

Having the Hard Conversations: A guide to good practice in Indigenous health and cultural safety education

About this project

This 'Guide to Good Practice' (the Guide), is one of the major educational resources arising from a National Senior Teaching Fellowship awarded to Professor Dennis McDermott in 2014 by the (then) Australian Government Office of Learning and Teaching (OLT). The programme of work, *Having the Hard Conversations: Strengthening pedagogical effectiveness by working with student and institutional resistance to Indigenous health curriculum*, involved a team of national and international scholars in the field of Indigenous health and cultural safety education. Over a four-year period, they collaborated to develop, refine and disseminate a framework for conceiving of, and delivering, effective strategies to meet student and institutional resistance to the personal, professional, and political challenges encountered by many in curriculum material and teaching processes alike.

The Guide aims to be well-evidenced, accessible and practical in application. It is designed to be used in tandem with a suite of video resources that are directly applicable to a range of health professional educational settings (whether university courses or professional development workshops). In particular, six three-minute video resources, drawn from interviews with key national and international scholars in this field, aim to assist educators looking to keep students and practising health professionals engaged and successfully traversing a journey of change, despite any cognitive dissonance or emotional discomfort. Titles available include: Challenges; Cultural Safety; Power Imbalances; Self-Reflection; Listening; and Mechanisms of Change. A thirteen-minute video, suitable for use in organisational change contexts is also available, as are other downloadable video recordings of seminars, webinars and other presentations aimed at supporting educator comprehension and pedagogical success.

All video resources, and accompanying facilitator material, are available for free download at the Poche Adelaide website at:

<http://www.flinders.edu.au/medicine/sites/poche.adelaide/cultural-safety.cfm>

and will also be available from the Lime Network's Resources Hub at:

<https://www.limenetwork.net.au/resources-lime-publications/resources-hub/>.

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Section 1

1.1 What do we mean by 'Having the Hard Conversations'?

Non-Indigenous health professionals deliver the majority of interventions and programmes to Aboriginal and Torres Strait Islander Australians. Their work is pivotal to improving a range of Indigenous health outcomes, which for many indicators are the worst of any population group in the nation.ⁱ Yet many, thoroughly competent, professionals report uncertainty regarding how to engage with Indigenous health issues, cultures, clients and communities. Many cite a personal lack of social relations with Aboriginal and Torres Strait Islander peoples, particularly evident where encounters with Indigenous Australians pass unrecognised in the wake of inaccurate views of what diverse Indigenous Australia looks like, and where it resides. When ranged alongside a still-existent inadequacy in health professional training in Indigenous health, in the contemporary consequences of colonisation, and in the provision of culturally-safe care, for a number of practitioners the response to the possibility of such a professional encounter is unease, even fear (McDermott, 2016).

To provide services that Indigenous Australians would want to engage with, it is crucial for service providers to be aware of their own assumptions, attitudes, beliefs, and values. This requires not only fostering health professional reflection on their own culture in relation to a professional's therapeutic interactions but, also, the re-positioning of such reflective practice as the default setting for effective cross-cultural work - i.e. as core clinical, health promotional, and organisational business. One exemplar approach which encapsulates the need for the mitigation of power differentials, for the development and embedding of self-reflective practice, and for treating clients 'regard-ful', rather than regardless, of difference - is the above-mentioned one of cultural safety.

The same precepts of recognising and reducing power differentials, self-reflexivity, and conscious avoidance of a conflation of equity and sameness of treatment (often expressed as 'I just treat everyone the same') are central to a number of other approaches that are of similar pertinence to Indigenous health education - and utility to a future practitioner's clinical, or health promotional, effectiveness. These include: cultural humility (Tervalon & Garcia, 1998); the more-nuanced and flexible models of cultural competence offered by Weaver (1999) (a model from a Native American perspective) and Goode and colleagues at the (US) National Center for Cultural Competence (Goode, 2014); as well as the Australian-developed Integrated Model of Gabb and McDermott (2008). These approaches inform our comprehension of the minimum good practice requirements for effective cross-cultural service provision, yet their implementation holds major ramifications for individual practitioner training, organisational quality assurance, and overall service configuration.

The very content of Indigenous health and cultural safety training, along with the potentially-disquieting degree of critical analysis involved, challenges many students and health professionals on personal, professional, organisational and political levels. Where students or practitioners respond with resistance - and, in particular, with disengagement - teaching and learning can fail. The development of a workforce that is genuinely effective in Indigenous health settings is jeopardised. Institutions, such as universities, hospitals or government departments, can also resist. The comprehensiveness of Indigenous health subjects may be diluted, Indigenous perspectives can be discounted and core subject status dismantled.

Student resistance can be expressed in many ways: non-engagement, discounting the authenticity of an Indigenous experience, prejudices and blatant racism. Students may fail to see the relevance of the curricula and resent it (Downey, Ward, Daniels et al (2014 use the term the "groan zone" to characterise student resistance to decolonising pedagogy. As noted above, significant discomfort can arise when encountering alternative worldviews, uncovering taken for granted prejudices and learning history from Aboriginal and Torres Strait Islander perspectives. Significantly, however, discomfort and dissonance may also be pathways to desired changes. Thus, managing resistance implies a balancing act for educators - provoking levels of discomfort and dissonance that facilitate change without students rejecting or retreating from the material all-together.

Students tell us that they come to health professional education ill-informed by schooling and up-bringing, as well as ill-informed by a pervasive stereotyping in sections of print, electronic and social media. We know that those who deal in 'shock-jock' tactics, whatever their medium, deploy negative stereotyping as a means for putting a complex topic beyond cool examination. In doing so, they also reinforce a widespread misunderstanding of crucial elements of both a shared national history and the nuance of, and sophistication within, Indigenous knowledge systems. In turn, such disinformation can diminish the willingness of students and practitioners to engage with Indigenous health and cultural safety education whenever the dissonance with existing knowledge and value systems becomes too great.

One lesson arising, then, from the widespread colonial legacy of the demeaning, even demonising, of Aboriginal and Torres Strait Islander culture, knowledge and perspectives might be for an educator to *expect* to meet some discomfort, even some desire for disengagement, from students. The substantial body of work of the University of Hong Kong's Professor LC Chan, in seeking to embed medical humanities into medical student training - in the service of creating healers rather than mere medical technicians - is premised on a foundational strategy of 'turning *towards* dissonance', rather than away, whenever it is encountered (Chan et al, ...). We need a pedagogy that assists us to work *with* student discomfort, to make any disquiet manageable, to create a sufficiently-safe space to have the 'hard' conversations.

1.2 Why do we need a guide?

Although the models referred to above have been developed to better prepare the health workforce to be more effective, there is little evidence that, across the range of approaches, cultural training for health professionals can produce better health outcomes for patients or clients. It is even difficult to clarify whether, or not, specific elements of health professional training can be shown to influence the future behaviour of a practitioner. One of the events central to developing the framework upon which this guide is based, 2015's Poche Key Thinkers Forum, FINDING COMMON GROUND - AVOIDING THE TERMINOLOGY TRAP: *Identifying and applying the critical elements of Cultural Competence/Humility/Safety for effective cross-cultural work*, suggested that we have little evidence that, whatever the model, health care systems have been able to successfully operationalise them for incorporation into the work practices of a service. In fact, evaluation of system-wide programmes from a New South Wales health region (Hunter New England Health) and a Canadian province (Provincial Health Services Authority of British Columbia) point to very real difficulties in embedding culturally respectful/competent/safe ways of working as the system's normative practice. We do know, though, many of the conceptual and training approaches through which we have been attempting to develop more-effective practitioners have not been working. In the development of the framework, and subsequent guide, we needed firstly, then, to jettison what's been shown to be unhelpful. A second response was to develop a shared understanding of the domains of greatest promise for further scholarship and better training. A major recognition arising from the 2015 forum (whose contribution to the strategies discussed in this guide are dealt with in more detail in Section 1.4, below) was that, in the search for better health outcomes, there is an imperative to deal with any 'terminology trap': the issues are beyond semantics or any need to come up with the one, 'right' model.

In the search for which dimensions may be key, this forum set out to examine the workings of the different models: what sets them up for effectiveness? It became clear, however, that there were also pre-conditions to examine:

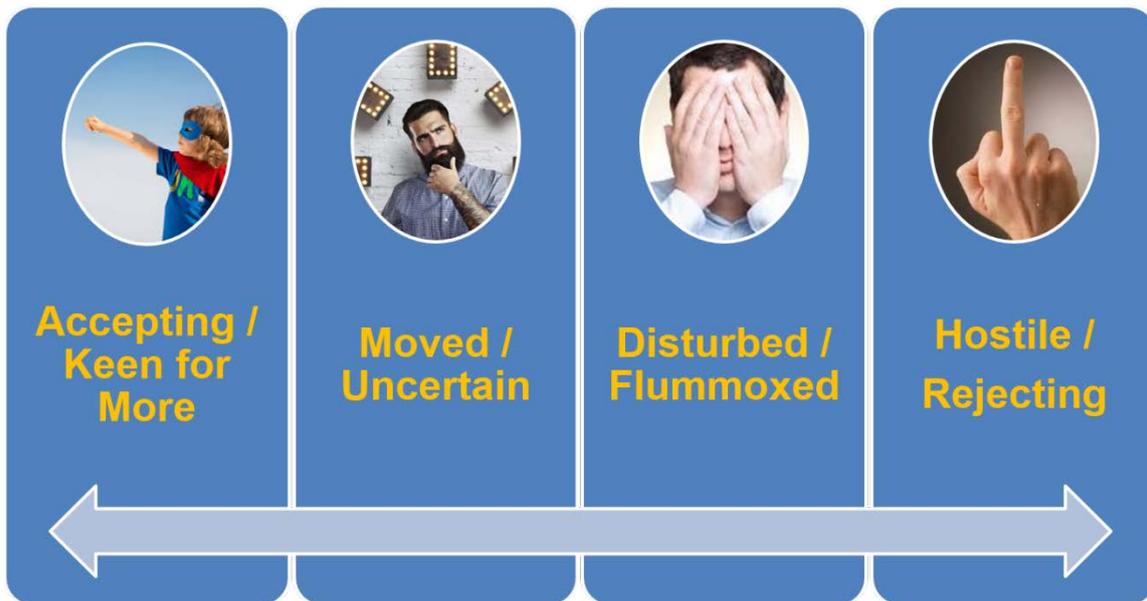
- Firstly, what are the **contexts** in which patient or client lives are lived? This requires close attention to the historical and contemporary circumstances of a particular community, or wider population group - this forum particularly addressed Indigenous Australians, Canadians and New Zealanders, along with African-Americans. On the positive side, what strengths or resilience (including cultural resilience) need to be factored-in? On the negative, what's the role of 'white' or 'settler' privilege, colonisation and racism?
- Secondly, what are the **mechanisms** by which a model can bring about change in a health professional, or health organisation? Does it involve imparting foundational knowledge about health inequities, as much as building necessary knowledge about a specific cultural group? Is it important for its working to provide cultural encounters- and what kind? Does the model seek to teach skills, challenge beliefs or invoke empathy - or some combination of such particular mechanisms?

Beyond descriptive terminology, we need a deep comprehension of the dynamics at play when a particular model is applied to practice if we wish to improve practice through strengthened training. It's possible that our terminology referring to working across cultural divides is, in itself, problematic. There may be an inherent 'Othering' in focussing too strongly on being more effective 'cross-culturally': "Every clinical encounter you come up against is a cross-cultural encounter" (Dr Rhys Jones, Finding Common Ground). Until a more-accurate term emerges, 'cross-cultural' should, perhaps, be bookended by scare quotes. If, indeed, "culture has many axes that describe who we are" (Dr Melanie Tervalon, Finding Common Ground), then that mandates a caution in approach - a perceptual humility - that actively avoids a too-simple characterisation of the patient or client. If relational humility is essential to working well with the unique person presenting for health care, then there is a tension here between health systems that demand competence of practitioners - especially in doing no harm - and the need for those practitioners to acknowledge a very real 'not knowing'. No level of practitioner skill guarantees a real comprehension of how the person they're working with actually experiences the world, nor how they might wish to proceed right now.

1.3 How has the guide been developed?

As noted, above, the Guide offers a comprehensive suite of responses to the dilemma of how best to maximise the continuing engagement of a student or health professional with Indigenous health and cultural safety education, despite a range of reported challenges thrown up by the nature of curriculum material and pedagogical approaches. The need for a comprehensive response to resistance and disengagement initially arose in the delivery, by Diane Gabb and Dennis McDermott - over a ten-year period, in NSW and Victoria - of a sequence of Indigenous and multicultural mental health workshops. Evaluations over this period gave evidence of the issue of emotional responses from participants, to challenging material, as a constraint on the effectiveness of the educational process. This was bolstered by subsequent evaluations of undergraduate and postgraduate health professional Topics (course subjects) over a seven-year period, at Flinders University, yielding similar findings.

Figure One - SPECTRUM OF RESPONSE



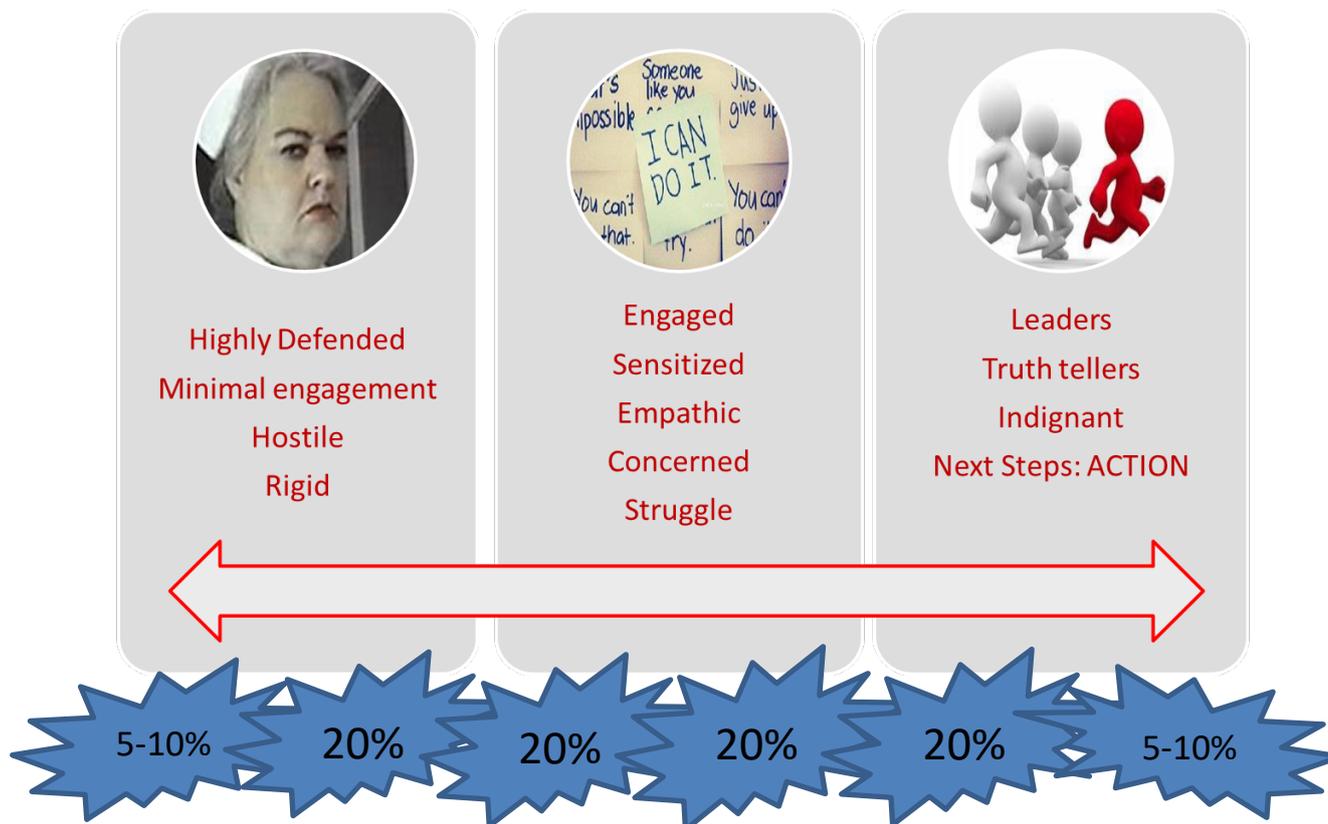
Our findings have been paralleled by large scale evaluation data reported from a province-wide, sophisticated on-line cultural safety training delivered in British Columbia (Daniels & Ward 2015). In both the Australian and Canadian jurisdictions, we note the emergence of distinctive modes of responding to the challenging material that many students are meeting, in a comprehensive way, for the first time.

Both sets of responses ranged from very negative to very positive. Students and practising professionals alike showed evidence of at least four response styles, merging one into the next along a spectrum. The first, which we have dubbed 'Accepting/Keen for more' (in the Canadian context 'Truth-tellers/Champions' (Daniels & Ward 2015)), could be characterised by its openness and willingness to engage, together with a desire to know and learn, no matter the difficulty of some of the material (McDermott 2016). In the second mode, 'Moved/Uncertain', there was often a sense of sorrow around the events and consequences of colonisation; a perception of a national shame, but no indication of feeling personally blamed. The third discernible grouping, 'Disturbed/Flummoxed', responded to challenging material with evident distress, a number of participants believing that they were being judged, and found guilty. To many within this group, the material was a source of major dissonance. Comments displaying a sense of betrayal jostled with others indicating denial or resistance. A reluctance to stay engaged with curricular material was evident. The final group, dubbed 'Hostile/Rejecting', often evidenced anger and class disruptiveness (McDermott 2016).

The San'Yas Indigenous Cultural Safety team of the Provincial Health Services Authority of British Columbia had gathered data (by 2018) on 30,000 interactions with the on-line training by practicing health professionals - and found a parallel pattern of responding, a spectrum, or continuum, of emotional response they termed the Participant Profile Continuum. Their schematic representation of the groupings is depicted in Figure Two, overleaf.

Figure Two - Participant Profile Continuum

(Daniels and Ward, 2015)



[This slide depicts findings from the work of the San'yas Indigenous Cultural Safety Training, Provincial Health Services Authority of British Columbia, Canada. It is used with permission and acknowledgement]

Substantive work on generation of a good practice framework - upon which to base such recommended strategies as are captured in this Guide to Good Practice - began with a rapid evidence assessment of the pertinent literature, as part of a wider realist review. Our evidence gathering continued through individual and group interviews with selected Indigenous health academics involved with related curriculum development and teaching delivery in both Australia and New Zealand, to which were added interviews with key scholars in the field who were presenting at a first event, in April 2015. A summary of our approach, and findings, are captured in the Fellowship Report, available on the Australian Government's Department of Education and Training website. For those seeking a more-comprehensive account, the same report lists, amongst its appendices, a full account of this aspect of the fellowship's programme of work.

Over two days then, in April, 2015, a **Symposium and Roundtable: *Having the Hard Conversations: Good practice in working with resistance to Indigenous health and cultural safety*** was held at Flinders University in Adelaide, South Australia. It attracted 42 national and international participants with expertise in the field, who contributed to the further development, or refining, of issues, approaches and good practice strategies. A number of **Dissemination Workshops** (Melbourne, Perth, Sydney and Canberra) followed, in 2015 and 2016, which provided opportunity for educators and other stake-holders - including the National Aboriginal & Torres Strait Islander Higher Education Consortium (NATSHEC) and the Australian Government Office of Learning and Teaching (OLT) - to engage with the issues, and strategies-in-response, arising from the Fellowship's **Literature Review, Interviews**, and other elements of its programme of work. Numbers of participants at each site ranged from 45 to 70). The developing findings of the Fellowship also informed a further sixteen national and international **Seminars, Webinars and other Fora**.

A number of direct **Consultations with Government and Industry**, including the Australian Government's Department of Health and Ageing, and the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM), provided opportunities to embed Fellowship findings in the implementation of nationally-relevant policies and training.

Academic outputs included five keynote **Conference Presentations**, invited **Plenary Presentations** and **Invited Public Seminars**, as well as seven **Concurrent Sessions**. Two Fellowship-related, refereed **Journal Articles** have been published - Sjoberg, DB and **McDermott, DR** (*International Journal of Critical Indigenous Studies*, 2016) and Lavery M, **McDermott, DR** and Calma T (*Medical Journal of Australia*, 2017) - with a third article submitted and a fourth in draft form.

Print and Electronic Media Coverage: Fellowship-related content informed coverage in The Australian newspaper's Higher Education Supplement, along with interviews with Indigenous radio and ABC Television News. Both activities and content continue to inform educational discourse and practice in the form of freely-available, web-based video-recordings of seminars/webinars (Australia and Canada), as well as post-conference video interviews.

1.4 Some notes on terminology

To have meaningful conversations around education for effective practice in Indigenous health settings means that individuals and organisations need to sift through the array of cross-cultural models to navigate a path between competing frameworks. These include, but aren't limited to cultural awareness / respect / appropriateness / competence / capability / sensitivity / safety / security / humility / ease. The models overlap on many agreed elements, but can also take differing positions on some fundamental principles. One such is the central question: Is it more important to know reams about the 'other', or better know and understand the self? Definitive answers on which language and models offer the most effective outcomes are hard to come by, the evidence available is limited and made less-reliable by widespread inconsistency in how frameworks are defined and applied.

In attempting to find common ground, a 2015 forum of national and international scholars, expert in this area, explored different ways of conceptualising, then responding to, approaches to developing effectiveness in health care delivery within Indigenous health contexts - then sought ways out of the '**terminology trap**'. This Poche Key Thinkers Forum, FINDING COMMON GROUND - AVOIDING THE TERMINOLOGY TRAP: *Identifying and applying the critical elements of Cultural Competence/Humility/Safety for effective cross-cultural work*, attempted to clarify our understanding of which elements, across the array of models, are critical to success, along with identifying any less-obvious barriers to effectiveness. They contributed to a video resource and an opinion paper, which sought sharper understanding of good practice in identifying, integrating, and applying the key dimensions of successful approaches.

FINDING COMMON GROUND ... WHICH ELEMENTS, OR ISSUES, APPEAR ESSENTIAL TO A GOOD-PRACTICE MODEL?

The forum critically examined the experiences of teaching and applying such common approaches as cultural safety, cultural competence and cultural humility. A number of key issues emerged which are capable of informing good practice.

A. We need more-sophisticated frameworks

If improved health outcomes are our goal, then we have to respond to all the areas that need addressing to allow relevant aspects of health practice to be properly addressed. Firstly, our theoretical underpinnings must be clear. Secondly, the wider contexts in which training and delivery take place require a fully consideration - and response. Finally, the spectrum of student and institutional response - which runs from 'accepting' and 'fully embracing' at one end, to 'hostile' and 'rejecting' at the other - needs factoring in. "We have to avoid the 'black box' of the learner". Our models need to be both comprehensive enough to address such issues as health equity and nuanced enough to allow a real flexibility in how a practitioner engages with the person in front of them.

B. "Every clinical encounter is a 'cross cultural' encounter"

If diversity is the only norm, embracing complexity becomes the only option. Localised, population-specific cultural awareness may provide useful signposts, but we certainly can't reduce the person in front of us to a collection of givens, or easily-knowable 'facts'.

C. Effective clinical or population health practice occurs at the intersection of population-level social determinants and personal uniqueness of identity and experience

This intersection comes with flashing amber lights - proceed with care. The health professional may need to, simultaneously, hold in mind social determinants of health of potential relevance to the person or community, whilst remaining alive to the unique identity and experience of the person or, indeed, community, with whom they're

working. There are aspects of both cultural safety and cultural humility that can contribute, here, to a common ground of good practice. These could be summarised as:

- (a) keeping your professional skill set at the ready, but accepting you can't presume to know the complex circumstances behind this patient's, or client's, presentation;
- (b) working with consequent humility; and
- (c) creating a sufficiently safe space for both engagement and a helpful narrative to emerge.

D. "What is shared is oppression."

A good practice model would foster comprehension of the role of structured power and privilege. This is a difficult task. The issues involved are central, but sensitive as they include analysis of what has been termed 'white' privilege or 'settler' privilege: an un-earned advantage bestowed simply by membership of the culturally-dominant group. Analysis can usefully include examination of how control exercised by a dominant culture not only shapes the way things are done, but imbues them with the aura of the 'normal' - they become the automatic 'default' position for the way things are done - which then drives the ways services are designed and delivered: "Settler health institutions are designed for settlers". Addressing, and freeing up the automatic nature of this dominance, would require institutions - a health service or a university faculty - to take stock of which of their processes side-line Indigenous knowledge or experience, or constrains an active role for Indigenous perspectives.

Students need strategies to minimise power differentials in their own health encounters - such as self-reflective practice - along with the means to deal successfully with oppressive clinical or organisational hierarchies. Taking such charged material on board requires ways with which to examine things that may have never been questioned before. This suggests a powerfully-useful role for building both student and institutional criticality (explored further in Point H, below). Criticality can engender discomfort, at least initially, and discomfort can produce resistance. It is important, then, for institutions to be fully live up to their oft-stated goals of being socially-accountable. Thus, a truly-comprehensive model would incorporate modes to successfully address institutional resistance, recognising that institutional change requires "deep change".

E. Cultural competence, like all models, needs to evolve so we can attain the health outcomes we desire

Forum discussion on cultural humility, which was developed in contra-distinction to cultural competence, noted that "We [all] made a contribution - at a particular time in history - that was useful." We now need to come to some place that works for all of us. It was additionally noted that it's "all about the dialogue ... we shouldn't get bogged down by definitions, but rather expand. It's important not to be trapped by the terminology, but instead keep the conversation going." There was a recognition that many of the ways that we've been developing cultural knowledge are not working. For example, a simplistic, piece-meal, cultural 'voyeurism' is not cultural competence. Neither is cultural awareness about how much content you know. Succinctly put, we have "only whispers of understanding about others".

If the question is 'does a health professional need to know about *self* or *other*', the answer is '*both*!' There is no place, however, for the anthropologist's gaze: it's not about 'knowing the native'. Simplistic models of cultural competence have been criticised as lacking flexibility, sometimes leading to a 'check-list' approach to interacting with a person from another culture. More sophisticated versions avoid this patient-stereotyping pitfall by acknowledging that we are *all* culture 'bearers'. There are strong calls to build cultural competency into the processes of all university faculties. Whichever model is utilised would need to embed practitioner listening and critical reflection into its schema, in the service of de-colonising the academic environment and avoiding culturally-unsafe interactions.

F. "Could you just listen?" Listening, hearing - then responding to what is heard - as a crucial, 'common ground' dimension: resonance with Indigenous notions of 'deep listening'

As with models that fore-ground cultural safety, a major contribution of cultural humility is recognition of the pre-eminence of the individual patient's desires, or that of their community. Both practitioner and organisation need to hear, then heed, how people wish others to understand their identity. Similarly, there needs to be an ability to pick up on how they would prefer services to be structured and delivered, that: 'We get to say: who we are and what we want'. For these models, the community member also guides the individual health professional in not only how their narrative unfolds but, also, their treatment preferences. This can be simply expressed as: "Listen as if the speaker is wise".

If, then, there is something that needs to be done about a wrong, it is not enough to simply acknowledge the wrong. There are strong resonances here with Indigenous notions of 'deep listening'. In Australia, though going by particular

names in different language groups - such as Dadirri, Ngara, or Kungun - this is a widespread mode of respectful, attentive listening, combined with real-time reflection, that importantly also includes an *obligation to act* on what has been gleaned.

G. “When your belly hurts, that’s the process of self-reflection.”

Life-long, self-reflective practice is a key to ‘knowing self’, rather than (presuming) to know the ‘other’. Critical self-reflection is a core strategy for minimising barriers to practitioner understanding and maximising communication and engagement. It is, however, not necessarily a comfortable process - particularly at the outset. In educational settings the deliberate creation of a ‘safe’ classroom, for *all* - or its on-line equivalent - is vital. When allied with comprehensive moves to create a culturally-safe environment within a faculty or organisation, this supports a necessary ‘un-learning’. It assists students or professional development participants to disassemble some of the planks of their existing learning that may actually hamper their practice. Self-reflection also ‘interrupts’ racism.

H. “We fail our medical students if we don’t help them become critical in their approach.” The persistence of colonial narratives, student and health practitioner stereotyping, and racism in the delivery of health care, all call for a workforce that thinks critically.

Teaching experience suggests that students of the health professions can fail to see Indigenous people as fully human. The elements of their training that would assist them to attain a de-colonised world-view - one where Indigenous people and culture were valued - are, however, often viewed as peripheral to ‘real’ clinical work. Yet a medical degree, for example, that doesn’t include core elements of criticality and medical humanities, risks the tag of a medical ‘technician’s’ degree. Students, also, may be so anxious about attaining clinical competence, that it dominates their view of what is important to learn. Along with the ‘right/wrong’ styles of assessment required in some parts of their courses, this can lead to a ‘concrete’ thinking that is uncomfortable with ‘not knowing’. Finding the ‘common ground’ of good practice for such a dimension, then, would involve the explicit teaching of critical thinking, with particular focus on the areas of:

- de-colonising our taken-for-granted thinking;
- de-constructing our unchallenged stereotypes; and
- working through racism’s impact on health, on health service engagement, on treatment adherence, and on systemic failure to follow proper procedure.

Attaining workforce criticality would greatly assist the creation of culturally-safe environments that allow effective treatment, or a healing practice, to occur

I. Reciprocal relationships are a key

“Relationships are built over time ... they have to be conscious”. There are potent, international examples of health services, including hospitals, needing to rebuild community trust. Trust may have dissolved as a consequence of a range of historical and contemporary practices. One of the most internationally-potent of these has been through either inappropriate compliance with, or misapplication of, child-removal policies. Mechanisms that develop, then maintain, on-going trusting relationships in the service of better health outcomes are our final, central ‘common ground’ dimension. In some Indigenous Australian contexts, genuine relationships have been succinctly described as centring on the ‘Three Rs’: Respect, Responsibility, and Reciprocity. In the next section, under, we introduce a number of Indigenous notions that can serve a genuine, organic development of such relationships. They include *Kanyini*, *Ngapartji Ngapartji* and *Ganma*.

Section Two

Contexts relevant to effecting change in both educational and health care settings

Effecting change requires a comprehensive re-think of what could be characterised as an uncritical approach to organisational 'business as usual'. Influential writers on the principles underlying success in developing culturally-safe practitioners, Kerry Taylor and Pauline Guerin, exhort us to be "regard-ful" (not regardless) of the unique health care context involved (Taylor and Guerin, 2016). Other authors expand these concerns to include developing a nuanced understanding of subtle constraints in educational settings, including: *curricula* (the existence of informal and 'hidden' curriculum, as well as the better-recognised formal curricula), *pedagogy* (the need to develop approaches that account for student, and staff, resistance); and *organisational processes* (the existence and effect of 'gate-keeping') (Gabb and McDermott, 2008; Paul, Ewen and Jones, 2014; Sjoberg and McDermott, 2016).

1. Recognise the breadth and depth of Indigenous health inequities - and act on them

The 2015 Finding Common Ground Forum noted that given there was "very little evidence that one model provides better outcomes, more so than another, what is important might be to focus, rather, on what contributes to health inequalities." A major question for teaching practice then becomes: 'What processes are driving disparities between health outcomes that are both unfair and avoidable - outcomes termed health inequities?' There is a real need for health professional training courses to both acknowledge, and incorporate into teaching, any determinants of health of specific relevance to Aboriginal and Torres Strait Islander health, or African-American health, or other population-level groupings. This is a separate, though practice-related, task to developing the self-knowledge and modes of working that may lead to a higher level of (say) culturally-safe practice. A comprehensive understanding of the social determinants in relation to health equity may well provide an essential, prior frame within which other elements of good practice can develop.

2. Racism and health

Medicine and health always sees itself as benevolent and caring for people. It's not true for many Indigenous people, it's a violent encounter. (Lavallee, 2017)

A genuine engagement with Indigenous health issues challenges students of the health professions and practitioners alike. When participants in Indigenous health education analyse racism as a social determinant of health, the challenge deepens. The experience can range from disquieting to profoundly disturbing. For educators, the experience can be stressful, even daunting.

Analysing racism, though, is not an optional extra, given that there is a nationally mandated objective of training health professionals to work effectively with Aboriginal and Torres Strait Islander Australians. A solid grounding is needed in the health consequences of racism and an appreciation of the widespread, systemic discrimination that exists. This includes understanding how the resultant inequitable access to services, patient non-compliance, "taking own leave" from hospital and ineffective health promotion compromise Indigenous health outcomes (McDermott, 2012).

The literature provides solid evidence that racism is a noteworthy determinant and driver of inequities in health. Several meta-analyses have shown many effects on mental health and over 100 studies from the past 15 years address the increasingly recognised physiological consequences for the person targeted with racism, including cortisol dysregulation. Racism is not only an everyday occurrence for many Indigenous Australians, but also one that gets under the skin, and "makes us sick". (McDermott, 2012)

In brief, Aboriginal and Torres Strait Islander Australians face a number of racialised modes and experiences:

- 'Everyday Racism' - Some 97 per cent of recently surveyed Aboriginal Victorians had experienced racism in the previous 12 months. (Szoke, 2012)
- Structural/Institutional Racism- *Aboriginal people admitted to hospital are much less likely to get a procedure for that condition than non-Aboriginal people in Australia.* (Australian Institute of Health and Welfare, 2014)

- Unconscious/Implicit Bias - Evidence of the damaging physiological, as well as psychological, health impacts of overtly racist and discriminatory practices are slowly forcing change in Indigenous health policy and health professional training. Less-discernible and, unsurprisingly, less-addressed are the range of ways in which 'business as usual' in healthcare translates into Aboriginal and Torres Strait Islander Australians receiving fewer interventions in hospital than their presenting diagnoses call for: just one aspect of 'institutional' or 'structural racism'.

Of all such issues that require a rethink of health care practice and health practitioner education, a particular 'sleeper' issue is the harm arising from 'unconscious', or 'implicit', bias. Stereotypical beliefs can override good clinical decision-making, with resultant poor treatment outcomes, avoidable injury, even death. Yet, how do you change practices that clinicians may not even be fully aware of? And how do you assist students to work through material that can profoundly challenge them?

This fellowship's seminar/webinar of August 2028, on 'Outing' Unconscious Bias, suggests that unconscious bias may not be fixed, but can be "malleable". The task is not easy, though: in Canada, the Indigenous patient is described as entering the health system only in stereotype. Suggested strategies relevant to all three countries from which the presenters were drawn included:

- Working towards a race-critical agenda, one that recognised realness of race and racism, and found ways to make the brutality of unconscious bias explicit.
- This would involve developing the racial literacies of health students and a moving beyond one's own emotion, intentions, or virtue.
- It would also involve developing intellectual and other environments for change.

3. Our duty of care: professionals and stewardship

In Port Hedland, in the north of Western Australia, an Aboriginal woman (since known as) Ms Dhu died on 4 August 2014 (after three days in police lock-up) from staphylococcal septicaemia - a severe bacterial infection - and pneumonia, which were complicated by a previously obtained rib fracture. Ms Dhu's medical care in one instance was deemed "deficient" and both police and hospital staff were influenced by preconceived notions about Aboriginal people.

CCTV footage showed Ms Dhu moaning from pain, saying it was ten out of ten.

An emergency doctor considered her pain real, but exaggerated for "behavioural gain". Another doctor also noted Ms Dhu suffered from "behavioural issues" while a constable thought she was "faking" her suffering

Ms Dhu's aunty, Vanessa Brockman, said:

Everybody seems to forget that the hospital and the Dept of Justice are responsible for what happened. She was taken to the hospital three times, three times, and they sent her home. They breached their duty of care ... they've done it now and they'll do it again.

Embracing Indigenous notions of an 'interconnectedness-of-all-things' can lead, in turn, towards not just an expectation of interpersonal responsibility - a professional seriousness to 'duty of care' - but also an intra-society responsibility (Kanyini), along with a disposition for stewardship.

4. Building on Indigenous foundations: Embedding Indigenous knowledge, values and processes

Apart from pan-Indigenous and African-American scholarship on cultural safety/humility/competence, this fellowship drew, specifically, on core Indigenous Australian epistemologies - ways of knowing, being and doing - that offered concepts and approaches applied and honed over millennia for contextual problem-resolution. Such concepts included: *dadirri* (deep listening); *seeing 'two-ways'* (considering both sides simultaneously); *kanyini* (the principle of interconnectedness, activated through stewardship and responsibility); *ngapartji ngapartji* (reciprocity); and *gamma* (the potential for new knowledge arising from the intersection of western ['saltwater'] knowledge and Indigenous ['freshwater'] knowledge).



Aboriginal Elders Uncle Lewis Yerloburka O'Brien (Kurna) and Aunty Miriam-Rose Ungunmerr-Bauman (Malak Malak), who have, respectively, introduced non-Indigenous Australia to notions of Dadirri and Seeing-two-ways ('Doublies')

A further teasing-out of pragmatic strategies that not only simply enabled, but also facilitated, a 'wrap around' commitment - a student engagement that could yet persist through the dissonance of encountering the (profoundly-disturbing) 'new' - encouraged the introduction of a Western-Desert (north of Western Australia) notion of Kanyirninpa, or 'holding'. This is one manifestation of a widespread Aboriginal mechanism to assist difficult or threatening transitions, such as the passage into adulthood. 'Holding' students through a necessary, but challenging, transition is an educational duty-of-care that models the duty-of-care of the later, culturally-safe, health professional. Through the development of relationship and trust, of 'safe' educational spaces, resistance is lessened, disengagement is minimised and disquiet rendered manageable.

Consider, then, whether elements of such approaches, honed over millennia, might assist a student, or practicing health professional's, better grasp of curricula they may find challenging, as well as aiding their progress towards practicing with criticality and cultural safety.

Dadirri (Deep Listening)

An inner, deep listening and quiet, still awareness ... something like what you call contemplation (Ungunmerr-Baumann, 1988)

Deep Listening is more than western notions of 'active' listening. It is the more-comprehensively articulated manifestation (to western audiences) of a widespread Aboriginal mode of positively-structuring interpersonal communication so that authenticity, comprehension and validation are all privileged - a 'deep listening'. It evokes poly-attentiveness - to what's being said, and not-said - with simultaneous reflection on what's being proffered, or gleaned, leading to a listener responsibility to take up, and potentially act upon (if needed), the information so-gained. Under different names, in varied Aboriginal nations, it yet shows a remarkable consistency of purpose and application. In Pitjantjatjara/Yankunytjatjara, in Central Australia, the verb to listen to, *kulini*, also implies 'to heed'. At the bottom of the continent, the Ngarrindjeri word, *kungun*, means 'to respectfully listen'. On the east coast, in the Eora language of the Sydney region, the verb, *ngara*, carries the sense of listening that involves simultaneous reflection - and obligation to act. In the Kurna language of the Adelaide plains, listening emerges as a self-immersion in what is being proffered -- a search for the import of the communication -- with the verb, *yurringarnendi*, translating as 'inquiring with the ears'. Deep listening, a process with a strong resonance with mindfulness, is a 'performative epistemology' across the breadth of Aboriginal Australia that is capable of adding a dimension of purposeful, person- and perspective-inclusive, cooperative activity towards mutually-important goals - a crucial activity for arriving at the kinds of research outcomes that both extend academic knowledge of the social determinants of health equity and offer realisable application in policy and programmes.

Dadirri - Listening with your ears and heart (Atkinson, 2002)

'Doubles' (Seeing 'two-ways' - considering both sides simultaneously)

The most profound philosophy I learnt from our people is this idea of seeing the world differently - in two ways. What about the hidden story? You need to ask: Have you looked around the mountain? What's on the other side? What's beneath the story? What's between the lines? What else can you gather? (Yerloburka O'Brien, 2011)

It has obvious parallels to western modes of critical inquiry, but adds the element of seeing utility in holding disparate, even contradictory, views at the same time. Yunkaporta makes use of the similar principle under the name of Dwongtjen, a Yaidtmidtung word from the Snowy Mountains, one he describes as:

[R]eferring to the pluralistic ability to hold multiple world-views. (Yunkaporta, 2009, p vii)

The interface is a complex and often contradictory domain, a space in which oppositional thinking must be acknowledged alongside calls for a non-oppositional paradigm (Yunkaporta, 2009, p55)

Kanyini (the principle of interconnectedness), activated through stewardship and responsibility

Stewardship implies a conscious, and conscientious, embrace of responsibility for pro-actively fostering national health and well-being.

Ngapartji ngapartji (reciprocity)

Ngapartji Ngapartji ... turn in turn. Not one / listen to one ... that's why we got to do it together - Ngapartji Ngapartji. (Togni, Heffernan, Nangala, Bonney (2017)

Ngapartji Ngapartji is the Pitjantjatjara term for a core value of Aboriginal and Torres Strait Islander nations that involves an expectation of a, many-faceted, interpersonal reciprocity - one linked to the spiritual reciprocity seen in the obligation for stewardship of the land.

Ganma

The Yolgnu concept of Ganma also notes the potential for new, mutually-beneficial, knowledge from the confluence of western ('saltwater') knowledge and Indigenous ('freshwater') knowledge:

In coming together, the streams of water mix across the interface of the two currents and foam is created. This foam represents a new kind of knowledge. The forces of the stream combine and lead to deeper understanding and truth (Laycock et al, 2011 p50)



As with 'deep listening' and 'yarning' as research methodologies, Ganma's 'foam' can allow 'what we don't know we don't know' (to paraphrase Donald Rumsfeld) to emerge:

In order to hear the quiet sounds of foam, one needs to listen with one's heart, "to be aware of the experiencing not just the experiences" (Kelly, 2008. p90 - after Yunggirringa & Garnngulkpuy, 2007)

Section Three - *In the classroom / building the curriculum / refining pedagogy*

1. Creating a safe space

“Why don’t we just give them all guns, so they can shoot themselves?”

Many non-Indigenous people find studying Indigenous health a confronting experience. The incorporation of history and racism as significant social determinants requires exposure to unsettling ways of looking at Australian society. Given the long-existent paucity of education about Indigenous Australia and the thin apprehension of the concept of a shared national history in our primary and secondary schools, many come to a tertiary institution with not only little knowledge, but also a mindset mired in myth and misinformation.

Once at university, some students are silenced in class by the fear of sounding ignorant or causing offence, perhaps inhabiting a space of hypervigilance (Rasmussen, Willingham & Trinh 1996), or paralysis, that is not conducive to learning. At Flinders University, many non-Indigenous students have reported in their evaluations of their topics (subjects within their health professions courses) that they appreciated a space within which they could participate in discussions about sensitive issues and, yet, experience a measured response from fellow students and tutors or lecturers; one that ensured a safe learning environment free from judgement. In Section 1.2, ‘Why do we need a guide?’, four groups were identified, who each exhibited a different emotional response to Indigenous health and cultural safety curricula. The third of these groupings, described as ‘Disturbed/Flummoxed’, often evidenced dissonance - arising from the new information - and, commonly, a subsequent airing of a sense of betrayal - from being let down by the old sources of information. The unsettling emotions reported could manifest as negative class comments. A ‘safe’ classroom was noted to be even more under threat from the final group, dubbed ‘Hostile/Rejecting’. Along with the anger and class disruptiveness, noted in Section 1.2 as, often, being evidenced by members of this cohort, at times this spilled over into overt racist commentary or behaviour (McDermott 2016). Perhaps the most graphic of this group’s comments was, “Why don’t we just give them all guns, so they can shoot themselves?”.

When teaching a group of health profession students, one may not expect to hear such a comment-one, perhaps, more likely to be aired in a front bar, rather than a tutorial setting. Yet, this comment was proffered in response to a discussion concerning the social determinants of Indigenous health. Such a comment is commensurate with colonial, discursive practice evidencing a genocidal flavour (Said 1978; Spurr 1993). The tutor, in this instance, was shocked and unsure of how to progress with a student’s contribution that was not only non-academic and unprofessional, but quite disturbing. Whilst debriefing and supporting the tutor, supervisors and/or mentors were compelled to consider ongoing discussions about alternate pedagogies and the development of curricula focussed on Indigenous health education.

We argue that tutors must be supported to cope with overt racism, as well as ‘common sense’ racism (Hollinsworth 1998), utilising teaching strategies that facilitate an unpacking of these types of comments, so as to comprehend how a racialised framework might present itself in the tutorial setting. Extreme comments, such as the one under discussion, are an indicator of a level of negative socialisation that persists regarding Indigenous peoples and one which educators need to facilitate the critical analysis of, in order to genuinely assist health profession students to make the transition into culturally safe health practitioners.

In a topic or subject that first exposes students to the principles of cultural safety, a ‘culturally violent’ response is not uncommon. To name offending, ignorant comments as ‘culturally violent’, however, is going to make tutorial discussion strained and unproductive. To avoid combative or ineffective interaction, we train tutors to deal with racist and problematic student responses in a manner that maintains student engagement, and cares for the student struggling in a confronting space, whilst still promoting learning. Developing teaching strategies that specifically target racialised, belligerent or ignorant attitudes is a challenging and exciting field, and one that requires reflective practice from educators and students alike.

One method employed is to start the semester with an ‘anonymous question’ session, so that students are able to ask questions about Indigenous Australia in a non-threatening environment. It is essential that facilitators or tutors foster a ‘safe room’ for a discussion that may be highly charged with emotion, misinformation, fear and confusion, and which can easily become counterproductive, if the tutor is not well versed in guiding students on a non-combative journey

of learning. An approach that confronts students with difficult material, yet lacks a manageable pathway for learning, is more likely to cement entrenched misinformation than to develop or enhance criticality.

Providing a 'safe room' models the principles of cultural safety. Students often ask questions in the initial, anonymous forum that they may not feel comfortable asking publicly. Instead of answering all of the questions, the tutor can proffer some of them for group discussion, not immediately, but throughout the semester, so as to provide an opportunity for the discussion to coalesce with the weekly module or issue. It is during these discussions that the tutor can introduce the students to how a 'culturally safe' (Papps & Ramsden 1996) approach might materialise.

A carefully facilitated approach - one that closely monitors the emotional tenor of the teaching environment, whether online or face-to-face - is crucial, so as not to overwhelm students with input that is difficult to digest. Much of the evidence about historical and contemporary injustices, and the consequences for Indigenous health outcomes, is incommensurate with what might be considered 'common knowledge', which, in turn, is heavily influenced by structured 'white' or 'settler' privilege, and reinforced by a robust culture of denial that pervades Australian institutions, the media and, in turn, our student cohorts (Hage, 1998; McDermott 2004; Ziersch et al 2011).

Teaching strategies that are informed by Indigenous knowledge systems, together with authors such as Fanon (1968), Foucault (1985), Freire (1972), Said (1988) and Moreton-Robinson (2004), give students an opportunity to consider power and its construction of knowledge and 'truths', whilst introducing concepts such as 'structured white privilege' and 'the other'. Comparative studies of patterns of power abuse and its effects on the powerless also canvass the experience of many countries, informing the students of global issues, rather than supporting any perception of a simple focus on Australia as a 'rogue nation'. It is not enough to identify 'whiteness' and its impact on continuing Indigenous disadvantage if we do not handle the fallout of receiving such unsettling perspectives of Australian society.

'Introducing the invisible' is always a shock and the presenter must expect and manage the resultant surprise (Sjoberg, Guerin & McDermott, 2011).

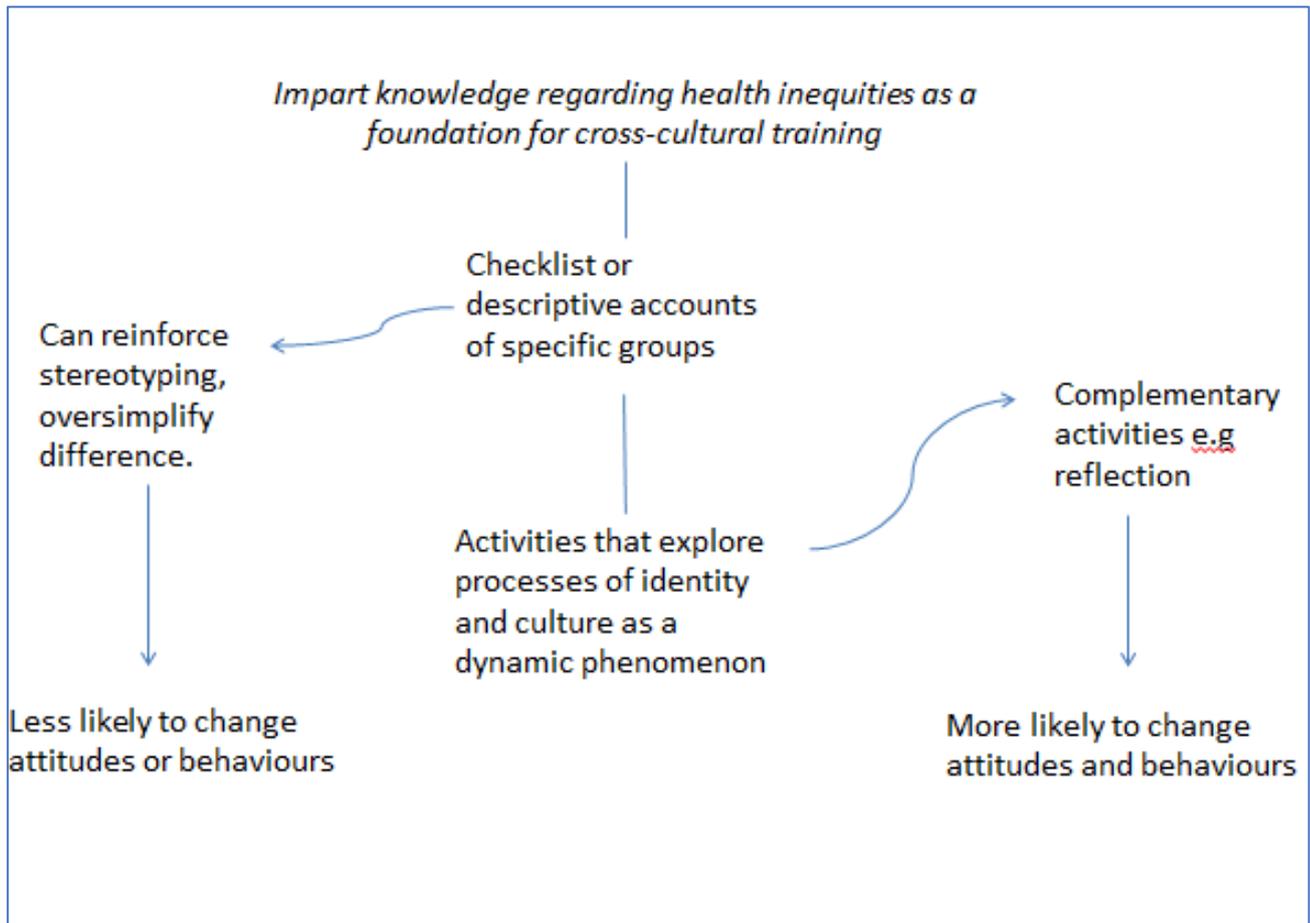
2. Invoking empathy

While the literature finds a role for invoking empathy, some authors, such as Wear and Aultman (2005) raise questions about the efficacy of reflective exercises, usually on narratives, in generalising to other experiences - does the empathetic response "follow them out of the classroom door?" Whilst a student may empathise with an individual character or person it may not lead to reflection on the broader structural issues or their role in these. These authors also found many students were unable or unwilling to engage critically with a selected text that drew on oppression. They drew on Boler's 'pedagogy of discomfort' (1999) to suggest there is a need to move beyond passive empathy, sympathetically connecting with another, to understanding one's social position and power which implicates oneself in the issues raised in the text. This would suggest a role for critical reflection and challenging of beliefs in the curriculum.

3. Dealing with culture

Australia has a decades-long history of deploying cultural awareness training as a major Indigenous health training modality. Sometimes this has been locally-specific, but often it has taken the form of either an amalgam of 'helpful' hints - such as "Always avoid eye-contact" - or a generic, catch-all form. However, neither the provision of cultural knowledge, nor exposure to other cultural groups does not necessarily directly facilitate culturally competent care. It is in combination with strategies that encourage reflexivity that positive outcomes are more likely (Durey 2010). The number, type and duration of cultural encounters may mediate the effectiveness of this mechanism with a risk that generalisations may be made from a small number of encounters (Campinha-Bacote 2002). Pedersen, Walker et al (2005) warn that while positive results of inter-group contact to decrease racism have been documented, intergroup contact alone may do more harm than good.

Figure Three



One large scale program reported the importance of providing a diversity of speakers to challenge commonly held stereotypes of Aboriginal people and the success of engaging large numbers of Aboriginal tutors providing students with “the opportunity to meet professional Aboriginal people (Kickett, Hoffman et al 2014).” The lack of diversity in the medical workplace overall means the majority demographic comprise the majority of role models and exert significant influence on the broader school context and culture (Paul, Ewen et al 2014).

4. Learning to listen

Our expert informants interviewed for the set of video resources constantly returned to the skill of listening, Aboriginal way - deep listening as a foundational attribute of good practice. They reinforced, though, the lessons of deep listening as more than western approaches - expecting, and respecting, silence was an important element. Listening was verbal and non-verbal. Listening, then hearing what was trying to be conveyed, carried an obligation, that:

Listening requires something of you ... you need to complete the circle. Hearing should lead to action.

One presenter noted that an ability to listen was the key factor arising from research into what kept doctors, in their jurisdiction, still practising a in a rural location a decade later.

5. Building critical reflection: deconstruction as a decolonising strategy

What Happens when We Employ ‘Deconstruction’ as a Strategy-and Why?

The deconstruction exercise shifts the direction of the ‘white gaze’ so that the focus is no longer the ‘colonised other’ (Fanon 1968; Said 1978). The analytical focus is redirected to the process of colonisation; the reflective focus is now the health practitioner themselves:

The transcultural paradigm is the ‘equation’ formed when individuals of different cultures interact... Transcultural teaching for health professionals requires that the study of ‘clients in the fishbowl’ should be abandoned, as in that model there is no account taken of the culture and values of the clinician, who forms part of the clinical equation. (Gabb & McDermott 2008, pp69 & 78)

Employing deconstruction as a pedagogical approach innovatively harnesses an Indigenous-generated strategy, designed to maintain engagement of non-Indigenous discussants within a race relations discussion, in the service of enhancing the critical thinking of students of Indigenous health. It offers particular utility with regard to decolonising students' cognitive processes and, in turn, their practice; a key prerequisite of culturally safe health care (NACCHO 2011). This assessment exercise at the heart of the strategy utilises questions about Indigenous Australia from students of varied health professions. The questions are then deconstructed in a manner that foregrounds the role of language in simultaneously perpetuating stereotypes and masking the racialised assumptions that underpin particular questions (Taylor 2011). Discussions about prejudice and privilege often expose 'white fragility' (Bond 2015; DiAngelo 2011). This approach gives an opportunity for productive, sustained educator-student engagement within what, otherwise, might be a highly charged, unproductive discussion. Through a closely facilitated disruption of common default positions, it allows an apprehension of challenging material to proceed in the face of both a potential cognitive dissonance and emotional disquiet. It sets the conditions for a move into critical reflection and addresses some of the 'hard conversations' (McDermott 2016) that Australia must have.

In particular, this exercise responds to "the critical and pressing need to develop race scholarship within health" (Bond 2015). Our method highlights the pedagogical process by which the *very question* becomes the focus, rather than any attempt at an answer. Students are actively requested to *not* answer the question and are supported in learning appropriate mechanisms to interrogate the question itself. Students critique the worldviews, philosophical positions and assumptions inherent in the question. Analysis of the question itself must build a cogent argument that examines the position from which the question was asked. In order to start the journey toward cultural safety, it is essential to equip students with an analytical tool that enables the unpacking of deeply ingrained, racialised understandings of Australian society. The pragmatic nature of this exercise is designed with the knowledge that many non-Indigenous peoples are unaware of the privilege they hold-as 'settlers' in a colonised land-and often resist attempts to reveal it.

6. Decolonising educational institutions and health care organisations

Taking a process of organisational or institutional decolonisation as a serious, and worthy, endeavour adds a deeper dimensionality to the work of cultural safety described thus far. The changes are even less-obvious and require a deep, nuanced understanding of, not only, the devaluing of Indigenous culture, knowledge and ways resulting from colonisation, but an appreciation of the consequences for the content of academic courses, the relevance of university processes and the retention of Indigenous students and staff. In 2015, Universities Canada recognised the need to exhaustively decolonise the academy in a comprehensive way. Amongst other benefits of creating a more culturally-safe and supportive institution, it noted that embracing a fuller Indigenisation agenda is a crucial facilitator of Indigenous student retention and completion (Universities Canada, 2015).

Indigenous perspectives talk, also, of the benefit of addressing an underlying context enabling racism and bias: it notes the potential to shift the academy's assumptions and givens by decolonising the university and its processes.

7. Evaluating our practice

A sustaining of good practice, over time, within any teaching institution requires a well-articulated and enacted commitment to on-going research and evaluation. Both are needed to inform and refresh programme development, as well as to contribute to the collaborative knowledge base regarding Indigenous health and cultural safety training.

Section Four - Building the scaffold / setting the stage / organisational change

1. Organisational readiness/support

Educators wishing to bring about change would benefit from a systematic plan to evidence the need for change, then co-create - with institutional-wide representation - an agreement with specific, but whole-of organization, measures. Many educational or health organisations are particularly reluctant to take on issues of overt and systemic racism. Non-Indigenous health professional disbelief/dismissal of racism and its impact. Even health professionals who see themselves as non-racist can resist the role of 'white privilege' / 'settler privilege'.

A scaffold for real change would have collegial, potentially-challenging, but non-blaming/non-shaming modes to ensure real group engagement with the substantive issues built-in. Sophisticated strategies and experienced facilities are essential.

Developing organisation-specific ways to bring Indigenous perspectives on racism and cultural safety from the periphery to the centre are key. The noted scholar of cultural humility, Dr Melanie Tervalon, suggests that a necessary step is to embed measures of cultural humility / cultural safety into organisational core business:

Part of the success ... at Children's Hospital (Oakland) had to do with the fact that it was simultaneously an education program and ... an organising effort ... and so [we] were clear that in order for the program to be successful it had to be embedded in the institution and that wasn't simply going to happen by us asking ... but that we had to think of the ways in which transformation would occur within the relationships in the institution so that it would become part of what was important for the institution to hold on to. (Tervalon, 2017)

2. Leadership

Early, possible initial, Indigenous cultural safety training for institutional leaders and line managers is required before other change measures can take hold. To ensure that, potentially-difficult, change is seen as real, happening and authorised, it is critical that senior management undergo effective training. There is a need for both top-down understanding and bottom-up good practice.

The imprimatur of senior management is essential to successfully facilitating the necessary 'hard conversations' for educational or health organisational change in the service of developing culturally-safe health professionals, services and programmes. It also maximises the likelihood of building or retaining critical funding mass and capacity - particularly if overall funding is contested, or shrinks.

3. Well-Being and resilience of educators

Hard-won experience in both Australia and Canada point to a central need - to ensure both the sustainable delivery of Indigenous health and cultural safety training over time, as well as the retention and continued well-being of the educators involved - is to recognise the 'emotional labour' involved in this work. Student resistance, staff isolation, collegial denial of the effects of colonisation - or contemporary manifestations of racism and structural discrimination - the effects of the 'hidden' curriculum, constraints on curriculum time or comprehensiveness, under-resourcing, all combine to create the potential for staff-overload. Comprehensive, centrally-mandated measures to support Indigenous health and cultural safety teaching staff are essential for not only the continuity of their careers, but also that of the teaching programme.

4. Partnerships and networks

The barriers thrown up by institutional resistance, manifesting as gatekeeping, marginalisation or underfunding, may require organisational change mandated by standards. (Lavery, McDermott and Calma, 2017)

Individual course or departmental change is vulnerable to marginalisation or 'gate-keeping'. An organic movement from scholarly or disciplinary collaboration into wider-based partnerships of enhanced potency is one measure to maximise the likelihood of embedding real change over the long-course. In the Indigenous health policy literature it has been posited that one way in which aspects of Indigenous-preferred approaches deemed controversial by key policy actors within the bureaucracy - including culture, the social determinants of health and racism - were

successfully included in a landmark national Indigenous policy remake, was that the cohort pushing for change was adjudged sufficiently credible and authoritative to established a 'claim to a hearing', in the sense used by policy scholar John Kingdon (Battams et al, 2018).

Establishing such committed partnerships and networks, then harnessing their power - not just for disciplinary and institutional change, but also in the service of sectoral transformation - may be a necessary, final step in ensuring the 'hard conversations' are had beyond the academy, wherever structural, policy and discourse barriers threaten effective, culturally-safe Indigenous health care delivery, or health promotion. One mechanism of change would be to ensure partnerships or networks develop the capacity and potency to shape the standards to which disciplinary, educational and health care bodies must be accountable - to embed cultural safety within quality assurance requirements.

As Lavery, McDermott and Calma note:

Cultural safety requires embedding in not only course accreditation for each health profession -including measures to reduce resistance-but also in the standards governing clinical professionalism and quality, such as the Royal Australian College of General Practitioners Standards for general practices, 19 and the Australian Commission on Safety and Quality in Health Care National safety and quality health service standards.

Such commitment will need investment in clinician education and professional development, together with measures for accountability. [We need partnerships and networks] to formally collaborate on a systematic revision of standards to embed culturally safe practice and develop health settings free of racism.

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