their journey and their nursing careers under the Flora and Fauna Act (Best and Gorman, 2016), but that time has now passed, we have overcome many adversities since then. In a sense, it is these adversities that have often provided the catalyst for us to strive
harder and harder to extend our wingspan and slow our wing beat to fly to greater heights - to be strong ‘Black Swans’.

There have been many difficult challenges on our journey. We have had our feathers ruffled, and sometimes we have lost our flight feathers, temporarily leaving us unable to fly. In academia, we have witnessed a lack of respect and interest in listening to what cultural knowledge our people contribute, especially when it comes to matters of the nursing curriculum. When teaching Indigenous health to resistant and racist mainstream nursing students, we have experienced a lack of cultural safety. Some of us have felt as if we were teaching with a target positioned on our chests. However, some of us ‘Black Swans’ have reacted to this situation by using it as an opportunity to provide cultural awareness training to students in an attempt to make meaningful progress in a somewhat challenging and often hostile teaching environment.

Our journey is a lonely one. We may be the only ‘Black Swan’ amid a ‘ballet’ of white swans. We often experience a much heavier workload compared to our white peers. Our workload is increased by the failure for others to understand the importance of cultural safety; that is, exploring, reflecting on, and understanding not only their own culture but its impact on others. For example, there are many occasions in the workplace where the ‘Black Swan’ is called upon to be a human rights advocate for every Indigenous issue. As ‘Black Swans’, our expertise in teaching nursing students about cultural safety leads to an expectation that we teach our white swan peers about cultural safety, often repetitively. Sometimes it feels like we are always paddling against the current.

At every point along this journey, we battle racism. Racism can appear at every bend of the river, in every pool or eddy. In the tearoom, the classroom, the coffee line or the car park of the university. This unpleasant, insidious, hidden factor increases workload and rarely finds its way into any position description. As a ‘Black Swan’ we are often expected to act as the Indigenous voice and as a representative for every Indigenous issue on numerous committees, boards and working parties across the university environment. We often complain to each other about having to be constantly ‘on duty’ as the only ‘Black Swan’. It is all very exhausting.
These extra activities are imposed on us solely due to our cultural inheritance as a 'Black Swan', our expert knowledge and our position of being (often) the only active and capable 'Black Swan' leader in nursing academia. Our ‘Majestic Black Swans’ lament that they hope that eventually the white swan leaders will join us and work alongside us to support our struggle, to help us strengthen our workforce and help us rear our ‘Black Cygnets’ our ‘Black Swans-to-be’. Sadly, only a few white swans are prepared to fly with ‘Black Swans’ in a strong and formidable ‘V’ formation. We love their support, but others, often more influential in the ranks of nursing academia, are reluctant to join us. With our ‘Black Swan’ nursing leaders growing in number, we are now sending out ‘trumpeting calls’, and have great hope that there is a way forward for the future.

As we ‘Black Swans’ glide majestically along our glittering rivers, there are other hidden snags and dangerous currents. There is the external Indigenous community workload that many of us inherit, as well as industry Indigenous health partnerships where we are called upon and expected to represent the entire Indigenous perspective to both black and white audiences. As ‘Black Cygnets,’ we were constantly encouraged by our Elders to pursue an education. These Elders always provided strong cultural guidance for us, and told us to fly to greater heights so that we could make a greater contribution to our Aboriginal families and community. Therefore, as ‘Black Swans’ we have entered academia with a broad experience in the nursing field and, with diverse clinical nursing experience, yet our teaching roles are often confined to Indigenous health rather than drawing upon our professional clinical nursing expertise.

Along the way, faced with these difficulties, some of us leave our positions, migrating from the river of academia, opting for the attraction of a different journey. Although some ‘Black Swans’ have begun paddling along a different tributary away from the river of academia, they still poke their red bills in occasionally, to keep up with progress. For the ‘Black Swans’ who stayed, academia has presented constant challenges; however, we are getting closer to our destination by influencing the next generation of nursing students to care for our people with more respectfully.

As we develop as ‘Black Swans’ we have been called upon to take many leadership roles. Because of our involvement in these roles, we have led change over time in those areas
that are of importance for progressing ‘Black Swan’ academic issues. However, we believe that while it is important for us to look out for others, it is equally important for us to pay attention to our own self-care and spruce up our own plumage when needed, so we can continue to be the strong ‘Black Swans’ that we are. As ‘Black Swans’ we also know that it is important for us to manage our stressful workloads, to nurture ourselves, and when our feathers get really ruffled and start falling out, we know we need to take time out and go for a swim up the river and be with nature again. As ‘Black Swan’ nursing leaders, we also know how important it is to provide support for each other when we go through difficult periods, and to remember the bigger picture of ‘Black Swan ‘Dreaming’ of which we are all a part.

As we approach graduation time, we start to feel like big proud ‘Black Swans’. We feel a great sense of joy when talking about attending graduation and seeing our ‘Black Cygnets’ waddle across the stage, attaining their goal of being an Indigenous registered nurse. These are the times that we can reflect on our mentoring work in supporting these ‘Black Cygnets’, and the times that we had to carry them in the ruffled feathers on our backs when they grew tired and bewildered during their own journeys. We have passed our cultural knowledge as ‘Black Swans’ to this new generation of Indigenous nursing graduates and the ‘Black Swan’ leaders of tomorrow, and we take pride and draw strength from seeing that our hard work has paid off.

As we progress down river, paddling with the current, we are optimistic and make ‘whistling’ sounds about growing our ‘Black Swan’-led nursing research, and supporting the expansion of our national ‘Black Swan’ nursing body, the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM). This helps to assist in growing a strong wedge of ‘Black wans’, so more of us can fly together to achieve our goals and provide better health outcomes for our people.

Our story of ‘Maroochy Dreaming’ will continue for generations because there is much more work to be done…this is the story of our beginning.
An Introduction to the storytellers

I will begin with a brief introduction of the eight storytellers (participants) in this study. My storytellers were Murtle (the researcher), Pearly, Ruby, Flora, Pauline, Daisy, Ningi and Titch. It was a great privilege and honour to have these storytellers gift their stories for this research.

**MURTLE**

Murtle is a pseudonym used to represent the researcher and a participant in this research study, as well as the narrator of the core story. Murtle is a strong and determined Mandandanji Aboriginal woman. She is a direct descendant of King Jimmy of Wallumbilla Station. The Mandandanji are the original people from the Maranoa district in southwest Queensland. Murtle has always strived for excellence in Indigenous nursing matters, yet always felt like she was being held back by the slow, bureaucratic and at times, racist institutions. Murtle was interviewed at her workplace by an experienced qualitative researcher. She has a long clinical nursing work history, but is now focused on striving for a PhD. Murtle is preparing to submit her PhD thesis. In her story, she shows a great measure of strength, resilience and determination to make things better for the next generation of Indigenous nurses.

**PEARLY**

Pearly is a strong and proud Aboriginal woman with Gurreng Gurreng and Boonthamurra bloodlines. Pearly maintains that her core identity, before anything else, is her Aboriginality, saying that it informs every aspect of her being. Pearly started her nurse training at a large metropolitan tertiary hospital in the late 1980s, and has continued to work in Aboriginal health since that time. I arranged to interview Pearly on her research day, as it was the only time that she could afford the downtime in her busy academic schedule to undertake the interview. Pearly was one of two key Aboriginal nursing academics in this study, and her support was invaluable in providing referrals for other potential study participants. Pearly demonstrated, throughout her story, her commitment to advancing all matters surrounding Indigenous nursing advancement.
RUBY

Ruby is a strong warrior woman from the Kalkadoon nation. She was inspired by her family to work in Indigenous health to make a difference in the health of her people. Ruby was working for a government health agency at the time that I interviewed her, having left academia for a more family-friendly job and a better paying position. Ruby’s interview had to be re-scheduled a few times, as her work covered a large geographical area, and it was difficult to arrange a suitable time. Ruby was one of two key Aboriginal nursing academics in this study. It was through her support in connecting me with additional participants that I was able to contact and interview others. Ruby continued to advance her work in Indigenous nursing through partnerships between academia and her government health position to continue to promote Indigenous nursing and midwifery excellence.

FLORA

Flora is a very grounded and proud Nudjon Aboriginal woman; her people originate from the rainforest areas in Queensland. Flora has a long family history of resilience that was built over time. Her family has been involved in advancing Aboriginal rights across all issues. It is because of this family history that Flora has strived to do the same. Flora was working for a government health organisation at the time of my interview with her; however, she keeps abreast of academic matters through her part-time post graduate teaching work in Indigenous mental health. Flora aims to undertake a PhD in the future with a focus on Indigenous mental health. She has successfully managed a family and studied consistently for over a decade, demonstrating her strong resilience.

PAULINE

Pauline is a powerful and strong Gubbi Gubbi Aboriginal woman, who previously worked in academia, but now works hard in leading a community health organisation to help advance the health outcomes of her people. I arranged to interview Pauline at her home after work late one evening; I remember the sounds of the birds chattering in the background as we spoke. This was the only time that she could allocate for the interview due to her busy work schedule. Pauline expressed a strong focus on the importance of cultural safety in her interview, an area she is extremely passionate about, and she
described herself as a walking cultural awareness tool. I was moved by the strong determination of Pauline to help others grow more in their careers in Indigenous health.

**DAISY**

Daisy is a quietly confident Wakka Wakka Aboriginal woman, who was first motivated into becoming a nursing academic through her love for research. Although Daisy told me she was adopted out as an Aboriginal baby, she was raised by a strong Aboriginal woman who inspired her to go and reach for the highest heights in academia. After completing her honours program in the whiteness of nursing, Daisy made the decision to leave her employment in nursing academia and take up medical studies. I appreciate that Daisy took time out of her busy study schedule to allow me to interview her. Throughout her story, she demonstrated incredible resilience as the youngest participant in my study.

**NINGI**

Ningi is a proud Yagalingu and Bidgera Aboriginal woman, who highlights the importance of honouring her grandmother’s Dreaming by gaining a better education. Ningi is a nursing academic and I arranged to interview her at her workplace. The same week her daughter had a little grandbaby, and it was wonderful to interview Ningi at such a happy time in her family’s life. Ningi has a long working history as an Aboriginal registered nurse, as well as a strong involvement with the early CATSIN years. Her stories are reflective of this long and strong history. It is rare to speak to an Aboriginal nurse with such a long history promoting Indigenous nursing advancement. Ningi emphasised the importance of teaching holistic nursing practice in nursing education in her interview.

**TITCH**

Titch is a Kuku-yalanji Aboriginal woman with a strong and proud history. Titch has overcome a lot of challenges due to working in many different areas of nursing and academia throughout her work history. She is one of the few participants that I interviewed that still works as a nursing academic today. I arranged to interview Titch from her workplace, and there were times that I had to stop the tape recorder so that Titch could gather up her thoughts before proceeding. The interview chronicled over 30 years of work
experience all rolled into one story, which was quite an emotional journey for her. Titch continues to teach Indigenous health with successful outcomes.

The journeys of the storytellers

Ten milestone events were identified that constitute the plot of the storytellers’ journey’s: (1) becoming a nurse, (2) journeying into academia, (3) teaching from indigenous knowing, (4) building a sense of community, (5) helping indigenous nursing students, (6) coping with racism, (7) exposing the whiteness of nursing, (8) being a leader, (9) showing the resilience of our mob, and (10) setting personal and professional boundaries. Those events were woven together by the author to construct a single core story that represents the cumulative ‘journey of the storytellers’ for this narrative study.

Becoming a nurse

The storytellers each told of their journey of becoming a nurse, how they were encouraged to respect the importance of education and how education played a pivotal role in that journey. Ningi told about her experiences from right back to the Flora and Fauna Act in the early days of Aboriginals becoming nurses.

When I first started nursing we were still under the Flora and Fauna Act; we weren’t even classed as people. So my nursing journey has been a challenge and still is to this day. Institutional racism was very present and significant when I first started nursing. (Ningi)

Three of the participants, Ningi, Daisy and Titch, revealed their passion for choosing a career in nursing from a younger age.

My grandmother taught us about the ‘Dreaming’ and taught us about forward Dreaming - Dreaming about what we wanted to be. From a little girl, I always wanted to be a nurse; I learnt about caring and holistic care at my mother’s side. I used to go with my mother and help her look after all these old white ladies. She would carry them outside and sit them under the tree and then tell them stories
about the environment and birds and trees from our culture. They, in return, taught my mother to read and write because she didn’t [read or write] and wasn’t allowed to go to school. (Ningi)

I was very young when I first had the desire to become a nurse. I think as a school child, I always saw nursing as helping people. I think a personal experience was when I had my son; the care that I received was not good at all. The nurses were really patronising and really talking down to me, which I understood to be because I was not only a teenager, but Aboriginal as well. I thought that even if I were the only Aboriginal person on the ward, just being able to help was an inspiration to me. So, I did follow through on that dream and I became a nurse. (Daisy)

I was only 16 years old when I started nursing. I had support from another Aboriginal nurse who was a third-year nurse. We became great friends. I also met a young soldier that I was madly in love with. (Titch)

Murtle and Ruby told how they were inspired to do nursing by family members.

I began my nursing career in my early 20’s. My sister was a nurse and my mother worked in hospitals as a community care worker, but her whole life, all she ever wanted was to be was a nurse. So I became a hospital-trained nurse and later a university-trained nurse. (Murtle)

At the time, I was an Indigenous health worker with the Royal Flying Doctor service out at Mount Isa, working alongside the flight nurses. So, the opportunity was there, and that’s how I became a registered nurse. Also, my mum, who’s been a health worker for 42 years, inspired me. (Ruby)

Pauline spoke of how she just stumbled into nursing from her career as an Aboriginal health worker.

I stumbled into nursing; well I was an Aboriginal health worker to start with. I chose to study nursing, in terms of not just the nursing; it consolidates and advances your primary healthcare understanding and practice. There was a group of five of us Murris who started nursing. At the end of the program there was only myself and one other who ended up finishing. (Pauline)
Both Ningi and Daisy gave accounts of how their grandmothers and mothers helped them to understand and learn the value of education.

Right back to my grandmother’s generation, they knew the importance of education. We used to go out hunting and we lived on bush tucker. Just like when you go out hunting and you’ve got to know all about that animal you’re looking for, or trying to hunt, it’s the same with education. I need to remember and honour my grandmother’s Dreaming and, to acknowledge our culture and our heritage as ‘first people’. (Ningi)

My mother was removed to Cherbourg as a two-year-old. She grew up there in a dormitory, separated from her mother and her grandmother. She went to work when she was 14 years old, but as an adult, my mother went on to go to university. Unfortunately, my mother didn’t complete her degree, because of the lack of basic education as a child. But just to see her try was what motivated me to study. (Daisy)

Pauline told how her grandmother, although teaching her to value education, also gave her confusing messages about how education may work against you.

My grandmother didn’t expect Murris to get further than what she did, because that was just the way it was, but she always used to push education. It was a strange message I was getting: you can’t go any further than this, but we want you to be educated. The message was if you get too smart it might work against you. (Pauline)

Ningi highlighted a Nelson Mandela quote that she is motivated by, which hails education as a powerful weapon.

I’d like to share a quote by Nelson Mandela. He says that, ‘Education is the most powerful weapon you can use in which to change the world’. That's our answer, education. (Ningi)

Ningi further commented on the support that she received from non-Indigenous nurses in the early days.
I need to say up front that I wouldn't have made it in the early days of my nursing career without the support of non-Indigenous nurses, and some of them are still friends to this day. But it was an unusual relationship in that they supported me, but really they didn't understand me in one sense. I can barely remember sharing or celebrating my culture with any of them. (Ningi)

Journeying into academia

The storytellers told contrasting experiences about how they journeyed into academia. However, it appears that none of the participants really had their current positions as career goals prior to coming into academia. Pearly shared how she was asked to do a guest lecture and how that facilitated her pathway into academia.

I got asked to do some guest lectures at a university in sexual health back in the late ‘90s; this was my introduction into teaching at a university level. I started working as an academic in an Indigenous education unit. I went to hand in my resignation and the Deputy Vice Chancellor said to me, ‘Why wouldn't you be teaching in a department of nursing’? And they gave me a twelve-month contract basically. In academia, I grew a lot and I learnt how to be an academic, a skill that I didn’t have prior. I was also invited onto a research team so that taught me invaluable research skills. (Pearly)

Pearly also spoke about the recognition of gaining a Churchill Fellowship.

I got a Churchill Fellowship to go overseas. We were going to teach Indigenous health as a core nursing curriculum course. I went to universities in Canada, the United States and New Zealand and gathered as much information as I could. (Pearly)

Murtle described how her journey into academia was made smoother as she was mentored into the position.

My predecessor was still working here at this university as an Indigenous nursing academic and she began informally mentoring me to replace her in her academic role. When I started working as a nursing academic I saw a struggle for
Indigenous people to achieve where it could have been so easy. The barriers were just everywhere, and the expectations that Indigenous students would succeed were low. (Murtle)

In contrast to Murtle’s journey, Ruby described her journey into academia as a baptism by fire.

A job came up at the university’s Indigenous health unit. I was successful in gaining the position, which was surprising because I didn’t have any teaching experience or qualifications. Academia was baptism by fire; I was given the responsibility to coordinate the Indigenous health course content. I was advised that previously, complaints about the course had gone to the national university union. So, that was the level of the resistance to this subject. The best weapon for the course, I think, was embedding it across the nursing curriculum. (Ruby)

It was also a tough journey into academia for Daisy and Titch and their stories reflect their difficulties.

My motivation for becoming a nurse in academia was I saw it as a professional pathway to do what I love doing and combine it with my love of research, within a role that supported Aboriginal and Torres Strait Islander nursing students. The journey into academia wasn’t a smooth one for me, not by any means. I think entering a new environment, as a new academic trying to learn the ropes was difficult, let alone entering a predominantly white environment as an Aboriginal woman. In many ways, I felt I was a token Aboriginal within the nursing department. I always had the feeling that I was patronisingly being patted on the head just for being in the role I was in… because it was just something that universities should do. (Daisy)

The Aboriginal health unit were looking for a registered nurse who was Indigenous and who wanted to teach. So I applied and I got the job as a lecturer. I finished my masters and started my PhD. My PhD studies were focused on cervical cancer and what Koori (Aboriginal people from the state of New South Wales) women may believe and perceive about cervical cancer. I was already
struggling and then I lost my sister. I just chucked it all in and I haven't touched it since. (Titch)

Flora lamented that she felt like she was faking it a bit at times within the academic environment.

_I started working in academia teaching part-time into a post-graduate mental health degree. I've been doing that since 2005. Within academia, at times, I've felt a bit like I was faking it. I'm there and I'm accepted but there's still a bit of foreign stuff going on that I don't really understand. There are a lot of unsaid rules that you are expected to know immediately. Basically, I just wanted to be part of the teaching team informing new graduates coming through and developing their practice for them to be able to have an influence around understanding the needs and the issues in mental health care for Aboriginal people._ (Flora)

Pauline, Titch and Flora found solace in the helpful support given to them by their non-Indigenous academic peers.

_When I started in academia I had an unsure feeling at first. I felt I had a lot of experience as an Aboriginal health worker, but had not been a nurse for very long. Starting a nine-to-five job was a lot better for my family back then. I had a non-Indigenous role model. Anything in academia that I was struggling with… she was the person that I could go to and ask for help._ (Pauline)

_I am fortunate because the Head of School here is a fair person and does provide me with good support and understands my cultural value. And yes, I believe that she wants this position to work._ (Titch)

_There were two professors at our university who supported me. I was able to ring one of them and debrief. Also, my Deputy Head of School at the time was very supportive; she was somebody that I could just go and say, ‘You'd never believe what just happened to me in the classroom’. (Flora)
Teaching from Indigenous knowing

Teaching Indigenous health, especially when the person is an Aboriginal academic, is often met with challenges, and the storytellers provided examples of this. Ruby and Daisy discussed their teaching transformation from novice to expert.

You teach a subject within the context of Indigenous health, and you’re a novice in your responses, emotionally, intellectually and physically. As you get more experience and you realise you’re hit with the same questions, you start to realise that you need to depersonalise it because it isn’t about you. You need to really focus on the good stuff and not get too disillusioned with some of the little stuff, because when you think about it, that’s relatively small in comparison to life expectancy. (Ruby)

The teaching role within the department was not an area that I excelled in; I think this was due to a combination of a lack of self-confidence, juggling personal problems, and a lack of guidance and support from fellow academic staff. (Daisy)

Flora told of teaching non-Indigenous students being confronted with hearing about Indigenous health for the first time.

I taught non-Indigenous nursing students the Indigenous health subject; sometimes they’re only hearing our Aboriginal history for the first time. I guess giving them the space to be shocked and to be able to challenge and argue and so forth was important. But it was also important to support them through that. It’s a quick and sharp journey for non-Indigenous students. Always at the end of the course the students would say that the Indigenous health course was one of the most confronting courses of their degrees. (Flora)

Titch described how she was undermined by a non-Indigenous nursing academic.

I was working with a co-teacher that kept referring to ‘them’ and ‘us’ when delivering Indigenous health content. I told her many times, ‘Don't do it’. She didn’t take any notice of me, and started to undermine me and I could see that happening. But I'm not going to let anybody else walk all over me and I'll say what
I feel like saying now. I’m going to let staff and students know that they must treat my people with respect. (Titch)

Daisy told her experience of struggling, and how she felt like a token black in her Aboriginal nursing academic role.

The only way I felt I could manage the other, non-Indigenous staff was using avoidance as my main strategy, just staying in my office, because I didn't want to be seen by others as struggling. I already felt that I was this token black, so I didn’t want to be seen by others as struggling as well. (Daisy)

As Indigenous people, we are so often the minority group, meaning we can be five black people amongst 100 white people. But when these statistics and the ratios are reversed, non-Indigenous people become extremely threatened and afraid. (Pauline)

Ruby and Titch highlighted the team teaching approach as a protection for Aboriginal nursing academics.

When teaching Indigenous health, the team teaching approach was far more successful, because when Indigenous people are teaching this course by themselves… it’s like standing in front of the classroom with a target on your chest. (Ruby)

There is no protection at all for Indigenous nursing academics when students are disrespectful, so I hired a non-Indigenous tutor and she came in and was supporting me. She’s got that same attitude and values and knows how to act as a professional person in cultural matters. (Titch)

Ruby and Daisy spoke about the cultural safety risks for Aboriginal nursing academics.

I don’t think I’d ever go back to a university job full-time. That’s because the cultural safety of our Indigenous nursing academics is being put at risk. We often talk about the cultural safety of the students and forget about the cultural safety of our academics. (Ruby)

I keep thinking about the cultural care policies, but there is no one governing those practices. If staff are discriminatory to Aboriginal people, what’s going to
happen to them anyway, just a talking to or a rap on the knuckles? There are no consequences for their actions apart from making me feel like shit and their Indigenous patients feel like shit, but no real consequences. (Daisy)

Ruby said she was required to combat bad media when teaching Indigenous health.

When you are teaching Indigenous health, the other factor is what students see on the media. They come in with these misconceptions about Aboriginality. You’ve got to peel all of that back before you even start teaching them. I liked the moments of having students who were particularly challenging and resistant to the Indigenous health content, then by the end of it having them say thank you. (Ruby)

Ruby and Titch talked about the impact of stressful workloads and work stress.

I’ve seen many staff attempt to teach in Indigenous health and they end up going on stress leave. To get things in balance, you need to say one-third is going to be convinced before they get there, one-third you’re never going to convince no matter what you put in front of them, and you’ve got one-third that’s sitting at the halfway point. (Ruby)

We need to be paid accordingly; don’t bring someone in to do probably the hardest job in the school, and then put them on a lectureship role when they’re already working 60 hours a week and they’re coordinating the highest risk group within the university, within the country, and then expected to be educating non-Indigenous nurses as well on top of that. (Ruby)

My contract wasn’t renewed and I was in a terrible state. I believe in naturopathy so I ended up going to a naturopath because I couldn’t walk. I’m thinking, ‘What’s wrong with me’? She said to me, ‘If you didn’t come and see me today, you’d be dead because you’re on the verge of a heart attack’. (Titch)

Pearly, Pauline, Daisy, Ningi and Titch provided their individual experiences of unmanageable workloads in academia.
It’s quite hard to teach, do your research and support black students, even though I was given a reduced teaching load to be able to support Aboriginal and Torres Strait Islander nursing students. (Pearly)

I think there are many unfair areas allocated into the Indigenous academic workload. I don’t know why the expectation is so great and why they heap it on us when we don’t heap it on them for their non-Indigenous and international students. It’s almost like as soon as we get the blackfella academic in there, they think we’ve also got magic wands; where it’s not just the black academic there for supporting Indigenous nursing students, we are expected to support all the students. (Pauline)

I think as Aboriginal nursing academics, our experiences are always going to be different to those of non-Indigenous nursing academics. We’re always going to be a minority within academia. You always need to prove the need for Indigenous support. You always need to prove the need for Indigenous research and you are always needing to prove the need for Indigenous content within nursing programs. You will always be doing more than the job description. (Daisy)

There is a big difference for an Aboriginal academic because not only have you got all the obligations as an academic, including teaching and research, but also, you’ve got your family and community responsibilities and obligations as an Aboriginal community member. You do lots of pastoral care and mentoring, we must make sure that our Indigenous nursing students are safe. (Ningi)

Another thing is I’m doing half Indigenous student support and half academic teaching. The next year they said ‘Oh, we need to review this workload’. So they ended up reviewing it and nothing really has changed. (Titch)

Flora, Murtle and Ningi brought attention to the different workloads of the clinical nursing arena compared to academia.

When you are directly in touch with clients in the clinical field you can deal with the clinical issues on the ground; you get a bit removed when you are teaching in academia. The difference is in the clinical area you get paid accordingly for the
work you do; working in academia you never ever get paid for all the hours you
do, especially if you are Aboriginal. (Flora)

In one workplace, I’m valued for my skills as a clinical nurse in the hospital setting.
Then, when I start working in the university setting, the only thing that people see
is: you’re an Aboriginal. Then because I have fairer skin, people are questioning
your Aboriginality all the time. (Murtle)

The biggest problem I see is that with clinical capability, universities will go far
and beyond. But I think we’re still struggling around cultural capability. We need
to teach that clinical capability and cultural capability must go side-by-side. But
it’s got to be embedded into clinical practice. (Ningi)

Pauline and Murtle spoke about becoming Aboriginal experts in their field, but also how
some experts moved out of academia.

The best piece of advice that my aunty ever gave me was, ‘If you’re ever, ever
doubting yourself in your stance as an Aboriginal person and an Aboriginal nurse,
just remember you are the expert in that field, nobody else’. I keep those words
with me all the time. (Pauline)

I see a lot of my Indigenous peers moving out of academia and into the
government areas that pay more and things like that, because they are moving a
bit faster on Indigenous matters. (Murtle)

Cultural safety was spoken about by Pearly, Ningi and Pauline, and Ruby noted that
knowledge of cultural safety cannot be transferred.

New Zealand does the whole cultural safety theory and framework stuff well, and
that's in all nursing and midwifery curricula, whereas here in Australia, we still
don’t teach cultural safety in our nursing courses. (Pearly)

I’m very, passionate about holistic care for our people and indeed for all people.
It needs to be embedded in our practice; it’s the only way that we can close the
life expectancy gap. I also have a cultural obligation and a responsibility to teach
nurses and midwives so that they are equipped with the knowledge and the skills
to care for our people in a respectful and culturally appropriate manner. Our only
answer to closing the gap then is having a culturally capable workforce, giving people the knowledge and the skills and hopefully the behaviour to plan, improve and support culturally respectful and appropriate care for our people. (Ningi)

I’ve always considered myself a walking cultural awareness tool, so I saw it as an opportunity to support her and make it easy for the next Murri that’s got to work with her. (Pauline)

We teach what we know. I’ve concluded in the last year or so that we can’t transfer this knowledge. We spend so much of our effort trying to increase the cultural awareness of non-Indigenous staff… There’s so much that we can’t do, that we can’t teach, that we can’t teach in a university setting. We have these qualifications, but the cultural knowledge that we have, that cannot be taught to others. It’s our birth right, so it cannot be transferred. (Ruby)

Ruby and Ningi concluded by discussing challenges and ways of better working with our mob.

Indigenous people themselves can be partly to blame about how the students perceive Indigenous health content. We’ve created such a hyper-sensitivity to working with our mob that people don’t want to offend us to the extent that they stop thinking around stuff altogether. (Ruby)

I do a lot of work around communication with nurses because I think that it is fundamental to closing the gap. I always say to nurses and doctors that relationships, particularly with our mob, should come first, even before business. It’s important that we do that because of the past policies that our people have lived under and not even being recognised and treated as people. (Ningi)

Building a sense of community

All things that occur in Indigenous communities hinge, and are reliant, on having a strong sense of community. Aboriginal people have an inherent commitment to their communities and Pearly and Ruby both vocalised their strong sense of community.
We as Aboriginal academics have a sense of community obligation. The bottom line is I'm an Aboriginal woman who's a nurse, you know what I mean. So I have a commitment to our community. (Pearly)

I've had Elders and my grandmother who have always worked towards improving life conditions for our mob, in housing, legal aid and health. So we had it in our blood to help our community. (Ruby)

Pearly and Pauline spoke about their interpretations and experiences and their interest in giving back to their respective Aboriginal communities.

In my 25 years of nursing experience, I've seen that most Murri and Torres Strait Islander nurse graduates want to work with and in their communities. That can mean a whole range of areas from community-controlled Aboriginal organisations, to primary health care settings, to hospital clinics and in the tertiary sector. (Pearly)

The thing that inspired me to keep growing academically was honestly based on the need of the community that was around me, which was a predominantly large rural and remote community with a significant Aboriginal population. I was really interested because being a Murri person, you're just interested in what happens for Murri people in the place that you live. (Pauline)

I know my grandmother always said, you get your education, and you bring it back to your mob. I'm not just going to do it for the money; for me it's always about the opportunity to give back to community. (Pauline)

Ruby and Daisy provided examples about how they have been, and will continue to be, instrumental in providing support for their communities.

I received a phone call about the little infant that had passed away from the leader of an Indigenous community. I said to him, 'I'm not quite sure what you need from me'. He said, 'We need leadership from people who are respected, who have the clinical knowledge, and who can instil calmness back into the community'. I barely felt like I'd done anything. I was just there, but my presence had a phenomenal impact on the 30 Indigenous staff working in that community. Because of that
cultural intervention from an Indigenous perspective the outcome was good. (Ruby)

It’s critical to have a connection to community not only for them, but for me, because that’s where I draw my strength from. And community not just outside of the hospital, but the community that is within the hospital, which is the Indigenous health workforce… They’re the reasons why you stay and work in the positions that you do, because they need a voice. Until such time that they develop the skills to do that, you’re holding the gate open for them. I’m very mindful of that. (Ruby)

I witnessed decisions that were being made for Aboriginal patients that were very disease-focussed and not considering the social determinants. After they’ve finished seeing the doctor, she just sent them away with scripts upon scripts, without addressing the social determinants that they’re going home to. I’ll get my program health professionals involved and get together a holistic approach to help not only the patient but the whole family as well. (Daisy)

Pearly and Daisy brought attention to the importance of acknowledging the sacredness of women’s and men’s community business.

Take, for example, feminism as a white woman’s construct, only a couple of decades old, basically, as a framework. We are matriarchal; my grandmother’s line has only been broken for 200 years, or so, or whatever it is since whitefellas came. I think our black women essentially run most of our community business. (Pearly)

As an Aboriginal woman undergoing these unusual times in history where our population is suffering such extremely poor health, I am aware of how important it is to look after myself and my family. I need to keep my energy levels balanced so I can manage all the stress just so I can keep going. (Daisy)

I also think we desperately need more Indigenous male nurses. One way that we need to be helping our Indigenous men is with their health checks, and the reality
is there's a construct, a cultural construct around women messing in men’s business. (Pearly)

Titch spoke about the heartache of being excluded from her own mob...where other Indigenous people from far away had been welcomed.

Sometimes I am excluded by my own mob, which makes things hard...because this is my country here and this is where my family are from. But I've still been excluded by the Indigenous people who are working here at the university. (Titch)

Helping Indigenous nursing students

Many of the Aboriginal nursing academics also had Indigenous nursing support roles attached. They spoke about the good and the challenging aspects of these roles. Pearly, Murtle and Pauline spoke about hope for the future in bringing on more Indigenous nurses and support.

Canada at one university had 200 Aboriginal nursing students enrolled in nursing. It allowed me to think, ‘This stuff can happen in Australia too’. (Pearly)

At the time we started our nursing degree there wasn’t an Indigenous nursing academic in the nursing department, but we were in hope that she would be arriving soon, and that kept us going. (Murtle)

Being one of the only Murri nurses standing on a ward is very hard, and I'd really like to be part of developing the next generation of the Indigenous nursing workforce, and do whatever it's going to take to put our black faces in those wards. (Pauline)

Pearly and Daisy told of their love for the job, and starting a sense of community by supporting Aboriginal nurses in the making.

I fell in love with the job. I was given a lot of leeway and support to nurture and build up the Indigenous nursing student cohort. I started to get some sort of sense of community going amongst them. That just became a real wild journey. I used to get run down stupid and ragged. (Pearly)
The part that I did absolutely love about the other part of the role was supporting my fellow Aboriginal registered nurses in the making. It’s an indescribable feeling just knowing for them that their life is going to change for the better. Not only will they improve their own life but the lives of their family as well. (Daisy)

Pearly and Flora highlighted the importance of nourishing Indigenous nursing students with strong academic support.

It’s about actually giving the students that academic nourishment but also really nurturing and revitalising and progressing culture that helps them to progress. Mostly I’d get them in my room and we used to - I’ll be honest - laugh, cry, carry on. Sometimes I’d have to have a go at them, you know, that type of stuff. So, it was a whole spectrum of emotions that I went through supporting those students. (Pearly)

I was full time Indigenous nursing academic for three years at a university teaching into an undergraduate nursing program. I was directly able to assist and have a direct influence on providing the needed academic support for the Indigenous nursing students. (Flora)

Pearly went on to give an account of the pressure she felt from her nursing academic peers.

Juggling the Indigenous nursing support role can be tricky and not always understood by academic peers. For example, I had to move one of the Aboriginal students on a weekend. We were just yarning around the lunch table, and I said, ‘I helped one of my Aboriginal nursing students move house’. You could have heard a pin drop. There was this look of shock, horror and disapproval. (Pearly)

Murtle spoke about her successes, but also her frustrations and nearing breaking-point because of knowing what’s possible.

I think the real near-breaking-point for me was when I started here as an academic, and I had no textbook resources for my Indigenous nursing students. I went and I had a discussion with the Dean of Sciences at the time, and he
provided funds out of the Dean’s discretionary funds to support the students; without that I wouldn’t have stayed. (Murtle)

When you quadruple enrolments, it’s because it’s possible. It’s not because you are trying to be better than anybody else, it’s just that it’s possible. So in a sense I’m sustained by my success. It’s very frustrating for me to see that things can work so easily, yet it is not done across the board. (Murtle)

Murtle mentioned how her non-Indigenous colleagues would go above and beyond to support the Indigenous nursing students.

One of my non-Indigenous colleagues is supporting two of our Indigenous students in a critical care course, going above-and-beyond what she should do and she’s even more excited than me that both students are going to graduate soon. She’s giving her support with real genuineness. I really received a lot of support from the non-Indigenous nursing academics and they’re there for all the students. We’ve really got some very committed people, committed to reconciliation, and wanting things to improve for Indigenous people. (Murtle)

Flora, Pauline and Murtle revealed their thoughts on what they perceived to be the barriers to Indigenous student success.

The time and the demand on them from their family and the community is way different for Indigenous students. I don’t think the academic community understands. Extended family is not recognised as a reason for needing family leave. (Flora)

Other issues that emerged were lack of money and financial support. Once again, if you’re financing a whole family, an extended family and then having to finance your studies, you’ll have issues, so financial stress was a big barrier to study. I found the students who succeeded were the people who already had successful studies under their belts, such as your trade qualifications or certificates or diplomas. (Flora)

I have a lot of students and I can guarantee that if they have issues with their studies, it is because of a social issue; someone’s passed away in the family, or
they’ve had some financial deficit, or there’s a relationship issue. They get so distressed that, obviously, they can’t focus on their studies anymore. (Pauline)

While I was a student at the university, one of my research projects was, ‘What are Indigenous funds used for in the university, and how are they used to support Indigenous students’? I found out that the money went to one pool for all student resources, but it doesn’t directly benefit Indigenous students, it just benefits every student in the university. (Murtle)

Ruby observed student support services and inferred that International student support was superior to Indigenous student support.

In comparison, if you look at our international student coordinator, the level of infrastructure that’s put around that person to support the international students is phenomenal, yet as Indigenous people in universities, we’re not afforded that same level of consideration. (Ruby)

Pearly spoke of graduation success, wearing Indigenous colours and Indigenous people starting to smash the ceilings.

My greatest joy came from, seeing my Indigenous nursing students graduate, seeing each one of them walk across the stage. When I could start wearing the Indigenous colours at our graduation ceremony that was the payback for me, and seeing our Indigenous community just absolutely starting to smash the ceilings. (Pearly)

Coping with racism

Racism is something that Aboriginal people have experienced since the time white people invaded Australia. The study participants provided their personal and professional experiences with racism. Pearly maintained that racism had been experienced by blackfellas from day one of invasion, and said in a study of six decades of Aboriginal nurses, racism was a common theme.
Nurses can be incredibly vicious and we’re an incredibly ignorant profession when it comes to Aboriginal health. Racism is something that blackfellas have coped with from day one of invasion. (Pearly)

For my PhD I interviewed six decades of Aboriginal nurses, and guess what one of the common themes was for them? Racism and how the white nurses just need to learn more about us. (Pearly)

Flora and Daisy told of their personal experiences with being a victim of racism in the workplace and how unsettling it was.

When I was a student nurse at a rural hospital and they had me working on a private ward I was looking after an Italian lady and we got along just great. Then one day she said, ‘Are you Italian’? I said, ‘No, my olive skin colouring is because I’m Aboriginal’. Then I was told by the sister in charge that I wouldn’t be looking after that lady again through my placement. (Flora)

I was working part time in a non-government aged care place with first generation migrants and now they’re at the stage of dementing. In their dementia, the speech that comes out is lots of horrible, nasty things that are directed toward me and other Indigenous nurses. It’s not a nice feeling to hear these things. (Flora)

I was working in an aged care home; the oldies used to call us negro’s and blacks and all that sort of stuff. It’s probably because they are a bit demented, or maybe because it was accepted in their day. I don’t know if it was done with any ill-intentions or anything, but it still affects you. You go home and think about it. Not a good experience. There is also the discrimination that I saw directed toward Aboriginal patients. Having to be in a position where you’re witnessing discrimination towards Aboriginal patients and being the only Aboriginal registered nurse is really unsettling. (Daisy)

Murtle expressed her shock of becoming aware of the Indigenous industry, where non-Indigenous people set up services to make money out of dysfunctional Aboriginal communities, making her aware of how badly Indigenous people are treated.
I started nursing in the Northern Territory and predominantly the clients were Indigenous. I learnt a lot, but it was just sickening to see the way that they were treated, because they could not defend themselves or stand up for themselves. That’s when I became aware of the Indigenous industry and how people flock to it to get blood money and suck the life out of the dying carcass of the Indigenous people every day. (Murtle)

Pearly and Flora described how it was necessary to protect Indigenous nursing students from racism.

Obviously, the darker skinned Aboriginal nursing students would cop racism whilst they were on clinical [placement], and one student was called ‘abbo’ and ‘coon’, being made to feel incredibly uncomfortable by facilitators. (Pearly)

It’s like a kind of double-edged sword of racism for the fair skinned Murri. They proudly identify that they’re Aboriginal or that they’re Murri, and then they cop racism; like, ‘You’ve got fair skin, why do you identify as Aboriginal, are you 1/16?’, that type of shit. (Pearly)

There were also times that some of the Indigenous students needed support through their experiences with racism, I guess just needing someone to spend time with them and just hear them, allowed them put all that emotion somewhere right at the time. (Flora)

Pearly, Ruby and Flora gave accounts of the challenging times they encountered dealing with racist behaviour from non-Indigenous students.

If students were openly racist I would talk to them about the inappropriate behaviour; it’s about educating them. Thankfully there are policies and procedures to address racist, homophobic, misogynous behaviours at universities now. The whole notion of having racist comments thrown at me, it's not new, and it's been happening for decades. So, the reality is you become at times quite resilient to it, and if it did my head in a little bit more than what it normally did, I'd talk to family. (Pearly)
They could barely say the word Indigenous, or barely say the words Aboriginal and Torres Strait Islander. One of the students said, ‘It’s just the word Indigenous’. I said, ‘Yeah it is. It’s almost stigmatised, isn’t it?’ They said, ‘Yeah. Why don’t you change it?’ I said, ‘Why don’t I just change it to apples and oranges just so you’re comfortable?’ They say this because for most of their lives they have avoided these words. (Ruby)

It was the ignorance and the blatantly outwardly racist comments. But they didn’t realise that they were racist. I don’t think that the intent was there to offend, but they’d never had the political issues affecting them personally. Racism is always out there and I never dismiss it, but you must learn how to channel it, because you haven’t taught this course without experiencing racism before. (Ruby)

I was teaching a session… the topic was the 1967 referendum… one day sticks out in my mind. There were a couple of granddaughters of agriculturalists; one said, ‘Oh, my grandfather bought the Aboriginal people who worked on our property a new suit of clothes every year for the show’. Right there was my demonstration of prejudice. (Flora)

Ruby, Pauline, Ningi and Titch were affected by racism from their peers.

Being an Indigenous nurse academic, from my standpoint, I’m in a very small minority group of nursing academics. Some of my colleagues from the university that I was working at, I thought I had a good relationship with, when I asked the questions on Indigenous health matters, some of their responses were, well, surprising. (Ruby)

A challenge for me was the new senior academic; she had it fixed in her head exactly what Aboriginal people were like and treated them accordingly. It was racism at its best and there were times that I had to call her on it, but then the racism became more overt. If sometimes the Indigenous nursing cohort were not doing so well, she straightaway attributed it to an intellectual deficit and started to run remedial courses. I should have just went, ‘You know, just because we’re black, we’re not dumb’. (Pauline)
I’ve had negative experiences too, and couldn’t believe some of the racism that I have endured. Sadly, racism is still very evident to this day. It was just incredible really, and from my peers who - because of my Aboriginality - they couldn’t accept me as being not only an Aboriginal woman but an academic. (Ningi)

There was a charge nurse who wanted one of her friends to get the job, and I got the job over this other person. When we were by ourselves, the charge nurse attacked me personally; I think it was because she was racist. (Titch)

Flora had a different experience and found her peers supportive.

I can’t say that I’ve ever had a problem from my nursing colleagues with racism, and most of my support has been because of the support of the non-Indigenous colleagues who see me as a value-add and someone they want working for them. (Flora)

Ruby and Titch stood-up to racism in their work place, although it affected them daily.

In the hospital where I work, I used to let matters about racism go, but I started calling them on it. I was perceived as a typical black, I was very angry. I was very disillusioned…It takes some real resilience to remain in the profession. It’s a very high needs community that I am overseeing and I am dealing with episodes of racism every day. (Ruby)

My experience as an Indigenous nursing academic has been a lot different to mainstream nursing academics because I’ve experienced a lot of racism in my life and that has affected me. (Titch)

Murtle highlighted the importance of showcasing her Aboriginal culture and continually striving to overcome stereotypes.

Working at a university is an opportunity for me to showcase my culture, but it was also an opportunity for me to excel and to demonstrate that it doesn’t matter what stereotype you throw at me, I’m going to do better and I’m going to be better. I’m going to do better than my very best every time, because it’s that important to me. It’s more than my culture; it’s about my family and my family’s honour. It’s about setting that precedent for my children, not listening to someone just
because they have a negative stereotype about Indigenous people. So I announce loudly and proudly, ‘I’m this people’. (Murtle)

I think that it only became apparent to me when I came to university that people expect or accept that Indigenous people, if they’re out drinking and at the racetrack, or if they’re not achieving, that it’s okay. But as soon as an Indigenous person becomes educated, the dominant people in white society keep them isolated and excluded. (Murtle)

Exposing the whiteness of nursing

The whiteness of nursing is something that impacts adversely on Aboriginal nurses. They are always the minority group. Pauline commented on the pedestal of whiteness in nursing and its effects.

I think a lot of the challenges have a lot to do with their whiteness; everything must be done from their perspective, because it is their whiteness that makes them think that they are right all the time. They stand on that pedestal of whiteness and they think there is no other way. They think that they are superior just for being in the conversation. (Pauline)

Pearly believed that the whiteness of nursing needs to be dealt with on an academic level, as it affects the progress of Indigenous nurses.

Nursing is an incredibly white profession. Florence Nightingale wrote a review on the training of nursing for the colonies, which it clearly said that we’ve got to train Indigenous nurses, and our nursing profession here in Australia actively chose not to do anything about that. (Pearly)

When we start dealing with the whiteness of nursing on an academic level, where we can push the boundaries in academic literature, I think we’ll be taken a little bit more seriously. (Pearly)

Ruby suggested that one way for combating the dominance of whiteness in nursing is to increase the number of Indigenous nursing academics.
It doesn’t measure up, and I think it has a lot to do with whiteness of nursing, that they’re not actually seeing what we do as Indigenous academics. Supporting Indigenous nursing students and liaising with Elders and our Indigenous communities is even a workload. I think we need more Indigenous nursing academics, I really do, and I can’t emphasise enough how critical they are. (Ruby)

Daisy had a strong research focus on the whiteness of nursing and provided a personal account of how this impacted her immediate family in the health care setting.

My masters honours topic was on whiteness of nursing. I can give an experience about this from my own personal family experience. My Nan had breast cancer; she was in a hospital towards the end of her illness. Within our culture, having family to come and pay their respects towards the end of life is important. But Nan was not allowed to have this, just because of the visiting times and the constraints on how many visitors you’re allowed to have. It just made her last days not as peaceful as they could have been, just because of visiting constraints. I was young at the time, but I remember it very distinctly as a really distressing time for me and my family. (Daisy)

Murtle voiced her frustrations about the perceptions that white people have of Aboriginal people, and how difficult it has been for her to make progress as a black woman in a white world.

My personal story is about an acculturated woman in a white woman’s world. So suddenly, as much as the white woman appears to be progressing, the literature says if you’re a black woman, your progression is not even started yet. In fact, in the hierarchy of universities, the black woman is at the bottom of the hierarchical ladder. (Murtle)

It’s a really westernised, white-dominated university, strongly embedded with values of neoliberalism and totally devoid of Indigenous culture. So, there’s always that fanciful idea from the mainstream academics that Indigenous people are artistic and are dressed in animal skins and are mostly surrounded by colourful tribal art and things like that. (Murtle)
Titch spoke about how when white people feel threatened, they turn Indigenous people against each other.

Then there was a review at the university I was working at; there were a lot of politics, because the whitefellas felt threatened, they turned the Indigenous people against each other, and they didn't take any Indigenous person's point of view at all. (Titch)

Being a leader

Leadership in Aboriginal nursing in academia is a new concept; until only recently, there were only Indigenous nursing academics. The storytellers spoke about Aboriginal nursing leadership in its many forms. Pearly spoke of an Aboriginal nurse leading the way from over 100 years ago.

I found an Aboriginal nurse in New South Wales who trained in 1908, so they need to be proud of the profession that they're walking into, because black women have been doing it in Australia for over 100 years. (Pearly)

Ruby brought attention to the notion of how sometimes Aboriginal nurses are leading on their own.

It’s really frightening, because I often say, ‘You’re not born with wanting to be a leader. But there are not a lot of Indigenous leaders. So, if you're called on to lead, you're often leading on your own’. (Ruby)

Pauline described the challenge of being thrust into leadership roles.

Indigenous nurses and leadership, it is like you’re sort of thrust into it sometimes, whether you want to be a leader or not, that’s from my Murri community. Then you get the other side, as they have Murri academics, they want their opinions or views on anything to do with Aboriginal issues, and I don’t hold all the opinions and views for Aboriginal people. I used to never solve any problems for people; I used to challenge them in a way that they were dealing with the situation themselves. Which is a form of leadership I guess? Because sometimes it was just such an easy cop-out to go, ‘Just give it to the black nurse’. (Pauline)
Ningi talked about the influence of her grandmother’s words, and being a leader in every sense.

I remember my grandmother’s words too, that me being a nurse is her Dreaming. My desire to become a nurse educator came from my grandmother, to teach and help people understand where our mob is coming from. I probably don’t regard myself as a leader, but I am a leader in every sense of the word. (Ningi)

Flora and Pearly identified some of the cultural aspects associated with leading, and how this informed their leadership style.

I contribute in the area around acknowledging the cultural aspects and how that impacts on broader mental health assessments. Diagnosis often hinges on correct understanding around spirituality; people may be labelled with frank mental illness when the symptoms that they’re speaking about are a spiritual occurrence. It’s like anything around Aboriginal culture; it’s never one person. There’s certainly a group of people, including Indigenous health workers, and a lot of support from non-Indigenous clinicians willing to support us and give us a voice, to keep the momentum going to be part of these changes, but sometimes it can become very draining. (Flora)

Blackfellas walk the line, so we walk almost shoulder to shoulder. It’s a community response, whereas non-Indigenous people, they’re all very competitive and there must be a head girl, there must be that person of leadership right at the top. It’s a straight line, you know, straight up and down, whereas ours is across. (Pearly)

Pearly and Daisy provided insight into their responsibility to lead and be a role model for Indigenous nursing students.

I think that most Aboriginal students look toward me as an Aboriginal nursing academic responsible for leading them. Several of the academics said to me early in the piece that they hadn’t seen Aboriginal nursing students walking through the department of nursing like they did after I arrived. (Pearly)
In my role as an Aboriginal registered nurse, I talk to a lot of young Aboriginal girls who ask you about being a registered nurse and how I got to being where I am, and how they can go about doing the same. I suppose they sort of see me as a role model, which I take very seriously. (Daisy)

Daisy and Ningi understood this by bringing attention to the importance of having positive community role models.

I suppose, in a way, when you go to university you're seen as a bit of a trailblazer and a role model. Especially in my family, I'm the only one with a degree. In the community, as well, I'm a role model because of my role as a nurse. (Daisy)

We need positive role models, with a commitment to making a difference to the lives of Aboriginal and Torres Strait Islander people through improved health outcomes. (Ningi)

Pearly, Ruby and Murtle discussed the importance of leadership in educational institutions and taking things forward.

We also need to push schools of nursing and midwifery to have Indigenous academics attached; there are still only three in Queensland that have Indigenous nurse academics. It's about making Aboriginal nursing, midwifery and health core business that is not negotiable. (Pearly)

The opportunity to implement the findings of my PhD has been phenomenal. That's in two Queensland universities that I'm doing that. So now there's the evidence base that's informing the strategies that the schools of nursing and midwifery are implementing. (Ruby)

Indigenous issues are never a priority in universities, and it's never core business; at my own university, I feel like nothing moves unless I'm beating it from behind. So I think that there's no real commitment from the university. (Murtle)

Pearly, Murtle and Ningi suggested recommendations for leading into the future, and being united in leadership.

It's also about getting black nurses on to boards, such as the AHPRA (Australian Health Practitioner Regulation Agency) Board, the regulatory authority, and
getting them on to the board of the ANF (Australian Nursing Federation), the College of Nurses. It's also about getting into the ear of the Chief Nurse of Australia. It's about collaboration; it's not about leadership. (Pearly)

When some situations get too difficult for me to manage, I must retreat and then regroup and then try another angle, but I never give up. I never give up, because it’s working. It’s not like I’m beginning at the beginning. I have had runs on the board, and now I am leading into the future. (Murtle)

In closing, I would like to remember CATSIN's motto: unity and strength through caring. If we are united, then we all have the strength to achieve our dreams. (Ningi)

Murtle and Pearly spoke of the changes needed to make progress towards a stronger voice in Aboriginal nursing matters.

Sometimes I have this almost limitless personal energy and drive, held back by slow bureaucratic, and at times racist, institutions. Being a change agent is difficult because systems and people are almost innately set up, it seems, to want things to be the same - I think as much as I’m pushing and I have that confidence and the passion. So it’s like you’re feeling like you’re invincible and then suddenly all the literature says black women are behind the eight ball. But they are becoming stronger and they’ve got to use their own personal power now to fight for change. (Murtle)

There should be a caucus of Indigenous nurse academics across Queensland, to create statements and advice to advance our nursing leadership. (Pearly)

Pearly, Ruby and Daisy concluded with highlighting the power of research to help our students and build capacity for more Aboriginal researchers.

We need to start to research and harness together the experience of the black nurse academics out there. I figure that they're the most experienced, so if we can start at the top, I believe that we can improve things in the long run. (Pearly)
There was also a research activity where we could employ one of our Aboriginal nursing students as a research assistant, which helped the student consider research as a future career choice. (Pearly)

In regards to the research, we've just started an Indigenous nursing student working party that meets weekly. We've developed a risk assessment tool, and depending on the level of risk that the student is at, that stipulates the contact needed. The minute they miss a tutorial, a lab or an assessment, we will get notified. (Ruby)

The research opportunities of that role and being able to co-research with fellow Aboriginal nurse academics, I think that was what kept me in the role for so long. (Daisy)

Showing the resilience of our mob

Resilience is a common finding in populations that have encountered oppression. The storytellers provided insight into how their people demonstrated resilience. Surviving invasion was one thing that Pearly said screams resilience.

I think our mobs are extremely resilient. We've survived invasion for over 200 years. If that doesn't scream resilience, nothing does. So racism, I think for blackfellas, can build resilience. (Pearly)

Titch, Flora, Pauline and Ruby provided accounts of how they had been inspired by stories of family resilience.

One story of resilience that inspires me to achieve as an Aboriginal woman is my father's story. He was one of the original Rats of Tobruk. When he was in England he saw what it was like to live as a white man, when he came back here, he wasn't given any of those privileges. (Titch)

I guess that I do come from a family of strong people who have challenged the system. My great, great, grandfather was the first white person to be granted permission in Queensland to marry a full-blooded Aboriginal woman. Then my grandparents were also very active, with lots of other people, in politically
agitating around the 1967 referendum. My uncles were instrumental in setting up the first community run health centres, legal aid services and the housing services. I guess my resilience does come from my family. (Flora)

I've had to be resilient at times and I guess I attribute that to my grandma to start with, but also it ends with my children. I've just got to show them that absolutely anything's possible. (Pauline)

I often use that as a contextual tool for when I think that I'm having a tough time or life is hard, in comparison to what my ancestors went through, and my Elders, to provide me with the opportunities that I have in front of me today. (Ruby)

Ruby, Murtle and Ningi gave examples of how they endured and showed resilience in their role as Aboriginal nursing academics.

The expectations of Indigenous academics are above and beyond that of non-Indigenous academics. I learned a lot of things quickly. I don’t know whether it was the best, positive experience, but it certainly was resilience-building. (Ruby)

You get tired, and get really demotivated sometimes, but I have learnt to celebrate the little wins along the way, and I’m always excited when I’ve got something coming up that’s going to be great. The way I look at it, change could be a lot faster, and I get impatient, waiting for things to rock-and-roll in the Indigenous space. (Murtle)

To keep your resilience strong, you've got to maintain that strong connection to your country and kin. But all through my career, and even to this day, I believe that we always must do things 120% better than anyone else. (Ningi)

Pearly provided stories of resilience from Indigenous nursing students, and talked about the importance of strong identities.

One of the examples of resilience was one of the Aboriginal nursing students who copped phenomenal amounts of racism throughout her nursing course. Despite all of that, she has gone on to do multiple post-graduate qualifications. To me, that’s resilience. (Pearly)
Another Aboriginal student from one of the mission communities had experienced many deaths in her family circle. There were a few funerals this student had to attend, as well as keep abreast of her nursing studies. She’d fail a unit, and then she’d get up, dust herself off and just keep going. I have never seen resilience like it in any other student body or ethnicity or culture or gender. (Pearly)

As much as I love teaching, my Aboriginality is my central point, that’s who I am and how I function and operate in the world. There’s a big difference between those who say, ‘I’m of Indigenous heritage’ but know nothing of their community or their links to land, or who are not active members in the Indigenous community, then somebody who says, ‘Yes, I’m a Murri’ or, ‘I’m a blackfella’. (Pearly)

One of my Aboriginal Murri nursing students was going through the link-up process to find her birth family. She had knowledge of stolen generations and removal of Aboriginal children, and all that had really played a pivotal role in her growing and developing. She got stronger as she was re-establishing her link to land and gaining knowledge about where her blood lines came from. (Pearly)

Setting personal and professional boundaries

There are many joys, as well as challenges, that impinge on the Aboriginal nursing academic’s personal and professional experiences. Ruby, Ningi, Daisy and Pearly showed the importance of receiving support from their Aboriginal nursing academic peers.

Other Indigenous academics were supportive [and] to have other people to validate you was weirdly comforting. It makes me go harder when something gets tougher. At stressful times like these, you must keep surrounding yourself with people who share the same vision. You always should keep asking yourself, ‘Why am I here?’ (Ruby)

I am proud of the progress that we have made, and I’m proud of all the Aboriginal and Torres Strait Islander nursing academics from around the country that are making a difference. If I were to pass on my cultural knowledge to Aboriginal and Torres Strait Islander nursing academics, firstly, I would tell them to be proud of
who they are and to be confident about their cultural heritage. I would also tell them to never second-guess themselves because you are the voice and the cultural experts. (Ningi)

I also think by seeing role models for myself. Seeing other Indigenous registered nurses and Indigenous nursing academics that have gone before me and just seeing the difference that they made for themselves and for their Indigenous communities. That's just a big motivation and a big source of resilience for me to see that I'm not the only one. (Daisy)

But I never ever for a second thought that this would be where my life would lead, with a PhD and travelling the world and running with an amazing pack of Aboriginal nurses and midwives. (Pearly)

Ruby recommended that universities put supports in place to keep Aboriginal nursing academics on staff.

I think that's where they're at a greater risk of burning out. You also must genuinely support the person that you recruit to that position, just not tick the Indigenous box. There are a lot of other skills and attributes that person needs for them to be successful in that position. Universities must ensure that this Indigenous stuff isn't just a tag on; if they want to employ Indigenous academics, Indigenous stuff needs to be first and foremost because there are non-Indigenous academics that can pick up the other stuff. I would like to see more Indigenous nurses and midwives, because obviously, we can't have Indigenous nursing academics if we're not getting them out at the university level. (Ruby)

Daisy, Ruby, Murtle and Pauline talked about how they coped with stress that was forever present in their line of work.

Sometimes work can be stressful. Your job as an Aboriginal registered nurse is not just your job description, it's so much more. It's educating your non-Indigenous counterparts constantly. It's exhausting at times, exhausting and frustrating. My number one method of coping is accessing family support. Just going home at the end of the day and dissociating from all that stress, as much
as possible. Just going home and being with mum and the kids. I am also strengthened by them as well. (Daisy)

The tea room - I will always avoid [it] like the plague because somehow your presence just seems to instigate discussions about race relations. (Ruby)

I’ve been told I’m very impatient, apparently. But I think Indigenous people have waited long enough, I really do. Impatience, it’s a bit inaccurate, because if the health issues were affecting mainstream people the way they affect Indigenous people, they wouldn’t want to be patient either. I think sometimes when you bring attention to Indigenous issues, it brings out the worst in people, because they’d rather not know about it and be reminded. I think sometimes my commitment to advance Indigenous educational opportunity comes through as very strong and then that could be seen by other people as aggression, and then you’re seen as an angry black person. (Murtle)

It’s almost like you just lost respect for the system about what was happening and it just eroded you eventually…but I didn’t want to leave the job by any means, I moved on about three years later. (Pauline)

Pearly, Ruby, Murtle, Daisy and Ningi all spoke about the importance of looking after yourself.

It’s about me doing really good things for my body in a cultural way, so whether that’s visiting my 95-year-old Aboriginal grandmother, or doing some reading that’s going to nourish me, I'm going to enjoy myself doing all that type of stuff. (Pearly)

Since I finished my PhD, I exercise every day now. One of my biggest mistakes doing my PhD was that you live in your head and I was never doing any physical activity. By far, I found that physical activity is the best way to deal with stress for me. You need to look after yourself. Our experiences are so different to non-Indigenous nurses; there’s a greater responsibility that’s placed upon us. We’re expected to support the Indigenous students, as well as do the research and all of that together. So, I think more value needs to be placed on the uniqueness of
the skills that we bring so we’re not treated and managed like a normal academic. The big improvements are that we’re getting better at Indigenous nurses and midwives completing. (Ruby)

I’m really focussed. I’ll go home - when I’m tired I’m not as effective and I know that - so I know that I must look after myself physically so that I can sustain that high, vital level of energy. But I very rarely get exhausted. I have a strong blood flow, a strong life force. (Murtle)

My family nourishes me as well, but personally, I think as weird and as warped as it sounds, study nourishes me as well. The research, the writing, that sort of thing - it does really nourish me. It’s the writing and knowing that my contribution through research is going to make a greater contribution to the future. (Daisy)

When I’m at my limit, it’s important for me to go home to country and reconnect. When I get there, I go and walk out in the bush, go to the creek and sacred areas that we went to when we were kids growing up. Then I’m revived again to keep on going. (Ningi)

Pearly and Murtle noted the importance of good mentoring.

My first mentors were beautiful Murri registered nurses. I was immediately put into a position where I had these older Murri nurses, and I could look up to them and learn from them as a young Aboriginal registered nurse. I’ve also maintained a relationship with all my past nursing graduates. (Pearly)

I think basically I’d thought of five mentors that supported my growth when I started in academia: the first one was the non-Indigenous person that worked in the Indigenous education unit, he convinced me to stay when I wanted to leave. (Murtle)

Pearly and Pauline concluded by providing their hopes for the future.

My biggest hope for the future is to have black nurse academics attached to every school of nursing. The white schools of nursing and midwifery must deal with this as a core issue that needs urgent addressing. The other thing we need to be
doing is teaching Aboriginal and Torres Strait Islander health in all undergraduate nursing and midwifery curricula. It's no longer negotiable. (Pearly)

A PhD is next on the cards for me; I’ll complete my masters in research first. Now, we’re calling it nurses’ stories about cultural competence in nursing, and how they embed that into everyday practice. I’ll turn that into a PhD at some point. (Pauline)

Summary

This chapter introduced the eight participants of the study and highlighted components of their narratives. I introduced the narrative storyline of the ‘Black Swans’, which is presented as the ‘core story’ entitled ‘Maroochy Dreaming’. The ten significant event themes that constituted the plot of the storytellers’ journey were outlined, and the core elements of the findings were presented. The final chapter of this thesis brings together the research findings from the participants’ stories to provide a strong focus in the discussion and conclusion.
CHAPTER 5: DISCUSSION AND CONCLUSION

Advancing knowledge based on the study findings

The aim of this doctoral research was to document the stories of Aboriginal nursing academics to reveal, explore, and ultimately develop a deeper understanding of their experiences. A more comprehensive understanding of the experiences of Aboriginal nursing academics will inform the development of recommendations for optimal support for this important group within the tertiary education sector. The focus of this research study was participant experiences, including the challenges faced and the opportunities participants have created, or that have arisen, during their nursing careers. Also, key to this understanding, was the identification of how these participants have balanced both the challenges and opportunities to advance their roles as Aboriginal nursing academics. The data are rich and deep, and give unique insight into how Aboriginal nursing academics perceive and manage their workloads in relation to their personal and professional interactions with work colleagues and students, both Indigenous and non-Indigenous, together with the barriers and enablers they have experienced throughout their journey into academia. Based on these findings, recommendations are made for current policy, practice, education and for further research on a national scale, within schools of nursing and midwifery (SONMs) across Australian universities.

The four major themes generated from this research study will be discussed in the context of current literature:

1. Becoming a nurse and journeying into nursing and academia;
2. Being situated in the Indigenous academic world;
3. Racism and the whiteness of nursing; and
4. Developing resilience to further develop leadership.
Theme 1: Becoming a nurse and journeying into nursing and academia

Study findings revealed the experiences of each of the participants in their journey to become a nurse, and their successive professional journeys from clinical nursing into academia. Participant experiences were similar, although personal accounts of each journey showed individual perspectives. In exploring the key theme of ‘becoming a nurse and journeying into nursing and academia’, six sub-themes were identified: becoming a nurse, discrimination and racism: primary barriers, job satisfaction in nursing, journeying into nursing and academia, working between Indigenous and non-Indigenous worlds, and journey into research. These sub-themes will be discussed in turn.

Becoming a nurse

Many of the participants chose to pursue the goal of a career in nursing from a very early age. They were inspired and encouraged by others in their family and community to reach this goal. Barriers and challenges to achieving their goal of becoming a nurse were evident in each participant’s journey; however, there was also a high level of job satisfaction attained, mainly from the love of working with their own ‘mob’. One participant (Ningi), related how her grandmother taught her about ‘forward Dreaming’, and how it was important for her to hold a strong vision for attaining a future career in nursing. She credits her natural nursing and healing abilities, used in her everyday holistic nursing practice, as starting with her grandmother’s stories about where to find ‘bush tucker’, the native birds and trees, and the Dreaming to which she attributes this knowledge, making her strong in culture.

In a book by Sveiby and Skuthorpe (2006) about Aboriginal hidden wisdom and culture, there are multiple accounts that link to this concept of ‘Forward Dreaming’, where Aboriginal people have ancient wisdom and practices passed down to them by their Elders to keep their culture strong. Another participant (Pauline) spoke of how her grandmother encouraged her to get her nursing education so that she could become a leader for her people and bring those skills back to help her mob. These findings show that strong matriarchal lines and women’s business still exist in Aboriginal communities, despite the continuing loss of traditional knowledge. It was regarded as very important by
participants to draw on these skills for the success of their families. Fredericks, Adams and Best (2014) describe how Indigenous women’s business is an important part of women’s health. Women’s… ‘customs, cultural practices and laws are taught to young women by their female Elders, but not shared with men’ (pp. 74-75). Similarly, men’s business is not shared with women.

*Discrimination and racism: primary barriers*

In the current study, participants’ journeys to become a nurse revealed many challenges and barriers hidden and intertwined within discriminatory practices in nursing. Kingma (1999) defines discrimination in nursing as, ‘A showing of partiality or prejudice in treatment; action or policies directed against the welfare of minority groups’ (p. 87), where Indigenous peoples and ethnic groups were cited as examples. Goold’s (1995) seminal work focusing on why there are so few Aboriginal nurses reflected a similar view. Many discriminatory practices embedded within the nursing profession were cited in this study as a major barrier that discouraged Aboriginal nurses from succeeding, and the main reason nurses made the decision to leave the profession. What has not been clear until now is whether this situation has changed in the last 20 years. Several studies (Best and Nielsen, 2005; Usher et al., 2005b; West, Usher and Foster, 2010) have identified that barriers, such as social, financial and cultural issues, as well as lack of educational preparation, can be attributed to past and present discriminatory practices, and these factors have contributed to fewer Indigenous nurses achieving tertiary nursing qualifications. Discriminatory practices in nursing also have the potential to affect non-Indigenous nurses to some extent; however, this study’s findings suggest that discrimination against Indigenous nurses has been accepted as commonplace in the nursing practice over many years.

Historically, Australian Indigenous people have been subjected to racism in healthcare. Kidd (1997) highlighted that Aboriginal people had been victims of racist treatment in Queensland’s health institutions decades ago, as recorded in her analysis of high-profile official Queensland Government documents. The documents indicated that Aboriginal patients were refused treatment and turned-away by hospitals well into the twentieth
century, and that the hospitals that did accept Aboriginal patients housed them in outlying sheds (Kidd, 1997). Similar reports to this are recorded by Best (2015), who wrote about the historical accounts of colonial and post-colonial nursing in Australia. A decade earlier, Indigenous academics, Edwards and Sherwood (2006), reported that Indigenous affairs of the past were predicated on racist views of Indigenous people entrenched in mainstream media, leaving them denigrated, and which clearly marginalised them in the healthcare system. There are many reports where Indigenous people on a day-to-day basis are still being subjected to racist treatment in our healthcare services, education, employment, society and justice systems (Priest et al., 2011). The racist attitudes and behaviours acted out by health care professionals towards Indigenous patients, and Indigenous nurses and nursing students, is an experience consistently reported by other authors who have examined racism in the provision of healthcare (Larson et al., 2007; Trueman et al., 2011).

Two key studies focusing on the effects of racism in the healthcare setting (Paradies and Cunningham, 2012; Waterworth et al., 2016) determined that the presence of racism in healthcare is a risk factor that needs to be acknowledged as a determinant of health. The poorer health outcomes experienced by these participants were reported to be associated with experiences of racist incidents (Paradies and Cunningham, 2012; Waterworth et al., 2016). Durey (2010) drew attention to the way racism can act as a barrier to Indigenous people seeking help, showing that when health services are racist toward Indigenous people, there is greater reluctance for Indigenous people to attend medical appointments to receive needed treatment (Durey, 2010). If healthcare professionals are permitted to continue to act out racist behaviours in the healthcare setting without consequences, the health of Indigenous Australians is unlikely to improve. Anderson (2013) strongly condemns the act of racism, as he ascertains that it contributes directly to poor mental and physical Indigenous health outcomes; just the anticipation of racist innuendos, apart from acts of racism, is enough to generate a physical fight or flight stress response in the intended victim.

There is a recognised history of Indigenous people in nursing, and some of these stories are recorded in a ground-breaking book that shared the stories of Aboriginal and Torres Strait Islander nurses, *In Our Own Right: Black Australian Nurses’ Stories* by Goold and
Liddle (2005). This book identified barriers as well as enablers encountered by Indigenous nurses, which closely resembled the journeys of the Aboriginal nursing participants in this study. For example, Goold, herself an Aboriginal nurse, was discriminated against in her nursing training. She expressed how she felt devastated while reading her past nursing training notes, where a nursing assessor had written an entry about her that stated, ‘This nurse is totally incapable of learning’ (Goold and Liddle, 2005, p. 86). Goold interpreted this statement to mean that the assessor was implying that she did not have the intelligence or capability to learn due to her Aboriginal heritage.

Nielsen (2010) conducted qualitative research into the cultural challenges of Aboriginal registered nurses and their experiences working in mainstream nursing in Queensland, Australia. The findings from Nielsen (2010) were similar to the participants’ stories in this study, and also consistent with the experiences of Aboriginal and Torres Strait Islander nurse participants described in Goold and Liddle’s (2005) book. The participants from research conducted by Nielsen (2010) and Goold and Liddle (2005) recalled experiencing the effects of institutional racism and discrimination on a regular basis, which negatively impacted on their nursing journeys. Some participants also recounted that the most stressful times they experienced were when they felt powerless to speak up after witnessing acts of discrimination directed towards Indigenous patients. One participant in Nielsen’s (2010, p. 15) study stated, ‘Seeing racism against your people when you are looking after them in healthcare services can be really, really disheartening’. Nielsen (2010) also reported that while most participants communicated that they gained immense joy from being a nurse, and in looking after their mob, these nurses frequently felt totally powerless to protect themselves and their mob from acts of discrimination.

Ulrich et al. (2007) focused on ethical climate, stress and job satisfaction of nurses and social workers, finding that black nurses were three times more likely than white nurses to want to leave their job. These authors presented a recommendation to counteract workforce attrition, which comprised of building a positive ethical climate in the workplace by having open dialogue on strategies to increase respect, which in-turn would improve job satisfaction (Ulrich et al., 2007, p. 8). Indigenous nursing academics who decide to leave the university sector and start new positions elsewhere have the potential to stifle their career advancement opportunities. This issue of having an unstable Indigenous
nursing academic workforce may also be a key factor in why effective progress in the improvement of Indigenous health has continued to be such an insidious challenge.

Job satisfaction in nursing

Findings from the current study showed that, notwithstanding barriers and challenges, participants gained high levels of job satisfaction, but incurred high stress. One participant (Ruby) spoke about how, before entering academia, she worked as a flight nurse with her mob in regional and remote areas to improve their health outcomes. Another participant (Daisy) articulated that the job has other responsibilities, ‘Your job as an Aboriginal registered nurse is not just your job description; it’s so much more. It’s educating your non-Indigenous counterparts constantly’. It can be argued that this part of the job can be satisfying in the sense that it can positively influence poor attitudes towards Indigenous people and communities through informal education in the work place.

The participants in this study lamented that the lack of cultural safety in nursing has impacted on their level of job satisfaction while working in the nursing profession. ‘Cultural safety’, first developed by Māori nurse, Irihapeti Ramsden (Ramsden, 2002), set out a framework for analysing relationships involving power between health professionals and those they care for, and made recommendations to ensure that the cultural norms and values of the health professionals were not passively imposed upon their vulnerable patients (Christie and Asmar, 2012). The positive effect of this approach was articulated by Bin-Sallik (2003), who affirmed that, ‘Cultural safety goes beyond cultural awareness… It empowers individuals and enables them to contribute to the achievement of positive outcomes… It encompasses a reflection on individual cultural identity and recognition of the impact of personal culture on professional practice’. Ranzijn et al. (2009) concurred, describing cultural competence as including aspects and knowledge about cultural awareness, cultural safety and cultural respect.

Participants from Wilson’s (2007) study of African American nurses reported a high level of job satisfaction from the bond and connectedness that they developed and experienced while looking after their African American patients. Stuart and Nielsen’s (2011) Australian study also described a similar bond of connectedness, which was evident when Aboriginal
nurses were assigned to care for their Indigenous patients. These authors highlighted the importance of cultural communication in nursing care as a way of contributing to healing Indigenous patients, explaining that Aboriginal nurses have inherent knowledge of Indigenous society and culture to care for Indigenous patients from their cultural groundings embedded within their ancestral lineage. Similarly, a New Zealand study by Simon (2006) also found that Māori nurses shared an affinity with their Māori patients. Simon (2006) concluded that Māori nurses’ job satisfaction levels were strongly associated with their identities of firstly being Māori nurses, and secondly practising under Māori nursing models of care positioned within a Māori cultural knowledge framework.

Journeying into nursing and academia

The journeys of the study participants into nursing and academic roles varied. Many participants spoke of the complexities in working between two worlds, and the importance of the need for more Indigenous nurses, specifically in academia.

The skill of nursing and midwifery was practised in Australian Indigenous communities prior to the arrival of non-Indigenous people in Australia, and continues today. A participant in this study (Ningi) emphasised the importance of ‘teaching holistic nursing practice in nursing education’. Notions of health and illness are embedded in Indigenous people’s cultural beliefs and practices, and because they practise in a holistic way, they believe that ‘an individual’s spirit is fundamental to their health’ (Clarke, 2008, p. 5). This makes Indigenous nurses and midwives unique in their delivery of healthcare, as they practise their health care delivery through cultural groundings (CATSINaM, 2016). Due to the colonial perception of Aboriginal people and culture being ‘primitive’ (Clarke, 2008), many Indigenous people have struggled against this stereotype to achieve their career goals of becoming a nurse or midwife, and many of these struggles are recorded in the stories of Indigenous nurses and midwives (Goold and Liddle, 2005). These accounts are similar to the participants in this current study, where they reported being subjected to discrimination, racism, lack of educational preparation and support to make a direct transition from school into university, and limited role models. These barriers may negatively impact individuals’ aspirations for higher education goals.
As highlighted by Curtis et al. (2012) these factors are not just an Australian problem, and have been clearly identified in research related to Indigenous peoples across the world and in a range of health professions. There are many strategies highlighted in the literature that provide strong evidence for improving outcomes for Indigenous people and their subsequent journey into nursing. There are a combination of factors involved with why Indigenous people are not on par with non-Indigenous people when it comes to entering the nursing profession. These factors are steeped in historical, social and cultural issues, racism, financial hardship, inadequate preparation for university and limited Indigenous role models (Anonson et al., 2008; Curtis et al., 2015; Martin and Kipling, 2006; Usher et al., 2005a; West, Foster and Usher, 2016). One of the major factors identified that hindered the facilitation and success of Indigenous people in nursing was when non-Indigenous academics demonstrated a lack of cultural awareness. Strategies that helped address this deficit in cultural awareness of non-Indigenous academics was providing opportunities for them to engage and listen to Aboriginal community leaders and Elders, and arranging for them to attend Indigenous cultural events (Anonson et al., 2008). This resulted in an improvement of cultural awareness skills and respect of the non-Indigenous academics for Indigenous people and culture, making them more sensitive in their interactions with Indigenous students and staff.

Increasing the number of Indigenous nurses enrolling in university nursing programs is urgently needed to increase the number of Indigenous people represented in Australia’s Indigenous health workforce, which is seriously lacking. For this to be addressed in a strategic manner, it is important that universities, with the support of their Indigenous centres, conduct outreach programs and work in partnership with schools and Indigenous communities to build strong relationships. In this manner, they can encourage and support Indigenous students to transition into universities (Behrendt et al., 2012; Rochecouste et al., 2016; Wilks and Wilson, 2015). Curtis et al. (2012, p. 9) highlighted the importance of developing a pipeline from schools into the tertiary setting that can be used to transition Indigenous students into health programs. They emphasised four main areas: (1) early exposure - focused on schools visits, academic preparation and students visiting tertiary institutions; (2) transiting - focused on support with admission processes, enrichment programs and matriculation support; (3) retention/completion - focused on
support programs from staff and faculty, curriculum development and financial and accommodation support; and (4) across the pipeline - focused on role models, mentoring, community involvement, work experience, evaluation/tracking, spiritual and cultural values and creating tertiary mission statements (Curtis et al., 2012, p. 9).

This approach of developing a sustainable pipeline for Indigenous students from schools into higher education has strong potential to prepare Indigenous students socially, financially, culturally and academically to succeed at their university studies and beyond (Milne, Creedy and West, 2015). This is important as Indigenous students are mostly first in their families to attend university, and often come via alternative pathways (Curtis et al., 2012; Milne et al., 2016). Wilks and Wilson (2015) categorised some alternative pathways that Indigenous students have entered in the university system: entry via the Vocational Education and Training (VET) sector, pre-tertiary pre-programs, direct application and entry via scholarship programs. One school-to-university scholarship program established in 2008, the Australian Indigenous Education Foundation (AIEF), has had outstanding success; now working with 35 schools and funding approximately 500 scholarships per year (Penfold and Wynne, 2014, p. 31). The AIEF was initiated by merchant banker Andrew Penfold who stated, ‘I strongly believe that the gap between Indigenous and non-Indigenous Australians is the most challenging social issue in this country’. He is determined to close that gap, but adds, ‘It’s not all about helping Indigenous kids, but helping our nation…and that is reconciliation in the making’ (Penfold and Wynne, 2014, p. 31).

**Working between the Indigenous and non-Indigenous worlds**

The findings from this study showed how Aboriginal nursing academics’ journey’s into academia varied. For some participants, entering academia was a natural progression or opportunistic, whereas others were mentored by existing Indigenous nursing academics and made conscious career decisions to undertake an academic role. The resounding opinion of study participants was that they struggled to operate effectively in a higher education work environment that was rarely supportive of their needs, or those of Indigenous nursing students. One participant (Ruby) described her transition from
working in a university Indigenous support unit to entering full-time employment within the nursing academic environment as a ‘baptism by fire’. The literature demonstrates that moving into academia is difficult if you are a woman (Baker, 2010; Caplan, 1993; Potts, 2003), and even harder if you are Indigenous (Bin-Sallik, 2000; Fredericks, 2009; White, 2010). Indigenous nursing academics are forced to operate between two cultures within the university environment. This can be mentally exhausting due to the constant requirement to operate within a bi-cultural thinking process. Blackman (2010), an Aboriginal nurse, shared a reflection which included her experience of being forced to travel two paths; Indigeneity, and simultaneously ‘non-Indigenous’ life. In the preamble from the Congress for Aboriginal and Torres Strait Islander Nurses (CATSIN; now Congress for Aboriginal and Torres Strait Islander Nurses and Midwives; CATSINaM), a principal description of this anomaly is provided, ‘Many Aboriginal and Torres Strait Islander nurses are forced to live a ‘double life’. This living between two worlds and two cultures causes internal conflict. We see this as a continuation of the assimilation process and support all measures to reverse or challenge the process’ (CATSIN).

Irihapeti Ramsden (2002), a Māori scholar in nursing, carried out ground-breaking research into cultural safety and nursing education, and identified how Indigenous nurses are forced to navigate between their Indigenous world and the non-Indigenous world. She concluded that cultural difference is intensified where nurses are subjected to working between their own culture and another. Fitzgerald (2006) expanded on this phenomenon of walking between two worlds, reporting that participants in her study struggled with operating within their dual roles of interpreting the many unwritten rules in the white man’s world. This required them to stimulate a new personality to switch roles between two worlds. Effectively operating between two cultures has been strongly articulated by our contemporary Indigenous nursing academic leaders who state, ‘We have become hybrid creatures that can navigate both the Indigenous and western worlds’ (Power et al., 2015, p. 148). The findings from the literature are consistent with the participants’ experiences shared in the current study. These Indigenous nursing academics expressed that they were required to work between two cultures, which required them to continually challenge the existing model of nursing care practice in Australia to facilitate a more equitable and culturally safe environment for their Indigenous patients.
Journey into research

Of the eight Aboriginal nursing academics who participated in this study, two were about to complete their doctoral degree, and two were on their PhD journeys. Six participants were employed at junior academic levels, and two were employed as senior lecturers. No participants were at the associate professor or professor level, and none of the participants had attained a doctoral qualification at the time of interview. In Australia, it is common for junior nursing academics to have only a masters level qualification, and be working towards a doctorate. The nursing curriculum has not been offered at universities for long (previously being taught at vocational institutions instead), so there are relatively few mainstream nurses with PhDs, compared to other disciplines. While this is improving within the profession, this lag for Indigenous nursing academics, due to past decades of discriminatory educational practices and because Indigenous Australians are a numerical minority within the population, has been acknowledged by nursing scholars (Bin-Sallik, 2000; West, Geia and Power, 2013b).

Before the 1950s, Aboriginal people were excluded from opportunities to attain tertiary education qualifications due to their cultural heritage (Bock, 2014; Rigney, 2011). Although progress has been slow from the 1950’s, it has begun to escalate in recent years. For example, In 2014, 400 Indigenous people have completed doctoral degrees in Australia across a variety of discipline areas (Bock 2014). The growth in Indigenous doctoral graduates can be partially attributed to increased funding for Indigenous health research from the National Health and Medical Research Council (NHMRC), which grew from $9.4 million in 2003 to $45 million in 2013 (Bock, 2014). This funding helped to attract Indigenous doctors, nurses and allied health professionals to undertake doctoral degrees. Following funding cuts of $534 million dollars in the 2014 Indigenous affairs budget, there is a strong likelihood that the number of Indigenous health professionals enrolling into doctoral studies will diminish (Redfern Statement, 2016). If Indigenous-specific funds, which support Indigenous health initiatives, are not reinstated within a timely manner, the life expectancy gap between Indigenous and non-Indigenous people of Australia is likely to continue to widen.
Once Indigenous nurses enter the area of academia, workload issues can make it difficult for them to complete their PhDs within allocated timeframes. Attainment of a doctoral qualification is the key to opening a pathway within academia, to prepare academically and to mentor other Indigenous nurses to aspire to, and enrol in, post-graduate higher education degrees. Such capacity building will make a positive contribution, albeit slowly, to counteract the current under-representation of nursing and health focused Indigenous postgraduate research outputs which are urgently required to close the gap between Indigenous and non-Indigenous life expectancy (Usher, 2011). This approach will build on Indigenous Australian research capacity by developing a sustainable cohort of professional Indigenous health researchers, using Indigenous methodologies, which will underpin and facilitate the development of culturally appropriate interventions that aim to improve Indigenous health outcomes (Elston et al., 2013). In Usher’s (2011, p. 104) study, which focused on Indigenous health PhD students’ study experiences, one participant acknowledged that her PhD studies supported her to ‘develop higher level thinking, superior skills in writing and public speaking’. This supported her to take on a higher leadership role within nursing academia. Being proficient at public speaking is an essential skill in sharing the message about the urgent need to address the plight of Indigenous health in Australia and our Indigenous nurses are the leaders in this field.

Indigenous nurses in university leadership roles are a crucial inclusion in promoting the Closing the Gap initiatives to achieve equity in health between Indigenous and non-Indigenous people (Power et al., 2015). Leadership can be manageable when you have followers and supporters, but being the only person leading Indigenous health in the school/faculty is not sustainable over a long period and there is great potential for burn out. Indigenous nursing leadership needs to be managed and fostered by SONMs, making Indigenous nursing core business that is not negotiable. One Indigenous person is not representative, but instead, tokenistic. Tokenism, although not intended, could be argued to not be enough to positively impact the status quo, which will not bring about the needed change in Indigenous Australians’ health.
Theme 2: Being Situated in the Indigenous Academic World

Study findings revealed that being situated in the Indigenous world was a common location for each of the participants in this study. Their roles often involved teaching Indigenous health, managing excessive workloads and providing support for Indigenous nursing students within a community context. In exploring the theme of ‘being situated in the Indigenous academic world’, seven sub-themes were identified: being situated in the Indigenous academic world, teaching Indigenous health, academic workloads and job satisfaction, importance of community, interactions at the university interface, support needs for Indigenous nursing academics and supporting Indigenous nursing students. These sub-themes will be discussed in-turn.

Being situated in the Indigenous academic world

The stories of all participants highlighted the challenges and rewards experienced within the academic nursing environment, which were both satisfactory and stressful. An Australian study by Asmar and Page (2009) investigated sources of satisfaction and stress among Indigenous academics, and explored ways that these academics attempted to make sense of their struggles as they tried to survive and thrive in what was described as the ‘rough terrain of academia’. The major study finding was that the workloads of Indigenous academics were qualitatively different to that of their non-Indigenous nursing academic counterparts; a sentiment similarly articulated by the participants within the current study.

Teaching Indigenous health

Asmar and Page (2009) highlighted that teaching was identified by the participants as a key stressor, due to their interaction with non-Indigenous students who were resistant to Indigenous-specific content. Fesl’s (1994) book about Aboriginal people being ‘conned’ by the British invaders proposed that it is not easy for white people to hear that they are descendant from people who massacred, poisoned and raped Aboriginal woman and children, and some will respond with exclamations of disbelief, followed by strong denial.
A common finding from the current study, and also highlighted in Bond’s (2014) work, shows that non-Indigenous students who are uncomfortable hearing about our shameful Australian history frequently respond by exhibiting antisocial behaviour, which may be directed towards the Indigenous academic teaching the content. This shameful history clearly affects numerous victims on both sides, as this content can be very distressing to hear (Christie and Asmar, 2012). Two participants from the current study (Ruby and Titch) explained that they anticipated this type of distress, and took the team teaching approach, which they believed was the safest way to teach Indigenous health content; a strategy that reduced the threat to cultural safety and being targeted by hostile students.

The example above illustrates a positive approach to facing hostile students in the classroom, as this type of hostility can be distressing, shocking and demoralising, especially for junior Indigenous nursing academics. Bond (2014) argued that non-Indigenous students can be resistant to the presence of Indigenous academics in universities, and lamented that when Indigenous academics are regularly exposed to hostile students, they can become quite broken and may decline to do further teaching in this area. Possibly one of the reasons that this poor response occurs in contemporary settings is due to the hangover from Australia’s ‘history wars’, where historical revisionists claimed that hundreds of historical reports recording Aboriginal massacres in Australia were invented, and Aboriginal death tolls fabricated (Bond, 2014; Elder, 2009). This misperception became clear in the 1990s when even an Australian prime minister argued that the Indigenous view of history was a guilt-inducing, ‘black arm band’ view of our history. His words had the untoward effect of making bad behaviour from non-Indigenous students acceptable (Bond, 2014; Howard, 1996). Discomfort and denial about Australia’s shocking history expressed by non-Indigenous students can quickly transfer to ignorant non-Indigenous staff. According to the racial stereotype theory, non-Indigenous academics can respond by unconsciously undermining an Indigenous staff member in an attempt to shield non-Indigenous students from further distress (Asmar and Page, 2009; Bond, 2014). This type of behaviour from a non-Indigenous academic in an already tense situation can place the cultural safety of the Indigenous academic at risk. Research by Asmar and Page (2009) and Christie and Asmar (2012) identified this teaching stress as emotionally challenging for Indigenous academics in that it can cause traumatic memories.
to resurface, particularly if the heartbreaking narratives are representative of the lived experience of the Indigenous academic themselves. A participant from the current study (Ruby) had previously taught Indigenous health content and reflected on her transition from ‘novice to expert’ and stated, ‘Early in my career, my responses were overly emotional, whereas as I became the expert, my responses became more depersonalised’.

All participants in the current study expressed difficulties associated with confronting students with Indigenous history, and feeling resistance from students. One participant (Ruby) compared teaching Indigenous health to ‘teaching with a target on your chest’, but then explained that sometimes by the end of the session these resistant students would turn around and thank you. Despite these difficulties, their overriding motivation to keep standing in front of the classroom was to be front and centre in teaching non-Indigenous students about the vulnerabilities of Indigenous peoples in the healthcare setting. Aboriginal nursing academics in the current study did this by sanctioning the need for all students to practise in a culturally safe and intelligent way when working with all cultures, and particularly when working with Indigenous people. One participant (Pauline) made the point succinctly, ‘I have always considered myself a walking cultural awareness tool’. This demonstrates that even in a ‘rough teaching terrain’ Aboriginal nursing academics do concurrently gain a high level of job satisfaction from teaching non-Indigenous students. It is a major achievement for the Aboriginal nursing academic to encourage non-Indigenous students to reflect on why they are uncomfortable hearing the history of Australia, rather than leaving them to cascade into denial. According to Durey et al. (2016), who presented and evaluated an intercultural academic leadership program, it is important for academics to facilitate safe learning spaces where resistant students can contend with conflicting concepts, allowing them to emerge with new positions of knowledge to better prepare them for working in Indigenous health contexts.

*Academic workloads and job satisfaction*

Findings from this study indicate that some participants regarded their previous clinical nursing workloads as more manageable than their academic workloads. Their larger-
than-normal academic workload is due to the breadth of responsibilities faced by Aboriginal nursing academics. Their complex and emotionally demanding work environment is compounded by the fact that they may be the only Aboriginal academic, prohibiting opportunities to consult and share their views. Workload stress is exacerbated by the ‘everything Indigenous’ consultant roles and responsibilities that are unofficially allocated to Aboriginal nursing academics across the entire academic setting, which rarely if ever, appear in their job description. Several researchers have written about the dilemma of Indigenous academics’ excessive workloads, including countless roles where they are perceived by white notions of empirical evidence to be the ‘expert’ about all Indigenous areas, and other roles where they are leading and advocating within their communities (Asmar and Page, 2009; Hart, 2003; West et al., 2014). This dual and complex workload is rarely imposed upon non-Indigenous academics, as in most cases, within their areas of expertise there are at least several, if not many colleagues, with whom they can share the load. Indigenous nursing academics, however, are required to carry out an additional and unpaid workload in connection to their Indigenous communities, which may be one reason that junior level Indigenous nursing academics fail to progress. At the beginning of this study, no participants had completed a PhD. However, one participant did complete their PhD during this study, and their promotion was very rapid. Without official recognition, these excessive workloads can hinder teaching and research outputs, which place further limitations on promotion opportunities.

The Aboriginal nursing academics in the current study reported heavy and often unmanageable academic workloads. They were expected to support Indigenous students, who often have complex needs (which was not expected of non-Indigenous academics) and teach undergraduate students in addition to managing their personal and community responsibilities while being on the lower end of the junior academic pay scale. This shows the lack of recognition for the hidden and distinctive workload for Aboriginal nursing academics, which expects them to balance multiple roles and needs; a problem that must be addressed if they are to be retained in these roles and progress through the levels of academic hierarchy. Rigney’s (2011) review of Indigenous higher education also drew attention to Indigenous academic workloads, and the high burden imposed on Indigenous academics to embed Indigenous perspectives across the curricula of the
institution, while assuming the unpaid workload of providing student support for Indigenous students. An African American study by Hassouneh and Lutz (2013, p. 62) on faculty of colour having influence on schools of nursing illuminated that this cohort was ‘underappreciated’ and ‘conducted hidden work…everyday’, highlighting the importance of their contribution to academia. These findings correspond with the findings of the Aboriginal nursing academic participants from the current study, where they too have been subjected to insidious hidden workloads.

Extra workloads experienced by Indigenous academics in higher education were investigated by Page and Asmar (2008a), whose qualitative research study focused initially on three areas: research, administration (such as committee work) and teaching; however, they also found another workload area: community. The authors likened this workload to an iceberg, where the bottom part of the iceberg under the waterline was the ‘Indigenous student support’ workload. The irony in this situation was that the Indigenous academics never complained about this additional work, as they regarded Indigenous students as their community. The work satisfaction gained by the Indigenous academics who provided student support for the Indigenous students circumvented their frustration of being overloaded. The Aboriginal nursing academic participants in the current study regard support of Indigenous students, who are also members of their community, as an investment in the future from which they gain enormous satisfaction. They are invested in their success, and rarely complain. However, this hidden role, once acknowledged, is additional and needs to be recognised in workload allocations for these under-resourced academics so that they don’t burn out.

The extra community workload for Indigenous academics was also the subject of commentary by Gunstone (2009, p. 4) who stated, ‘Universities fail to support their Indigenous staff, by not recognising the substantial and invaluable community involvement work of Indigenous staff in workload policies’. A study by Fitzgerald (2006) focused on Indigenous women and educational leadership, and highlighted the importance of community responsibilities and accountability, such as ‘not being able to leave being Aboriginal at the door, or being able to abandon those who have come before me’ (p. 209). One Australian Indigenous participant from Fitzgerald’s study said, ‘My mob would have a thing or two to say if I didn’t meet their expectations’ (p. 209). On reflection,
universities in the post-colonial setting have no obligation to incorporate Indigenous customs and societal rules into their daily practices, which causes a clash of cultures between the neoliberal university and Indigenous value systems. However, this does not mean that the cultural and community responsibilities for Aboriginal nursing academics who work in universities can be disregarded. They still need to be able to engage fully with their Indigenous communities, which means attending Indigenous cultural and community events, internal and external to the university, no matter where they work or live.

*Importance of community*

The participants in this study articulated that they drew a great deal of strength from their Indigenous community, but also felt the weight of community expectations and their own expectations in the face of student needs. This finding is congruent with previous research (Mercier, Asmar and Page, 2011; Nakata, 2004; Page and Asmar, 2008b; Phillips et al., 2007), which concurred that student support work increases stress. This stress is amplified by teaching and research obligations and tension between the Indigenous academic and their Indigenous communities. The findings of this study showed that Aboriginal nursing academics perceive that they are continually expected by university SONMs to undertake an extra community workload hidden within their nursing academic role, and this extra workload has the potential, over time, to stall their academic career progression. This can also result in Indigenous academics being forced into casual employee roles, to effectively manage their academic workload (Rigney, 2011). Worse still, they may eventually burn out trying to keep abreast of their heavy workload, and must choose this over their cultural obligations, which can result in undue emotional and physical work stress. Page and Asmar (2008a, p. 116) expressed this conundrum aptly stating, ‘Indigenous academics are not going to abandon their Indigeneity, nor will institutions change entrenched attitudes’. This calls for a third option of making space for an academic position description that accommodates a workload that clearly acknowledges cultural accountabilities for Indigenous nursing academics, perhaps under the university expectation of community engagement. These examples illustrate potential
significant reasons why the retention of Indigenous nurses in Australian SONMs is so problematic. Findings of this study revealed that Indigenous nursing academics are being forced to choose between their academic workload and their cultural obligations, which often ends in these academics leaving their university positions.

Findings from this study consistently show the importance of community, and that all things that occur in Indigenous communities are reliant on having a strong sense of community. One participant (Ruby) recounted her reasons for being there for community and building trust in hard times, being a community leader, and being a strong community voice. In turn, her community proved beneficial for her wellbeing in the way that she drew strength from her larger cultural support network. To foster, retain and develop a skilled Indigenous academic workforce, university SONMs should ensure that they actively acknowledge Indigenous nursing academics’ cultural and personal responsibility to engage with their Indigenous communities, and work with them to develop strategies to acknowledge this hidden workload. SONMs can achieve this by informing new Indigenous nursing academics that they should be aware of the danger in taking on unmanageable workloads and that they, therefore, should be proactive about support and mentorship; not waiting for signs of burn out to appear or occur. This approach will ensure that expectations and deliverables for both the Indigenous nursing academic in terms of career satisfaction and advancement, and the university expectations of the delivery of a quality educational and research agenda, are achieved.

*Interactions at the university interface*

This study revealed that the Aboriginal nursing academic participants had expressed concerns of being undermined by non-Indigenous staff and when they were made to feel lesser than their non-Indigenous academic peers in carrying out their academic roles. One participant (Daisy) voiced that she felt like her presence in academia was only to tick the box for her institution so that they would not be labelled as discriminatory. The study participants’ experiences resonate with the findings of several researchers (Fredericks, 2009; Mihesuah, 2004; Page and Asmar, 2008b) who presented accounts of Indigenous academics that were positioned in key university areas to imply that their institutions were
culturally inclusive. However, the voices and intellectual knowledge of these expert Indigenous academics are rarely called upon in academia due to their small numbers; therefore, the teaching of Indigenous content is delivered by mostly non-Indigenous academics (Christie and Asmar, 2012; Mihesuah, 2004).

There have been many cultural clashes between Indigenous people and the university interface in the past few decades. These clashes have become more frequent in recent times, prompting Universities Australia (2011) to release a best practice framework for cultural competency to be embedded across all Australian universities. This framework is intended to ensure that universities become more inclusive of Indigenous content within their higher education curricula, thereby supposedly meeting the aim ‘provide encouraging and supportive environments for Indigenous students and staff’ (Universities Australia, 2011, p. 3). This initiative has been an important step in addressing the unbalanced view of knowledge systems that exist within Australian universities, which not so long ago was devoid of Indigenous knowledge and perspectives, and had considerably fewer Indigenous staff and students. The initiative taken by Universities Australia (2011), although timely, has resulted in an unsurmountable burden for Indigenous academics, as it is a complex, continuous and arduous process which places Indigenous academics’ cultural safety at risk (Jackson et al., 2013). Rigney (2011) stated, ‘Indigenous academics carry an institution imposed “burden” to Indigenise the entire university, its curriculum, policy and practice that results in a division of labour rarely expected of other academics’ (p. 9). It can be argued that the Aboriginal nursing academics in the current study who are employed by universities would also be allocated this workload of indigenising nursing and midwifery curricula.

The reason that Indigenous traditional knowledge was initially excluded by universities has its roots in historical institutional knowledge structures that did not value Indigenous knowledge and perspectives as integral to academic rigour (Rigney, 2011; Universities Australia, 2011). This exclusion further impacted on the cultural safety of Indigenous nursing academics, as they are subjected to work within institutional knowledge systems that continually oppress their own. Hart’s (2003) perspective as an Aboriginal academic teaching Indigenous content to non-Indigenous students presented the dilemma of Indigenous educators in higher education. He argued that ‘Aboriginal teachers in
professional academic roles are dominated by non-Aboriginal processes, theories and notions of “best practice” in relation to equity and social justice’ (2003, p.12).

Hart’s (2003) point was that Indigenous academics are forced to teach Indigenous content not from their own Indigenous perspectives, but from a non-Indigenous perspective. This is a significant point, as it may be one of the reasons that the Aboriginal nursing academics in this study could be subconsciously conflicted and stressed when teaching Indigenous health in the white academic environment. This indicates that Aboriginal nursing academics are placed in the uncomfortable position where they are expected to choose which cultural threshold they speak through: their own theories from their perspectives as Aboriginal academics, or that of non-Indigenous theories. This discomfort can be intensified for Aboriginal nursing academics because when they teach Indigenous content they are sharing deeply personal and political stories, which are interwoven with the stories from their ancestors (Jackson et al. 2013). In stark contrast, Wilson, McKinney and Rapata-Hanning (2011) studied the retention of New Zealand Indigenous nursing students, explaining that the Treaty of Waitangi and the Treaty of the Waitangi Act 1975 was included as teaching material in the delivery of their nursing degree, and cultural protocols and Indigenous ways of knowing were included to balance western knowledge delivered in the programs.

The cultural safety risk for Aboriginal nursing academics in Australia required to teach from non-Indigenous theories poses the problem of securing a culturally safe space in the university environment for them. One participant in the current study strongly suggested that the cultural safety of Indigenous nursing academics in the current teaching environment is certainly at risk. Usher (2011) wrote about Indigenous higher degree research students, where one participant stated, ‘Being educated doesn’t mean there is acceptance as an equal to one’s peers…and until non-Indigenous people become culturally competent, change will not occur and we will not move forward’. Continually placing Indigenous nursing academics in positions where their cultural safety is at risk certainly has the potential to impact on the retention of these Indigenous academics in our higher education systems.


Support needs for Indigenous nursing academics

The literature shows a limited amount of research about the experiences of Indigenous nursing academics. In contrast, there is a plethora of literature about the cultural issues that Indigenous nursing students face, including suggestions for support measures and strategies to improve their university experiences (Best and Stuart, 2014; Curtis et al., 2012; Omeri and Ahern, 1999; Usher, 2011; West, Geia and Power, 2013; Wilson, McKinney and Rapata-Hanning, 2011). Closer examination of the ways the student journey has been improved may reveal similar strategies to inform, or apply to, processes that aim to advance the journey of Indigenous nursing academics.

Due to small numbers and their Indigenous heritage, the Aboriginal nursing academic study participants revealed that they were prone to cultural isolation. Cultural isolation is also pervasive among Indigenous nursing students. In responding to this issue, Meiklejohn, Wollin and Cadet-James (2003) developed an Indigenous nursing support program focusing on student retention. Strategies used to reduce cultural isolation for the Indigenous nursing students included hosting regular academic staff/student morning teas, providing drop-in sessions for students to speak informally with academic staff, and staff-initiated telephone calls to ‘check-in’ with students. This was an effective strategy in building trust and relationships between the staff and the Indigenous nursing students, which promoted retention and nursing completions. A study by West, Geia and Power (2013) found a similar impact from networking and mentoring processes, where Indigenous nursing students expressed feeling less culturally isolated when they networked with other Indigenous nursing colleagues. This approach could also be used to retain Indigenous nursing academics in SONMs, as building trusting relationships between Indigenous and non-Indigenous academic nursing staff is paramount in making the academic work space culturally safe and welcoming for Indigenous nursing academics.

Supporting Indigenous nursing students

Indigenous nursing students often arrive in the university space ill-prepared for the academic work ahead, which means that they often require more support than their non-
Indigenous counterparts (Smith et al., 2011; West, Foster and Usher, 2016). As discussed earlier, most Indigenous students are the first in their families to attend university. Their reasons for choosing to attend university (which are often reliant on their strong respect and connection to community) generally differ to those of non-Indigenous students; many Indigenous students enrol in university nursing programs to meet the health needs of their Indigenous communities (Milne, Creedy and West, 2016; Smith et al., 2011). A study on cultural safety in Indigenous health education (Rigby et al., 2011) revealed that Indigenous nursing students had a strong sense of community, which was underlined as integral in motivating them to succeed in higher education, and promoted a strong focus on self-determination. Because Indigenous people of Australia share a common history, it is only natural that when Indigenous nursing students need additional support in the university space, they seek this support from the Indigenous nursing academic. These interactions between Indigenous nursing students and Indigenous nursing academics are consistent with Indigenous relationships embedded within natural cultural protocols. One participant in the current study (Flora) explained how she cherished the times that she could spend time with the Indigenous nursing students, as she felt that she was making a great difference to their lives by providing the needed academic support. Another participant (Pearly) simply stated ‘I fell in love with the job...I started to get some sort of sense of community going amongst them’. This participant spoke of having flexibility to support and nurture Indigenous nursing students over time, which enabled her to build a strong Indigenous nursing cohort.

West, Geia and Power (2013) highlighted the importance of retaining and building a strong Indigenous nursing workforce, and Indigenous nursing students interviewed for her study strongly voiced the value of having the support of an Indigenous nursing academic. They found the Indigenous nursing academic inspirational, and seeing that another Indigenous person had achieved made them realise that becoming a registered nurse was a possibility for them also. In the same study, non-Indigenous academics spoke of their wonder at how the Indigenous nursing academics liaised and supported the Indigenous nursing students, explaining that it was something they could never do, because they had no lived experience as an Indigenous person (West, Geia and Power, 2013). This is a good example of how Indigenous nursing academics can challenge
percieved stereotypes and build strong professional Indigenous nursing identities. For more Indigenous nurses to graduate and embark on careers in the nursing profession, robust and consistent support is needed by both Indigenous and non-Indigenous academics to keep Indigenous nursing students enrolled and progressing in nursing programs.

Indigenous nursing students achieving their goals of becoming graduands are a cause for celebration for all staff. One participant from the current study (Pearly) spoke about the excitement of graduation, wearing Indigenous colours and how Indigenous people are starting to ‘smash the ceilings’. The phrase ‘smash the ceilings’ has been used in the literature previously and is used as a metaphor to signify how women, in particular, have broken through restrictive barriers to achieve higher success (Cook and Glass, 2012; Womack-Gregg, 2010). This metaphor is appropriate to use in this context as the participant (Pearly) was referring to a new phenomenon, where Indigenous nurses could ‘smash the ceilings’ by wearing Indigenous colours and celebrating their culture, signifying that they had overcome many restrictive barriers to arrive at their graduation day. While some Indigenous nursing students have struggled, others have attended universities that provide greater support. This may be through growing Indigenous nursing cohorts in partnership with industry nursing bodies, such as CATSINaM, and/or resourcing their SONMs with Indigenous nursing academics, who provide exemplar support strategies to recruit, retain and graduate Indigenous nurses.

Study findings have shown that Indigenous nursing academics are crucial in supporting, and being role models and mentors for, Indigenous nursing students. Their role modelling is of vital importance for Indigenous nursing students to succeed in their nursing programs so they can join the Indigenous health workforce to help close the gap. This is an area in which universities can take the lead to foster strong partnerships between Indigenous nurses and students, Industry health partners and the university, as ultimately graduation and employment of Aboriginal nurses is a vital part of reducing inequities in the health of Aboriginal people in Australia, which is also an international priority (Milne, Creedy and West, 2016; Smith et al., 2011, p. 17). Proactivity by universities can also extend to support and graduate Indigenous nurses enrolled in higher education research degrees, as their presence and input into universities research agendas will assist in accelerating
Indigenous health outcomes (Chirgwin, 2015; Elston et al., 2013; Usher, 2011). Findings from this study show the many joys of the Aboriginal nursing academic participants, and how their work of improving the experience of Indigenous nursing students in academia helped them to persevere and remain in their roles. It is understandable that due to the Indigenous nursing academic and the Indigenous nursing students originating from common cultural groundings, these cultural and social interactions would, in a sense, be reciprocal.

Theme 3: Racism and the whiteness of nursing

Study findings revealed that experiences of racism were common amongst participants. In exploring the key theme of racism and the whiteness of nursing, six sub-themes were identified: racism embedded in nursing, racism in the academic workplace, racism and skin colour, addressing racism, Indigenous nurses and whiteness, white in the workplace. These sub-themes will be discussed in-turn.

Racism embedded in nursing

Findings from the current study exposed racism in its many forms as a common theme, and something that impacted on the Aboriginal nursing academic participants' journey's, regardless of their individual circumstances. Episodes of racism surfaced in the participants' clinical nursing roles, and continued into their roles as nursing academics. Forsyth (2007) found in the delivery of health care for Indigenous patients in Australia over a few decades that racism from non-Indigenous nurses was acted out towards Indigenous patients. She proposed that it was common for the predominantly non-Indigenous nursing workforce to hold strong racist views about Indigenous people and patients, and that this was not seen as unusual in Australia over the decades.

Two participants in the current study (Daisy and Flora) shared their experiences of being subjected to racism on the job from patients with dementia, who were perhaps acting out racist attitudes and behaviours from their memories of the past. One of the Aboriginal nurses (Daisy) acknowledged that while racism was not actively intended by these
patients, she was still deeply affected on a personal level. It can be argued that racism is not a new phenomenon for Indigenous Australians, so it is not surprising that racism is embedded in the nursing profession, as Indigenous people have experienced racism in their own country from the time that white settlement began.

*Racism in the academic workplace*

Although Indigenous people value university education as a means of advancing opportunities for their people, Australian universities are systems built on the back of colonialism, and therefore are not completely safe places for Indigenous people. Indeed, universities have been described as small-scale versions of the larger societal struggle in which racist behaviours are entrenched (Alfred, 2004). A few participants in the current study spoke about how difficult and unsettling it was to be the only Aboriginal nursing academic present when race relations were being discussed. One participant (Ruby) said, ‘The tea room - I will always avoid like the plague because somehow your presence just seems to instigate discussions about race relations’. This finding demonstrates how an Indigenous nursing academic’s presence can be perceived by some through a non-Indigenous racial lens, and because of this perception, social interaction can become confined to a discussion focused specifically around Indigenous topics.

Racially based discrimination in nursing is also reported internationally. Wilson (2007) described the experiences of African American registered nurses. An important finding identified was that many participants felt ‘invisible and voiceless’ in the workplace. Although Wilson’s participants were of African American descent, findings are comparable to the experiences of the Aboriginal nursing academic participants in the current study. Like findings from Goold and Liddle (2005), participants from Wilson’s (2007) study also reported receiving disparaging and critical feedback from superiors, which could contribute to workplace environments where black nurses felt unsafe and voiceless.
Racism and skin colour

One study participant (Pearly) observed that racism was a double-edged sword, where the fair-skinned Indigenous nursing students who identified as Indigenous would then ‘cop racism’, like someone asking, ‘You’ve got fair skin…why do you identify as Aboriginal…are you 1/16?’ This white stereotypical perception of Indigeneity challenges a student’s Indigenous identity because of their skin colour in an already stressful environment. Several researchers proposed that skin colour could be used to represent difference in biological hierarchy amongst human beings, with white skin colour perceived to be more dominant and intelligent and darker skin colour perceived to be more mentally deficient and primitive, signifying that the lighter the skin colour the more salvageable the human (Elder, 2009; Paradies, 2006; Pilger, 2003). Racism from mainstream nursing students directed towards Aboriginal nursing academics was also identified as a concern in the current study. Students can record racist views through anonymous student feedback modalities that universities provide for students to evaluate lecturers’ course delivery. This feedback is permanently recorded on academics’ teaching and learning profile, and has the potential to hinder promotional opportunities if universities use student feedback to grade their teaching capabilities - which many do.

In the current study, one participant (Ruby) highlighted how some of the racist mainstream students she taught cringed when they heard the words ‘Indigenous’ and ‘Aboriginal’, indicating that these words were perceived as stigmatising by some non-Indigenous students. It could be argued that the practice of quantifying Indigeneity and students being repulsed by Indigenous content and Indigenous words could have its origins in institutional racism. Henry, Houston and Mooney (2004, p. 517) defined institutional racism as ‘ways in which racist beliefs or values have been built into the operations of social institutions in such a way as to discriminate against’; in this instance exerting control and oppression over Indigenous Australians. The racist contexts that emerge through teaching Indigenous content, although confronting, can inadvertently present many valuable teaching opportunities for skilled Indigenous nursing academics to positively influence the poor attitudes and behaviours of non-Indigenous students (Jackson et al., 2013).
Addressing racism

One participant from the current study (Pearly) expressed gratitude that there are now policies and procedures that addressed ‘racist, homophobic, misogynous behaviours at universities’, which made her feel safer. Rogers-Falk and Vidler (2012) identified racism as a barrier needing to be dealt with if Indigenous students are to be retained in university programs. They described anti-racism strategies to reduce and manage incidents of racism, including policy implementation and education of staff and students about what constitutes acceptable behaviour. Those approaches to combating racism may also be valuable for retaining Indigenous nursing academics on staff, especially if they have confidence that reports of racism will be taken seriously and acted upon. Processes for addressing racism would increase the cultural security for all Indigenous nursing students and allow Indigenous nursing academics to feel valued as employees, as well as culturally safe in the university environment (Grant et al., 2009). As part of embedding the cultural agenda, terminology in the university space describing Indigenous people may sometimes require asking Indigenous people on an individual basis what they feel comfortable with; interpretation of terminology varied between participants within this study.

One participant (Ruby) protested that it would be unlikely that an Indigenous nursing academic could be employed in teaching Indigenous health and not experience racism, but acknowledged that building resilience to deal with racist behaviour is an opportunity to change the status quo and resistant ideas about Indigenous health. Another participant (Pearly) stated, ‘The whole notion of having racist comments thrown at me, it’s not new, and it’s been happening for decades. So, the reality is you become at times quite resilient to it’. The majority of the participants articulated that they had experienced racism in their academic working lives in some form, but only one reported that they had made an official complaint (this participant later asked me to remove any identifying entries relating to this complaint). If Indigenous nursing academics who are educated and have the resources to change the status quo are supported by institutional policies that aim to protect against racism, but still experience racism and do not report it, this drives us to ask, ‘Why?’ Possibly participants did report racism, but actively chose not to disclose this information. The participants interviewed were highly experienced in their field, and had built a strong
measure of resilience, so perhaps they did not see those events as threatening, but just a part of their job. It is unlikely experiences of racism will change until cultural safety is assured for all Indigenous Academics.

Indigenous nurses and whiteness

The whiteness of nursing is represented in a set of behaviours in the nursing profession that are historically, socially, politically and culturally produced, and connected to dynamic associations represented as white racial domination (Schroeder and Di Angelo, 2010). To develop recommendations for change, white privilege and anti-racist education needs to extend beyond celebrating cultural diversity in nursing and instead focus on the social, cultural and institutional powers that shape the meaning of racial difference. Hall and Fields (2013) confirm in their paper on nursing and racism that it is white nurses themselves who benefit from white privilege. The social status of white privilege provides them with the collective authority to affect change by raising the awareness and the consciousness of white people to understand what racism and whiteness is, and how it works. Racism and whiteness in nursing and midwifery are expressed in various Acts; it is an established system in which we are all enmeshed.

The nursing system in Australia is situated in a white framework, with which the Indigenous nursing participants in the current study have often experienced conflict. One participant (Pauline) described the position of white nurses aptly saying, ‘They stand on the pedestal of whiteness and they think that there is no other way’. Another recommended that the whiteness of nursing needs to be addressed and taken more seriously if things are to improve, and that whiteness issues need to be written about in the academic literature. Another participant (Ningi) mentioned her experience of working alongside her white nursing colleagues and lamented that although they were more than willing to support her in her nursing practice, and said ‘They rarely took the time to get to know me or understand me’. Participants in Nielsen, Stuart and Gorman’s (2014) research into the whiteness of nursing from the perspective of Aboriginal Australian registered nurses revealed similar experiences to those in the current study in regards to whiteness being a deterrent to them working in mainstream nursing, due to a lack of
cultural safety, as opposed to working in Aboriginal Community Controlled Health Organisations (ACCHO).

Participants in the current study expressed that there was a lack of understanding about their Aboriginal cultural heritage from their non-Indigenous colleagues. To some extent this is because the large majority of nurses in Australia are non-Indigenous. Researchers suggest that a predominantly white nursing workforce, and whiteness of the social and educational structure of nursing, may encourage white race privilege and be one reason why well established inequities continue (Allen, 2006; Nielsen, Stuart and Gorman, 2014; Puzan, 2003; Schroeder and Di Angelo, 2010). To understand how debilitating the phenomenon of whiteness of nursing is for the Indigenous nursing academics in their daily work, it is important to gain a contrasting view about what whiteness is like from a white perspective. Gustafson (2007, p. 153), who took up the challenge to examine the unearned benefits and privileges that came to her as a white educator in a racialised educational system, researched ‘white on whiteness’ by the following four characteristics: the absent presence of whiteness, the need for an oppositional identity, the entitlement of choice and subjectivity, and denial of a dominant position and relation to the racialised other. These privileged positions of power were not experienced by the participants of this study, which explains why study findings identify the whiteness of nursing as a concern. This notion of whiteness was further described by Wilby (2009, p. 57) who articulated, ‘When the world is white, the white uniform may be outdated, but the white woman is still the prominent figure in professional nursing’. Moreton-Robinson (2005), a prolific Indigenous researcher in whiteness studies, conceded that whiteness constructs exist across all domains in Australia due to the establishment of colonial rule, leaving Indigenous Australians subject to an overall white system of governance.

White in the workplace

The numerical dominance of white staff in SONMs, and more generally across university settings, meant that participants in the current study were constantly exposed to working within an environment where they were outnumbered in a cultural context. Thus, their only allies with a shared understanding of culture were other Indigenous staff, and the
Indigenous nursing students, of which there were few and not easily accessible. Indigenous people have been regularly subjected to experiencing the nursing profession from a whiteness perspective. One participant (Daisy) described her line manager as patronising, ‘I felt that I was being patted on the head just for being in the role I was in…because it was something that universities had to do’. Another participant (Murtle) felt that being tested and tried by her non-Indigenous nursing colleagues made her stronger and more resilient, and forced her to try harder. Murtle stated that these experiences challenged her to ‘do better than her very best’.

An American study by Hassouneh (2000) researched the challenges faced by faculty of colour in white schools of nursing, and proposed that changing the white system toward an equitable system would be slow, but noted that every privileged white faculty member could make a difference by advocating for an increase in ethnic and racial diversity in faculty. This approach resonates with the views of isolation in the Aboriginal nursing academic participants in the current study. In more recent research, Hassouneh and Lutz (2013, p. 156) concentrated on the influence of faculty of colour in a white school of nursing, and uncovered the phenomenon of the ‘good old girls’, or the white nursing faculty that were the ‘guardians of the status quo’. Fundamentally the ‘presence of faculty of color challenges the status-quo’, resulting in insurmountable barriers for faculty of colour. This means that the Aboriginal nursing academics in white schools of nursing become further isolated by the explicit whiteness that permeates the higher education sector where they work on a day-to-day basis. Gunstone (2009) describes many active features of whiteness in higher education, such as ‘marginalisation, discrimination and oppression of non-white groups and individuals and the privileging of white groups and individuals’ (p. 1). The situation of whiteness in universities shows that the Aboriginal nursing academic participants in this current study were frequently subjected to working conditions that were culturally unsafe and inappropriate.

Theme 4: Developing resilience to further develop leadership

The need to build resilience to remain in Aboriginal nursing academic leadership positions was emphasised by study participants. Leadership roles for Aboriginal nursing academics
is a relatively new concept that takes on many forms. In exploring the key theme of developing resilience to further develop leadership, four sub-themes were identified: resilience of Aboriginal nursing academics, the resilience factor, being an Indigenous nurse leader, and building future Indigenous leaders. These sub-themes will be discussed in-turn.

**Resilience of Aboriginal nursing academics**

The findings of the current study highlighted how resilient Aboriginal nursing academics must be while working in Indigenous health and the academic environment. Each of the participants in the study who remained in academia noted that it was crucial to continue to build on and further develop their resilience as a protective mechanism for managing and continuing in their leadership roles. The participants who left their positions in academia chose other leadership roles in Indigenous health. It must be noted that had they received the needed support while employed in academia, these nurses indicated that they may have continued in their academic roles. In Australia, Grant et al. (2009) conducted research into how to ‘bullet proof’ Aboriginal and Torres Strait Islander students and staff against racism, and incorporated resilience training as a focus for building effective coping mechanisms. As adapted from the work of Kanel (2002), Grant et al. (2009, p. 6) identified three levels of coping to help build resilience and provided a model to frame the skills necessary to help victims build the emotional fortitude to move forward. The model was proven effective in building resilience in Indigenous staff and students (Grant et al., 2009), and is therefore appropriate for use in building resilience in Indigenous nursing academics, many of whom may not yet have the skills and abilities to do so on their own.

The participants from the current study emphasised the importance of having a good measure of resilience to cope with the demands of Aboriginal nursing leadership. Penehira et al. (2014) discussed the importance of Indigenous academics contextualising Indigenous peoples as resistant and resilient, which has been required to combat racism and oppression as the legacy of colonisation. This point was emphasised by the participants of the current study who stressed their cultural survival for over 200 years.
under a racist government system. They spoke of harnessing knowledge of Aboriginal history and their own experiences to make changes in their approach to their life and career, which they believed made them stronger and more resilient. Some of the participants also spoke about their families and communities who demonstrated remarkable resilience. Witnessing these stands in the face of adversity gave the participants strength to lead in their own nursing and academic roles. The participants were also conscious of the stressors present in their multi-faceted workload and how they needed to look after themselves to maintain a resilient stance and prevent burn out. The fact that Aboriginal Australians are the longest continuous culture on the planet today demonstrates that the endurance of culture is an unprecedented measure of resilience inherent in Aboriginal nursing academics. This is articulated well in the CATSINaM (2016) position paper entitled ‘Uniqueness of our nursing and midwifery workforce’ which highlighted that Aboriginal and Torres Strait Islander nurses and midwives bring with them unique knowledge systems, at the core of which lies their culture. They travel a life-long journey of fulfilling cultural obligations and commitments to their communities, families and themselves. The cultural connection to country, community and family strengthens Indigenous identity, which builds resilience. This notion is supported by Healy’s (2006) description of the marks of cultural resilience: the capability of a cultural system to maintain its core identity and structures across a continuum during and after major disruptions and changes. The findings of this study have supported a resounding, and remarkably high, level of resilience and strength in the Aboriginal nursing academic participants. Resilience is an important human attribute required for working in Indigenous health and leadership (Geia, Power and West 2013b).

*The resilience factor*

If maintaining and growing more Indigenous nurse leaders is a priority for SONMs in universities, then the magnitude of the roles of the Indigenous nursing academics must be understood. The onus should not be exclusively on individuals to manage excessive workloads and to become resilient to survive in their workplace. The notion of ‘do it all’, is compounded by Indigenous women in universities being a minority within a minority,
where they are underrepresented in research and leadership, and have dual minority positions of gender and ethnicity. This inequitable situation requires more training and understanding of the non-Indigenous staff about Indigenous culture. Milne, Creedy and West (2016, p. 392) state, ‘Schools of nursing and midwifery education need to adapt policies, guidelines and actions that provide cultural safety training for academics’, which will promote a culturally safe setting for Indigenous nursing academics and students to feel valued in the nursing profession. In addition, Indigenous nursing academics must be provided with educational opportunities to build their own personal resilience so that they can remain resilient, active and effective in their Indigenous nursing leadership positions.

Penehira et al. (2014) ‘recognise that resilience has been critical in assisting Indigenous people to survive colonialisit regimes’. The human attribute of having strong resilience is an important factor in Indigenous nursing leadership. Several authors have described the concept of ‘resilient’ people as human beings making meaning out of adversity and having a positive outlook despite continuing hardship (Coutu, 2002; Flemming and Ledogar, 2008). Resilience has been described by other researchers as a multi-faceted phenomenon, relying on the interplay of social, biological and environmental circumstances. These can be influenced by many human factors, but ultimately resilient humans still survive despite serious threats in the process of adaption or development (Deveson, 2003; Masten, 2001). Pearson (2000) argued that resilience is crucial for Indigenous people, and when developed, action follows; without it, victimhood becomes manifest. Wilson (2006), who researched Indigenous health and politics, concurred that Indigenous people in present day society are testimony to their strong resilient natures and their capacity to survive amidst the historical injustices that they experienced.

Research by Kooker, Schoultz and Codier (2007) highlighted the importance of developing emotional intelligence in the professional nursing practice, which strengthens a person’s self-awareness, leaving them better prepared to manage their emotions. Many researchers applaud the importance of academics building strong emotional intelligence, in which practising reflexivity is an important factor that can promote academic leadership and enhance their strategic roles within higher education (Coco, 2011; Horton-Deutsch, 2008). Training opportunities for Aboriginal nursing academics need to be led and actively championed by their SONMs and the university’s human resources division, so that the
academic can access culturally safe training, support and mentorship that will provide opportunities for them to build strong leadership skills. This will prepare them for working in culturally contentious places within the wider university environment.

*Being an Indigenous nurse leader*

The participants in this study spoke about leadership and being a leader, and how early leaders in Indigenous nursing experienced hardships greater than those experienced today. Because of this, they felt that as the present generation of Indigenous nurses, more is expected of them from themselves, their families and their community. One participant (Ruby) explained that because of the small number of Indigenous nursing academics, most times ‘when you are called on to “lead”, you are actually leading on your own’. This comment highlights the cultural differences in expectations of leadership. In the cultural context, the Indigenous nursing academics are expected to lead from their cultural groundings where there is a life-long journey in fulfilling obligations to community, family, and self. In contrast, at an institutional level one Indigenous person may be expected to be a spokesperson for all things Indigenous. This approach does not resonate with a collective leadership approach/style. Instead, it terms of Indigenous culture, it bears more similarity to the servant leadership style described in the literature (Ruwhiu and Elkin, 2016). Ruwhiu and Elkin (2016) define servant leadership as ‘one which is based on teamwork and community; one which seeks to involve others in decision making; one which is strongly based on ethical and caring behavior: and one which enhances the growth of people’ (p. 310).

Another participant (Pearly), who has a position in Indigenous nursing leadership in Queensland Health spoke about the difference in Indigenous and non-Indigenous leadership styles, ‘Blackfellas walk the line, so we walk almost shoulder to shoulder. It’s a community response, whereas non-Indigenous people, they’re all very competitive and there has to be a head girl’. Power et al. (2015) described similar sentiments, explaining that the model of western leadership often has one head person speaking on behalf of all, where Indigenous culture contrasts, in that there is no ‘one voice’ that speaks; instead, there are collective voices. This finding is interesting, as in a book by Reynolds (1982)
about Aboriginal resistance to European invasion, Aboriginal society was referred to as being a true democracy, where members of that society were often sharing and equal and placed minimal interest in advancing as individuals. The post-colonial regime has forced these behaviours to change so that Aboriginal people can advance in western society. This means that Aboriginal people have had to participate in western education systems to gain professional qualifications to advance their chosen careers, and so that they could become leaders and have influence around Indigenous policy-making to improve the plight of their Indigenous communities. Several of the participants in this study spoke about their PhD research, and of their study recommendations that have been, and may in the future be, used toward quality improvements in Indigenous nursing policy. Throughout the study, participants voiced that they were often overwhelmed and frustrated with the responsibility of leading change on the Indigenous front; both in healthcare and university settings, which was, at times, hampered by slow bureaucratic processes and institutional racism.

**Building future Indigenous leaders**

Aboriginal nursing academics Best and Stuart (2014) highlighted the importance of graduating Indigenous nurses in larger numbers to generate the potential for more Indigenous nurse leaders on the ground, which would help lead cultural change across Australia. A study by West, Foster and Usher (2016) asserted that, ‘Aboriginal and Torres Strait Islander nurse academics were identified by all students as a critical catalyst for instilling in them the belief that they could successfully complete their course and move to the next phase of their nursing career’. This resonates with the aspirations of Wenitong et al. (2007, p. 491) to build stronger health leadership and ideals from which a resilient ‘Indigenous workforce can provide cultural and professional leadership, that will challenge views that Indigenous Australians are not taking responsibility’ for improving their own health.

West, Geia and Power (2013) wrote from their own perspectives as Indigenous nursing and midwifery leaders on how Indigenous nurses and midwives can be instrumental in making positive cultural changes in the profession through the mechanisms of effective
leadership and research. These exemplary Indigenous nurse leaders highlighted the importance of maintaining strong culture and identity, paving the way forward for others, using their research knowledge to train and support others and the need for Indigenous health advancements (West, Geia and Power 2013). Indigenous nurse leaders in Australia highlighted the importance of Indigenous nursing leadership (Power et al., 2015); a topic highly relevant to the current study as the Aboriginal nursing academic participants are leaders in their areas of Indigenous health expertise, their SONMs and their wider Indigenous communities.

In the current study, one participant (Pauline) expressed her annoyance at leadership being thrust upon her, as in her view ‘it’s just an easy cop-out for the white nursing academics to give everything Indigenous to the black nurse’. This demonstrates that Indigenous nursing leadership often does not come with an option to say ‘No’, signalling that for Indigenous nursing academics, leadership can be unwanted, unanticipated and lonely. For those reasons, cultural leadership in all things Indigenous should not fall on the Indigenous nursing academic. Instead, a collaborative approach about how cultural matters will be managed needs to be agreed upon and adopted by both Indigenous and non-Indigenous nursing academics.

There is strong hope for the future for positive Indigenous nursing leadership, in collaboration with culturally aware non-Indigenous colleagues, in terms of reducing incidents of racism, and in promoting cultural awareness and valuing of Indigenous culture. However, unless there is consistent support and awareness from all groups within universities and health, these things will not change. Contemporary Indigenous nursing leaders have confidently stated, ‘Prepare to step aside and watch us transform the rhetoric of self-determination into reality as we work together and speak life into each other’s spirits’ (Power et al., 2015, p. 148). These sentiments are the loud clarion call in the current study that have been shared through the Aboriginal nursing academic stories.
Recommendations

Recommendations from this study based on the summary of findings are directed towards addressing the disparities between Indigenous and non-Indigenous nursing academics, and to specifically promote the employment and retention of Indigenous nursing academics in SONMs across Australia.

The following recommendations are proposed.

1. Inclusion of time allocation for the support of Indigenous nursing and midwifery students within the workload of Indigenous nursing and midwifery academics. This should be considered in conjunction with the academic’s university teaching, research and engagement commitments, and established with agreement between the academic and the university’s senior leaders/departments for leading and managing.

2. Allocation of workload time for Indigenous nursing and midwifery academics set at 20% teaching, 40% research and 40% community and cultural engagement commitments, to support Indigenous nursing and midwifery students.

3. Implementation and monitoring of effective policies and strategies to ensure that the cultural safety of Indigenous nursing academics and students is maintained and upheld throughout the university environment.

4. Support for a minimum of two tenured Indigenous nursing academic positions (with academic positions increasing in line with Indigenous student numbers) within SONMs to provide collegiality, manage academic workloads, lead cultural support and/or lead Indigenous health content and embed this content (with the support of non-Indigenous colleagues) across nursing and midwifery curricula, and lead and inform Indigenous health research agendas. Staff also need to be supported to network with other Indigenous nursing and midwifery academics to build a stronger, coherent research community.
5. Enforcement of ‘no tolerance to institutional racism’ policy, and the requirement that incidents of racism be reported to the university’s senior leaders/departments for leading and managing for swift evaluation and management.

6. Implementation of processes for monitoring and analysing student feedback evaluation of Indigenous nursing academics’ teaching capabilities by the university’s senior leaders/departments for leading and managing to record objective feedback only, to avoid any inclusion of unjustified/uninvestigated controversial feedback that could impact on the academic promotional opportunities for Indigenous nursing academics.

7. Implementation of requisite cultural awareness training for non-Indigenous nursing academic staff. This must be addressed by the university’s senior leaders/departments for leading and managing to ensure that Indigenous academics are culturally safe.

8. Provision of opportunities for Indigenous nursing academics to engage in resilience development training supported by the university’s senior leaders/departments for leading and managing to mitigate the identified high risk of burn out.

9. Allocation of funding for Indigenous nursing academics by the university’s senior leaders/departments responsible for leading and managing to attend Indigenous health conferences and engage in research opportunities to gain up-to-date information to promote leadership opportunities and to network with their Indigenous academic peers from other universities, to build teams and collaborate as researchers.

10. Establishment of support pathways for Indigenous nursing academics undertaking PhDs to include senior mentors and opportunities for study leave to progress completions. This will facilitate the development of Indigenous nursing/health researchers to supervise emerging Indigenous nursing and midwifery research higher degree (RHD) students. A pipeline for Indigenous nurses coming into academia needs to be established so that the cycle of continually growing Indigenous nursing academics can be achieved and sustained.
These recommendations are highly achievable, with recommendations one, two and four being implemented over the short-term, recommendations three, five, six, seven and eight being continuous, and recommendations nine and ten occurring over the long-term period. These recommendations will have maximum impact with moderate social and economic investment, especially when compared to the costs of increasing burden of disease on the Australian Indigenous population, which is the current status quo (Alford, 2015).

Further research

Several priorities for further research have been identified through examination of the literature and issues raised by participants in this study.

In the current study cultural safety was identified as a means of accelerating progress in all areas of Indigenous nursing and Indigenous health outcomes. Further research should investigate the various models of cultural safety delivery in existence, and evaluate which models create the most change in the behaviours and attitudes of the participants. This will help determine which models yield the best outcomes and whether there are multiple effective approaches for teaching cultural safety.

This study highlighted that a strong Indigenous health workforce is paramount in improving Indigenous health outcomes. Current evidence suggests that the number of professionals in the Indigenous health workforce is declining, as these people are abandoning their Indigenous health positions for other careers, joining the casual health workforce or becoming transient in the health workforce. Research that explores the reasons for this workforce erosion may provide important information to help retain this workforce.

Lastly, this study explored the qualitative experiences of Aboriginal nursing academics in Queensland universities. Future qualitative and quantitative studies should include Indigenous nursing academics in all SONMs across Australia. This would significantly expand on this study’s contribution and would identify how state policy and/or local social
and political environments and support processes may influence experiences. The results would provide evidence for strategies that may assist in improving recruitment, experiences and retention of Aboriginal nursing academics in Australia. This could also include a comparative study of those who came through the high school pipeline, and those who did not.

**Strengths and limitations of the research**

**Strengths**

Few studies have focused on the perceptions of Aboriginal nursing academics. From the existing literature and the stories of the Aboriginal nursing academic participants in this study, we know that there is a range of burdens experienced by this cohort. Aboriginal nursing academics are an important part of the Indigenous health workforce that is urgently needed to help closing the gap in Indigenous health inequities. This research will therefore bring new knowledge and provide greater understanding about how to grow this important workforce.

A narrative methodology was used for this research and, as documented by Holloway and Freshwater (2007), offered the opportunity to create coherent participant stories from interview transcripts. I acknowledge that Indigenous people over thousands of generations have developed the art of storytelling, passing on stories from generation to generation. The rich data gained from this research approach generated a strong body of information to substantiate the participants’ experiences. This, in-turn, supported the rationale of selecting a narrative inquiry (storytelling/yarning) methodology, which was identified as a strength for this study.

The research was conducted by using a qualitative narrative methodology and rigorously followed the processes described in the literature (Patton, 2002; Sandelowski, 1991). I was aware that, being an Aboriginal nursing academic myself and a participant in this research study, this close engagement could have created the potential for possible biases on my behalf, influencing within the analysis and interpretation of data and the research processes. Critical reflection upon my role and the methodology provided
opportunities to identify and utilise several strategies to ensure academic rigour. My own perspectives and experiences were made visible via a self-introduction. Interview transcripts and narratives were returned to each of the participants for member-checking. Verbatim quotes from the participants were used to ensure that the research data was reported as authentically as possible and to minimise potential bias through my role as researcher and participant. Throughout the study, feedback was requested and obtained from my PhD supervisors for peer-debriefing in relation to the review of interviews and the ensuing analyses.

An additional strength was my ability to closely engage with participants, due to my own ethnicity as an Aboriginal Australian. The participants in this research study were all from Australian Aboriginal backgrounds. Each of the participants held post graduate qualifications and had a strong understanding of the research process. This proved to be a strength in the research, as all participants had experience being employed in academia and had a comprehensive understanding of each stage of the research process, which in-turn allowed for efficient operation.

**Limitations**

Several limitations of this study are acknowledged. The sample was restricted to Aboriginal nursing academic research participants who were employed in Queensland universities. This study is therefore limited to the experiences of Aboriginal nursing academics in one part of Australia. It is not possible to determine if the common themes found within this Queensland cohort would mirror Indigenous nursing academics working in other Australian states and territories.

Another limitation in this study was associated with the participant sample. Participants were all female and all identified as Aboriginal; therefore, there was the omission of male Indigenous nursing academics and Torres Strait Islander nursing academics. Future research in this area should include male Indigenous nursing academics to incorporate their view, which would be particularly important given the need to support the development of the Indigenous male health workforce. There is also the lack of Torres Strait Islander Indigenous nursing academic perspective, which should also be included.
in a broader Australian study on the topic. This will ensure the representation of all Indigenous Australian cultural backgrounds. Lastly, this study was conducted part-time over a period of seven years, and is reflective of the experiences of academics at the time of data collection. It is possible that there have been changes in university support, resourcing and recruitment of Indigenous nursing academics since the data were collected. As a result, participants’ experiences and perceptions may now differ, for better or worse.

**Conclusion**

By interviewing Indigenous nursing academics, my aim was to describe, analyse and share their collective voice and experience. To date, there has been limited research undertaken specifically pertaining to the broad experiences of Indigenous nursing academics themselves. It is therefore feasible to suggest that this thesis work, based on the stories of a small, yet insightful, cohort of Aboriginal nursing academics will facilitate an understanding of the contemporary issues faced by these academics, and be a valuable and original inclusion to the new knowledge base within this academic genre. Over the past decade, only a few Indigenous nursing academics in Queensland have undertaken doctoral studies within the Indigenous nursing sphere. This research study highlighted the importance of Indigenous nursing and the capacity for these nurses to provide culturally appropriate care to Indigenous patients, the importance of building a pipeline of Indigenous nurses to help close the gap, and the enthusiasm of Indigenous academics to engage with Indigenous students. However, general racism in Australia has negatively influenced the development and progression of Indigenous nursing academics. The isolation and workload of Indigenous nursing academics is a considerable additional burden (compared to non-Indigenous academics) and needs to be managed, or it is possible that strong leadership in Indigenous nursing will not develop and flourish.

It needs to be understood by the non-Indigenous academic community that, when Indigenous academics engage with their Indigenous communities, interaction is not optional, but a cultural obligation that is rooted deep within the psyches of Indigenous
peoples. This engagement provides concurrent and symbiotic high levels of cultural respect and connection between the individual and their communities. The stories of the Aboriginal nursing academics in the current study confirms that community workload is something that they embrace, and it is an important and significant part of both their cultural identity and their academic workload. The investigation of the unique cultural and community drivers of Indigenous nurses/Indigenous nursing academics makes this research project distinctive and noteworthy compared to the large majority of non-Indigenous nursing research projects. Results of this study suggest that until the cultural and community workload obligations of Indigenous nursing academics are respected and understood in SONMs, progress in growing this unique cohort of academics will continue to be constrained.

Key take home messages from this research study clearly indicate that to improve the overall health of Indigenous people and address Indigenous health disparities, Indigenous nursing academics in SONMs need to be supported to attract, retain and graduate a highly skilled Indigenous nursing and midwifery workforce. The study findings reveal that there is a deficit in the support provided for Indigenous nursing academics, which prevents them from continuing in their positions in universities. Recommendations from this study have been developed to address these deficits to ensure that Indigenous nursing academics are better supported in the university environment through the implementation of university policies, processes and staff development opportunities.

These recommendations address key areas, including acknowledging hidden workloads, ensuring cultural safety, increasing the number of Indigenous nursing academics per SONM, addressing racism, acknowledging barriers to academic promotion, providing cultural awareness training to non-Indigenous staff and providing resilience training for Indigenous nursing academics. Investment in these recommendations to attract and retain Indigenous nursing academics will reap financial rewards well-beyond those afforded by better health outcomes (Alford, 2015). Universities also need to provide opportunities for their Indigenous academic staff to develop professionally into leadership positions, including extra support for them to complete doctoral studies, which will help advance the Indigenous nursing research portfolio within the higher education sector and help grow more Indigenous nursing researchers. One overarching action that universities
can take is to create specific Indigenous nursing leadership positions in duplicate (at least), which will contribute significantly to advancing the Indigenous nursing portfolios in Australian universities, and ultimately improve higher education outcomes for Indigenous people.

In February 2017, the Prime minister of Australia, Malcolm Turnbull, acknowledged that Australia is failing in six out of the seven target areas to improve Indigenous disadvantage, and that this failure needs to be addressed (Department of the Prime Minister and Cabinet, 2017). The current failure to close the gap has the potential to create further disadvantage upon Australian Indigenous people and communities. This issue alone calls for urgent action to be taken to increase the numbers of Indigenous nurses and midwives, an evidence-based strategy to improve Indigenous health outcomes, so that health equality between Indigenous and non-Indigenous Australians can be finally achieved. There has never been a better time for a call to action for universities to extend their wingspan and create culturally safe environments to support an increase in Indigenous nursing academics, our Black Swans, so they can grow, flourish, and continue their ‘Maroochy Dreaming’ storyline.

This original study is timely as it has highlighted that achieving a critical mass of skilled Indigenous health professionals is integral to developing the leadership required to impact positively on Indigenous health into the future. There is much work still to be done in recruiting, educating, graduating and retaining greater numbers of Australian Indigenous nurses and midwives. The method used in this study was appropriate to explore the experiences of the Indigenous nursing academics participants (Black Swans) who are key to providing leadership and culturally appropriate health care to improve Indigenous health and outcomes. The resilience demonstrated by participants in this study has illustrated how the story of ‘Maroochy Dreaming’ will continue to be told by our mob until health equality for all Indigenous Australians is achieved and sustained for generations to come.
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APPENDICES

APPENDIX A: Ethics approval

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Thursday, 14 February 2013

Ms Lynne Stuart
Dept of Nursing and Midwifery
Faculty of Sciences
USQ

CC: Professor Gath Rogers-Clark, Supervisor

Dear Lynne

The Chair of the USQ Human Research Ethics Committee (HREC) recently reviewed your responses to the HREC's conditions placed upon the ethical approval for the below project. Your proposal now meets the requirements of the *National Statement on Ethical Conduct in Human Research (2007)* and full ethics approval has been granted.
The standard conditions of this approval are:

(a) conduct the project strictly in accordance with the proposal submitted and granted ethics approval, including any amendments made to the proposal required by the HREC

(b) advise (email: ethics@usq.edu.au) immediately of any complaints or other issues in relation to the project which may warrant review of the ethical approval of the project

(c) make submission for approval of amendments to the approved project before implementing such changes

(d) provide a 'progress report' for every year of approval

(e) provide a 'final report' when the project is complete

(f) advise in writing if the project has been discontinued

For (c) to (e) forms are available on the USQ ethics website: 

For (d) to (e) please diarise the applicable dates now, to ensure that your reporting obligations are fulfilled.

Please note that failure to comply with the conditions of approval and the National Statement (2007) may result in withdrawal of approval for the project.

You may now commence your project. I wish you all the best for the conduct of the project.

Melissa McKain
Manager, Research Integrity
Office of Research and Higher Degrees
APPENDIX B: Letter to key stakeholders

The title of my research project is “What are the Stories of Indigenous Nursing Academics working in Australian Universities between 2001-2011”.

Ethics Approval No. – H12 REA193.

Dear Key Industry Stakeholder,

Firstly, thank you for agreeing to be a research participant to support my PhD research project. I have selected you as one of two key industry stake holders for my research because you work closely with Indigenous nursing education and educators. Your profile as an Indigenous registered nurse, and your past employment as an Indigenous nursing academic means that you belong to a strong informal network of university trained Indigenous registered nurses and have strong links within that network.

The research is centred around the “Stories of Indigenous Nursing Academics”, and I believe that you would be one of the most influential people in this group. As you have agreed to participate in this study, after my interview with you, I will ask you to then facilitate contacts for myself as the researcher with your contacts. Professional processes of gaining informed consent for you and any contacts that you refer to me will be initiated, and privacy rights will be adhered to, to protect the identity of all research participants.

The broad aims of this doctoral research are to research the stories of Indigenous nursing academics working in Australian universities over a period of a decade. I hope to develop an understanding of the challenges they have experienced and the opportunities that have presented to them while carrying out their roles as Indigenous nursing academics. It is hoped that after researching these stories more will be revealed about their experiences in the workplace and how their students, Indigenous nursing students they mentor and act as role models for, are attracted to university studies. By reviewing these personal stories of being an Indigenous nursing academic, it is the author’s intention to then analyse the data obtained during the individual interviews and collate this information into a doctoral research Thesis titled, “The Stories of Indigenous Nursing Academics working in Australian universities between 2003-2013”.

I understand that for our interview, arrangements are I will phone your landline (of which you will provide this number by return email) at 12pm on Thursday the 7th of March 2013. If you could please sign and return an electronic copy of the attached consent form prior to the interview that would be great. Thanks again for agreeing to support my PhD research project.

Yours gratefully,

Lynne Stuart (Researcher).
APPENDIX C: Participation information sheet and consent form

Participant Information Sheet

HREC Approval Number: H12REA193

Full Project Title: “What are the Stories of Indigenous Nursing Academics working in Australian Universities between 2003-2013”?

Principal Researcher: Lynne Stuart

Other Researcher(s): Nil

You are cordially invited to participate in a research project conducted by Lynne Stuart (PhD student, University of Southern Queensland). The principal supervisor is Professor Cath Rogers-Clark. The focus of this research involves accessing personal and professional stories relating to the lived experiences of Indigenous nursing academics working or who have previously worked in Australian universities.

1. Procedures

Participation in this project will involve

- If you agree to join this study, you will be required to participate in 1 x face to face or phone audio-taped interview for the duration of 1 – 2 hours. This interview will be conducted at a venue chosen by you the participant. With your permission this interview will then be transcribed by the principal researcher and then sent to you for you to verify its accuracy.

- The research will be monitored by Lynne Stuart (Principal Researcher) on Ph: (07) 46 312 972

- The benefits to participants – The study has the potential to enable participants to tell their stories and contribute to Indigenous knowledge in this relatively new area, and share understanding of current and future Indigenous concerns.

- There are low risks.
2. **Voluntary Participation**

Participation is entirely voluntary. If you do not wish to take part you are not obliged to. If you decide to take part and later change your mind, you are free to withdraw from the project at any stage. Any information already obtained from you will be destroyed.

Your decision whether to take part or not to take part, or to take part and then withdraw, will not affect your relationship with the University of Southern Queensland or the Department of Nursing and Midwifery at USQ, or exclude you from future research projects.

Please notify the researcher if you decide to withdraw from this project.

Should you have any queries regarding the progress or conduct of this research, you can contact the principal researcher:

*Lynne Stuart*

*Faculty of Sciences – Department of Nursing and Midwifery*

*17 Sylvan Court, Rangeville, Toowoomba, QLD, 4350*

*W - (07) 46 312 972, A/H - (07) 46 359 260*

If you have any ethical concerns with how the research is being conducted or any queries about your rights as a participant please feel free to contact the University of Southern Queensland Ethics Officer on the following details.
Consent Form

HREC Approval Number: H12REA193

TO: Participants

Full Project Title: “What are the Stories of Indigenous Nursing Academics working in Australian Universities between 2003-2013”?

Principal Researcher: Lynne Stuart

Student Researcher: Nil

Associate Researcher(s): Nil

- I have read the Participant Information Sheet and the nature and purpose of the research project has been explained to me. I understand this information and agree to take part in this study.
- I understand the purpose of the research project and my involvement in it.
- I understand that I may withdraw from the research project at any stage and that this will not affect my status now or in the future.
- I confirm that I am over 18 years of age.
- I understand that while information gained during the study may be published, I will not be identified and my personal results will remain confidential.
- I understand that I will be audio taped during the study and the tape will be stored in the researcher’s office, on a computer with password protection. Hard copy documentation involving identifying data about participants will be stored in a locked filing cabinet in the researcher’s office, and will be only accessible to them. Data relating to participants that has been used for this study will remain stored for a requisite of 5 years in the researcher’s office. After the expiration date of 5 years the research data will be destroyed.

I agree to participate in this study by Lynne Stuart. I understand any information I give will be kept confidential.

Name of participant...........................................................................................................

Signed........................................................................................................... Date
If you have any ethical concerns with how the research is being conducted or any queries about your rights as a participant please feel free to contact the University of Southern Queensland Ethics Officer on the following details.

Ethics and Research Integrity Officer  
Office of Research and Higher Degrees  
University of Southern Queensland  
West Street, Toowoomba 4350  
Ph: +61 7 4631 2690 – Email: ethics@usq.edu.au

(Question to guide the Interviews)

Sample of Open-ended Questions to Guide the Interviews

Opening question - What is your tribal affiliation?

1. What was it that motivated you to become a nursing academic?
2. Tell me what has the journey been like for you?
3. How do you do it all? What’s your method of coping?
4. Do you think that your experiences are different to mainstream nursing academics? How?

Example Questions for Prompts

Who did you turn to when you had difficulties ...?
How was it helpful...? Not helpful...?
How did you feel...?
When you experienced these feelings, how would you describe them:-
Their effect on you...?
At times the questions may need to become more specific in order to seek out or clarify the perceptions of the participants about their experience.
Could you give me an example of...?
Could you tell me how it felt when...?
What was that experience like for you...?

I will close the interview by asking...”Is there anything else you feel and think is important to say (or share) that will give deeper understanding of what your story of being an Indigenous nursing academics is like/ was like?

Every effort will be made to avoid interjecting commentary, aiming to minimise influencing the participants’ responses or stopping the flow of the “stories”. It is envisioned that each participant will provide personal and professional experiences within their stories...